GAVI Alliance

Annual Progress Report 2012

Submitted by

The Government of

Somalia

Reporting on year: **2012**

Requesting for support year: **2014**

Date of submission: **5/21/2013 3:33:24 AM**

Deadline for submission: 9/24/2013

Please submit the APR 2012 using the online platform https://AppsPortal.gavialliance.org/PDExtranet

Enquiries to: apr@gavialliance.org or representatives of a GAVI Alliance partner. The documents can be shared with GAVI Alliance partners, collaborators and general public. The APR and attachments must be submitted in English, French, Spanish, or Russian.

Note: *You are encouraged to use previous APRs and approved Proposals for GAVI support as reference documents. The electronic copy of the previous APRs and approved proposals for GAVI support are available at* http://www.gavialliance.org/country/

The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents will be shared with the GAVI Alliance partners and the general public.

GAVI ALLIANCE
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

The applicant country ("Country") confirms that all funding provided by the GAVI Alliance 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 the GAVI Alliance. All funding decisions for the application are made at the discretion of the GAVI Alliance Board and are subject to the Independent Review Committee (IRC) and its processes and the availability of funds.

AMENDMENT TO THE APPLICATION

The Country will notify the GAVI Alliance in its Annual Progress Report (APR) if it wishes to propose any change to the programme(s) description in its application. The GAVI Alliance will document any change approved by the GAVI Alliance, and the Country's application will be amended.

RETURN OF FUNDS

The Country agrees to reimburse to the GAVI Alliance all funding amounts that are not 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 the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

SUSPENSION/ TERMINATION

The GAVI Alliance 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 programmes described in the Country's application, or any GAVI Alliance-approved amendment to the application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in its application if a misuse of GAVI Alliance funds is confirmed.

ANTICORRUPTION

The Country confirms that funds provided by the GAVI Alliance 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.

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance 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 Alliance 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 Alliance 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 the GAVI Alliance in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the Country confirm that its application, and APR, are accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programmes described in its application, as amended, if applicable, in the APR.

CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and complies with the requirements therein.

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 the GAVI Alliance 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 the GAVI Alliance 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 the GAVI Alliance. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The GAVI Alliance 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.

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

By filling this APR the country will inform GAVI about:

Accomplishments using GAVI resources in the past year

Important problems that were encountered and how the country has tried to overcome them

Meeting accountability needs concerning the use of GAVI disbursed funding and in-country arrangements with development partners

Requesting more funds that had been approved in previous application for ISS/NVS/HSS, but have not yet been released

How GAVI can make the APR more user-friendly while meeting GAVI's principles to be accountable and transparent.

1. Application Specification

Reporting on year: **2012**

Requesting for support year: **2014**

1.1. NVS & INS support

Type of Support	Current Vaccine	Preferred presentation	Active until
Routine New Vaccines Support	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	2015
INS			

DTP-HepB-Hib (Pentavalent) vaccine: Based on current country preferences the vaccine is available through UNICEF in fully liquid 1 and 10 dose vial presentations and in a 2 dose-2 vials liquid/lyophilised formulation, to be used in a three-dose schedule. Other presentations are also WHO pre-qualified, and a full list can be viewed on the WHO website, but availability would need to be confirmed specifically.

1.2. Programme extension

No NVS support eligible to extension this year

1.3. ISS, HSS, CSO support

Type of Support	Reporting fund utilisation in 2012	Request for Approval of	Eligible For 2012 ISS reward
VIG	Yes	N/A	N/A
COS	No	No	N/A
ISS	No	next tranche: N/A	Yes
HSS	Yes	next tranche of HSS Grant Yes	N/A
CSO Type A	No	Not applicable N/A	N/A
CSO Type B	No	CSO Type B extension per GAVI Board Decision in July 2012: N/A	N/A
HSFP	No	N/A	N/A

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2011 is available here.

2. Signatures

2.1. Government Signatures Page for all GAVI Support (ISS, INS, NVS, HSS, CSO)

By signing this page, the Government of Somalia hereby attests the validity of the information provided in the report, including all attachments, annexes, financial statements and/or audit reports. The Government further confirms that vaccines, supplies, and funding were used in accordance with the GAVI Alliance Standard Grant Terms and Conditions as stated in this Annual Progress Report (APR).

For the Government of Somalia

Please note that this APR will not be reviewed or approved by the Independent Review Committee (IRC) without the signatures of both the Minister of Health & Minister Finance or their delegated authority.

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Duale Adam Mohamed, Director General, Directorate of Health, Ministry of Human Development and Public Services, The Federal Government of Somali Republic	**Name**	
Date		**Date**	
Signature		**Signature**	

<u>This report has been compiled by</u> (these persons may be contacted in case the GAVI Secretatiat has queries on this document):

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2.2. ICC signatures page

If the country is reporting on Immunisation Services (ISS), Injection Safety (INS) and/or New and Under-Used Vaccines (NVS) supports

In some countries, HSCC and ICC committees are merged. Please fill-in each section where information is appropriate and upload in the attached documents section the signatures twice, one for HSCC signatures and one for ICC signatures

The GAVI Alliance Transparency and Accountability Policy (TAP) is an integral part of GAVI Alliance monitoring of country performance. By signing this form the ICC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management.

2.2.1. ICC report endorsement

We, the undersigned members of the immunisation Inter-Agency Coordinating Committee (ICC), endorse this report. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

Name/Title	Agency/Organization	Signature	Date

ICC may wish to send informal comments to: apr@gavialliance.org

All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

2.3. HSCC signatures page

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC), HSC , endorse this report on the Health Systems Strengthening Programme. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

The GAVI Alliance Transparency and Accountability Policy is an integral part of GAVI Alliance monitoring of country performance. By signing this form the HSCC members confirm that the funds received from the GAVI Alliance have been used for purposes stated within the approved application and managed in a transparent manner, in accordance with government rules and regulations for financial management. Furthermore, the HSCC confirms that the content of this report has been based upon accurate and verifiable financial reporting.

Name/Title	Agency/Organization	Signature	Date
Marina Madeo, Somali Health Sector Coordinator	Somali Health Sector Committee		

HSCC may wish to send informal comments to: apr@gavialliance.org

All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

2.4. Signatures Page for GAVI Alliance CSO Support (Type A & B)

Somalia is not reporting on CSO (Type A & B) fund utilisation in 2013

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4. Baseline & annual targets

Countries are encouraged to aim for realistic and appropriate wastage rates informed by an analysis of their own wastage data. In the absence of country-specific data, countries may use indicative maximum wastage values as shown on the **Wastage Rate Table** available in the guidelines. Please note the benchmark wastage rate for 10ds pentavalent which is available.

Number	Achievements as per JRF		Targets (preferred presentation)					
	2012		2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2012	Current estimation	Previous estimates in 2012	Current estimation
Total births	369,091	369,093	380,164	380,164	391,569	391,569	403,316	403,316
Total infants' deaths	40,231	39,862	41,438	41,438	42,681	42,681	43,961	43,961
Total surviving infants	328860	329,231	338,726	338,726	348,888	348,888	359,355	359,355
Total pregnant women	369,091	461,366	380,164	380,164	391,569	391,569	403,316	403,316
Number of infants vaccinated (to be vaccinated) with BCG	184,546	137,342	209,090	209,090	234,941	234,941	282,321	282,321
BCG coverage	50 %	37 %	55 %	55 %	60 %	60 %	70 %	70 %
Number of infants vaccinated (to be vaccinated) with OPV3	246,645	154,049	270,981	270,981	296,555	296,555	323,420	323,420
OPV3 coverage	75 %	47 %	80 %	80 %	85 %	85 %	90 %	90 %
Number of infants vaccinated (to be vaccinated) with DTP1	295,974	251,185	311,628	311,628	327,955	327,955	348,574	348,574
Number of infants vaccinated (to be vaccinated) with DTP3	246,645	200,180	270,981	270,981	296,555	296,555	323,420	323,420
DTP3 coverage	75 %	61 %	80 %	80 %	85 %	85 %	90 %	90 %
Wastage[1] rate in base-year and planned thereafter (%) for DTP	0	25	0	0	0	0	0	0
Wastage[1] factor in base-year and planned thereafter for DTP	1.00	1.33	1.00	1.00	1.00	1.00	1.00	1.00
Number of infants vaccinated (to be vaccinated) with 1 dose of DTP-HepB-Hib		0	292,152	292,152	327,955	327,955	348,574	348,574
Number of infants vaccinated (to be vaccinated) with 3 dose of DTP-HepB-Hib		0	292,152	292,152	296,555	296,555	323,420	323,420
DTP-HepB-Hib coverage	0 %	0 %	80 %	86 %	85 %	85 %	90 %	90 %
Wastage[1] rate in base-year and planned thereafter (%) [2]		20	0	25	25	25	20	20
Wastage[1] factor in base-year and planned thereafter (%)		1.25	1.33	1.33	1.33	1.33	1.25	1.25
Maximum wastage rate value for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	25 %	0 %	25 %	25 %	25 %	25 %	25 %	25 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	263,088	161,811	287,917	287,917	313,999	313,999	341,387	341,387
Measles coverage	80 %	49 %	85 %	85 %	90 %	90 %	95 %	95 %
Pregnant women vaccinated with TT+	166,091	238,314	209,090	209,090	254,520	254,520	282,321	282,321

Number	Achievements as per JRF		Targets (preferred presentation)					
	2012		2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2012	Current estimation	Previous estimates in 2012	Current estimation
TT+ coverage	45 %	52 %	55 %	55 %	65 %	65 %	70 %	70 %
Vit A supplement to mothers within 6 weeks from delivery	0	0	0	0	0	0	0	0
Vit A supplement to infants after 6 months	263,088	833,615	287,917	287,917	313,999	313,999	341,387	341,387
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	17 %	20 %	13 %	13 %	10 %	10 %	7 %	7 %

** Number of infants vaccinated out of total surviving infants

*** Indicate total number of children vaccinated with either DTP alone or combined

**** Number of pregnant women vaccinated with TT+ out of total pregnant women

1 The formula to calculate a vaccine wastage rate (in percentage): [(A B) / A] x 100. Whereby: A = the number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period.

2 GAVI would also appreciate feedback from countries on feasibility and interest of selecting and being shipped multiple Pentavalent vaccine presentations (1 dose and 10 dose vials) so as to optimise wastage, coverage and cost.

5. General Programme Management Component

5.1. Updated baseline and annual targets

Note: Fill in the table in section 4 Baseline and Annual Targets before you continue

The numbers for 2012 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2012.** The numbers for 2013 - 2015 in Table 4 Baseline and Annual Targets should be consistent with those that the country provided to GAVI in previous APR or in new application for GAVI support or in cMYP.

In fields below, please provide justification and reasons for those numbers that in this APR are different from the referenced ones:

- Justification for any changes in **births**

  No change

- Justification for any changes in **surviving infants**

  No change

- Justification for any changes in targets by vaccine. **Please note that targets in excess of 10% of previous years' achievements will need to be justified.**

  Due to the prevailing insecurity in south/central parts of the country, targets could not be achieved.

- Justification for any changes in **wastage by vaccine**

  No change in wastage

5.2. Immunisation achievements in 2012

5.2.1. Please comment on the achievements of immunisation programme against targets (as stated in last year APR), the key major activities conducted and the challenges faced in 2012 and how these were addressed:

Program Management

- Implementation of annual plan of the country's cMYP, 2011 – 2015
- Pentavalent introduction preparatory activities planned and implemented
- EPI Units of Somaliland, Puntland and SC zone supported technically and financially.
- Zonal coordination meetings in Somaliland and Puntland supported

Service delivery

- About 300 MCHs were provided with supplies by UNICEF
- Despite continued security and access problems, partners were able to continue routine immunization activities in many areas of the country.

VPD surveillance

- Provided technical, financial and logistics support to measels laboratories in Somaliland, Puntland and Mogadishu
- Refresher training for health workers conducted

Communication

- Conducted annual Vaccination Week in Somaliland, Puntland and Mogadishu
- Conducted communications workshop in Hargeisa and Garowe
- Carried out social mobilization activities in all outreach activities
- Development of communication strategy for immunization (with special emphasis on Pentavalent Vaccine)

5.2.2. If targets were not reached, please comment on reasons for not reaching the targets:

Targets for 2012 were not reached. The main reason was insecurity and inaccessibility of most regions of southern Somalia. In CSZ, only 3 out of 10 regions were accessible, and immunization sessions can only be done at the health facilities. Activities outside the MCH such as outreach or mobile immunization activities, CHDs or others immunization campaigns were not allowed.

An externa EPI review was conducted in Northern Somalia, with the following general findings:

- EPI Management teams of the 3 zones are weak, and have limited management and coordination capacity.
- The national EPI programme has limited to no resources, with no dedicated budget, and it depends entirely on external funding
- Supervision and monitoring is very limited.
- Health personnel are insufficient in term of quantity and quality. Staff morale and commitment is very low due to low and/or delayed salaries.
- The delivery of basic health-care services is poor, particularly with respect to rural and nomadic populations.
- Catchment population is not defined and data management tools are missing at the health facilities, reporting system is weak and there is no system of tracking defaulters.
- Vaccine management capacity is weak at all levels. This leads to frequent stock-outs in many health facilities.
- Demand is low, due to low awareness of mothers and caregivers.

5.3. Monitoring the Implementation of GAVI Gender Policy

5.3.1. At any point in the past five years, were sex-disaggregated data on DTP3 coverage available in your country from administrative data sources and/or surveys? **yes, available**

If yes, please report the latest data available and the year that it is from.

Data Source	Reference Year for Estimate	DTP3 Coverage Estimate	
		Boys	Girls
MICS Somaliland	2011	14%	12.9%

MICS Puntland	2011	9.6%	9.3%

5.3.2. How have any discrepancies in reaching boys versus girls been addressed programmatically?

According to MICS 2011, in Somaliland and Puntland, no discrimination was observed between girls and boys in terms of immunization. Coverage of boys is slightly higher than that of girls, but the difference is not statistically significant.

In Somalia, no discrimination has been observed in terms of immunization services. In all training sessions, vaccinators are instructed to advise parents to present all their children, irrespective of sex, for immunization. Vaccinators are advised to report any such discrimination, if and when they occur.

5.3.3. If no sex-disaggregated data are available at the moment, do you plan in the future to collect sex-disaggregated coverage estimates? **Yes**

5.3.4. How have any gender-related barriers to accessing and delivering immunisation services (eg, mothers not being empowered to access services, the sex of service providers, etc) been addressed programmatically ? (For more information on gender-related barriers, please see GAVI's factsheet on gender and immunisation, which can be found on http://www.gavialliance.org/about/mission/gender/)

With GAVI HSS support and in pilot districts, data will be collected at community level with the support of Female Health Workers. This will help achieve the goal of collection of sex-disaggregated data. In addition to data on routine immunization, the surveillance system collects sex-disaggregated data on EPI related diseases. The community-based Health Management Information System is expected to roll out in 2013.

5.4. Data assessments

5.4.1. Please comment on any discrepancies between immunisation coverage data from different sources (for example, if survey data indicate coverage levels that are different than those measured through the administrative data system, or if the WHO/UNICEF Estimate of National Immunisation Coverage and the official country estimate are different)

Immunization coverage is calculated administratively using data collected from MCHs, and outreach activities such as Child Health Days (CHD) and the Reaching Every Child (RED) approach. Data is collected and transferred to UNICEF by partners through the HMIS system, where coverage is calculated by UNICEF and WHO, and endorsed by local health authorities. These same figures are reported as the Official Estimates for Somalia.

However, there is a discrepancy between administrative data and MICS data. Immunization coverage as reported by MICS is lower than administrative coverage. The discrepancy can be explained by the lack of accuracy of numerator and denominator.

For the numerator, there are a few instances of duplication of routine data and incomplete reporting in some cases. In CSZ, where there is no strong local administration, some NGOs do not report the number of children they vaccinate to the HMIS. This can change the immunization coverage rate upward or downward.

In terms of denominator, the accuracy of UNDP population estimates is a critical issue as the last population census was in 1974. Additionally, the increasing number of districts; the large pastoral and nomadic population; and displacement of population due to drought/famine and civil unrest has made it difficult to determine an accurate denominator.

The current population in certain more stable regions may be higher because of the massive influx of populations from conflict areas, while the population may be lower in areas of conflict because of the displacement of populations to neighboring countries or to other regions.

* Please note that the WHO UNICEF estimates for 2012 will only be available in July 2013 and can have retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2011 to the present? **Yes**

If Yes, please describe the assessment(s) and when they took place.

A comprehensive EPI review was carried out in 2012 in Somaliland. One of the major concerns in regards to the administrative data system is the denominator issue, as the catchment population is not defined. Additionally, data is sent from MCH to the central level at the Ministry of Health without analysis from the base and is therefore not utilized to improve the performance at the operational level.

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2010 to the present.

Following activities have been undertaken to improve data management:

1. Transfer the ownership of HMIS from UNICEF to MOH in stable zones: NWZ Somaliland MOH and NEZ Puntland, through phase-out and tailored capacity building strategy.
2. Assist establishment and provide support, including technical, financial, and institutional support, to MOH National HMIS and regional HMIS units in NWZ and NEZ.
3. Standardization of HMIS tools across three zones, through consultation and coordination through Health Sector, and endorsement by three MOH.
4. Print, supply and distribute the standardized HMIS tools to MOHs and NGOs partner. Provide technical support for the implementation.
5. Support capacity building at all levels, through training, workshop, and field technical support, supervision, and feedback meetings, to strengthen the system and improve the needed capacity at each level.

Major activities conducted below:

a) HMIS tools/standardization training for all public MCH/Hospital health facilities in NEZ PL and NWZ SL, ToTs training for MCH/Hospital health facilities in CSZ.

b) HMIS tools/standardization refresher training for all public MCH/Hospital health facilities in NEZ PL and NWZ SL.

c) HMIS data management, analysis and computer skills training for MOH HMIS officers (national and regional level) in NWZ and NEZ.

d) Data management, analysis and computer skills overseas university short-term training/workshop for NEZ and NWZ MOH national HMIS unit.

e) MSc degree overseas university one year training for NWZ and CSZ MOH.

f) Through GF funding support, sub-contracting NGO CCM-Italy and providing routine technical and managerial support on field implementation.

g) Support (through phase out strategy) MOH conducting supervision and feedback meeting to improve timeliness of reporting, quality of data, and use of HMIS data, with all health facilities in NWZ and NEZ at least receiving two supervision per year.

1. Initiate some integration activities to mainstream the data collection system and avoid duplication.

a) Integrate training/feedback practice with other programme such as PCA management, PENTA introduction ToT training.

b) Adopt/harmonize case definition with CSR surveillance.

c) Cross-verification with surveillance and third party monitoring.

d) Using MOH HMIS unit at national regional level as platform to integrate routine data collection such as VCT/PMTCT data.

1. CSZ move to the similar system starting from the end of 2012, with initial goals to roll out in four accessible regions.
2. Introduce advanced data management skills and database at national level.
3. Health workers have been trained in data collection and EPI data management.

5.4.4. Please describe any plans that are in place, or will be put into place, to make further improvements to administrative data systems.

1) Further training for data management and analysis skills, through sub-contracting technical agency, overseas short term workshop/training.

2) Further promoting using data across organization, from MOH national, regional level, to service deliver level.

3) Focus on CSZ National and Regional HMIS unit establishment, capacity building, and implementation roll out, with further support and collaboration through Health Cluster and MOH (further funding support is needed).

4) Further integration efforts with vertical programme with phased strategy.

5) Ideally, innovation and high technical such as mobile technology shall be used to improve timeliness of reporting. However, there are constraints of supporting due to lack of funds and human resources.

5.5. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.5a** is to guide GAVI understanding of the broad trends in immunisation programme expenditures and financial flows. Please fill the table using US$.

Exchange rate used	1 US$ = 23000	Enter the rate only; Please do not enter local currency name

Table 5.5a: Overall Expenditure and Financing for Immunisation from all sources (Government and donors) in US$

Expenditure by category	Expenditure Year 2012	Source of funding						
		Country	GAVI	UNICEF	WHO	N/A	N/A	N/A
Traditional Vaccines*	1,139,556	0	0	1,139,556	0	0	0	0
New and underused Vaccines**	0	0	0	0	0	0	0	0
Injection supplies (both AD syringes and syringes other than ADs)	127,712	0	0	127,712	0	0	0	0
Cold Chain equipment	221,410	0	0	221,410	0	0	0	0
Personnel	99,360	0	0	41,760	57,600	0	0	0
Other routine recurrent costs	1,513,398	0	0	1,345,400	167,998	0	0	0
Other Capital Costs	0	0	0	0	0	0	0	0
Campaigns costs	4,735,085	0	0	0	4,735,085	0	0	0
N/A		0	0	0	0	0	0	0
Total Expenditures for Immunisation	7,836,521							
Total Government Health		0	0	2,875,838	4,960,683	0	0	0

* Traditional vaccines: BCG, DTP, OPV (or IPV), Measles 1st dose (or the combined MR, MMR), TT. Some countries will also include HepB and Hib vaccines in this row, if these vaccines were introduced without GAVI support.

5.5.1. If there are no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2013 and 2014

In Somalia, the new government is yet to fund immunization activities. So far, there are about 67 immunization partners that are funding immunization activities across CSZ with UNICEF and WHO as the major financers. UNICEF will continue to provide traditional vaccines in 2013 and 2014.

5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2012 calendar year? **No, not implemented at all**

If Yes, briefly describe progress against requirements and conditions which were agreed in any Aide Memoire concluded between GAVI and the country in the table below:

Action plan from Aide Mémoire	Implemented?

If the above table shows the action plan from Aide Memoire has been fully or partially implemented, briefly state exactly what has been implemented

If none has been implemented, briefly state below why those requirements and conditions were not met.

5.7. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2012? **4**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2013 endorsing this report.

List the key concerns or recommendations, if any, made by the ICC on sections 5.1 Updated baseline and annual targets to 5.5 Overall Expenditures and Financing for Immunisation

Two major concers have been discussed all along: population figures and sustaianbility of the prgram, especially the co-financing issue. The new government is yet to financially establish itself; and until then the co-financing issue need to discussed by the HSC.

Are any Civil Society Organisations members of the ICC? **Yes**

If Yes, which ones?

List CSO member organisations:
SRCS/IFRC
WVI
COOPI
Trochair
IMC
IRC
COSV
CISP
INTERSOS
ARD
CAFDARO
GARDO
SWISS Kalmo
HDC

5.8. Priority actions in 2013 to 2014

What are the country's main objectives and priority actions for its EPI programme for 2013 to 2014

Priority Actions for 2013-2014, based on cMYP 2011-2015

1. Introduce Pentavalent vaccine into the routine immunization programme.

2. Re-start immunization services in parts of southern Somalia where services were previously discontinued.

3. Increase routine immunization coverage through the implementation of RED approach.

4. Conduct EVM and improve cold chain and vaccine supply management

5. Develop and implement injection safety policy

6. Contain outbreak of wild polio virus.

7. Conduct communication and advocacy activities

5.9. Progress of transition plan for injection safety

For all countries, please report on progress of transition plan for injection safety
Please report what types of syringes are used and the funding sources of Injection Safety material in 2012

Vaccine	Types of syringe used in 2012 routine EPI	Funding sources of 2012
BCG	0.05 ml	UNICEF
Measles	0.5 ml	UNICEF
TT	0.5 ml	UNICEF
DTP-containing vaccine	0.5 ml	UNICEF
		UNICEF

Does the country have an injection safety policy/plan? **No**
If Yes: Have you encountered any obstacles during the implementation of this injection safety policy/plan?
If No: When will the country develop the injection safety policy/plan? (Please report in box below)

Injection safety policy will be developed in 2014

Please explain in 2012 how sharps waste is being disposed of, problems encountered, etc.

All sharp wastes are collected in safety boxes, and later on incinerated and buried.

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2012

Somalia is not reporting on Immunisation Services Support (ISS) fund utilisation in 2012

6.2. Detailed expenditure of ISS funds during the 2012 calendar year

Somalia is not reporting on Immunisation Services Support (ISS) fund utilisation in 2012

6.3. Request for ISS reward

Calculations of ISS rewards will be carried out by the GAVI Secretariat, based on country eligibility, based on JRF data reported to WHO/UNICEF, taking into account current GAVI policy.

7. New and Under-used Vaccines Support (NVS)

7.1. Receipt of new & under-used vaccines for 2012 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2012 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below

Table 7.1: Vaccines received for 2012 vaccinations against approvals for 2012

	[A]	[B]		
Vaccine type	**Total doses for 2012 in Decision Letter**	**Total doses received by 31 December 2012**	**Total doses of postponed deliveries in 2012**	**Did the country experience any stockouts at any level in 2012?**
DTP-HepB-Hib		0	0	Not selected

**Please also include any deliveries from the previous year received against this Decision Letter*

If values in [A] and [B] are different, specify:

- What are the main problems encountered? (Lower vaccine utilisation than anticipated due to delayed new vaccine introduction or lower coverage? Delay in shipments? Stock-outs? Excessive stocks? Problems with cold chain? Doses discarded because VVM changed colour or because of the expiry date? ...)

- What actions have you taken to improve the vaccine management, e.g. such as adjusting the plan for vaccine shipments? (in the country and with UNICEF Supply Division)

  GAVI would also appreciate feedback from countries on feasibility and interest of selecting and being shipped multiple Pentavalent vaccine presentations (1 dose and 10 dose vials) so as to optimise wastage, coverage and cost.

If **Yes** for any vaccine in **Table 7.1**, please describe the duration, reason and impact of stock-out, including if the stock-out was at the central, regional, district or at lower facility level.

7.2. Introduction of a New Vaccine in 2012

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2012, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
Phased introduction	No	
Nationwide introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	N/A

7.2.2. When is the Post Introduction Evaluation (PIE) planned? **December 2014**

If your country conducted a PIE in the past two years, please attach relevant reports and provide a summary on the status of implementation of the recommendations following the PIE. (Document N° 9))

7.2.3. Adverse Event Following Immunization (AEFI)

Is there a national dedicated vaccine pharmacovigilance capacity? **No**

Is there a national AEFI expert review committee? **No**

Does the country have an institutional development plan for vaccine safety? **No**

Is the country sharing its vaccine safety data with other countries? **No**

Is the country sharing its vaccine safety data with other countries? **No**

Does your country have a risk communication strategy with preparedness plans to address vaccine crises? **No**

7.2.4. Surveillance

Does your country conduct sentinel surveillance for:

a. rotavirus diarrhea? **No**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **No**

Does your country conduct special studies around:

a. rotavirus diarrhea? **No**

b. pediatric bacterial meningitis or pneumococcal or meningococcal disease? **No**

If so, does the National Immunization Technical Advisory Group (NITAG) or the Inter-Agency Coordinating Committee (ICC) regularly review the sentinel surveillance and special studies data to provide recommendations on the data generated and how to further improve data quality? **No**

Do you plan to use these sentinel surveillance and/or special studies data to monitor and evaluate the impact of vaccine introduction and use? **No**

Please describe the results of surveillance/special studies and inputs of the NITAG/ICC:

7.3. New Vaccine Introduction Grant lump sums 2012

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2012 (A)	114,000	2,622,000,000
Remaining funds (carry over) from 2011 (B)	0	0
Total funds available in 2012 (C=A+B)	114,000	2,622,000,000

Total Expenditures in 2012 (D)	114,000	2,622,000,000
Balance carried over to 2013 (E=C-D)	0	0

Detailed expenditure of New Vaccines Introduction Grant funds during the 2012 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2012 calendar year (Document No 10,11) . Terms of reference for this financial statement are available in **Annexe 1** Financial statements should be signed by the Finance Manager of the EPI Program and and the EPI Manager, or by the Permanent Secretary of Ministry of Health

7.3.2. Programmatic Reporting

Please report on major activities that have been undertaken in relation to the introduction of a new vaccine, using the GAVI New Vaccine Introduction Grant

The first tranche of NVI grante (114,000) was received in 2012. The second tranche of US$ 190,000, was released in 2013. The launching of pentavalent vaccines was held on 24 th April 2013 in the whole country. Major activities will be reported next year.

Please describe any problem encountered and solutions in the implementation of the planned activities

The introduction grant was recieved by WHO. But, transferring fund to UNICEF has taken long.

Please describe the activities that will be undertaken with any remaining balance of funds for 2013 onwards

1. Training of health workers on Pentavalent vaccines
2. Launching of Pentavalent vaccines
3. Social mobilization

7.4. Report on country co-financing in 2012

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2012?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
	Q.2: Which were the amounts of funding for country co-financing in reporting year 2012 from the following sources?	
Government		
Donor		
Other		
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
	Q.4: When do you intend to transfer funds for co-financing in 2014 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2014	Source of funding
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	September	JHNP

	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing
	Technical assistance is needed to develop a financial sustainability strategy.

If the country is in default, please describe and explain the steps the country is planning to take to meet its co-financing requirements. For more information, please see the GAVI Alliance Default Policy: http://www.gavialliance.org/about/governance/programme-policies/co-financing/

The country is not in default. But, the Somalia Federal Government requested UNICEF to assist by paying the contribution on its behalf. Joint Health Nutrition Programme (JHNP) funds will be used to cover the co-financing requirements for the first year. In total 291,500 US dollars will be paid by UNICEF to buy 136,500 doses of pentavalent vaccines. This cost includes international freight.

Is support from GAVI, in form of new and under-used vaccines and injection supplies, reported in the national health sector budget? **No**

7.5. Vaccine Management (EVSM/VMA/EVM)

Please note that Effective Vaccine Store Management (EVSM) and Vaccine Management Assessment(VMA) tools have been replaced by an integrated Effective Vaccine Management (EVM) tool. The information on EVM tool can be found at http://www.who.int/immunization_delivery/systems_policy/logistics/en/index6.html

It is mandatory for the countries to conduct an EVM prior to an application for introduction of a new vaccine. This assessment concludes with an Improvement Plan including activities and timelines whose progress report is reported with annual report. The EVM assessment is valid for a period of three years.

When was the latest Effective Vaccine Management (EVM) or an alternative assessment (EVSM/VMA) carried out? **September 2008**

Please attach:

(a) EVM assessment **(Document No 12)**

(b) Improvement plan after EVM **(Document No 13)**

(c) Progress report on the activities implemented during the year and status of implementation of recommendations from the Improvement Plan **(Document No 14)**

Progress report on EVM/VMA/EVSM Improvement Plan' is a mandatory requirement

Are there any changes in the Improvement plan, with reasons? **No**

If yes, provide details

The EVM was conducted in early 2013; and the improvement plan will be implemented and reported on in 2013.

When is the next Effective Vaccine Management (EVM) assessment planned? **February 2016**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2012

Somalia does not report on NVS Preventive campaign

7.7. Change of vaccine presentation

Somalia does not require to change any of the vaccine presentation(s) for future years.

7.8. Renewal of multi-year vaccines support for those countries whose current support is ending in 2013

Renewal of multi-year vaccines support for Somalia is not available in 2013

7.9. Request for continued support for vaccines for 2014 vaccination programme

In order to request NVS support for 2014 vaccination do the following

Confirm here below that your request for 2014 vaccines support is as per 7.11 Calculation of requirements
Yes

If you don't confirm, please explain

7.11. Calculation of requirements

Table 7.11.1: Specifications for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

ID		Source		2012	2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	329,231	338,726	348,888	359,355	1,376,200
	Number of children to be vaccinated with the first dose	Table 4	#	0	292,152	327,955	348,574	968,681
	Number of children to be vaccinated with the third dose	Table 4	#	0	292,152	296,555	323,420	912,127
	Immunisation coverage with the third dose	Table 4	%	0.00 %	86.25 %	85.00 %	90.00 %	
	Number of doses per child	Parameter	#	3	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.25	1.33	1.33	1.25	
	Vaccine stock on 31st December 2012 * (see explanation footnote)		#					
	Vaccine stock on 1 January 2013 ** (see explanation footnote)		#	0				
	Number of doses per vial	Parameter	#		10	10	10	
	AD syringes required	Parameter	#		Yes	Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	No	
	Safety boxes required	Parameter	#		Yes	Yes	Yes	
g	**Vaccine price per dose**	Table 7.10.1	$		2.04	2.04	1.99	
cc	**Country co-financing per dose**	Co-financing table	$		0.20	0.20	0.20	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0465	0.0465	0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.5800	0.5800	0.5800	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		6.40 %	6.40 %	6.40 %	
fd	**Freight cost as % of devices value**	Parameter	%		0.00 %	0.00 %	0.00 %	

* Vaccine stock on 31st December 2012: Countries are asked to report their total closing stock as of 31st December of the reporting year.

** Countries are requested to provide their opening stock for 1st January 2013; if there is a difference between the stock on 31st December 2012 and 1st January 2013, please explain why in the box below.

N/A

Co-financing tables for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID

Co-financing group	Low

	2012	2013	2014	2015
Minimum co-financing		0.20	0.20	0.20
Recommended co-financing as per APR 2011			0.20	0.20
Your co-financing		0.20	0.20	0.20

Table 7.11.2: Estimated GAVI support and country co-financing (**GAVI support**)

		2013	2014	2015
Number of vaccine doses	#	1,323,100	1,220,700	1,183,900
Number of AD syringes	#	1,296,400	1,131,800	1,160,800
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	14,400	12,575	12,900
Total value to be co-financed by GAVI	$	2,935,000	2,704,500	2,563,500

Table 7.11.3: Estimated GAVI support and country co-financing (**Country support**)

		2013	2014	2015
Number of vaccine doses	#	134,600	124,200	123,800
Number of AD syringes	#	0	0	0
Number of re-constitution syringes	#	0	0	0
Number of safety boxes	#	0	0	0
Total value to be co-financed by the Country ^[1]	$	292,000	269,000	262,000

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 1)

		Formula	2012	2013		
			Total	Total	Government	GAVI
A	Country co-finance	*V*	0.00 %	9.23 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	0	292,152	26,973	265,179
C	Number of doses per child	*Vaccine parameter (schedule)*	3	3		
D	Number of doses needed	*B X C*	0	876,456	80,918	795,538
E	Estimated vaccine wastage factor	*Table 4*	1.25	1.33		
F	Number of doses needed including wastage	*D X E*	0	1,165,687	107,620	1,058,067
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*		291,422	26,906	264,516
H	Stock on 1 January 2013	*Table 7.11.1*	0			
I	Total vaccine doses needed	*F + G – H*		1,457,609	134,572	1,323,037
J	Number of doses per vial	*Vaccine Parameter*		10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*		1,296,345	0	1,296,345
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*		0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*		14,390	0	14,390
N	Cost of vaccines needed	*I x vaccine price per dose (g)*		2,967,692	273,987	2,693,705
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*		60,281	0	60,281
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*		0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*		8,347	0	8,347
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*		189,933	17,536	172,397
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*		0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*		3,226,253	291,522	2,934,731
U	Total country co-financing	*I x country co-financing per dose (cc)*		291,522		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*		9.23 %		

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 2)

		Formula	2014			2015		
			Total	Government	GAVI	Total	Government	GAVI
A	Country co-finance	*V*	9.23 %			9.46 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	327,955	30,278	297,677	348,574	32,992	315,582
C	Number of doses per child	*Vaccine parameter (schedule)*	3			3		
D	Number of doses needed	*B X C*	983,865	90,834	893,031	1,045,722	98,976	946,746
E	Estimated vaccine wastage factor	*Table 4*	1.33			1.25		
F	Number of doses needed including wastage	*D X E*	1,308,541	120,809	1,187,732	1,307,153	123,719	1,183,434
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	35,714	3,298	32,416	0	0	0
H	Stock on 1 January 2013	*Table 7.11.1*						
I	Total vaccine doses needed	*F + G – H*	1,344,755	124,152	1,220,603	1,307,653	123,767	1,183,886
J	Number of doses per vial	*Vaccine Parameter*	10			10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	1,131,733	0	1,131,733	1,160,752	0	1,160,752
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	0	0	0	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	12,563	0	12,563	12,885	0	12,885
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	2,737,922	252,774	2,485,148	2,596,999	245,800	2,351,199
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	2,737,922	0	52,626	2,596,999	0	53,975
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	7,287	0	7,287	7,474	0	7,474
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	175,228	16,178	159,050	166,208	15,732	150,476
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	2,973,063	268,951	2,704,112	2,824,656	261,531	2,563,125
U	Total country co-financing	*I x country co-financing per dose (cc)*	268,951			261,531		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	9.23 %			9.46 %		

Table 7.11.4: Calculation of requirements for (part 3)

		Formula
A	**Country co-finance**	*V*
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*
C	**Number of doses per child**	*Vaccine parameter (schedule)*
D	**Number of doses needed**	*B X C*
E	**Estimated vaccine wastage factor**	*Table 4*
F	**Number of doses needed including wastage**	*D X E*
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*
H	**Stock on 1 January 2013**	*Table 7.11.1*
I	**Total vaccine doses needed**	*F + G – H*
J	**Number of doses per vial**	*Vaccine Parameter*
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*
P	**Cost of reconstitution syringes needed**	*L x reconstitution price per unit (cr)*
Q	**Cost of safety boxes needed**	*M x safety box price per unit (cs)*
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*
S	**Freight cost for devices needed**	*(O+P+Q) x freight cost as % of devices value (fd)*
T	**Total fund needed**	*(N+O+P+Q+R+S)*
U	**Total country co-financing**	*I x country co-financing per dose (cc)*
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*

8. Injection Safety Support (INS)

This window of support is no longer available

9. Health Systems Strengthening Support (HSS)

Instructions for reporting on HSS funds received

1. Please complete this section only if your country **was approved for <u>and</u> received HSS funds before or during January to December 2012**. All countries are expected to report on:

   a. Progress achieved in 2012

   b. HSS implementation during January – April 2013 (interim reporting)

   c. Plans for 2014

   d. Proposed changes to approved activities and budget (see No. 4 below)

For countries that received HSS funds within the last 3 months of 2012, or experienced other delays that limited implementation in 2012, this section can be used as an inception report to comment on start up activities.

2. In order to better align HSS support reporting to country processes, for countries of which the 2012 fiscal year starts in January 2012 and ends in December 2012, HSS reports should be received by the GAVI Alliance before **15th May 2013**. For other countries, HSS reports should be received by the GAVI Alliance approximately six months after the end of country fiscal year, e.g., if the country fiscal year ends in March 2013, the HSS reports are expected by GAVI Alliance by September 2013.

3. Please use your approved proposal as reference to fill in this Annual Progress Report. Please fill in this reporting template thoroughly and accurately and use additional space as necessary.

4. If you are proposing changes to approved objectives, activities and budget (reprogramming) please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavialliance.org.

5. If you are requesting a new tranche of funding, please make this clear in Section 9.1.2.

6. Please ensure that, **prior to its submission to the GAVI Alliance Secretariat, this report has been endorsed by the relevant country coordination mechanisms** (HSCC or equivalent) as provided for on the signature page in terms of its accuracy and validity of facts, figures and sources used.

7. Please attach all required supporting documents. These include:

   a. Minutes of all the HSCC meetings held in 2012

   b. Minutes of the HSCC meeting in 2013 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2012 calendar year

   e. External audit report for HSS funds during the most recent fiscal year (if available)

8. The GAVI Alliance Independent Review Committee (IRC) reviews all Annual Progress Reports. In addition to the information listed above, the IRC requires the following information to be included in this section in order to approve further tranches of HSS funding:

   a. Reporting on agreed indicators, as outlined in the approved M&E framework, proposal and approval letter;

   b. Demonstration of (with tangible evidence) strong links between activities, output, outcome and impact indicators;

   c. Outline of technical support that may be required to either support the implementation or monitoring of the GAVI HSS investment in the coming year

9. Inaccurate, incomplete or unsubstantiated reporting may lead the IRC to either send the APR back to your country for clarifications (which may cause delays in the release of further HSS funds), to recommend against the release of further HSS funds or only approve part of the next tranche of HSS funds.

9.1. Report on the use of HSS funds in 2012 and request of a new tranche

Please provide data sources for all data used in this report.

9.1.1. Report on the use of HSS funds in **2012**

Please complete <u>Table 9.1.3.a</u> and <u>9.1.3.b</u> (as per APR) for each year of your country's approved multi-year HSS programme and both in US$ and local currency

Please note: If you are requesting a new tranche of funding, please make sure you fill in the last row of Table 9.1.3.a and 9.1.3.b.

9.1.2. Please indicate if you are requesting a new tranche of funding **Yes**

If yes, please indicate the amount of funding requested: **3027162** US$

These funds should be sufficient to carry out HSS grant implementation through December 2014.

9.1.3. Is GAVI's HSS support reported on the national health sector budget? **Not selected**

NB: Country will fill both $ and local currency tables. This enables consistency check for TAP.

Table 9.1.3a (US)$

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)				2786791	2476727	2222902
Revised annual budgets (*if revised by previous Annual Progress Reviews*)					48150	1819212
Total funds received from GAVI during the calendar year (*A*)					2786791	2470387
Remaining funds (carry over) from previous year (*B*)						2738641
Total Funds available during the calendar year (*C=A+B*)					2786791	2738641
Total expenditure during the calendar year (*D*)					48150	897892
Balance carried forward to next calendar year (*E=C-D*)					2738641	4311137
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	0	0	0	2786791	2476727

	2013	2014	2015	2016
Original annual budgets (*as per the originally approved HSS proposal*)	2017222	2040538		
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	3346246	3027162	3303410	
Total funds received from GAVI during the calendar year (*A*)				
Remaining funds (carry over) from previous year (*B*)	4311137			
Total Funds available during the calendar year (*C=A+B*)	4311137			
Total expenditure during the calendar year (*D*)	841540			
Balance carried forward to next calendar year (*E=C-D*)				
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	3027162	3303410	0

Table 9.1.3b (Local currency)

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)						
Revised annual budgets (*if revised by previous Annual Progress Reviews*)						
Total funds received from GAVI during the calendar year (*A*)						
Remaining funds (carry over) from previous year (*B*)						
Total Funds available during the calendar year (*C=A+B*)						
Total expenditure during the calendar year (*D*)						
Balance carried forward to next calendar year (*E=C-D*)						
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	0	0	0	0	0

	2013	2014	2015	2016
Original annual budgets (*as per the originally approved HSS proposal*)				
Revised annual budgets (*if revised by previous Annual Progress Reviews*)				
Total funds received from GAVI during the calendar year (*A*)				
Remaining funds (carry over) from previous year (*B*)				
Total Funds available during the calendar year (*C=A+B*)				
Total expenditure during the calendar year (*D*)				
Balance carried forward to next calendar year (*E=C-D*)				
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	0	0	0	0

Report of Exchange Rate Fluctuation

Please indicate in the table Table 9.3.c below the exchange rate used for each calendar year at opening and closing.

Table 9.1.3.c

Exchange Rate	2007	2008	2009	2010	2011	2012
Opening on 1 January						
Closing on 31 December						

Detailed expenditure of HSS funds during the 2012 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2012 calendar year *(Terms of reference for this financial statement are attached in the online APR Annexes)*. Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health. **(Document Number: 19)**

If any expenditures for the January April 2013 period are reported in Tables 9.1.3a and 9.1.3b, a separate, detailed financial statement for the use of these HSS funds must also be attached **(Document Number: 20)**

Financial management of HSS funds

Briefly describe the financial management arrangements and process used for your HSS funds. Notify whether HSS funds have been included in national health sector plans and budgets. Report also on any problems that have been encountered involving the use of HSS funds, such as delays in availability of funds for programme use.

Please include details on: the type of bank account(s) used (commercial versus government accounts); how budgets are approved; how funds are channelled to the sub-national levels; financial reporting arrangements at both the sub-national and national levels; and the overall role of the HSCC in this process.

The General Assembly, through its Resolution 60/283 of July 2006, approved the adoption of International Public Sector Accounting Standards (IPSAS) to replace the United Nations System Accounting Standards (UNSAS). Under IPSAS, UNICEF changed from a modified accrual method of accounting to a full accrual method of accounting, resulting in improved transparency and accountability. UNICEF adopted IPSAS in 2012. UNICEF uses a well-established Enterprise Resource Planning (ERP) system known as VISION for processing the transactions and is an online web-based system. Vision supports not only transaction processing, but is also a Management Information System (MIS). The financial management systems and functions are well established to support the implementation of programmes. Critical functions are managed by professionals both at Nairobi-based UNICEF Somalia Support Centre and Zonal offices in Somalia. UNICEF receives funding from the donor through an account in UNICEF's New York Headquarters. These funds are then allocated to the respective office as a Grant Number which allows the field offices to charge expenses as appropriate based on contractual agreements on the grant. For transaction processing, internal control measures are in place. Adequate or additional measures are in place based on the risk assessment. The segregation of duties and oversight is ensured. The reporting and recording of the transactions are guided by the well-defined financial policies and rules. UNICEF has an Office of Internal Audit which conducts internal audits.<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

GAVI disburses funds to WHO/HQ in Geneva which then links these funds to the WHO Somalia country office GAVI work plan through WHO's Global System of Management (GSM). The GSM is WHO's Enterprise Resource Planning and Management System. WHO uses the GSM for all its planning, human resources, and financial management, travel and procurement systems in such a manner that allows all country, regional and headquarters offices real-time access to operate.

These HSS funds are not reflected in the national health sector plan or national health budget.

Has an external audit been conducted? No

External audit reports for HSS programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available during your governments most recent fiscal year, this must also be attached (Document Number: 21)

9.2. Progress on HSS activities in the 2012 fiscal year

Please report on major activities conducted to strengthen immunisation using HSS funds in Table 9.2. It is very important to be precise about the extent of progress and use the M&E framework in your original application and approval letter.

Please provide the following information for each planned activity:

- The percentage of activity completed where applicable
- An explanation about progress achieved and constraints, if any
- The source of information/data if relevant.

Table 9.2: HSS activities in the 2012 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2012**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
Activity 1.1:	Develop list of priority health facilities and conduct survey to identify gaps in 40 MCH centres	70	List of selected / recommended health facilities
Activity 1.2:	Rehabilitation of selected MCH centres (based on assessment)	33	Unicef Reports
Activity 1.3:	Procurement and supply of essential medicines and equipment for MCH services (based on gaps)	100	Unicef Reports
Activity 1.4:	Provide comprehensive support for BEMONC in selected MCH centres (3)	0	

Activity 1.5:	Development / adapt curriculum for training of MCH and EPI staff in supervision, outreach and HMIS	0	
Activity 1.6:	Conduct training of MCH and EPI staff (in 40 MCH centres) communities	0	
Activity 1.7:	Develop curriculum for training of all MCH staff in EPI injection safety and vaccine management	15	Training material and guidelines on various aspects of EPI developed by WHO
Activity 1.8:	Training of MCH centre staff (EPI, injection safety and vaccine management)	0	
Activity 1.9:	Renovation of cold chain equipment in all MCH centres	0	
Activity 1.10:	Develop a system of regular EPI outreach from MCH centres to the catchment areas of health posts and FHWs	15	There is an outreach system in place; however, its functioning is largely dependent on additional funds and will be subject to an external EPI review
Activity 1.11:	Develop a system for regular supervision for MCH centres from regional and zonal MOH	5	ToRs developed and external consultant identified
Activity 1.12:	Provide transport support to MOH for supervision of regional offices, facilities and communities	0	
Activity 1.13:	Provide transport support to regional managers for supervision of MCH centres	0	
Activity 1.14:	Provide incentives for EPI outreach and RH staff at MCH centres	0	
Activity 2.1:	Developing scope of work, incentives and criteria for selection, plan of supervision of FHWs	66	Compendium document. Funds allocated for annual review and preparing annual plans. Completed in 2 zones. Minutes of the meetings.
Activity 2.2:	Recruitment of FHWs	83	List of selected applicants
Activity 2.3:	Development/adapt curriculum for FHWs and supervisors	100	Curriculum (for FHWs and supervisors)
Activity 2.4:	Training of trainers	100	ToT Report
Activity 2.5:	Training of FHWs	10	Training monitoring report in Gabiley District
Activity 2.6:	Training of supervisors	10	Training monitoring report in Gabiley District
Activity 2.7:	Develop and implement a system of supportive supervision for FHWs and outreach activities	0	
Activity 2.8:	Develop and implement a community based HMIS	50	Unicef Reports
Activity 2.9:	Printing and distribution of HMIS tools	0	
Activity 2.10:	Procure and distribute/resupply FCHW kits	5	List of supplies; requests for quotations; letter of agreement with UNICEF on donation of three products
Activity 2.11:	Procure and distribute/re-supply medicines for Health posts (50%)	100	
Activity 2.12:	Refresher Training for FHWs and supervisor	0	
Activity 2.13:	Provide incentives to CHWs	0	

Activity 2.14:	Provide incentives to FHWs	10	
Activity 3.1:	Formative research to identify key maternal and child caring behaviours and barriers	20	UNICEF reports
Activity 3.2:	Develop five year strategic communication plan	40	UNICEF reports
Activity 3.3:	Develop print, audio-visual and IPC package for health workers	80	UNICEF reports
Activity 3.4:	Develop and broadcast radio programme on key child caring and health practices	50	UNICEF reports
Activity 3.5.	Identify three strong communication NGOs to build capacity of existing NGOs and to scale up public awareness at community level	30	UNICEF reports
Activity 3.6:	Strengthen and establishing structured/systematized partnership with religious leaders, religious organizations, clan leaders, community elders and networks	50	UNICEF reports
Activtiy 3.7:	Work with school structures to increase dialogue on key child survival and development messages	30	UNICEF reports
Activity 3.8:	Develop community friendly materials (discussion guides etc) with key iCCM messages for FCHWs, CHWs, TBAs for home based family promotion	30	UNICEF reports
Activity 3.9:	Partner with Text to Change company to use interactive SMS text messaging to remind on key child survival messages	30	UNICEF reports
Activity3.11:	Technical Assistance for BCC/C4D activities	100	UNICEF reports
Activity 4.1:	Conduct baseline and end-line surveys	20	UNICEF reports
Activity 4.2.	Establish and support operational research committee	10	Terms of Reference
Activity 4.3:	Commission operational research studies	0	
Activity 4.4:	Conduct focus groups for operational research	0	
Activity 4.5:	Support data analysis and use	0	
Activity 4.6:	Training of MoH managers in operational research	0	
Activity 4.7:	Organize study tour for health authorities	100	Mission report
Activity 4.8:	Technical Assistance for Operational Research	0	
Technical Support		80	

9.2.1 For each objective and activity (i.e. Objective 1, Activity 1.1, Activity 1.2, etc.), explain the progress achieved and relevant constraints (e.g. evaluations, HSCC meetings).

Major Activities (insert as many rows as necessary)	**Explain progress achieved and relevant constraints**

Activity 1.1. (WHO):	Health facilities identified and endorsed by the Health Authorities in all three zones. ToRs and tools for comprehensive health facility assessment have been finalized as an aligned activity of the baseline survey. Health Facility Survey conducted in 27 (Puntland and South Central Somalia) out of 40 facilities. Preliminary assessment of 13 health facilities in Somaliland had been conducted before the start of the programme in 2010; another survey is planned for 2013;
Activity 1.2. (UNICEF):	Joint assessments of 40 health facilities (South Central: 15, Somaliland 13, Puntland 12) were conducted in all three zones. Funds have been provided to the three zonal Ministries of Health (MOHs) to undertake the rehabilitation of GAVI-HSS-selected facilities and work is now in progress. This provision of funds was delayed until November 2012 in Somaliland, the MOH had initially requested additional funds. The MOH has since agreed that the rehabilitation will be done within the original, approved budget. Rehabilitation is completed in Puntland, while funds for Somali Federal Government (FG) are being delivered through Muslim Aid, as they cannot be delivered directly without a signed Letter of Agreement between UNICEF and the FG MOH.
Activity 1.3. (UNICEF):	Essential medicines and equipment have been procured and are continuing to be supplied to these facilities on a quarterly basis. UNICEF operational support is also on-going and will continue until the rehabilitation is complete, at which time WHO will take over the payment of staff incentives and other operational costs
Activity 1.4. (UNICEF):	None of the zonal health authorities have yet selected the three GAVI-HSS facilities where Basic Emergency Obstetric and Neonatal Care (BEMONC) will be provided. However, the health authorities have been informed that the GAVI-approved budget will not be sufficient to operate BEMONC facility 24 hours a day.
Activity 1.5.(WHO):	ToRs for an external consultant to develop a system for supervision have been developed and the selection process finalized. A number of review activities of the current EPI and outreach system will be carried out by UNICEF in the near future. It was therefore decided to await the results of these reviews.
Activity 1.6.(WHO):	Builds on 1.5. and will be repeated in 2014
Activity 1.7. (WHO):	WHO had developed curricula for all aspects of EPI to be used globally; GAVI/HSS focal point together with EPI WHO and UNICF EPI colleagues will review the available material; if needed, a short term consultant will be recruited for further compilation and adjustment of the material.
Activity 1.8. (WHO):	Builds on 1.7.; training of MCH staff is planned for 6 days and will be repeated in 2014.
Activity 1.9. (UNICEF):	Additional cold chain equipment has been procured and delivered to three zones. All 40 GAVI-HSS supported facilities have required cold chain equipment.
Activity 1.10. (WHO):	See 1.5.: A number of review activities of the current EPI and outreach system will be carried out by UNICEF in the near future. It was therefore decided to await the results of these reviews.
Activity 1.11. (WHO):	ToR for consultant developed and shared with the Health Authorities for review; recruitment in process.
Activity 1.12. (WHO):	Will be implemented after the supervision system has been developed and established.
Activity 1.13. (WHO):	Will be implemented after the supervision system has been developed and established.
Activity 1.14. (WHO):	• Somaliland Health Authorities provided list of staff at selected MCHs; staff has been deployed to clinics as of March 1; • Puntland and South Central: still outstanding pending agreement on the incentives level and staff to be paid by the three Health Authorities; to be finalized by May 2013;
Activity 2.1.(WHO):	Workshops were held in Somaliland and Puntland and annual zonal work plans for the two zones have been developed and endorsed by the Health Authorities. Planning work shop for South Central will be held in May 2013.
Activity 2.2.(WHO):	166 out of 200 FHWs have been recruited. In SC due to security and access issues, the remaining FHWs will be recruited and trained in June 2013.

Activity	Progress
Activity 2.3. (WHO):	Curriculum for FHWs and FHW Supervisors developed and adapted to the Somali context, translated into Somali.
Activity 2.4. (WHO):	Two ToT workshops were conducted in Hargeisa and Mogadishu. The first workshop was on the English version of the manual; the second on the Somali version (this version includes adjustments of the modules to the Somali context.
Activity 2.5.(WHO):	Preparatory activities for the Training of FHWs completed in Somaliland and Puntland in close collaboration with the Health Authorities. The training of FHWs will follow different schedules in the three zones; the first training for FHWs and their supervisors started on April 15 in Somaliland; Training activities in Puntland will begin on May 6; South Central Somalia is expected to start in June 2013.
Activity 2.6.(WHO):	Supervisors are participating in the training of FHWs and stay on for an additional month to be exclusively trained on supervision.
Activity 2.7. (WHO):	ToR for an external consultant have been developed and shared with health authorities for the development of a supportive supervision system; the recruitment is being finalized (May 2013); once the system is developed and endorsed by the health authorities, implementation will start.
Activity 2.8.(UNICEF/WHO):	Several preparatory meetings have been held between UNICEF and the Somali Health Authorities for the development of a community based Health Management Information System (HMIS). Community-based HMIS tools specific for GAVI-HSS project have been developed. UNICEF has transferred funds to WHO for the implementation of the community-based HMIS.
Activity 2.9.(UNICEF/WHO):	Will follow 2.8.
Activity 2.10.(UNICEF/WHO):	Three consultants from WHO developed the scope of work for the Female Community Health Workers (FCHWs) in January 2012. As the FCHW proposed kits are not available through UNICEF's supply chain, it has been agreed with WHO, that UNICEF will transfer the funds for these kits to WHO, and they will take care of procurement and distribution of FCHW kits during this project. UNICEF will be donating MUAC, Zinc tablets and ORS quantity required for one year. Funds for 2012 and 2013 have been transferred to WHO.
Activity 2.11.(UNICEF):	UNICEF has already procured regular supplies for health posts and will continue to provide these supplies on quarterly basis.
Activity 2.12. (WHO):	Will be carried out in 2014 and 2015
Activity 2.13. (WHO):	See Point 1.14.: incentives of CHWs will start with the first day of their training, starting in 2nd quarter of 2013;
Activity 2.14. (WHO):	FHWs will start receiving incentives with day 1 of their training; for details see 2.5.
Activity 3.1.(UNICEF):	The consultant identified to lead the formative research turned down the offer early 2013. The consultancy was re-advertised, 23 persons responded to the advert and 6 were shortlisted. The shortlisted consultants have taken the written interview. Based on the results of the written interview three consultants will be shortlisted for the oral interview. It is expected that the consultant will be on board in the second week of May 2013. All the three zones have put in writing their agreement to participate in the formative research and to support the process by identifying local data collectors and assistants to work with the lead consultant.
Activity 3.2. (UNICEF):	In order to avoid delay, the draft national communication strategy is being developed concurrently with the formative research into health behaviors. The strategy has been developed based on existing research completed in previous years. However it will be finalized with the findings from the formative research upon its completion. The zonal strategies will be developed based on the national strategy with participation from stakeholders.

Activity 3.3. (UNICEF):	Reality Media a communication company with participation of the Ministry of Health in Puntland and Somaliland developed a video on IPC skills to be used during the training of health workers. The video was pretested in all the three zones and all comments incorporated before the final production. Copies of the final production are in the process of being made and shared with each of the zones for use during trainings. Reality media also developed 8 radio spots on Antenatal Care, breastfeeding, immunization, diarrhea and hand washing. These spots were pretested too and are going to be aired on the selected radio stations in each zone.
Activity 3.4.(UNICEF):	In each of the zones, the Ministries of Health with UNICEF Support have developed Small Scale agreements with local radio stations that have the widest coverage in each zone to air twelve 30-minute programmes. The radio stations airing the programmes in each zone are: Radio Mogadishu in South Central Zone, Radio Hargeisa in North West Zone and Radio Daljir in North East Zone. The programmes will cover the following topics: immunization, danger signs of childhood illnesses, Antenatal Care (ANC), pregnancy danger signs, exclusive and complementary breast feeding. The effectiveness of the programme will be monitored through the number of phone calls in during the programme.
Activity 3.5.(UNICEF)	Though this activity is planned for 2013, two NGOs PSI and BBC Media Action have been identified to support and mentor at least 5 local NGOs in Behaviour Change Communication. Concept notes from each of the NGOs have been received and reviewed internally. The concept notes are being discussed and reviewed with the Ministry of health and guidelines on how to conduct the mentorship programme will be agreed on as well. However the funding allocated under this activity is not sufficient to address mentorship effectively. The recommendation is that the funds for the four years be pulled together and used to conduct C4D training for all the newly established Health Promotion departments in each zones and partners
Activity 3.6. (UNICEF):	The Ministries of Health and Religious Affairs are working together to identify credible religious organizations that can be trained to support the implementation of the Behaviour Change Communication interventions at the community level. In Puntland the IHSAN Religious Leaders Network (IRLN) has signed a small scale agreement with UNICEF to work with the Ministry of Health to promote Child Health in 12 communities within the GAVI districts. In Somaliland an agreement has been signed with the International Horn University to reach communities especially the hard to reach areas with key child health and messages mainly on immunization, childhood illnesses, polio vaccination nutrition, sanitation and hygiene , prevention of HIV/ AIDS SCZ is still in discussions with the Ministry of religious affairs to identify credible institutions to work with.
Activity 3.7. (UNICEF):	In collaboration with the Ministries of Health and Education, Kow Media Corp (KMC), an ‘edutainment’ media NGO with presence in all the three zones has been identified to support implementation of this activity. In liaison with the MOH Somaliland, 10 schools were identified in Somaliland to educate school children on basic immunization, water and childhood illnesses through interactive puppet shows followed by dialogues. However, upon developed of the detailed proposal the funding available could only cover 3 public primary schools: Shiekh Madar, Waraaba Salaanand 18 May with a total of 600 pupils and 240 were girls. Approval of the identified schools for Puntland and Mogadishu is awaited from MOH’s. In order to sustain the intervention, the school clubs will be trained and equipped to conduct puppet shows in their respective schools on various topics with the support of the Community Education Committees. Development of scripts and pretesting is on-going to ensure clear and correct messages are passed on. The same strategy will be duplicated in Puntland and CSZ during the first quarter of 2013.

Activity 3.8. (UNICEF):	Based on the FCHW training curriculum, user friendly materials are being developed for use at the community level to promote dialogues. A Grain Sack Chart set (a flip chart made out of grain sack) containing messages on hygiene around the home; how to make water safe; when to seek treatment from a health worker; dangers signs in pregnancy: postnatal care and delivery; importance of nutrition for pregnant women, children and the family; how to treat diarrhea; exclusive breastfeeding; malaria prevention and treatment; measure malnutrition; immunization and side effects; childhood illnesses signs and treatment; and HIV spread and prevention is under development. Related posters will also be developed for key behaviors on maternal and child health.
Activity 3.9. (UNICEF):	Funding under this activity was not adequate to enable the engagement of a private company. In Somaliland the Ministry of Health and Nation Link telecom are piloting the mother reminder messaging on their own. Currently phone numbers for mothers willing to take back in the programme are being collected by the health workers. Results for this activity are expected after three to four months of tracking the mothers. In Puntalnd discussions are going on with Golis to develop the mother reminder system. However, in South Central Zone discussions with the telecom companies is not positive because of security concerns. The Director General and his team are going to talk to one more company and it the response is negative they suggest that the funds be reallocated to other activities However, we recommend that a company or consultant be brought on board to advice on what is feasible in the Somalia context to use interactive SMS taking into account the security issues.
Activity 4.1. (UNICEF):	Consultative meetings were held with MOH and WHO on base line survey, and agreed to combine it with formative research. Minutes of the meetings with CSZ and NWZ Health Authorities are attached to this report.
Activity 4.2. (WHO):	ToRs of operational research (ORC) committees have been developed. Health Authorities are requested to nominate ORC members. The nomination lists are still pending.
Activity 4.3. (WHO):	Is planned to be implemented upon establishment of the Operational Research Committees.
Activity 4.4. (WHO):	Builds on 4.1.
Activity 4.5. (WHO):	Builds on 4.1.
Activity 4.6. (WHO):	This activity is re-planned for 2013.
Activity 4.7. (WHO):	In April 2012 WHO organized a study tour to Pakistan where Somali Health Authorities (including GAVI focal points identified by three Somali MoHs) had an opportunity to familiarize themselves with the Lady Health Workers Programme. As a similar program has been proposed for Somalia, the tour helped the team to identify key issues and lessons learnt that can be applied in the context of Somalia.
Activity 4.8.	Builds on 4.1. and further

9.2.2 Explain why any activities have not been implemented, or have been modified, with references.

Constraints encountered during the implementation period affected the implementation of the following activities: <?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

The HSS Programme faced significant delays between the approval of the HSS proposal and signing of the grant agreement, creating a gap of two years between when the proposal was drafted in 2009 and the funds received in 2011. This gap required the activity plan and budget to be reviewed in order to complete activities originally scheduled for 5 years in 4 years as well as to compensate for rising prices in the interim.

Program activities were jointly revised by UNICEF and WHO in consultation with the GAVI delegation, respective health authorities and approved by the Health Advisory Board (HAB) during the first quarter of 2012. The reprogrammed budget and activities were submitted to the GAVI Board for approval through the Annual Progress Report in May 2012, but the official approval of revised activities and budget from the GAVI Secretariat was received on 29th November 2012. This has further delayed the implementation of re-programed activities.

Constraints encountered during the implementation period affected the implementation of the following activities:

The recruitment of FHWs and FHW Supervisors required more time than anticipated due to a lack of suitably educated Somali candidates. For identifying candidates, the pre-determined qualifications of potential candidates were subsequently lowered. The qualifications were changed to less number of years in school (from 8 to 6). This all took much more time than anticipated. In addition, the Somali Health Authorities and WHO team went to communities on a promotional and recruitment initiative to search for qualified and suitable candidates. However, as of May 2013, the recruitment process for Somaliland and Puntland is being finalized; for the South Central Zone it will be brought to an end by June 2013.

As most of activities are inter-related, the prolonged recruitment process of FHWs subsequently delayed the beginning of their training, the incentive disbursements, training of facility staff, establishment of a supervision system etc. MCH and HP staff to be included under this programme is pending for Puntland and South Central Somalia but will be finalized in May and June 2013 respectively.

The establishment and support of Operational Research Committees (ORC) relies on the nomination of members by the Somali Health Authorities and is still pending in all zones.

Consultation process with zonal health authorities on work plans and TORs for formative research took some time to agree. Consultancy was announced but was turned down by the selected candidate. However, preparatory work on other BCC/C4D component was started in 2012.

9.2.3 If GAVI HSS grant has been utilised to provide national health human resources incentives, how has the GAVI HSS grant been contributing to the implementation of national Human Resource policy or guidelines?

It is only in Somaliland where a policy and planning document for Human Resources Development and Managmnet has been developed and is being implemented. A recent review on the compensation, salaries, incentives and benefits for health personnel has suggested three scenarios. Consensus was reached on the recommended medium scenario and endorsed by the HSC and HAB in March 2013. However, an implementation strategy needs to be developed. It is foreseen to align HR incentives under this programme to any national salary and incentive scheme. For this programme, Somali health authorities have been requested to agree on level of incentives for the various cadres. Payment of incentives has started in Somaliland for facility staff on March 1, for FHWs and their supervisors on April 15; in Puntland for FHWs and their supervisors on May 6. Facility staff in June; for South Central it is anticipated to start the payment of incentives for FHWs and their supervisors and facility staff respectively.

9.3. General overview of targets achieved

Please complete **Table 9.3** for each indicator and objective outlined in the original approved proposal and decision letter. Please use the baseline values and targets for 2011 from your original HSS proposal.

Table 9.3: Progress on targets achieved

Name of Objective or Indicator (Insert as many rows as necessary)	Baseline	Agreed target till end of support in original HSS application	2012 Target	Data Source	Explanation if any targets were not achieved

	Baseline value	Baseline source/date				

9.4. Programme implementation in 2012

9.4.1. Please provide a narrative on major accomplishments in 2012, especially impacts on health service programmes, and how the HSS funds benefited the immunisation programme

WHO organized a study tour to Pakistan in April 2012 for the Somali Health Authorities (including GAVI focal points identified by three Somali MoHs) to familiarize themselves with the Lady Health Workers Programme. As a similar program has been proposed for Somalia, the tour helped the team to identify key issues and lessons learnt that are applicable in the context of Somalia.<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

As part of the planned WHO activity to develop a list of priority health facilities to be included in the programme, all three zonal Health Authorities identified these health facilities and produced the list. ToRs and tools for a comprehensive health facility assessment have been finalized as an aligned activity of the baseline survey. The health facility survey was conducted in 27 (Puntland and South Central Somalia) out of 40 facilities. A preliminary assessment of 13 health facilities in Somaliland was carried out in 2010; therefore the health facility survey is planned for 2013.

Annual zonal work plans for Somaliland and Puntland have been developed and discussed in workshops held in Hargeisa and Garowe with the Health Authorities. The formulation of an annual zonal work plan for South Central Somalia is still pending.

WHO developed a training curriculum for master trainers, FHWs and FHW supervisors in close collaboration with the Somali Health Authorities. The inputs were collected from all partners involved and the training curriculum has been officially endorsed by the health authorities and translated into Somali language. This was followed by the involvement of four experts (nominated by the Health Authorities) from each zone who reviewed the document and adapted it to the Somali context. Two training of trainers workshops were conducted in this regard, in Mogadishu and Hargeisa.

The recruitment process for FHWs and FHW Supervisors will be finalized in May 2013. The recruitment took more time than anticipated due to a lack of suitably educated Somali candidates. In order to find candidates, the pre-determined qualifications (ie. completion of 8 years of school) of potential candidates was lowered. In addition, the Somali Health Authorities and WHO team went into the community on a promotional and recruitment initiative to search for qualified and suitable candidates. This all took much longer than anticipated, however, 166 FHWs in all three zones were selected with Somaliland and Puntland having finalized the process in April and May respectively and training has started. In Somaliland with the first batch on April 15, followed by Puntland on May 6. It is planned to start the training in South Central Somalia in early June 2013. FHWs will start receiving incentives with day 1 of their training.

For ensuring that FHW do not work in isolation but as an integral part of the PHC system, staff from the selected MCH clinics and Health Posts will be included into the programme. Health Authorities identified respective staff and suggested respective compesation levels for Somaliland and Puntland. Following the training of FHWs and their superviros, MCH and HP staff will be oriented and trained in key areas of EPI as well as Mother and Child Health.

ToRs for an external consultant to support the development of a supportive supervision system, not only for the FHWs but for the PHC system as a whole and in line with the existing Essential Package of Health Services (EPHS) , have been drafted and shared with Health Authorities. The recruitment is being finalized by May. It is anticipated that this activity which involves field visits, compilation of existing system and discussion and consensus building activities with the health authorities and partners will take three months. The production of training material on supervision and HMIS will follow this activity.

The production /adaptation of training material for MCH staff in EPI related areas such as injection safety and vaccine management will await the results of a number of EPI review activities. If required, the mentioned consultant will perform, in close collaboration with the WHO/UNICEF EPI technical team, this task.

ToRs for operational research (ORC) committees have been developed and the Health Authorities have been requested to nominate ORC members.

The ORC committee will be working in close collaboration with the Health System Analysis Team (HSAT) in

complementarity to evidence generated from other HSS programmes and areas to inform and guide policies and strategy formulation whilst at the same time build research and analytical skills of health authorities.

Somalia applied for GAVI Support in 2009 without having one of the necessary requirements which is a Health Sector Strategic Plan. The Strategic plans for the three zones were developed during 2012 and in March 2013 the Somali Health Authorities endorsed the first ever three zonal Health Sector Strategic Plans (HSSPs), for Puntland, Somaliland and South Central Somalia. The development of Somali HSSPs was funded through the Joint Health and Nutrition Programme which is a multi-donor, multi-agency programme whose aim is to improve maternal and child health in Somalia through strengthening the health system building blocks. The Somali Health Authorities have specified their priorities for the five-year period in the HSSPs alongside the health system building blocks. Of top priority is the roll out and provision of an Essential Package of Health Services that includes six core programs with maternal, reproductive, neonatal and child health on the top. (Three HSSPs are attached to the APR for more details: please see Strategic Priority 3).

During 2012, work plans were developed with three zonal health authorities, cold chain equipment and essential medicines were procured for all 40 health facilities. Joint assessments of 40 health facilities (CSZ: 15, NWZ: 13, NEZ: 12) were conducted across the three zones. TORs for a consultant were finalized with consultation with WHO and three zonal health authorities and consultancy was announced. However the selected consultant identified to lead the formative research turned down the offer. The consultancy was re-advertised, 23 persons responded to the advert and 6 were shortlisted. In order to avoid delay, the draft national communication strategy is being developed concurrently with the formative research into health behaviors. The strategy has been developed based on existing research completed in previous years. Community-based HMIS indicators and tools specific for GAVI-HSS project have been developed. Reality Media, a communication company, with participation of the MOH in Puntland and Somaliland, developed a video on Interpersonal Communication (IPC) skills to be used during the training of health workers. The video was pretested in all the three zones and all comments incorporated before the final production. In all three zones, the MOH with UNICEF support have developed small scale agreements with local radio stations that have the widest coverage in each zone to air twelve 30-minute programs. The radio stations airing the programs are: Radio Mogadishu in CSZ, Radio Hargeisa in North West Zone and Radio Daljir in North East Zone. The programs will cover the following topics: immunization; danger signs of childhood illnesses; ANC; pregnancy danger signs; and exclusive and complementary breast feeding. In addition two NGOs PSI and BBC Media Action have been identified to support and mentor at least 5 local NGOs in Behavior Change Communication. In Puntland the IHSAN Religious Leaders Network (IRLN) has signed a small scale agreement with UNICEF to work with the MOH to promote Child Health in 12 communities within the GAVI districts. Based on the FCHW training curriculum, user friendly materials are being developed for use at the community level to promote dialogues.

Progress on the programme are being regularly provided to the Health Sector Committee (HSC) and consequently to the Health Advisory Board (HAB).

9.4.2. Please describe problems encountered and solutions found or proposed to improve future performance of HSS funds.

Somali context requires frequent revisions and subsequent adjustments of planned costs as the security situation often affects cost fluctuations. In addition, this requires a fast response from all partners involved. In 2012, the reprogrammed budget and activities were submitted to the GAVI Board for approval through the Annual Progress Report but the decision letter regarding revised activities and budget from the GAVI Secretariat arrived six months later. This has affected appropriate planning as it was unclear whether the reprogramming was approved. In addition it had a negative impact and contributed to the delay of the implementation. In order to improve future performance of HSS funds it is recommended to disburse funds before the beginning of the calendar year for which funds are requested.<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

Under the Behaviour Change Component (BCC) of the programme some of the challenges encountered include: inadequate funding and insecurity to implement required activity this is in special reference to activity 3.5 aimed at twining local NGO with international NGOs for mentorship and activity 3.9 on engaging a company to use interactive SMS for improved ANC attendance through mother reminder messages.

In a bid to address the challenges together with the zones we have recommended that a foundational C4D training for all the newly health promotion departments in the zone and local NGOs involved in the implementation of C4D activities. For use of interactive SMS it is recommended that we engage a company to access the capacity of local telecoms to provide the required service for interactive SMS and to pilot on a small scale the mother reminder system and community quiz.

9.4.3. Please describe the exact arrangements at different levels for monitoring and evaluating GAVI funded HSS activities.

For the implementation of HSS interventions, no vertical M&E mechanism is suggested. The programme will strengthen the ongoing HMIS reform intervention. Community based FHW MIS will be an addition to the HMIS and will avoid a vertical approach. <?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

Use of agreed governance mechanism of Health Sector Working Group (HSWG), Health Sector Coordination (HSC) and Health Advisory Board (HAB) will enable the programme to follow an integrated approach for evidence based decision making process. Some gaps in the M&E mechanism will be covered through the operational research component of the HSS programme. Again, all such research activities will be linked with the work of the Health Systems Analysis Team (HSAT), thus avoiding any duplication of activities.

Global Fund and UNICEF support a National Health Management Information System (HMIS). Reports on monitoring of the HSS process and results (according to the process and output level indicators) will be integrated with current HMIS. This will be an ongoing process. The technical reporting will start at the health posts, submitted to the MCH centres on a monthly basis where the reports will be compiled and submitted to the regional health offices. The compiled regional report in consultation with the partners will be sent to the Zonal MOH where the reports will be compiled, analyzed, used for improving performance and disseminated to all partners and stakeholders on quarterly basis.

An annual progress report on the GAVI/HSS activities will be submitted jointly by implementing partners (Health authorities, WHO, UNICEF) to the HSC Coordinator for synthesis and review of HSC before submission to GAVI.

Within the Health Sector Strategic Plans (HSSP) Joint annual health sector reviews are planned in which different development and implementing partners and health authorities from others zones will actively participate to also review progress and lessons learned from this and other HSS programmes.

Link with HMIS: The reporting starts at the MCH centers on a monthly basis where the reports are compiled and submitted to the regional health offices. The compiled regional report in consultation with the partners is sent to the Zonal MOH where the reports are compiled, analyzed, used for improving performance and disseminated to all partners and stakeholders on quarterly basis.

Progress update given on monthly basis in HSWG and HSC. An annual progress report on the GAVI/HSS activities is submitted jointly by implementing partners (WHO, UNICEF) endorsed by Health authorities to the HSC Coordinator for synthesis and review of HSC before submission to GAVI.

9.4.4. Please outline to what extent the M&E is integrated with country systems (such as, for example, annual sector reviews). Please describe ways in which reporting on GAVI HSS funds can be more organization with existing reporting systems in your country. This could include using the relevant indicators agreed in the sector-wide approach in place of GAVI indicators.

For the implementation of HSS interventions, no vertical M&E mechanism is suggested. The programme will strengthen the ongoing HMIS reform intervention. Community based FHW MIS will be an addition to the HMIS and will avoid a vertical approach. <?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

Use of agreed governance mechanism of Health Sector Working Group (HSWG), Health Sector Committee (HSC) and Health Advisory Board (HAB) will enable the programme to follow an integrated approach for evidence based decision making process. Some gaps in the M&E mechanism will be covered through the operational research component of the HSS programme.

Within the Health Sector Streategic Plans (HSSP) Joint annual health sector reviews are planned in which different development and implementing partners and health authorities from others zones will actively participate to also review progress and lessons learned from this and other HSS programmes.

Reports on monitoring of the GAVI supported HSS activities and results (according to the process and output level indicators) are planned to be integrated into the existing monitoing mechanisms. This will be an ongoing process.

9.4.5. Please specify the participation of key stakeholders in the implementation of the HSS proposal (including the EPI Programme and Civil Society Organisations). This should include organisation type, name and implementation function.

The successful implementation of the HSS support depends upon the effective participation of key stakeholders and civil society organisations. All stakeholders were involved in the development of HSS strategic plan. <?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

Selected activities will be contracted out to implementing partners (NGOs). Under the guidance of health authorities, NGOs will be responsible to assist in:

- Baseline and completion/exit surveys;
- Regular reporting via routine HMIS;
- Reporting against contractual obligations (utilization, coverage, targets, finances);
- Participation in collection and reporting on monitoring and operational research.

The Somali Authorities and the International Community are determined to make progress in the right direction and for this they agreed to Somali Health Sector Committee Reforms in June 2010.

For GAVI-HSS programme the same governance mechanism will be used (see GAVI-HSS Strategic Plan).

9.4.6. Please describe the participation of Civil Society Organisations in the implementation of the HSS proposal. Please provide names of organisations, type of activities and funding provided to these organisations from the HSS funding.

CSOs were involved in the planning process and will be responsible for implementation of selected GAVI-HSS activities. Names of organisations, type of activities and funding provided to these organisations from the HSS funding, will be provided later, once agreements are finalized and signed.<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

The SRCS (Somalia Red Crescent Society) supports some of the selected MCH centres and participate in the coordination of GAVI HSS activities including selection of FHWs and FHW supervisors, recruitment of additional staff for the MCH sites they support, participation of GAVI HSS WG meetings, rehabilitation of MCH centres,etc.

Community elders have been involved in the selection process of the FHWs and FHW supervisors. Daljir Radio, Religious Networks and SDO Local NGO support the dissemination of BCC messages.

In Puntland, the Haji Abdi Nursing School in Garowe and the Bosaso college of health sciences have provided their training centres for the training of FHWs.

Two NGOs PSI and BBC Media Action have been identified to support and mentor at least 5 local NGOs in Behavior Change Communication. Five local NGOs will be selected in 2013.

In Puntland the IHSAN Religious Leaders Network (IRLN) has signed a small scale agreement with UNICEF to work with the MOH to promote Child Health in 12 communities within the GAVI districts.

In Somaliland an agreement has been signed with International Horn University to reach communities, especially in hard to reach areas, with key child health messages mainly on immunization, childhood illnesses, polio vaccination nutrition, sanitation and hygiene, and prevention of HIV/ AIDS.

In collaboration with the Ministries of Health and Education, Kow Media Corp (KMC), an ‘edutainment’ media NGO with presence in all the three zones, has been identified to support implementation of Work with school structures to increase dialogue on key child survival and development messages.

9.4.7. Please describe the management of HSS funds and include the following:

- Whether the management of HSS funds has been effective
- Constraints to internal fund disbursement, if any
- Actions taken to address any issues and to improve management
- Any changes to management processes in the coming year

The management of HSS funds has not encountered any problems in 2012 as the carry forward amount from 2011 was sufficient for activities planned to be implemented in 2012. The second tranche of HSS funds were disbursed in the beginning of 2013. There are no planned changes to management processes of the HSS funds in the coming year.<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

Disbursement through tranches is made directly to WHO and UNICEF through their corporate agreements with GAVI.

The Somali Health Sector Committee (HSC) is involved in approval, oversight, and submission of GAVI APR reports. GAVI APR 2012 was presented to the HSC in May 2012 and shared with the Health Authorities. Minutes of the HSC meeting is attached to the APR.

For rehabilitation of health facilities UNICEF has given funds directly to health authorities in NWZ and NEZ, while in SCZ funds were given to DOH through a partner.

9.5. Planned HSS activities for 2013

Please use **Table 9.5** to provide information on progress on activities in 2013. If you are proposing changes to your activities and budget in 2013 please explain these changes in the table below and provide explanations for these changes.

Table 9.5: Planned activities for 2013

Major Activities (insert as many rows as necessary)	**Planned Activity for 2013**	**Original budget for 2013** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**2013 actual expenditure** (as at April 2013)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2013** (if relevant)
1.2	Rehabilitation of selected MCH centres (based on assessment)		75000		This is a 2012 activity which will be completed in 2013	75000
1.3	Procurement and supply of essential medicines and equipment for MCH services (based on gaps)	98000	69242		This will also include balance budget from 2012	196000
1.4	Provide comprehensiv e support for BEMOC in selected MCH centers (3)	72000			This will also include balance budget from 2012	157650
1.5	Development /adapt curriculum for training of MCH and EPI staff in supervision, outreach and HMIS				The activity was not foreseen for 2013 within last budget revision	15000
1.6	Conduct training of MCH and EPI staff (in 40 MCH centres)	24000			Budget needed to be adjusted taking into account expenses occurred during similar training conducted in Somalia.	65000
1.7	Develop curriculum for training of all MCH staff in EPI injection safety and vaccine management				The activity was planned for 2012 but was not implemented and reprogrammed for 2013.	15000
1.8	Training of all MCH centres staff (EPI, injection safety and vaccine management)	20000			As 1.6.	65000
1.10	Develop a system of regular EPI outreach from MCH centres to the catchment areas of health posts and FHWs				As 1.7	15000
1.11	Develop a system for regular supervision for MCH centres from regional and zonal MOH	35000				35000
1.12	Provide transport support to MOH for supervision of regional offices	26400				26400

1.13	Provide transport support to regional and district managers for supervision of MCH centres	81000				81000
1.14	Provide incentives for EPI outreach and RH staff at MCH centres Develop scope of work incentives and criteria for selection, plan of supervision of FHWs	288000				288000
2.1	Develop scope of work incentives and criteria for selection, plan of supervision of FHWs	30000			The activity is completed at the end of 2011-beginning 2012 (Compendium document sent with APR 2011)	
2.2	Recruitment of FHWs and supervisors.		1300		Initially planned for 2012 when activity implementation started but it was finalized in 2013.	15000
2.3	Development/ adapt curriculum for FHWs and supervisors	20000	23704			23704
2.5	Training of FHWs	53600			Training was initially planned to start in 2012 and only part of it to be conducted in 2013. Recruitment of FHWs was delayed thus training of all FHWs is reprogrammed for 2013. This is why the full cost is now moved to 2013.	189000
2.6	Training of supervisors	28200			As explained in 1.6	37000
2.7	Develop and implement a system of supportive supervision for FHWs and outreach activities	208768				208768
2.8	Develop and implement a community based HMIS	24000	24000		This is a 2012 activity which will be completed in 2013. Funds given to WHO to implement	24000
2.9	Printing and distribution of HMIS tools	20000	20000		This is a 2012 activity which will be completed in 2013. Funds given to WHO to implement	20000
2.10	Procure and distribute/resu pply FCHW kits	80000	100000		This is a 2012 activity which will be completed in 2013. This will also include balance budget from 2012. Funds given to WHO to implement	100000
2.11	Procure and distribute/re-supply medicines for Health posts	48000	18598		This will also include balance budget from 2012	96000

2.13	Incentives for CHWs	53568				53568
2.14	Incentives for FCHWs	207360			The number of FHWs initially selected in 2013 was less than foreseen and the training was delayed thus the amount allocated for this activity needed to be reduced.	150000
3.1	Formative research to identify key maternal and child caring behaviours and barriers	60000			This is an activity of 2012, but will be completed in 2013.	60000
3.2	Develop five year strategic communication plan	36000			This is an activity of 2012, but will be completed in 2013.	36000
3.3	Develop print, audio-visual and IPC package for health workers	10000	12500		This will also include balance budget from 2012	12500
3.4	Develop and broadcast radio programme on key child caring and health practices	30000	11000		This will also include balance budget from 2012	40422
3.5	Identify three strong communication NGOs to build capacity of existing NGOs and to scale up public awareness at community level	60000				60000
3.6	Strengthen and establishing structured/systematized partnership with religious leaders, religious organizations, clan leaders, community elders and networks	15000	4953		This will also include balance budget from 2012	40000
3.7	Work with school structures to increase dialogue on key child survival and development messages	20000			This will also include balance budget from 2012	40685

3.8	Develop community friendly materials (discussion guides etc) with key iccm messages for FCHWs, CHWs, TBAs for home based family promotion	15000			This will also include balance budget from 2012	30000
3.9	Partner with Text to Change company to use interactive SMS text messaging to remind on key child survival messages	10000			This will also include balance budget from 2012	40000
3.11	Technical Assistance for BCC/C4D activities	261909	118846		This will also include balance budget from 2012	436515
4.1	Conduct baseline and end-line surveys				This is a 2012 activity which will be completed in 2013	60000
4.2	Establish and support operational research committee	12000				12000
4.3	Commission operational research studies	36000				36000
4.4	Conduct focus groups for operational research	36000			This will also include balance budget from 2012	72000
4.5	Support data analyses and use	10000				10000
4.6	Training of MoH Managers in operational research	15000			As explained in 1.6	50294
4.8	Technical Assistance for Operational Research	22500				36000
Management Cost	Management Cost	152017	8683			192601
Technical Support (WHO)	Technical Support (WHO)	503280	108358			503280
M&E support costs	M&E support costs	54000	7172		This will also include balance budget from 2012	117629
Technical support Unicef	Technical support Unicef	132942	118846			132942
PSC (7%)		14274	54470		The 7% Programme Support Cost (admin fee which is not programmable amount) was not included in the original budget thus was deducted from activities which in addition contributed to the need to revise activity costs.	279181
2.4	Training of trainers		61872		Initially planned for 2012 only.	61872

		2923818	838544			4311011

9.6. Planned HSS activities for 2014

Please use **Table 9.6** to outline planned activities for 2014. If you are proposing changes to your activities and budget please explain these changes in the table below and provide explanations for each change so that the IRC can recommend for approval the revised budget and activities.

Please note that if the change in budget is greater than 15% of the approved allocation for the specific activity in that financial year, these proposed changes must be submitted for IRC approval with the evidence for requested changes

Table 9.6: Planned HSS Activities for 2014

Major Activities (insert as many rows as necessary)	**Planned Activity for 2014**	**Original budget for 2014** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2014** (if relevant)
1.3	Procurement and supply of essential medicines and equipment for MCH services (based on gaps)	100000	Procurement and supply of essential medicines and equipment for MCH services (based on gaps)	In original budget essential medicines component was missing, total budget has been increased to USD 392,000 (with $98,000 providing these supplies for 2014)	98000
1.4	Provide comprehensive support for BEMONC in selected MCH centres (6)	150000	Provide comprehensive support for BEMOC in selected MCH centres (3)	Budget has been distributed by year with the same total cost.	72000
1.6	Conduct training of MCH and EPI staff (in 40 MCH centers)	25000		Budget needed to be adjusted taking into account expenses occurred during similar training conducted in Somalia	45000
1.8	Training of all MCH centers staff (EPI, injection safety and vaccine management)	60000		Same as above (1.6)	60000
1.9	Renovation of cold chain equipment in all MCH centres	160000		All facilities will be equipped with cold chain in year 1 (2012) of implementation	
1.12	Provide transport support to MOH for supervision of regional offices	22500			26400
1.13	Provide transport support to regional managers for supervision of MCH centers	77100			81000
1.14	Provide incentives for EPI outreach and RH staff at MCH centers	288000			288000

2.7	Develop and implement a system of supportive supervision for FHWs and outreach activities	153600		Costing of GAVI HSS activities was developed in 2009. Costs have increased since 2009, especially for transportation.	205201
2.10	Procure and distribute/resupply FCHW kits	12000		Unit cost of FCHWs supplies has been increased. As per internal WHO/UNICEF agreement, funds will be transferred to WHO for procurement and distribution of FCHW kits.	80000
2.11	Procure and distribute/re-supply medicines for Health posts	4000		Unit cost was calculated in 2008. Kits cost as per EPHS criteria is high	48000
2.12	Refresher training for FHWs and Supervisors	100000			100000
2.13	Incentives for CHWs	76800		CHWs are working in the Health Posts (HP). There are no HP in South Central Somalia involved in GAVI HSS activities.	53568
2.14	Incentives for FHWs	172000		The level of incentives was increased from originally planned due to increased cost of living.	235200
	Activity 3.3: Develop, print and distribute IEC material (MCH centres, health posts)	6000	Activity 3.3: Develop print, audio-visual and IPC package for health workers	Unit cost has been increased as compared to 2008 plans	10000
	Activity 3.6: Develop radio programs		Activity 3.4: Develop and broadcast radio programme on key child caring and health practices	Unit cost has been reduced but funds will be required for three zones every year	30000
	Activity 3.8: Increase public awareness through print media	26000	Activity 3.5. Identify three strong communication NGOs to build capacity of existing NGOs and to scale up public awareness at community level	Unit cost has been increased	60000
	Activity 3.9: Organise advocacy/BCC events for community elders and religious leaders	96000	Activity 3.6: Strengthen and establishing structured/systematized partnership with religious leaders, religious organizations, clan leaders, community elders and networks	Unit cost has been reduced	15000
	Activity 3.10: Organise school events on key messages	48000	Activity 3.7: Work with school structures to increase dialogue on key child survival and development messages	Unit cost is increased however activity has been narrowed to schools related to GAVI facilities only	20000
	Activity 3.12: Produce and distribute IEC material (flipcharts) to FCHWs and CHWs	25000	Activity 3.8: Develop community friendly materials (discussion guides etc) with key ICCM messages for FCHWs, CHWs, TBAs for home based family promotion	Unit cost has been increased but will be produced for GAVI-HSS facilities only	15000
	Activity 3.13: SMS text messaging for BCC	9000	Activity 3.9: Partner with Text to Change company to use interactive SMS text messaging to remind on key child survival messages	Unit cost has been increased	10000

			Activity3.11: Technical Assistance for BCC/C4D activities	New activity	261909
4.2	Establish & support operational research committee	9000	Support operational research committee	Committees will be established in 2013 and support will be provided during 2014 and subsequent years.	12000
4.3	Commission operational research studies	15000		This activity was under-budgeted and as it was not implemented in previous year the savings are used for more realistic costing.	36000
4.4	Conduct focus groups for operational research	36000			36000
4.5	Support data analysis and use	6000		As in 4.3.	10000
4.6	Training of MOH managers in operational research			The activity is re-planned from 2012 (original plan) into the revised 2014.	15000
4.8	Technical assistance for operational research	22500			22000
	Management support costs	177660			190000
	Technical Support (WHO)	391942		The total 7% of agency cost was originally deducted on the expense of TA section leaving insufficient amount to cover for 1 P5, 3 NOB and Programme. Assistant positions. Also the P4 position was replaced with P5 as required by the scope of work and qualifications needed.	503280
	M&E support costs	35340		Costs has been adjusted to four years	54000
	Technical support (UNICEF)	90437		Costs has been adjusted to four years	132942
	7% PSC			Unicef costs less than 7% (66,000)	197785
		2394879			

9.7. Revised indicators in case of reprogramming

Countries planning to submit reprogramming requests may do so any time of the year. Please request the reprogramming guidelines by contacting your Country Responsible Officer at GAVI or by emailing gavihss@gavialliance.org

9.8. Other sources of funding for HSS

If other donors are contributing to the achievement of the country's objectives as outlined in the GAVI HSS proposal, please outline the amount and links to inputs being reported on:

Table 9.8: Sources of HSS funds in your country

Donor	Amount in US$	Duration of support	Type of activities funded
AUSAID	3131520	2012-2015	Joint Health and Nutrition Programme (JHNP) is a comprehensive multi-donor, multi-partner five year programme aimed at improving maternal and child health and reducing mortality, while strengthen the systems that support improved quality and access to health care.

DFID	20939443	2012-2015	Joint Health and Nutrition Programme (JHNP) is a comprehensive multi-donor, multi-partner five year programme aimed at improving maternal and child health and reducing mortality, while strengthen the systems that support improved quality and access to health care.
Global Fund (Round 10 Malaria HSS)	6467584	April 2012 -March 2014	• HMIS • Leadership & Governance • HP & EPHS • Supply Management
Global Fund (Round 8 HSS)	824589	2013-2014	1.Initiate balanced approach to improving health workforce clinical, diagnostic and management capacity; 2.Improved availability and quality of essential health services; 3.Improved medicines logistics, quality control and management capacity.
SIDA	4804680	2012-2015	Joint Health and Nutrition Programme (JHNP) is a comprehensive multi-donor, multi-partner five year programme aimed at improving maternal and child health and reducing mortality, while strengthen the systems that support improved quality and access to health care.
USAID	1149963	December 2012-March 2014	Joint Health and Nutrition Programme (JHNP) is a comprehensive multi-donor, multi-partner five year programme aimed at improving maternal and child health and reducing mortality, while strengthen the systems that support improved quality and access to health care.

9.8.1. Is GAVI’s HSS support reported on the national health sector budget? **No**

9.9. Reporting on the HSS grant

9.9.1. Please list the **main** sources of information used in this HSS report and outline the following:

- How information was validated at country level prior to its submission to the GAVI Alliance.
- Any important issues raised in terms of accuracy or validity of information (especially financial information and the values of indicators) and how these were dealt with or resolved.

Table 9.9: Data sources

Data sources used in this report	How information was validated	Problems experienced, if any
Minutes of Health Sector Committee (HSC) Meetings in 2012;	Review by respective following meeting;	
Notes of HSC Meeting where GAVI APR 2012 was presented	Agenda of the meeting	The quarterly full HSC meeting that involves the MoH will only be held in June 2013 where GAVI APR 2012 will be officially endorsed.
Various GAVI HSS Zonal Focal Point Reports	Verified by HSS Country Advisor	

9.9.2. Please describe any difficulties experienced in putting this report together that you would like the GAVI Alliance and IRC to be aware of. This information will be used to improve the reporting process.

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2012?6

Please attach:

1. The minutes from the HSCC meetings in 2013 endorsing this report **(Document Number: 6)**
2. The latest Health Sector Review report **(Document Number: 22)**

10. Strengthened Involvement of Civil Society Organisations (CSOs) : Type A and Type B

10.1. TYPE A: Support to strengthen coordination and representation of CSOs

Somalia **has NOT received GAVI TYPE A CSO support**

Somalia is not reporting on GAVI TYPE A CSO support for 2012

10.2. TYPE B: Support for CSOs to help implement the GAVI HSS proposal or cMYP

Somalia **has NOT received GAVI TYPE B CSO support**

Somalia is not reporting on GAVI TYPE B CSO support for 2012

11. Comments from ICC/HSCC Chairs

Please provide any comments that you may wish to bring to the attention of the monitoring IRC in the course of this review and any information you may wish to share in relation to challenges you have experienced during the year under review. These could be in addition to the approved minutes, which should be included in the attachments

12. Annexes

12.1. Annex 1 – Terms of reference ISS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS **FOR IMMUNISATION SERVICES SUPPORT (ISS)** AND **NEW VACCINE INTRODUCTION GRANTS**

I. All countries that have received ISS /new vaccine introduction grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2012, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. **At a minimum**, GAVI requires a simple statement of income and expenditure for activity during the 2012 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, based on ***your government's own system of economic classification.*** This analysis should summarise total annual expenditure for the year by your government's own system of economic classification, and relevant cost categories, for example: wages & salaries. If possible, please report on the budget for each category at the beginning of the calendar year, actual expenditure during the calendar year, and the balance remaining for each cost category as of 31 December 2012 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2012 financial year. Audits for ISS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.2. Annex 2 – Example income & expenditure ISS

MINIMUM REQUIREMENTS FOR **ISS** AND VACCINE INTRODUCTION GRANT FINANCIAL STATEMENTS 1

An example statement of income & expenditure

Summary of income and expenditure – GAVI ISS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2012	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

12.3. Annex 3 – Terms of reference HSS

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **HEALTH SYSTEMS STRENGTHENING (HSS)**

I. All countries that have received HSS grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2012, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2012 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on the next page.

a. Funds carried forward from the 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, based on your government's own system of economic classification. This analysis should summarise total annual expenditure for each HSS objective and activity, per your government's originally approved HSS proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2012 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2012 financial year. Audits for HSS are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.4. Annex 4 – Example income & expenditure HSS

MINIMUM REQUIREMENTS FOR **HSS** FINANCIAL STATEMENTS:

An example statement of income & expenditure

Summary of income and expenditure – GAVI HSS		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2012	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

12.5. Annex 5 – Terms of reference CSO

TERMS OF REFERENCE:

FINANCIAL STATEMENTS FOR **CIVIL SOCIETY ORGANISATION (CSO)** TYPE B

I. All countries that have received CSO 'Type B' grants during the 2012 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2012, are required to submit financial statements for these programmes as part of their Annual Progress Reports.

II. Financial statements should be compiled based upon countries' own national standards for accounting, thus GAVI will not provide a single template to countries with pre-determined cost categories.

III. At a minimum, GAVI requires a simple statement of income and expenditure for activity during the 2012 calendar year, to be comprised of points (a) through (f), below. A sample basic statement of income and expenditure is provided on page 3 of this annex.

a. Funds carried forward from the 2011 calendar year (opening balance as of 1 January 2012)

b. Income received from GAVI during 2012

c. Other income received during 2012 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2012

f. A detailed analysis of expenditures during 2012, based on your government's own system of economic classification. This analysis should summarise total annual expenditure by each civil society partner, per your government's originally approved CSO 'Type B' proposal, with further breakdown by cost category (for example: wages & salaries). Cost categories used should be based upon your government's own system for economic classification. Please report the budget for each objective, activity and cost category at the beginning of the calendar year, the actual expenditure during the calendar year, and the balance remaining for each objective, activity and cost category as of 31 December 2012 (referred to as the "variance").

IV. Financial statements should be compiled in local currency, with an indication of the USD exchange rate applied. Countries should provide additional explanation of how and why a particular rate of exchange has been applied, and any supplementary notes that may help the GAVI Alliance in its review of the financial statements.

V. Financial statements need not have been audited/certified prior to their submission to GAVI. However, it is understood that these statements should be subjected to scrutiny during each country's external audit for the 2012 financial year. Audits for CSO 'Type B' are due to the GAVI Secretariat 6 months following the close of each country's financial year.

12.6. Annex 6 – Example income & expenditure CSO

MINIMUM REQUIREMENTS FOR **CSO 'Type B'** FINANCIAL STATEMENTS

An example statement of income & expenditure

Summary of income and expenditure – GAVI CSO		
	Local currency (CFA)	**Value in USD ***
Balance brought forward from 2011 (balance as of *31Decembre 2011*)	25,392,830	53,000
Summary of income received during 2012		
Income received from GAVI	57,493,200	120,000
Income from interest	7,665,760	16,000
Other income (fees)	179,666	375
Total Income	38,987,576	81,375
Total expenditure during 2012	30,592,132	63,852
Balance as of 31 December 2012 (balance carried forward to 2013)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2012, the exchange rate at closing 31.12.2012, and also indicate the exchange rate used for the conversion of local currency to US$ in these financial statements.

Detailed analysis of expenditure by economic classification ** - GAVI CSO						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2012	42,000,000	87,663	30,592,132	63,852	11,407,868	23,811

** Expenditure categories are indicative and only included for demonstration purpose. Each implementing government should provide statements in accordance with its own system for economic classification.

13. Attachments

Document Number	Document	Section	Mandatory	File
1	Signature of Minister of Health (or delegated authority)	2.1	✓	MoH signature 1.pdf File desc: Date/time: 5/22/2013 3:17:23 AM Size: 136816
3	Signatures of members of ICC	2.2	✓	RE APR 2012.txt File desc: Date/time: 6/26/2013 11:07:28 AM Size: 3471
4	Minutes of ICC meeting in 2013 endorsing the APR 2012	5.7	✓	January 2012.pdf File desc: Minutes of EPI working group meeting Date/time: 5/13/2013 4:54:30 AM Size: 441134
5	Signatures of members of HSCC	2.3	×	HSCC signatures page_2.pdf File desc: Date/time: 5/22/2013 3:17:41 AM Size: 74094
6	Minutes of HSCC meeting in 2013 endorsing the APR 2012	9.9.3	✓	HSC General Meeting December 2012.pdf File desc: Date/time: 5/13/2013 7:57:32 AM Size: 240273
19	Financial statement for HSS grant (Fiscal year 2012) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	×	Grant_Utilization_Details_by_Activity Unicef 2012.pdf File desc: Date/time: 5/15/2013 10:09:01 AM Size: 60699