

Joint appraisal report

Country	Somalia
Reporting period	January to December 2014
cMYP period	2011-2015
Fiscal period	<i>January to December</i>
Graduation date	<i>Not Applicable</i>

1. EXECUTIVE SUMMARY

1.1. GAVI grant portfolio overview

Gavi grants in Somalia operate in an extreme challenging context. Somalia has been without a functional central government and in a continued civil strife since 1991, until the formation of the internationally recognized Federal Government in 2012. It has some of the worst health and nutritional indicators in the world and is 'off-track' to reaching health related MDGs. According to the WUENIC for 2013, Somalia ranked fourth among the countries with the lowest DTP3 coverage globally (42%).

The country is divided into three major administrative entities: Somaliland (3,331,109 People), Puntland (2,054,883 people) and Central/South zones (7,361,993 people), with Puntland operating under the Federal Government and Somaliland being semi-autonomous. Each zone operates its own health system and immunisation program with varying levels of security challenges, health system functionality and capacity constraints.

Somalia implemented two active GAVI grants in the reporting period of 2014 namely: the New Vaccines grant for DTP-HepB-Hib that procured US\$ 2,190,500 worth of vaccines (cumulatively adding to US\$ 7,300,292), which renewal request is included and the Health Systems Strengthening (cash grant) that provided US\$ 3,738,808 as last tranche in 2014, amounting to a total of US\$ 11,545,500 through WHO and UNICEF. Somalia will develop a new HSS application with USD 25 million ceiling for submission by early 2016. The country is currently preparing for its IPV launch planned for October 2015.

The HSS grant activities progressed over the course of 2014, however due to its design, limited scope and scale, the grant did not contribute to the improvement of any of the impact targets set for 2014. Notably, DTP-3 reported coverage increased from 34% to 49% in 2013 and 2014 respectively. The DTP-1 coverage on the other hand declined from 59% to 56%. The drop-out rate for DTP1-DTP3 decreased from 16% reported for 2013 to 12% reported for 2014. In addition, some of the important vaccine management activities and data verification surveys and audits were delayed.

A combination of factors informed under-performance of immunisation program below targets set for 2014, and they included: security issues that affected access to certain areas of the country, in particular in the South Central zone; limited health system functionality and huge gaps in service availability and delivery in the 3 zones; limited data availability and overall low quality of data; and vaccine management challenges. In addition, the implementation arrangements through WHO and UNICEF and the three health ministries' respectively have been challenging.

1.2. Summary of grant performance, challenges and key recommendations

Grant performance (programmatic and financial management of NVS and HSS grants)
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Achievements

- Support to 40 selected MCH facilities: rehabilitation; provision of incentives; training in EPI and MCH services delivery; provision of supplies and equipment (31/40 fully functional by the end of 2014 as 9 still do not have cold chain capacity);
- Deployment of a new pilot cadre of Lady health Workers (200) across the three Somali zones, providing a set of preventive, promotive and curative services at community level with potential to be expanded based on lessons learnt and seen as catalytic in terms of creating awareness in remote communities;
- System for supportive supervision of MCHs and establishment of a supervision system of LHWs through trained LHW supervisors;
- Revision of EPI situation analysis and development of “one EPI plan” for Somalia, which is to be implemented in 2015;
- Development of zonal strategies for Behavioral Change Communication (BCC), raising awareness about health issues including immunization in schools and communities.

Challenges

The immunization performance indicators did not meet targeted improvements in 2014, which was linked to a combination of factors:

- Weak design and limited scope and scale of the existing HSS grants;
- Lack of funding to implement critical EVM recommendations and the One EPI plan;
- Security impediments severely restricted the implementation and monitoring of immunization activities, especially in the South Central zone;
- Geographical distance between the UNICEF and WHO program management team in Nairobi and the zones poses a challenge to regular vis-à-vis communication and technical guidance needed on the ground;
- Weak EPI management and coordination capacities by Ministry of Health at all levels
Absence of regional / district health management teams;
- Weak joint supervision and monitoring at all levels and use of data for decision making;
- Limited access to EPI services including inaccessible areas;
- Lack of development and implementation of EPI operational micro-plans in line with the RED/C approach to immunization programming;
- Non-availability of immunization services in functional health facilities (lack of cold chain, vaccinators, care and treatment priorities in MCH clinics with limited human resources);
- Limitation of existing NHMIS, which covers only 50% of the country, resulting in incomplete data, possible underreporting of coverage, compounded by low data quality and delays in reporting;
- Poor vaccine management practices across the cold chain, leading to situations of over and understock;
- Gaps in health service delivery and absence of a referral system, especially in remote areas and for scattered populations;
- Several rounds of supplemental immunization activities for polio outbreak response affected the focus on strengthening of routine immunization services.

Key recommended actions to achieve sustained coverage and equity (list the most important 3-5 actions)

1. Improving equitable access to immunization, through:
 - a) Increase of the number of fixed sites and establishment of outreach services in response to very limited available services in the country;
 - b) Careful preparation of EPI services micro-plans, with realistic approaches (outreach/mobile) for target population should be undertaken;
 - c) Prioritization of selected districts may have to be considered for gradual improvement of immunization services;
2. Vaccine security and quality assurance, with emphasis on
 - a) Expansion of cold chain coverage;
 - b) Vaccine utilization monitoring; and
 - c) Establishment of an effective logistics information management system
3. Expand and enhance the performance of the NHMIS to generate good quality data and improve reporting on coverage indicators in particular.
4. Building on the existing HMIS system to create an immunization monitoring system that can track equity indicators for immunization services.
5. Scale up behavior change communication activities to create community demand for EPI services.
6. Implementation of the “One EPI plan”, using the polio outbreak response assets.

The country is planning to submit a new HSS application in early 2016 with a ceiling of U\$25.3 million.

1.3. Requests to Gavi’s High Level Review Panel

Grant Renewals

New and underused vaccine support

The country requests for continuation and future renewal of the New Vaccines Support for DTP-HepB-Hib in the amount of \$2,190,500 USD to be used to procure:

- 1,062,000 doses of DTP-HepB-Hib in the current 10-dose formulation estimated for reaching DPT3 target of 68% in 2016
- 1,011,200 pieces of 0.5ml AD syringes/needles and
- 11,125 pieces of safety boxes

1.4 Brief description of joint appraisal process

- Agreement on date and composition of mission team;
- Brief discussion by GAVI secretariat on key issues with MoH, UNICEF and WHO at side meeting during 21st EMR Regional Working Group meeting on GAVI in Djibouti, April 2015;
- Follow-up communication to the MOH in the respective zones and partners on the objectives and dates of the joint appraisal (JA) mission;
- Several teleconferences (GAVI, WHO, UNICEF) on mission preparation and development of preliminary JA report;
- Preliminary joint appraisal report developed by the EPI partners in Somalia;
- 4-days appraisal mission including field visit and extensive discussion with representatives of the federal ministry of health and representatives of the 3 zonal authorities and partners.
- Refining of the joint appraisal draft report with MOH and partners’ input;
- Presentation of the JA draft report to the HSCC in Nairobi;
- Finalization of the JA report for Somalia.

2. COUNTRY CONTEXT

The performance of GAVI grants in Somalia is affected by a large number of contextual factors:

Political context and governance

- Somalia has been without a functional central government since 1991 until the formation of the internationally recognized Federal Government in 2012. Over the years, the country has had a sustained civil strife. As a result, Somalia has some of the worst health and nutritional indicators in the world and is 'off-track' to reaching health related MDGs.
- The long-standing civil war in the country led to the division of the country into three major administrative entities: Somaliland, Puntland and Central/South zones. Puntland and Central/South zones operate under the Federal Government and Somaliland is semi-autonomous. As a result there are three zone-based health systems and three zone-based immunization programs, each with its own structure, variations in strength and barriers.
- Due to the absence of a national health and immunization structure, functional links between management at zonal MOH level, the regions and the MCHs on the ground are non-existent. This negatively affects planning, implementation and monitoring of immunization services, including GAVI supported activities.
- The HSCC (Health Sector Coordination Committee), currently seated in Nairobi, took over the functions of the ICC. Recommendations made by the HSCC are being forwarded to the Health Advisory Board (HAB) which is composed of the three health Ministers, Heads of Agency, donor and NGO representatives for decision making. Immunisation is a standing item on the agenda of the HSCC but discussions are largely erratic and in turn monitoring of GAVI grants remains ad-hoc. However, regular reporting on the implementation status of the HSS grant is being provided.

Programme management

- The three health authorities of Somalia provide oversight over immunization activities in their respective zones. However, current management, coordination and planning capacities are weak at all levels. There are also limited resources for supervision, monitoring and evaluation of immunisation activities, which affect the performance of the Gavi supported activities. This affects in particular the development, execution and implementation of EPI micro plans.
- The Directorate of Health within the Minister of Human Development & Public Services (MHDPS) in Mogadishu is now in the process of re-organizing itself and has assigned an EPI manager who coordinates immunization activities implemented by partners. The relatively stable zones of Somaliland and Puntland have each an EPI unit organized under their PHC department of respective MOH. These units coordinate all immunization activities in their respective zones. Regional EPI structures in Somaliland and Puntland have been strengthened and supported by partners.
- UNICEF Somalia and WHO Somalia are the major financiers and partners of EPI channeling GAVI support, along with more than 60 immunization partners. The large number of actors also brings its own coordination challenges in an already fragmented system. The contracting of EPHS roll out is often delayed and immunization services including outreach are not provided in a number of facilities. Most immunization partners have a coordination mechanism at Nairobi and at zonal level within the country.
- The two UN agencies (WHO and UNICEF) are the recipients of the Gavi HSS grant funding and UNICEF in addition manages the vaccine support.

Costing and Financing

- In 2014, the total immunization program cost was estimated at \$ 36,956,596. The majority

(75%) of the program costs were for the Polio and Measles supplemental immunization activities. The GAVI (NVS and HSS expenditures) accounted for 53% of the routine immunization program expenditure. The largest cost contribution of GAVI was the NVS grant that alone accounted for nearly 40%. UNICEF funds all traditional vaccines in the country.

- Health financing in the three zones is mostly depending on external funding and out-of-pocket payment with large contribution from Somali Diaspora. Government expenditure on health (GHE) is very low, but health ministries have included advocacy for an increased contribution to the health sector as one of their top priorities stated in the health sector strategic plans.
- In Somaliland the total government expenditure had increased, due to better tax collection, from 40 million to 180 million US\$ in 2015 (Public Expenditure Review 12/2014) with a five-fold increase of government health expenditure (US\$ 1.1 million in 2009 to 7.1 million in 2014), reflecting an increase from 3% to 5% of the total government expenditure. However, GHE per capita is only at 2.04 US\$ in 2014 (Somaliland). In Puntland, GHE has fallen from 2% of total government expenditure in 2011 to 0.7% in 2014. The budget of the Ministry of Health in South Central amounted to 881,332 US\$ of which three-quarters were used to pay personnel costs.
- Main funding for health systems strengthening comes from the Global Fund, with 112,000,000 US\$ reserved for the next three years (July 2015 to December 2018), the Consortium of NGOs with 43,342,536 US\$ (ending in 3/2016) and the Joint Health and Nutrition Program with 99,700,000 US\$ total funding, ending in 2016. For the upcoming Gavi HSS application, it shall be very important to demonstrate that investments and activities are aligned with other HSS supported initiatives/grants
- Somalia is currently not defaulting on its co-financing obligations, because the Joint Health and Nutrition Program (JNHP) funding is being used to meet this requirement. In the event that the JNHP ends in 2016, there is not a single assured source of funding for this obligation. It is extremely unlikely though that the Somali government will be able to take over the co-financing obligations in the short or medium term.

Service delivery organisation

- Improvement of immunisation coverage is affected by overall low coverage of services in Somalia, especially for rural and nomadic populations resulting in hardly any service utilization by remote communities. Immunization services delivery is currently mainly through the fixed/static sites.
- Utilization rates of services are also low due to poor quality. The management of human resources is weak, characterized by low and irregular payments and irregular mentoring/quality assurance visits to operational level staff. Health Workers employed by the MoH and working at the selected MCH do often not receive any regular salary but only the modest incentive under GAVI HSS support. LHWs and their supervisors are exclusively funded by the GAVI/HSS grant.
- In response to fragmented delivery of and limited access to health services, SHAs developed an 'Essential Package of Health Services (EPHS)', that outlines organizational and management structures of four facility-based health care provision levels (referral center, health center, primary health unit, hospital) and a community based programme. It comprises six core and four additional programmes. Currently, the EPHS is being rolled out in 9 out of 17 regions.
- Due to absence of district health structures, EPI micro-plans are not systematically developed and implemented to ensure equitable distribution of immunization delivery points and design of outreach services. The planned health facility mapping and services assessment (planned to take place in October 2015) provides an opportunity to document equity in distribution of immunization services delivery points.

Polio and Routine Immunisation

- The wild polio virus outbreak, whose last case was in August 2014, will end in 2015. In turn, the saved time and disruptions that came with several rounds of OPV/SIAs shall stop while all the polio assets will now focus their attention to strengthening of routine immunization services.
- In line with the Global Polio End Game Strategy, the Ministry of Health, UNICEF and WHO have jointly agreed that:
 - OPV/SIAs micro-plans will be used to inform development of routine immunization services micro-plans
 - The Polio surge human resources with their skills and competencies will now have the time to train, mentor and provide hands on support to the national authorities in routine immunization services strengthening.
 - The remaining OPV SIAs will be used to update the cold chain inventory and in turn inform cold chain expansion planning, preventive and corrective maintenance plans.
 - The behavioral maps (zero dose mapping), studies (non-participation surveys) and knowledge (from independent monitoring) gained will also be used to inform behavior change communications for routine immunization
 - The IPV introduction preparations will specially be used to identify routine immunization services bottlenecks.
- The funding and implementation of the “One EPI plan” concept for harmonizing actions for immunization systems development shall be critical to the success of improvement of immunisation outcomes and is to be taken into account in context of HSS reprogramming and the new HSS application.

Cold chain and vaccine management

- Although the structure of vaccine supply chain covers the whole country, vaccine utilization monitoring and reporting is weak, making wastage monitoring and reduction initiatives difficult.
- An EVMA was conducted and reported in April 2013. The EVM improvement plan was developed and implemented since December 2013. Of the 32 EVM improvement planned activities 26 (81%) have been partially or fully implemented. However, there are major activities that have not been implemented on time namely: a) Comprehensive cold chain inventory and development of a cold chain expansion/replacement plan; b) establishment of vaccine utilization/wastage monitoring system; c) development of guidelines for safe disposal of immunization waste and d) Conducting annual self-evaluation of EVM improvement plan implementation. These pending EVM improvement activities are priority in the one-EPI plan of action (2015 to 2016).
- The current Gavi HSS grant supports the rehabilitation of health facilities but not cold chain equipment at the selected 40 MCH clinics. Solar powered refrigerators have been provided by UNICEF to only 31 of Gavi supported MCH units. UNICEF is also in the process of expanding cold chain warehouses and storage capacities and logistics.

HMIS and reporting

- The three zones have limited existing HIS, characterized by incompleteness, low data quality; delays in reporting. Data quality audits were not conducted on facility reported data.
- Compliance with data quality assurance and surveys has been weak. No data quality self-assessment or assurance activities were planned and implemented in the reporting period. However, there were several immunization coverage verification surveys that remained relevant. Specifically, Somalia used independent monitoring of immunization coverage in all

OPV/SIAs implemented in the reporting period. A routine immunization non-participation survey was conducted in Somaliland to determine the major reasons for immunization failure. The results of this survey are still being used to inform actions for improving community demand for immunization services.

- Although the country was due to conduct a post introduction evaluation of DTP-HepB-Hib introduction in 2014, this was not done due to competing activities for WPV outbreak response. This activity is now re-scheduled to be implemented in Q3 of 2015
- No nationwide system exists to allow for equity analysis of immunization coverage. However, equity analysis of immunization coverage has been obtained from: a) Wild polio outbreak response data which showed that minority ethnic populations in Somalia were at higher risk of immunization failure; b) no gender-related inequalities were identified in coverage from 2 EPHS implementing districts and c) Analysis of the AFP surveillance data-base shows no gender differences in OPV immunization rates.

Demand creation

- The demand for health services in Somalia is low due to a) lack of available and affordable health services near communities b) low quality of services and often stock out of essential drugs c) lack of health awareness d) cultural factors that affect demand and utilization of health services.
- The GAVI/HSS grant has been very strong on behavior change initiatives and interventions. A strategy for Behavior Change Communication was developed, based on findings from a formative research. In partnership with NGOs, Interpersonal Communication (IPC) training was conducted for the cohort of 40 MCH health staff and LHWs and radio messages broadcasted. It is expected that the LHWs will conduct approximately 100 dialogue sessions per annum. Networks with religious leaders, education institutions and students associations have been created to generate sustained behavior change communications

Regulatory authority and adverse effects

- The Joint Health & Nutrition Programme (JHNP) supports the development of a legal framework for the health sector. Currently, there is no National Regulatory Authority established in Puntland and South Central. Somaliland however, has a functional quality control unit, established following the passing of legislation on regulation of medicines and health supplies. In turn, there is no immunization safety policy in the country.
- Adverse events following immunization (AEFI) is given attention in the recently endorsed EPI policy and the newly developed vaccinators' manual; and injection safety practice is included in all training activities. Notably, all new vaccines introduction trainings include a session on AEFIs. Only during measles SIA have AEFI reporting taken place but no report is ever received from routine immunization services.

3. GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS

3.1. New and underused vaccine support

Grant performance and challenges

In the reporting period, Somalia had two active grants namely: the New Vaccines grant for DTP-HepB-Hib that procured US\$ 2,190,500 worth of vaccines (cumulatively adding to US\$ 7,300,292) and the Health Systems Strengthening (cash grant) that provided US\$ 3,738,808 as last tranche in 2014, amounting to a total of US\$ 11,545,500 through WHO and UNICEF.

NVS grant performance:

- None of the EPI coverage targets as stated in the APR 2014 were met, despite the improvements in coverage gains.
- The coverage levels for all the vaccines remain very low (<60%) for all vaccines. DTP-3 coverage increased from 34% to 49% in 2013 and 2014 respectively. The DTP-1 coverage also declined from 59% to 56%.
- While the 2014 targets were missed for all vaccines, the largest margin was for Penta-3 for which the target was missed by 26% points. It should be noted that the target for Penta3 was revised downwards from 85% to 75% for 2014. The drop-out rate for DTP1 to DTP3 decreased from 16% reported for 2013 to 12% reported for 2014. It should be noted that the drop-out rate target for 2014 was met.
- Vaccine wastage rate has been revised to 25% from 20% set and used in 2014.

Challenges:

- Weak design and limited scope and scale of the existing HSS grant to contribute to strengthening of the routine immunisation system capacities.
- Delays in implementation of critical EVM recommendations and the One EPI plan.
- Security impediments severely restricting the implementation and monitoring of the implementation of EPI activities, especially in South Central;
- The geographical distance between the program management team in Nairobi and the zones poses a challenge to regular visits, communication and technical guidance needed on the ground.
- Limited or no access to EPI services including inaccessible areas
- No district level EPI operations micro-plans at all levels (harmonized and aligned) with the “one EPI plan”);
- Non-availability of immunization services in functional health facilities (short work hours per day, stock outs of vaccines, lack of vaccinators, care and treatment priorities in MCH clinics with limited human resources, practically limited monitoring and supervision);
- Limited and un-harmonized and standardized capacity development for EPI staff;
- Limitation of existing HIS: incompleteness, low data quality; delays of reporting.
- Lack of standardized and harmonized awareness and community participation for EPI;
- Poor vaccine management across the cold chain, leading to situations of over and understock.
- No system for vaccine utilization monitoring and therefore the immunization wastage rates are collations from a few health facility assessment reports that were conducted in the year.
- Weak Joint supervision and monitoring at all levels and use of data for decision making;
- Maintaining full ownership of the health authorities is challenging due to competing demands on the respective decision makers and focal points; this relates to weak coordination of related activities such as health promotion, EPI, HIS;
- Gaps in health service delivery and absence of a referral system, especially in remote areas and for scattered populations;

Progress in the implementation of new introductions/campaigns:

- No NUVI cash-grants were received in the reporting period;
- There are no outstanding recommendations of the IRC that have not been implemented;
- In view of the polio assets for polio eradication, the AFP surveillance infrastructure was specifically planned to be the launching pad for VPD surveillance. It may take time, but eventually, the Polio assets are the single most important resources for strengthening VPD surveillance;
- Compliance with data quality assurance and surveys remains weak in Somalia. No data audit activities were implemented in the reporting period. The post introduction evaluation of DTP-HepB-Hib was not done due to competing activities for WPV outbreak response;
- There were several immunization coverage verification surveys that were however relevant;

Somalia used independent monitoring of immunization coverage in all OPV/SIAs implemented in the reporting period.

Corrective actions:

Weak governance to be corrected by:

- Implementation of ONE EPI plan;
- Development of EP/outreach micro plans at all levels;
- Continue implementation of EVM improvement plan, especially the establishment of a vaccine utilization monitoring system;
- Focused support to the institutional strengthening of regional and district health teams, including EPI units, with existing GAV HSS grant and in complementarity to ongoing activities supported by the JHNP.

Poor quality and inaccessible EPI services to be corrected by:

- Improve access to EPI services through a) increase coverage across all health facilities including PHUs, b) use of LHWs c) re-establish outreaches and acceleration initiatives;
- Increase utilization through standardized BCC approaches and community participation;
- Strong support to infrastructure and logistical component (supplies, warehouses and cold chains): conduct cold chain inventory and develop expansion / replacement plans;
- Strengthen and standardize in-service capacity development across all levels;
- The remuneration of health workers is low and in most times makes recruitment and retention of health workers difficult: explore innovative payment schemes like performance related pay.

Weak generation and use of data for action to be corrected by:

- Support HMIS strengthening and data quality improvement;
- Mentoring health facility staff in analysis and utilization of data at the point of collection;
- Use the Health Information Delivery Team (HIS-, M&E- and HSAT officer) established at the MOH to generate periodic feedback bulletins on HMIS derived indicators and to support the implementation of zonal M&E plans;
- Strengthen strong M&E competencies at MOH and lead agencies in GAVI/HSS implementation to foster use of data for decision making in immunization programming.

Others

- To overcome the security threats of road transport within the country, the program depends on the Humanitarian Air Service (UNHAS) to deliver vaccines to most of the vaccination hubs established in the accessible towns;

NVS renewal request

The country requests for continuation and future renewal of the New Vaccines Support for DTP-HepB-Hib. In the year 2015, the country requests for approval of \$2,190,500 USD to be used to procure:

- 1,062,000 doses of DTP-HepB-Hib
- 1,011,200 pieces of 0.5ml AD syringes/needles and
- 11,125 pieces of safety boxes

The target populations and coverage projections have not been revised. In turn vaccine estimates were also based on attaining the target DTP-3 coverage of 68%, based on the following pre-suppositions:

- a) The UNFPA Population Estimates Survey Somalia (PESS report 2014) report indicates that the total populations of Somalia have increased. The actual numbers to be immunized will be more than estimated from the current figures. Future investment proposals to GAVI will include the revised population estimates.;

- b) The community concerns around current and ongoing measles outbreaks will be used to raise the profile of immunization. In addition, the planned measles follow up SIAs will also be planned and implemented in such a way that they contribute to immunization systems strengthening;
- c) The implementation of the One EPI plan, using polio assets, includes integrated micro planning and is expected to strengthen data availability and quality;
- d) The investments in cold chain implemented by UNICEF (walk-in cold rooms in four satellite points in the country) and over 130 newly procured solar powered refrigerators to be installed in health points currently underserved are expected to improve the access to immunization services;
- e) The essential package of health services (EPHS) program is expected to have a further limited roll out in several regions of the country and includes immunization;
- f) Strategic initiatives to integrate routine immunization services in out-patient therapeutic feeding centers in inaccessible areas. This is expected to bring immunization services even closer to populations that have never been served for years. Given the acceptance of nutrition services, it's hoped that this initiative will provide captive populations for immunization;
- g) Improved access to inaccessible areas due to anticipated improved security and implementation of outreach.

Plans for change in any vaccine presentation(s) or type

- Given the challenges of human resources, limited cold chain storage volumes and coverage, it is the considered opinion of the country that no changes are made to the vaccine presentations or types supplied to Somalia;
- However, availability of 5-dose DTP-HepB-Hib presentations will be reviewed for possible consideration in the subsequent years provided the country is assured of a) adequacy of supply for a whole country to enable nationwide switch in presentation; b) non-significant differences in the cold-chain foot prints per dose; c) availability of funding to facilitate operational trainings for the switch and d) gains in wastage reductions that usually follow small-dose presentations.

New applications or new immunisation programme priorities

- No new vaccine introduction applications are expected in the next two years
- The current cMYP ends December 2015. The next cMYP is planned to be developed by end of current year after which the country will develop an application for a second generation of GAVI/HSS proposal to be submitted early 2016.

3.2. Health systems strengthening (HSS) support

3.2.1 Grant performance and challenges:

- The implementation start of this grant was initially delayed due to time elapsed between the approvals of the HSS proposal and signing of the grant agreement, creating a gap of two years between approval in 2009 and funds received in October 2011. A reprogrammed work plan and budget were submitted for approval through the Annual Progress Report 2013.
- It should be noted that while the baselines were set at the national level, the reporting has been done at a subnational level, which makes it difficult to judge the performance against targets. It should also be noted that the baselines for 6 out of 10 indicators were not available. The baseline survey which took only place in 2014 has not yet been validated by the health authorities. Available data as below were collected by LHS supervisor and WHO/MoH zonal teams.
- A national M&E framework had been developed for all three zones but there is no implementation and follow-up of national strategy implementation. The community based

HIS in place is collecting a lot of data but is not integrated in the national HMIS and valuable data are not analyzed to trigger further action.

- The GAVI HSS grant covers a small fraction of the country with few complementary health interventions to improve health facilities performance. The design of the grant focused in catalytic interventions and innovations in health systems development BUT did not have focus on improving immunization outcome indicators
- GAVI grant activities were generally implemented and largely on schedule (as per revised program timelines) and budget over the course of 2014, but the program did not achieve to contribute meaningfully to meeting any of the impact targets set in 2014 as it supports the deployment of only 200 LHWs and 14 LHW supervisors across the three Somali zones (since 18 months) and supports only 40 MCH facilities and adjacent (52) Health Posts. Vaccinators working in these clinics were retrained and their pre- and posttest results show 'good knowledge and skills' between 75 % (PL) and 100% (SC); some indicators could not be determined such as vaccine wastage rate at those facilities and DTP3 data verification.
- The Lady Health Workers, despite working in sometimes disperse populated catchment areas and challenging circumstances, generally proved their acceptance in the communities and contributed to a modest increase in awareness and uptake of MCH services, including immunization. The immunization of children fully immunized in the catchment areas of the LHWs was between 27% and 32%; for TT2 plus 16%. Most critical challenges for LHWs are the lack of services in vicinity of the communities, lack of immunisation outreach activities to their communities and absence of a referral system that includes transport
- Most of the 40 MCH facilities were rehabilitated, but only 31 were provided with cold chain, vaccines and supplies. Intensified training of vaccinators was conducted in all three zones, based on assessment findings of service provision in all facilities. The grant supports the preparation of district micro-plans and will carry out outreach activities at the 40 supported facilities. Unified tools for a supportive supervision system for PHC were developed and the training of trainers for supportive supervision is under preparation.
- A strategy for Behavior Change Communication was developed, based on findings from a formative research. In partnership with NGOs, Interpersonal Communication (IPC) training was conducted for the cohort of MCH health staff and LHWs and radio messages broadcasted. It is expected that the LHWs will conduct approximately 100 dialogue sessions reaching about 2,000 community members each.
- Annual production of operational research reports on programme relevant topics did not start as planned as the overall implementation of the grant was delayed and it was felt there was nothing yet to conduct OR on. This activity will be implemented in 2015 and beyond;

Corrective actions

Grant management

- To avoid future delay in transfer of payment to the Somalia Health Authorities: WHO prepared MoU/Direct Financial Contribution etc. for the duration of one year; national WHO staff supports liquidation, monitoring of and reporting on payments;
- Closer collaboration with EPI programme: remaining grant will support activities as outlined in the 'ONE EPI PLAN';
- WHO/UNICEF to provide technical support and guidance for discussions on routine immunization as standing agenda point at HSCC and zonal coordination meetings;

Government and leadership

- Intensify support to regional and districts health management: development of ToRs and job description with integration of GAVI / EPI related activities; this includes zonal MoH focal point who should ensure smooth implementation of planned activities;

- Implement the planned supportive supervision systems in line with the EPHS;
- Placement of embedded technical advisors in the three zonal MoH and maximize input from GAVI HSS focal points; The embedded technical support will be focused to EPI technical advisors and Logistics/cold chain advisors;
- Improve GAVI task force coordination mechanisms in the zones.

Service delivery

- Ensure provision of routine immunization services at all GAVI supported facilities;
- Support micro-plan development and implementation of EPI outreach activities;
- Improve linkages and complimentarily with the EPHS program.

Human resources for health

- Fast-track pending in-service training activities;
- Standardize in-service training package across MCH/ HP and community level.

Supplies, equipment and commodities

- Address drastically the unnecessary delays and shortages of supplies at all levels;
- Ensure and support supplies transport and distribution at remote areas;
- Review and contextualize LHW kits components;
- Increase utilization through standardized BCC approaches and community participation;
- Provide support to infrastructure and logistical component (supplies, warehouses and cold chains);

Health Information

- Establish and integrate the community health information system with broader and strengthened HMIS;
- Support the implementation of the zonal M&E plans and the use of integrated data for decision making.

3.2.2. Strategic focus of the HSS grant

The ongoing GAVI HSS grant (reflected in objective 1, 2 and 3) focuses on innovations and interventions that can be used to improve routine immunization coverage if implemented to national scale. Such innovations will provide inputs into future interventions for increasing access to and utilization of immunization services (priority 1 in cMYP 2011 to 2015) as well as to accelerating disease control through increasing the coverage of TT among pregnant women and those at reproductive age (priority 2 of cMYP). Supported by this grant, the development of standardized supportive supervision tools for PHC services have been developed as to improve programme management (priority 3).

The HSS cash-grant concentrates on the increase of access to basic health services and had introduced new cadres of community based health workers (200 Lady Health Workers and their supervisors). The grant also supports health facilities in which catchment areas the ladies are working (40 MCH clinics and attached health posts) through rehabilitation, including cold chain, the provision of vaccines, equipment and medicines, the payment of a moderate amount of incentive and intensified training for vaccinators and nurses in selected areas of maternal and child health.

To increase the low demand for immunization services, a mass awareness campaign using the C4D strategy is being implemented, sustaining the engagement for behavior change in Somalia. The programme also provides support to Ministry of Health zonal, regional and district focal points as to build capacities in public health management and planning.

Due to the limited scope and scale of the HSS grant, with geographical limitation of current implementation sites and small numbers of LHWs deployed and facilities supported, the strategic focus of the remaining period to implement this grant will support the implementation of the ONE EPI plan.

This includes the finalization of district micro plans and implementing outreach services in regions and districts supported by this grant. Special efforts will be made to achieve targets set for the intermediate result indicators: ensuring that all full 40 MCH facilities provide immunization and outreach services and vaccinators are well trained. Continuous training for the LHWs will be intensified as well as their supervision. The content of the kits will be revised and the data that they collect will be reviewed and discussed at zonal level. Unspent funds for the operational research component will support improvement of data generation for immunization. Support to exert governance key functions such as coordination, monitoring and supervision will be intensified through the existing MoH focal points.

3.2.1 Request for a new tranche, no-cost extension, re-allocation or reprogramming of HSS funding / Future HSS application plans

N.A. All funds under the current HSS grant have been disbursed.

- Health authorities have submitted an Expression of Interest (Eoi) on May 8 2015 for the second HSS Performance Based Funding Cash Support.
- A new cMYP will be developed towards end of 2015 to form the basis of a new GAVI HSS application. The current Health Strategic Plan is planned to be updated in 2016.
- The new application is expected to be submitted early/mid 2016.

3.3. Graduation plan implementation (if relevant)

N.A.

3.4. Financial management of all cash grants

[Comment on all bolded areas listed in the table in this section of the guidance document]

UNICEF and WHO manage the HSS funds. Financial statements have been submitted. Changes to management processes in the remaining life span of the grant are not foreseen.

3.5 Recommended actions

Actions	Responsibility (government, WHO, UNICEF, civil society organisations, other partners, Gavi Secretariat)	Timeline	Potential financial resources needed and source(s) of funding
Close collaboration with EPI programme: remaining grant will support activities as outlined in the 'ONE EPI PLAN';	SHA, WHO, UNICEF, HSC	Starting now and ongoing	0
WHO/UNICEF to support routine immunization as standing agenda point at HSC and zonal coordination; improve zonal GAVI task force / coordination mechanisms	WHO/UNICEF	idem	0

Support / review development of job descriptions (where not available) and ToRs for MoH GAVI focal points;	WHO	June	0
Implement the supportive supervision system	SHA, WHO	July	Pool funds with other programmes;
Ensure provision of immunization services / availability of cold chain / supplies at all 40 MCHs	UNICEF	June/July	See grant budget
Support development of micro plans and implement outreach services at GAVI sites	WHO	July to October	
Complete in-service training activities in IMCI and IMPACT	WHO	July to August	
Review composition LHW kit to reflect high demand for certain services	WHO/UNICEF/MoH	August	
Continuous training of LHWs	WHO	On-going	
Develop standardized BCC approach for MCH clinics and LHWs	UNICEF	July	
Support reporting and supportive supervision capacities	WHO	August to September	
Development of 3 rd generation cMYP	WHO	By end 2015	
Embedded EPI technical advisors in all three zonal MOH	WHO	By end of Q3	
Embedded cold chain and logistics advisors in all three zonal MOH	WHO	By end of Q3	

Note: technical staff from UNICEF and WHO involved in the implementation of the grant will provide up-dates on these recommended action points in addition to the regular programme implementation up-date provided at each HSCC meeting.

4. TECHNICAL ASSISTANCE

4.1 Current areas of activities and agency responsibilities

Under this grant, WHO has employed an international HSS advisor and three national officers at each zone to support:

- Technical oversight, grant management and reporting;
- Coordination;
- Data analysis and M&E;
- Improvement of quality of services: supportive supervision, development of treatment protocols, tailored training for vaccinators and nurses;
- Supply management at facility level;

UNICEF with the support of the grant has employed the Communication for Development Specialist at USSC (UNICEF Somali Support Centre) to guide strategic direction of the BCC component, a Communication Development officer based in Somaliland to support day to day implementation of BCC interventions and a Programme Assistant at USSC to support administration.

4.2 Future needs

Additional TA requested for:

As requested by the Somali Health Authorities (to be covered by current grant):

- Short term embedded TA at zonal level:
 - EPI Technical Assistance (to support capacity enhancement and to provide support from within MoHs to strengthen leadership and oversight of programme); to support the institutional capacity building of the existing EPI structures at zonal, regional and district level;
 - Logistics and cold chain management to: assist SHAs in cold chain inventory, establishing logistic vaccine reporting system;
- Long Term TA (new grant implementation):
 - EPI Technical Assistance (to support MoH capacity in Data management and coverage improvement process;
 - BCC/C4D Technical Assistance
 - HSS Technical Assistance (to support with integration and harmonization approaches between EPI and HSS)

Specific TA for support to:

- Coverage verification survey;
- External review and cMYP revision;
- HIS: immunization data quality self-assessment and development of an immunization data quality improvement plan;
- Formulation of new HSS grant proposal;

5. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT & ADDITIONAL COMMENTS

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism:

Ms. Faiza Ibrahim, Director of Planning, Somaliland on behalf of the state health authorities of Somalia presented the draft joint appraisal report to the Health Sector Coordination Committee meeting held on June 9th, 2015.

The joint appraisal report was then subjected to technical review and vetting of UNICEF regional office for East and Southern Africa, WHO regional office for Eastern Mediterranean Region and the GAVI focal points for Somalia. The review comments and edits were collated by WHO and UNICEF Somalia technical team to generate the final report.

Issues raised during debrief of joint appraisal findings to national coordination mechanism:

1. The stagnating reported EPI coverage but was concerned that the reported coverage rates should be interpreted and used in the context of varied rates of incompleteness of HMIS reporting by zones that is highest in Somaliland at 55% and lowest in South Central zone at less than 20%. Secondly, reported vaccinations do not include children above 12 months of age. And the HMIS system from which the reported data is generated does not have institutional data quality assurances.
2. The "One EPI plan" that was developed and circulated to all immunization partners is the harmonized document that outlines the priorities of the national immunization program in Somalia. Although delayed in implementation, all partners and donors are urged to support the roll out and implementation of all or parts of this plan based on their comparative advantages.
3. GAVI grants should be used to support EPHS implementation and vice versa. In addition, opportunities for integration of EPHS and GAVI grants should be pursued while designing the next generation of proposals
4. The GAVI non-cash grant for vaccines ends this year, December 2015. In the absence of a revised multi-year plan for immunization (cMYP), the HSCC learnt that any revisions to the end date of support can only be for one year. In addition, the HSCC recommended that a stock count of current DTP-HepB-Hib vaccines should be undertaken at all levels to generate actual status of balance vaccines in the country. This additional information is critical and should be shared with GAVI as soon as available.
5. In view of the weak HMIS and the plans to develop a 3rd generation cMYP, the HSCC meeting recommended that an EPI coverage survey should be undertaken in 2016 or earlier to provide baselines for future immunization program performance measurement

The Joint Appraisal report was then endorsed as a true reflection of the status of immunization program functioning in Somalia.

Any additional comments from

- Ministry of Health: were provide during discussions
- Partners: NONE
- GAVI Senior Country Manager: technical and editorial suggestions made included in this final version of the report

On behalf of the HSCC:

Abdihamid Ibrahim Ahmed
 Director of policy & planning
 MoH Federal Government of
 Somalia

[Signature]
 22-6-2015

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Version: March 2015

ANNEXES

[Please include the following Annexes when submitting the report, and any others as necessary]

Annex A. Key data (this will be provided by the Gavi Secretariat)

Annex B. Status of implementation of the key actions from the last joint appraisal and any additional High Level Review Panel (HLRP) recommendations

Key actions from the last appraisal or additional HLRP recommendations	Current status of implementation
Targets for OPV, DPT and Penta are all revised downwards for 2014 and 2015, but targets for BCG, measles and TT remain unchanged. Postponement of the penta shipment.	done
Country is required to provide further information on the progress in implementation of EVM recommendations and forward an updated Progress Report on the current status of EVM 'Improvement Plan'.	Included with APR
HSS disbursement of value US\$3,738,808 for 2015 is recommended (note there is a discrepancy of US\$10,000 between the amount requested in APR 9.1.2 and that shown in Table 9.1.3a. The amount recommended is taken as the higher figure)	Done

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

A pre-draft JA Report had been prepared by UNICEF and WHO country team and shared with key partners prior to the mission. Two staff from GAVI secretariat, together with technical officers from UNICEF's and WHO's regional and country offices Hargeisa, Somaliland on May 30.

Due to security concerns, planned visits on day 1 to the Somaliland Ministry of Health, regional health directorate and the regional cold chain were cancelled. A small group, composed of UNICEF, WHO and technical teams from the three zonal Ministries, met at Hotel Mansoor to prepare for the following days. Zonal teams convened as well to compile their presentations into one.

On day 2, all participants met at Ambassador Hotel. Participants included the Directors for Policy & Planning from Hargeisa and Mogadishu, the EPI manager of MoH Puntland, from Somaliland: regional (Marodijex) and district (Arabsyio and Gabiliey) health officers, EPI manager, GAVI HSS focal point, HIS officer, WHO NPO, UNICEF field office staff; from Mogadishu: GAVI HSS focal point, EPI manager from Benadir Region,

A presentation on the progress and implementation challenges of the GAVI HSS grant in the three zones was given by Faiza Ibrahim, the Director for Policy and Planning, MoH Somaliland, followed by an extensive discussion. Additional information was requested on the current immunization situation in the zones and respective presentations were made by EPI managers. On day 3, most of team members travelled to Gogogalwang and Ceelbaxay villages to visit LHWs as well as to MCH centres in Arabsiyo and Gabiley district. A small team composed of UNICEF and WHO technical officers, Directors for Policy & Planning from Hargeisa and Mogadishu as well as one GAVI staff stayed behind to further work on the report. On day 4 (June 3), findings from the field visit were shared as well as observations from the GAVI secretariat, followed by an extensive discussion. Conclusions and recommendations were presented to the HSCC on June 9, widely discussed and comments on the JA mission report considered and incorporated.

Annex D. HSS grant overview

General information on the HSS grant							
1.1 HSS grant approval date		29/09/2011 (WHO)					
1.2 Date of reprogramming approved by IRC, if any		Approved by HSC: 14-09-2013					
1.3 Total grant amount (US\$)		11,545,501 US\$					
1.4 Grant duration		5 years					
1.5 Implementation year		Jan 2010 to Dec 2015 (start delayed0					
(US\$ in million)	2008	2009	2010	2011	2012	2013	2014
1.6 Grant approved as per Decision Letter			2,786,791	2,476,727	2,222,902	2,017,222	2,017,222
1.7 Disbursement of tranches				2,786,791	2,470,387	0	2,549,515
1.8 Annual expenditure				7,758	1,412,524	1,461,831	1,277,818
1.9 Delays in implementation (yes/no), with reasons		Yes, there have been delays in implementation of the GAVI/HSS grant activities due to: <ul style="list-style-type: none"> ▪ Between submission of the application and approval; ▪ Between approval and transfer of first tranche; ▪ Between approval of re-programming and transfer of tranche in 2014; ▪ In 2015 due to late transfer of last tranche; ▪ Ongoing due to internal administrative procedures and at times delayed compliance from MoHs side; 					
1.10 Previous HSS grants (duration and amount approved)		NA					

1.11 List HSS grant objectives

- Improve availability and utilization of immunization and other essential MCH services;
- Improve access of rural communities to immunization and other basic services through support to HP and introducing 200 FHWs;
- Improve awareness and demand for immunization and other essential quality MCH services through BCC;
- Provide evidence on utilization, impact and cost of services for generating appropriate equitable and affordable health care delivery models for maximizing the efficiency and equity of immunization and other essential services through managing a programme of operational / health system research

- Amount and scope of reprogramming (if relevant)

Was within 15% flexibility of budget lines; more focus on activities in support to one-EPI-plan such as training of LLM and MLM in EPI and production of micro-plans and support to outreach services;

List of Abbreviations

AEFI	Adverse Events Following Immunization
BCC	Behavioral Change Communication
HMIS	Health Management Information System
HP	Health Post
HSAT	Health Systems Analysis Team
HSCC	Health Sector Coordination Mechanism
ICC	Immunization Inter-Agency Coordination
JHNP	Joint Health and Nutrition Programme
LHW	Lady Health Workers
MCH	Maternal and Child Health
NUVI	New and under-utilized Vaccines Implementation
PHU	Primary Health Unit
SHA	Somali Health Authorities
SIA	Supplementary Immunization Activities
WUENIC	WHO/UNICEF Estimates of National Immunization Coverage

<Copied from a separate document and embedded in the JA form>

**PRIORITIZATION OF TECHNICAL ASSISTANCE NEEDS
(BASED ON IMPLEMENTATION PROCESSES AT ZONAL LEVELS)**

S. Nr	TA need	Justification	Intended outcome	Duration	Cost estimate	Partner to Host Post
A. Short-Term						
A.1	Zonal EPI Technical Assistance (to support capacity enhancement and to provide support from within MoHs to strengthen leadership and oversight of programme)	<ul style="list-style-type: none"> • Support to improve low EPI coverage through coordinated efforts of planning, programme management, development of facility-based micro-plans by promoting uptake and delivery. • Support programme management at MoH, oversight and implementation. • Support regional and district level micro- plans development. • Support to implement ISS guideline and tools for adequate monitoring and evaluation of programme and to ensure alignment to the National M&E framework. • Support the MoH with the cMYP development based on the upcoming Sustainable Develop Goals (SDG) 2016 – 2020. 	<ul style="list-style-type: none"> • Better and more efficient EPI programme management through planning, micro-plans availability at various levels within the ministries to support coverage improvement approaches. • Assist in development of micr-planning based on regional, district, Health facility levels. • Conduct Training Need Assessment to improve implementation process. • Assist and provide the necessary advices to the zonal HAs in the implementation of the micro-plan for more efficient implementation. • To support ISS implementation, provide supportive supervision opportunities for MoH human resources and to effectively monitor programme through concerted M&E approaches. 	I year (Sept 2015 – Sept 2016)	As per UN payment standards at minimum rate P3	WHO

S. Nr	TA need	Justification	Intended outcome	Duration	Cost estimate	Partner to Host Post
A.2	Zonal Logistic and cold chain technical advisor	<ul style="list-style-type: none"> Improve the poor logistic management system for vaccines particularly at the facility level. Support data availability for vaccine utilization and stock availability reports. 	<ul style="list-style-type: none"> Assist the three zonal HAs with Inventory of cold chain system and vaccine management. Establish vaccine logistic reporting and management system 	1 year (Sept 2015 – Sept 2016)	As per UN payment standards at minimum rate P3	UNICEF
B. Long Term (New grant implementation)						
B.1	Long-term Zonal EPI Technical Assistance (to support MoH capacity in Data management and coverage improvement process)	<ul style="list-style-type: none"> Continue supporting long-term EPI coverage improvement through concerted coordinated efforts, planning, programme management, utilization of micro-plans. Support regional, district and facility level micro-plans utilization. Support to develop EPI data quality auditing (DQA). Continue supporting ISS tools for adequate monitoring and evaluation of programme. 	<ul style="list-style-type: none"> Assist MoH with the implementation of the 'One EPI Plan'. Support continued evaluation of the zonal implementation of the micro-plan annually to make the necessary improvements. Support to formulate quarterly, bi-annually and annual report for critical analysis EPI coverage data and utilization bottlenecks. Support to develop plans and relevant concept notes for operational research and EPI surveys. 	3 years	As per UN payment standards at minimum rate P3	WHO
B.2	Long-term Zonal BCC/C4D Technical Assistance	<ul style="list-style-type: none"> Support the development of relevant materials for improving the low community awareness of EPI benefits to increase demand and utilization EPI services. Support the implementation of full scale of BCC strategy implementation. Support to develop IEC material for the relevant Levels and particularly for the facility level. 	<ul style="list-style-type: none"> Support to implement BCC/C4D strategy. Train health workforce on BCC materials at all levels and support to create a pool of TOT for continued in-service training. Assist to design, test and develop IEC material. Design and conduct Knowledge, Attitude and Practice (KAP) survey on EPI utilization and demand behaviors. 	2 years	As per UN payment standards at minimum rate P3	UNICEF

S. Nr	TA need	Justification	Intended outcome	Duration	Cost estimate	Partner to Host Post
B.3	Long-term Zonal HSS Technical Assistance (to support integration and harmonization approaches between EPI and HSS)	<ul style="list-style-type: none"> Support system strengthening approach based on integration, harmonization and relevant linkage to EPI coverage improvement. Support enhancement of the facility based EPI with relevant outreach services based on the 'One EPI Plan'. Support with strengthening regional and district level EPI management and data usage for coverage improvement. Support with analytical report writing (reporting techniques) for annual reports, proposal and concept note formulation. 	<ul style="list-style-type: none"> Support with integration, harmonization to improve EPI coverage and utilization. Input to the full and successful implementation of the 'One EPI Plan'. Support to strengthen health system, regional, district and facility level management of EPI programme. Support with report writing, data utilization and data analysis. Support and contribute to M&E framework achievements including indicators (based on the M&E framework as per the HSSP). 	3 years	As per UN payment standards at minimum rate P3	WHO
C. Specific TA						
	Short terms TA (team) for conducting coverage verification survey;	<ul style="list-style-type: none"> Last survey that collected immunization outcome data was MICS 2011; Was not conducted in CSZ; GAVI grant requires conducting survey every 5 years; 	<ul style="list-style-type: none"> Up-date on immunization coverage figures; 	In 2016 (6 months)	Tbd.	WHO
	Short term TA (team) to conduct external review and cMYP revision;	<ul style="list-style-type: none"> Current cMYP ends in 2015; 	<ul style="list-style-type: none"> Reviewed and revised cMYP; 	1 month	Travel and operational cost	UNICEF/WHO country office team (desk review)
	Short term and continuous support to HIS: immunization data quality self-assessment and development of an immunization data quality	<ul style="list-style-type: none"> Currently, there is no mechanisms in place to ensure data quality; Majority of data collected at facility level through routine HIS; 	<ul style="list-style-type: none"> Mechanism and processes established to improve data quality; 	Q3 and 4, 2015	Travel and operational cost	UNICEF/WHO country office team

S. Nr	TA need	Justification	Intended outcome	Duration	Cost estimate	Partner to Host Post
	improvement plan;					
	Short term TA for formulation of new HSS grant proposal;	<ul style="list-style-type: none"> • Current HSS grant ends on October 1, 2016; • Country expressed interest to apply for new grant 	<ul style="list-style-type: none"> • New HSS grant proposal developed; 	2 months (in Q4)	30,000 US\$	WHO