GAVI Alliance

Annual Progress Report 2013

Submitted by

The Government of

Somalia

Reporting on year: **2013**

Requesting for support year: **2015**

Date of submission: **30/05/2014**

Deadline for submission: 02/06/2014

Please submit the APR 2013 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: **2013**

Requesting for support year: **2015**

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

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 2013	Request for Approval of	Eligible For 2013 ISS reward
ISS	No	next tranche: N/A	N/A
HSS	Yes	next tranche of HSS Grant Yes	N/A
CSO Type A	No	Not applicable	N/A
CSO Type B	No	CSO Type B extension per GAVI Board Decision in July 2013: N/A	N/A
HSFP	No	Next tranch of HSFP Grant N/A	N/A
VIG	Yes	Not applicable	N/A
COS	No	Not applicable	N/A

VIG: Vaccine Introduction Grant; COS: Campaign Operational Support

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2012 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	General Ahmed Mohamed Mahmoud	**Name**	NA
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):

Full name	Position	Telephone	Email

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), Health Sector Coordiantion Committee , 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
Dr. Mohamed Farah, Chair of the HSC	Ministry of Health, Federal Government Somalia		

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 2014

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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)			
	2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2013	Current estimation
Total births	380,164	382,433	391,569	391,569	403,316	403,316
Total infants' deaths	41,438	41,304	42,681	42,681	43,961	43,961
Total surviving infants	338726	341,129	348,888	348,888	359,355	359,355
Total pregnant women	380,164	478,042	391,569	391,569	403,316	403,316
Number of infants vaccinated (to be vaccinated) with BCG	209,090	125,473	234,941	234,941	282,321	282,321
BCG coverage	55 %	33 %	60 %	60 %	70 %	70 %
Number of infants vaccinated (to be vaccinated) with OPV3	270,981	82,285	296,555	209,332	323,420	244,222
OPV3 coverage	80 %	24 %	85 %	60 %	90 %	68 %
Number of infants vaccinated (to be vaccinated) with DTP1	311,628	106,331	327,955	261,666	348,574	279,110
Number of infants vaccinated (to be vaccinated) with DTP3	270,981	89,788	296,555	209,332	323,420	244,222
DTP3 coverage	80 %	26 %	85 %	60 %	90 %	68 %
Wastage*[1]* rate in base-year and planned thereafter (%) for DTP	0	25	0	20	0	20
Wastage*[1]* factor in base-year and planned thereafter for DTP	1.00	1.33	1.00	1.25	1.00	1.25
Number of infants vaccinated (to be vaccinated) with 1 dose of DTP-HepB-Hib	292,152	106,331	327,955	261,666	348,574	279,110
Number of infants vaccinated (to be vaccinated) with 3 dose of DTP-HepB-Hib	292,152	100,564	327,955	209,332	323,420	244,222
DTP-HepB-Hib coverage	86 %	29 %	94 %	60 %	90 %	68 %
Wastage*[1]* rate in base-year and planned thereafter (%) *[2]*	25	20	25	20	20	20
Wastage*[1]* factor in base-year and planned thereafter (%)	1.33	1.25	1.33	1.25	1.25	1.25
Maximum wastage rate value for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	25 %	0 %	25 %	25 %	25 %	25 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	287,917	100,564	313,999	313,999	341,387	341,387
Measles coverage	85 %	29 %	90 %	90 %	95 %	95 %
Pregnant women vaccinated with TT+	209,090	115,044	254,520	254,520	282,321	282,321

TT+ coverage	55 %	24 %	65 %	65 %	70 %	70 %
Vit A supplement to mothers within 6 weeks from delivery	0	0	0	0	0	0
Vit A supplement to infants after 6 months	287,917	161,844	313,999	313,999	341,387	341,387
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	13 %	16 %	10 %	20 %	7 %	12 %

** 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 2013 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2013.** The numbers for 2014 - 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 insecurity in the country, target could not be acheived.

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

  No change

5.2. Immunisation achievements in 2013

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 2013 and how these were addressed:

- **Major achievements in Somalia, 2013<?xml:namespace prefix = o />**

  - **New vaccine introduction**
    - Training conducted
    - Pentavalent vaccine introduced with launching in the presence of H.E the president of Somalia, dignitaries, GAVI/UNICEF/WHO colleagues
  - **Vaccine management**
    - EVM assessment conducted
    - EVM Improvement plan developed
  - **Restarting of Immunization services**
    - Immunization services were restarted in very few areas of southern Somalia, where access was established.
  - **Immunization Program Support:**
    - EPI unit of the three MOHs supported technically and financially
    - One round of CHD conducted in accessible areas of south-central zone, where access to immunization has been banned.

- Supported the training and implementation of RED approach.
- Strengthened cold chain facility with two cold rooms, freezers, refrigerators, cold boxes and icepacks

Policy and Planning

- EPI policy drafted and circulated to partners for discussion
- Situation analysis made
- Based on identified priority areas, Coverage Improvement Plan (CIP) developed.

Training and capacity building

- International workshop participation facilitated and supported for three MOH staff
- Training on Pentavalent introduction conducted for all MCH workers

Communication and advocacy activities conducted

- World Immunization Week conducted
- Communication strategy developed

Outbreak of polio contained

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

Targets for 2013 were not reached. The main reason was insecurity and inaccessibility of most regions of southern Somalia. In Central-South zone (CSZ), about half of the districts were not accessible, and immunization sessions could only be held at the health facilities. Activities outside the MCH such as outreach or mobile immunization activities, CHDs or others immunization campaigns were not allowed.

As indicated in the below table, the DTP coverage in SC zone, where about 70% of the population is found is almost half of the coverage in relatively stable areas of north Somalia.

Zone <?xml:namespace prefix = o />

DTP3 Coverage

in % percent

Remark

Somaliland

39

Fully accessible

Puntland

26

Fully accessible

SC Zone

14

About 50% inaccessible geographically

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? **no, not 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, immunization coverage of boys was slightly higher than that of girls. 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. Vaccinators are advised to report any such discrimination, if and when they occur. Health workers have been trained to provide services, irrespective of the gender of infants. Supervisors are advised to report and take immediate action, in an event of overt/covert gender discrimination. <?xml:namespace prefix = o />

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/)

In as much as possible, female vaccinators are given due priority in vaccinator selection during campaigns. Therefore, about 75% of vaccinators in CHD campaigns are females. 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.

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.<?xml:namespace prefix = o />

However, there is a discrepancy between administrative data and MICS data. Immunization coverage as reported by MICS is by far 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 population estimates is a critical issue as the last population census was conducted in 1974. Additionally, the increasing number of districts; the large pastoral and nomadic population; and displacement of population due to 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 2013 will only be available in July 2014 and can have

retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2012 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 catchment population is not defined for facilities. Additionally, data is sent from facilities to the central level at the Ministry of Health without analysis from the facility and is therefore not utilized to improve the performance at the operational level.<?xml:namespace prefix = o />

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2011 to the present.

Major activities undertaken to improve data management: <?xml:namespace prefix = o />

1. Transfer the ownership of HMIS from UNICEF to MOH in stable zones of Somaliland and 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 Somaliland and Puntland.

3. Standardization of HMIS tools across three zones, through consultation and coordination with Health Sector, and endorsement by three MOHs.

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.

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.

Major activities planned to improve data management

1. Further training for data management and analysis skills, through sub-contracting technical agency and overseas short term workshop/training.<?xml:namespace prefix = o />

2. Further promoting utilization of data across MOH: National, Regional, District level to service delivery level.

3. Focus on SC zone HMIS unit establishment

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

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 2013	Source of funding						
		Country	GAVI	UNICEF	WHO	JHNP	NA	NA
Traditional Vaccines*	467,541	0	0	467,541	0	0	0	0
New and underused Vaccines**	3,214,441	0	2,907,080	0	0	307,361	0	0
Injection supplies (both AD syringes and syringes other than ADs)	275,920	0	0	275,920	0	0	0	0

Cold Chain equipment	1,103,618	0	0	1,103,618	0	0	0	0
Personnel	63,400	0	0	0	63,400	0	0	0
Other routine recurrent costs	167,998	0	0	0	167,998	0	0	0
Other Capital Costs	0	0	0	0	0	0	0	0
Campaigns costs	3,100,000	0	0	0	3,100,000	0	0	0
Polio campaign: expenditure currently not available. Estimated at more than USD 15 million		0	0	0	0	0	0	0
Total Expenditures for Immunisation	8,392,918							
Total Government Health		0	2,907,080	1,847,079	3,331,398	307,361	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 2014 and 2015

In Somalia, the new government is yet to fund immunization activities. So far, there are about 67 immunization partners that are implementing immunization activities across CSZ with UNICEF and WHO as the major financers. UNICEF will continue to provide traditional vaccines in 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 2013? **4**

Please attach the minutes **(Document nº 4)** from the ICC meeting in 2014 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 concerns have been discussed all along: population figures and sustainability of the program, especially the co-financing issue. The new government is yet to financially establish itself; and until then the co-financing issue need to be discussed by the HSC.

NOTE

The Somali Health Authorities and Health partners did an institutional analysis of the organization and governance arrangements of the Somali Health Sector. This analysis was done in April and led to the temporary closure of the HS Coordination office, which was the secretariat to the HSC and all technical working groups. However there are plans

underway to revitalizing the HSC technical working groups which include the EPI/Child Health & Immunization Working Group and the Health Sector Committee. <?xml:namespace prefix = o />

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

If Yes, which ones?

List CSO member organisations:
Cosv
CISP
Trochair
WVI
SRCS/IFRC
COOPI
Trochair
IMC
IRC
INTERSOS
Swiss Kalmo
ARD

5.8. Priority actions in 2014 to 2015

What are the country's main objectives and priority actions for its EPI programme for 2014 to 2015

Based on the Coverage Improvement Plan (CIP) developed by the country, the main priorities to improve routine immunization coverage are identified as follows: <?xml:namespace prefix = o />

o **Governance, management and planning**

o Programme management: Partners will support MOHs build management structures in 20 regions.

o Denominators: Partners will help MOHs organize, a workshop to determine and agree on denominators.

o Micro-plans: Partners will assist the government develop 98 district microplans

o **Service Delivery**

o Partners will assist MOHs to expand immunization services to all population.

o Depending on fund availability, CHDs will be conducted to improve immunization coverage

o UNICEF/WHO and all partners will assist the government; conduct training at zone, region, and district and health facility level.

o Target for 2014: DTP3 coverage of 60%

o **Monitoring and evaluation**

o Data management and monitoring EPI activities: training will be conducted to improve data management and monitoring.

o Immunization safety /AEFI surveillance. AEFI guidelines will be prepared, focal persons for reporting identified and training conducted.

o Partners will support MOHs conduct supportive supervision.

- **Supply and logistics**
- Maintain vaccine and bundle supply
- Establishment of cold room in CSZ zone.
- **Community Demand**
- **Increase Involvement of higher Government authorities in advocacy and communication for immunization**
- **Train about 80% vaccinators on inter-personal communication skills**

Conduct World Immunization Week

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 2013

Vaccine	Types of syringe used in 2013 routine EPI	Funding sources of 2013
BCG	0.05 ml	UNICEF
Measles	0.5 ml	UNICEF
TT	0.5 ml	UNICEF
DTP-containing vaccine	0.5 ml	GAVI/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 2013 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 2013

Somalia is not reporting on Immunisation Services Support (ISS) fund utilisation in 2013

6.2. Detailed expenditure of ISS funds during the 2013 calendar year

Somalia is not reporting on Immunisation Services Support (ISS) fund utilisation in 2013

6.3. Request for ISS reward

Request for ISS reward achievement in Somalia is not applicable for 2013

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

7.1. Receipt of new & under-used vaccines for 2013 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2013 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below

Table 7.1: Vaccines received for 2013 vaccinations against approvals for 2013

	[A]	[B]		
Vaccine type	**Total doses for 2013 in Decision Letter**	**Total doses received by 31 December 2013**	**Total doses of postponed deliveries in 2013**	**Did the country experience any stockouts at any level in 2013?**
DTP-HepB-Hib	1,457,500	1,480,080	0	No

**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? ...)

  No significat difference

- 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.

  No problem encountered with Pentavalent vaccine

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 2013

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2013, 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	Yes	23/04/2013
The time and scale of introduction was as planned in the proposal? If No, Why ?	Yes	

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))

NA

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? **Not selected**

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

No special study.

7.3. New Vaccine Introduction Grant lump sums 2013

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2013 (A)	304,500	0
Remaining funds (carry over) from 2012 (B)	0	0

Total funds available in 2013 (C=A+B)	304,500	0
Total Expenditures in 2013 (D)	304,500	0
Balance carried over to 2014 (E=C-D)	0	0

Detailed expenditure of New Vaccines Introduction Grant funds during the 2013 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2013 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

- Training of health workers

- Cold chain maintenance and improvement

- Advocay and communications

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

Transfer of fund (UNICEF portion) from WHO to UNICEF has been very difficult.

Please describe the activities that will be undertaken with any remaining balance of funds for 2014 onwards

No balance is available

7.4. Report on country co-financing in 2013

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2013?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
	Q.2: Which were the amounts of funding for country co-financing in reporting year 2013 from the following sources?	
Government	0	
Donor	307,361	
Other		
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ 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 2015 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2015	Source of funding
Awarded Vaccine #1: DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		

	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing

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/

NA

Is support from GAVI, in form of new and under-used vaccines and injection supplies, reported in the national health sector budget? **Yes**

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? **February 2013**

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

No change

When is the next Effective Vaccine Management (EVM) assessment planned? **March 2015**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2013

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 2014

Renewal of multi-year vaccines support for Somalia is not available in 2014

7.9. Request for continued support for vaccines for 2015 vaccination programme

In order to request NVS support for 2015 vaccination do the following

Confirm here below that your request for 2015 vaccines support is as per 7.11 Calculation of requirements
Yes

If you don’t confirm, please explain

7.10. Weighted average prices of supply and related freight cost

Table 7.10.1: Commodities Cost

Estimated prices of supply are not disclosed

Table 7.10.2: Freight Cost

Vaccine Antigens	VaccineTypes	No Threshold	200,000$		250,000$	
			<=	>	<=	>
DTP-HepB	HEPBHIB	2.00 %				
HPV bivalent	HPV	3.50 %				
HPV quadrivalent	HPV	3.50 %				
Measles second dose	MEASLES	14.00 %				
Meningococcal type A	MENINACONJUGATE	10.20 %				
MR	MR	13.20 %				
Pneumococcal (PCV10)	PNEUMO	3.00 %				
Pneumococcal (PCV13)	PNEUMO	6.00 %				
Rotavirus	ROTA	5.00 %				
Yellow Fever	YF	7.80 %				

Vaccine Antigens	VaccineTypes	500,000$		2,000,000$	
		<=	>	<=	>
DTP-HepB	HEPBHIB				
DTP-HepB-Hib	HEPBHIB	25.50 %	6.40 %		
HPV bivalent	HPV				
HPV quadrivalent	HPV				
Measles second dose	MEASLES				
Meningococcal type A	MENINACONJUGATE				
MR	MR				
Pneumococcal (PCV10)	PNEUMO				
Pneumococcal (PCV13)	PNEUMO				
Rotavirus	ROTA				
Yellow Fever	YF				

7.11. Calculation of requirements

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

ID		Source		2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	338,726	348,888	359,355	1,046,969
	Number of children to be vaccinated with the first dose	Table 4	#	292,152	327,955	279,110	899,217
	Number of children to be vaccinated with the third dose	Table 4	#	292,152	327,955	244,222	864,329
	Immunisation coverage with	Table 4	%	86.25 %	94.00 %	67.96 %	

	the third dose						
	Number of doses per child	Parameter	#	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.33	1.33	1.25	
	Vaccine stock on 31st December 2013 * (see explanation footnote)		#	0			
	Vaccine stock on 1 January 2014 ** (see explanation footnote)		#	0			
	Number of doses per vial	Parameter	#		10	10	
	AD syringes required	Parameter	#		Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	
	Safety boxes required	Parameter	#		Yes	Yes	
cc	Country co-financing per dose	Co-financing table	$		0.20	0.20	
ca	AD syringe price per unit	Table 7.10.1	$		0.0450	0.0450	
cr	Reconstitution syringe price per unit	Table 7.10.1	$		0	0	
cs	Safety box price per unit	Table 7.10.1	$		0.0050	0.0050	
fv	Freight cost as % of vaccines value	Table 7.10.2	%		6.40 %	6.40 %	
fd	Freight cost as % of devices value	Parameter	%		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 2014; if there is a difference between the stock on 31st December 2013 and 1st January 2014, please explain why in the box below.

The central store is in Nairobi and the three zonal stores are within Somalia. Therefore, it is difficult to have the vaccince stock, as of now.

For pentavalent vaccines, GAVI applies a benchmark of 4.5 months of buffer + operational stocks. Countries should state their buffer + operational stock requirements when different from the benchmark up to a maximum of 6 months. For support on how to calculate the buffer and operational stock levels, please contact WHO or UNICEF. By default, a buffer + operational stock of 4.5 months is pre-selected.

Not defined

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

Co-financing group	Low

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

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

		2014	2015
Number of vaccine doses	#	1,229,500	713,900

Number of AD syringes	#	1,141,200	652,200
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	12,575	7,175
Total value to be co-financed by GAVI	$	2,570,000	1,510,000

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

		2014	2015
Number of vaccine doses	#	133,100	76,200
Number of AD syringes	#	0	0
Number of re-constitution syringes	#	0	0
Number of safety boxes	#	0	0
Total value to be co-financed by the Country <i>[1]</i>	$	272,500	158,000

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

		Formula	2013	2014		
				Total	Government	GAVI
A	**Country co-finance**	*V*	0.00 %	9.76 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	292,152	327,955	32,024	295,931
B1	**Number of children to be vaccinated with the third dose**	*Table 4*	292,152	327,955	32,024	295,931
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3	3		
D	**Number of doses needed**	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	876,457	983,865	96,072	887,793
E	**Estimated vaccine wastage factor**	*Table 4*	1.33	1.33		
F	**Number of doses needed including wastage**	*D X E*		1,308,541	127,775	1,180,766
G	**Vaccines buffer stock**	*((D - D of previous year) x 0.375) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.375)*		53,570	5,231	48,339
H	**Stock to be deducted**	*H1 - F of previous year x 0.375*				
H1	**Calculated opening stock**	*H2 (2014) + H3 (2014) - F (2014)*				
H2	**Reported stock on January 1st**	*Table 7.11.1*	0	0		
H3	**Shipment plan**	*UNICEF shipment report*		1,344,300		
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*		1,362,500	133,044	1,229,456
J	**Number of doses per vial**	*Vaccine Parameter*		10		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*		1,141,179	0	1,141,179
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*		0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) / 100 x 1.10*		12,553	0	12,553
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*		2,622,813	256,109	2,366,704
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*		51,354	0	51,354
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)*		63	0	63
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*		167,861	16,392	151,469
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)*		2,842,091	272,500	2,569,591
U	**Total country co-financing**	*I x country co-financing per dose (cc)*		272,500		
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*		9.76 %		

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

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

		Formula	2015		
			Total	Government	GAVI
A	**Country co-finance**	*V*	9.64 %		
B	**Number of children to be vaccinated with the first dose**	*Table 4*	279,110	26,919	252,191
B1	**Number of children to be vaccinated with the third dose**	*Table 4*	244,222	23,554	220,668
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3		
D	**Number of doses needed**	*B + B1 + Target for the 2nd dose ((B -0.41 x (B - B1))*	788,138	76,012	712,126
E	**Estimated vaccine wastage factor**	*Table 4*	1.25		
F	**Number of doses needed including wastage**	*D X E*	985,173	95,015	890,158
G	**Vaccines buffer stock**	*((D - D of previous year) x 0.375) + (((D x E - D) - (D of previous year x E of previous year - D of previous year)) x 0.375)*	- 73,397	- 7,078	- 66,319
H	**Stock to be deducted**	*H1 - F of previous year x 0.375*	121,911	11,758	110,153
H1	**Calculated opening stock**	*H2 (2014) + H3 (2014) - F (2014)*	455,290	43,911	411,379
H2	**Reported stock on January 1st**	*Table 7.11.1*			
H3	**Shipment plan**	*UNICEF shipment report*			
I	**Total vaccine doses needed**	*Round up((F + G - H) / vaccine package size) x vaccine package size*	790,000	76,191	713,809
J	**Number of doses per vial**	*Vaccine Parameter*	10		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) x 1.10*	652,112	0	652,112
L	**Reconstitution syringes (+ 10% wastage) needed**	*(I / J) x 1.10*	0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) / 100 x 1.10*	7,174	0	7,174
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*	1,539,710	148,497	1,391,213
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*	29,346	0	29,346
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)*	36	0	36
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*	98,542	9,504	89,038
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)*	1,667,634	158,000	1,509,634
U	**Total country co-financing**	*I x country co-financing per dose (cc)*	158,000		
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*	9.64 %		

Given that the shipment plan of 2014 is not yet available, the volume approved for 2014 is used as our best proxy of 2014 shipment. The information would be updated when the shipment plan will become available.

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 2013**. All countries are expected to report on:

   a. Progress achieved in 2013

   b. HSS implementation during January – April 2014 (interim reporting)

   c. Plans for 2015

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

For countries that received HSS funds within the last 3 months of 2013, or experienced other delays that limited implementation in 2013, 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 2013 fiscal year starts in January 2013 and ends in December 2013, HSS reports should be received by the GAVI Alliance before **15th May 2014**. 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 2014, the HSS reports are expected by GAVI Alliance by September 2014.

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 2013

   b. Minutes of the HSCC meeting in 2014 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2013 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 2013 and request of a new tranche

For countries that have previously received the final disbursement of all GAVI approved funds for the HSS grant and have no further funds to request: Is the implementation of the HSS grant completed ? **Not selected**

If NO, please indicate the anticipated date for completion of the HSS grant.

Final disbursement due in 2015, end of grant December 2015

Please attach any studies or assessments related to or funded by the GAVI HSS grant.

Please attach data disaggregated by sex, rural/urban, district/state where available, particularly for immunisation coverage indicators. This is especially important if GAVI HSS grants are used to target specific populations and/or geographic areas in the country.

If CSOs were involved in the implementation of the HSS grant, please attach a list of the CSOs engaged in grant implementation, the funding received by CSOs from the GAVI HSS grant, and the activities that they have been involved in. If CSO involvement was included in the original proposal approved by GAVI but no funds were provided to CSOs, please explain why not.

The main implementation partner of this grant are the three zonal Ministries of Health, Kow Media Corp (KMC), IHSAN religious network Puntland, Puntland Students Consultancy Association, Radio Daljir, Telsom media and Radio Hargeisa.

Please see http://www.gavialliance.org/support/cso/ for GAVI's CSO Implementation Framework

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

Please attach the latest reported National Results/M&E Framework for the health sector (with actual reported figures for the most recent year available in country).

9.1.1. Report on the use of HSS funds in **2013**

Please complete Table 9.1.3.a and 9.1.3.b (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: **3728808** US$

These funds should be sufficient to carry out HSS grant implementation through December 2015.

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)$

	2008	2009	2010	2011	2012	2013
Original annual budgets (*as per the originally approved HSS proposal*)			2786791	2476727	2222902	2017222
Revised annual budgets (*if revised by previous Annual Progress Reviews*)				48150	1019474	2839438

Total funds received from GAVI during the calendar year (*A*)				2786791	2470387	0
Remaining funds (carry over) from previous year (*B*)					3257258	2382731
Total Funds available during the calendar year (*C=A+B*)				2786791	5727645	2382731
Total expenditure during the calendar year (*D*)				7758	1412524	1461831
Balance carried forward to next calendar year (*E=C-D*)				2779033	4315121	920900
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	2786791	2470387	0

	2014	2015	2016	2017
Original annual budgets (*as per the originally approved HSS proposal*)	2040538			
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	3899631	3738808		
Total funds received from GAVI during the calendar year (*A*)	2549515			
Remaining funds (carry over) from previous year (*B*)	653062			
Total Funds available during the calendar year (*C=A+B*)	3202577			
Total expenditure during the calendar year (*D*)	1983738			
Balance carried forward to next calendar year (*E=C-D*)	1218839			
Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]	2549515	3738808	0	0

Table 9.1.3b (Local currency)

	2008	2009	2010	2011	2012	2013
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

	2014	2015	2016	2017
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	2008	2009	2010	2011	2012	2013
Opening on 1 January						
Closing on 31 December						

Detailed expenditure of HSS funds during the 2013 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2013 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 2014 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. <?xml:namespace prefix = o />

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.

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 planning of activities and human resources management as well as for all aspects of financial management, travel and procurement systems allowing country, regional and headquarters offices to access relevant information in real-time.

These HSS funds are not reflected in the national health sector plan or national health budget. However, currently a Joint Annual Review is ongoing of the HSSPs AWP 2013. Later the year, a JANS is planned of the zonal HSSPs. WHO is supporting an assessment of the financial management system and a health expenditure review is underway. All these activities aim on improving the planning and budgeting process of the SHAs and to align ongoing and future projects to one health plan and 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 2013 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 2013 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2013**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
1.2.: Rehabilitation of selected MCH centers		100	UNICEF reports Partners reports MoH certification documents
1.3. Procurement and supply of essential medicines and equipment for MCH services (based on gaps)	ongoing	100	UNICEF reports Partners reports

1.4. Provide comprehensive support for BEMONC in 3 selected MCH centers in the 3	The health facilities have been identified in 2013; support will be done in 2014 as per the work plan	75	UNICEF reports Partners reports MoH Meeting minutes
1.5. Development / adapt curriculum for training of MCH and EPI staff in supervision, outreach and HMIS	idem	100	Training report; manual;
1.6. Conduct training of MCH and EPI staff (in 40 MCH centres) communities	repetetive activity	33	Training report
1.7. Develop curriculum for training of all MCH staff in EPI injection safety and vaccine management	idem	100	EPI manual
1.8. Training of MCH centre staff (EPI, injection safety and vaccine management)	also foreseen in Y4 and 5	33	Training report
1.9. Renovation of cold chain equipment in all MCH centres	idem	100	UNICEF reports Partners reports Cold chains equipment were purchased and provided to the selected MCH
1.10. Develop a system of regular EPI outreach from MCH centres to the catchment areas of health posts and FHWs	idem	20	Plans developed for GAVI supported facilities; however, it was decided to first support the production of zonal EPI mircro plans before engaging in selected outreach activities
1.11. Develop a system for regular supervision for MCH centres from regional and zonal MOH	idem	20	Tools
1.12. Provide transport support to MOH for supervision of regional offices, facilities and communities	ongoing throughout project	100	WHO DFC reprorts
1.13. Provide transport support to regional managers for supervision of MCH centres	ongoing throughout project	100	WHO DFC reports
1.14. Provide incentives for EPI outreach and RH staff at MCH centres	ongoing throughout project	100	WHO DFC reports
1.15. Provide incentives for MoH HSS focal points	ongoing throughout project	100	WHO DFC reports
2.2. Recruitment of LHWs	idem	100	Selection reports MoH
2.5. Training of LHWs	idem	100	Training reports; DFC WHO
2.6. Training of LHW supervisors	idem	100	Training reports; DFC WHO
2.7. Develop and implement a system of supportive supervision for FHWs and outreach activities	idem	100	Supervisors' reprot
2.8. Develop and implement a community based HMIS	idem	100	HIS forms
2.9. Printing and distribution of HMIS tools	idem	100	Bill, forms

2.10. Procure and distribute/resupply FCHW kits	idem	100	Bill
2.11. Procure and distribute/re-supply medicines for Health posts (50%)	idem		UNICEF reports Partners reports MoH supervision reports
2.13. Provide incentives to CHWs	ongoing throughout project	100	WHO DFC
2.14. Provide incentives to LHWs	ongoing throughout project	100	WHO DFC
3.1. Formative research to identify key maternal and child caring behaviors and barriers	idem	75	UNICEF reports
3.2. Develop five year strategic communication plan	idem	40	UNICEF reports
3.3. Develop print, audio-visual and IPC package for health workers	idem	100	UNICEF reports
3.4. Develop and broadcast radio programme on key child caring and health practices;	idem	75	UNICEF reports
3.5. Identify three strong communication NGOs to build capacity of existing NGOs and to scale up public awareness at community level	idem	30	postponed to 2014
3.6. Strengthen and establishing structured/systematized partnership with religious leaders, religious organizations, clan leaders, community elders and networks	idem	75	UNICEF reports
3.7. Work with school structures to increase dialogue on key child survival and development messages	idem	75	UNICEF reports
3.8. Develop community friendly materials (discussion guides etc) with key iCCM messages for FCHWs, CHWs, TBAs for home based family promotion	idem	60	UNICEF reports
3.9. Partner with Text to Change company to use interactive SMS text messaging to remind on key child survival messages	idem	45	UNNICEF reports
4.1. Conduct baseline and end-line surveys	idem	30	UNICEF report
4.2. Establish and support operational research committee	idem	75	MoH reports

4.3. Commission operational research studies	idem	0	
4.4. Conduct focus groups for operational research	idem	0	
4.5. Support data analysis and use	idem	10	Community based HIS forms
4.6. Training of MoH managers in operational research	idem	0	
4.8. Technical Assistance for Operational Research		0	

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):	Assessments had been completed earlier; by now, all 40 MCH clinics have been visited and re-assessed as part of the continued monitoring and supervision of the programme, utilizing the elaborated supervision tool; No. of facilities: SL: 13 MCHs; 28 HPs; PL: 12 MCHs; 24 HPs; SC: 15 MCH; 0 HPs;
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. Rehabilitations were completed and certified in the 3 Zones.
Activity 1.3. (UNICEF):	Essential medicines and equipment have been procured and are continuing to be supplied to these facilities on a quarterly basis. Ongoing activity throughout the project lifecycle.
Activity 1.4. (UNICEF):	The 3 health facilities have been identified in each Zone in 2013; Midwifery kits have been provided to these HF in 2014 as per the work plan
Activity 1.5.(WHO):	Curriculum MCH staff: existing curricula have been adapted for training purpose; since EPHS implementation has been launched (or will be launched) in 9 regions, it was decided to develop standard training material for all health workers implementing EPHS and strategize training activities (link to Health Workforce Planning and HR development) ;
Activity 1.6.(WHO):	Training MCH staff: in each zone initial training utilizing available material, had been conducted with emphasis on immunization and MCH (see below); orientation had been given on the role of the LHWs and their responsibilities vis-à-vis the MCH facilities; In Somaliland, it has also been suggested to register health workers prior to training by the National Health Professions Council (NHCP) as to decide on their continued employment and strategy to up-grade their knowledge and skills; training should not be an open-end activity but follow a strategic direction and plan; • SL, a training workshop was held for 39 MCH staff from 13 GAVI-HSS MCH clinics on MCH services including nutritional screening, antenatal care and EPI; • PL: 24 CHWs (health post based) from Bari, Nugal, Sool, Haylan Region on key areas of GAVI HSS; 36 MCH staff from Bari, Nugal Sool, Hayland on key areas of GAVI HSS;
Activity 1.7. (WHO):	Curriculum development for EPI staff: after the reprogramming that had been successfully submitted in October 2013, more emphasis was given to key activities related to EPI: the Somali vaccinator manual was developed and translated, based on WHO guidelines and endorsed by the SHAs;

Activity 1.8. (WHO):	Training of EPI staff: • SL: training was conducted for 31 MCH staff in Marodijeex region on vaccine and cold chain management; SL: 31 MCH staff from EPI sections of 31 MCHs in Maroodijeex region trained on EPI basics including administration of Vaccines, cold chain management, and vaccine preventable diseases. • in SC, 34 MCH staff were trained in EPI with focus on vaccine management In PL 36 MCH staff was trained in Basic EPI;
Activity 1.9. (UNICEF):	UNICEF has procured additional cold chain equipment and delivered them to the three zones. All 40 GAVI-HSS supported facilities have required cold chain equipment.
Activity 1.10. (WHO):	Develop/implement EPI outreach system: zonal teams have developed plans to include the GAVI HSS supported health facilities in outreach activities; however, it was discussed and decided that zonal (national) micro plans should be produced before engaging in outreach activities; these micro plans included into the national Coverage Improvement Plan (CIP) and need to follow standard criteria; the grant will support the production of these micro plans and implement related activities in those areas included under the grant.
Activity 1.11. (WHO)	Supervision system developed: tools that are in line with Somalia's EPHS have been developed for the supervision of PHC services in Q3/2013; SHAs, in complementarity to the Joint Health & Nutrition Programme (JHNP), decided that the supervision system, supported by this grant and as contribution to health systems strengthening, should address and include all facilities and relevant MoH staff; concept notes and training plans for supervisors are being development and a first draft will be shared by end April.
Activity 1.12. (WHO	Transportation support for supervision from central MoH to RHT: in most of the regional the RHT are not fully function as yet, especially outside the capital, and do often only comprise of one Regional Health Officer without a budget and office space. So far, joint supervision visits have been carried out by a team from WHO, UNICEG, central MoH and RHT to the respective locations in the field. However, included in the JHNP, support to RHT is foreseen. The supervision system for the implementation of the EPHS will not only integrate various programmes but also pool available resources.
Activity 1.13. (WHO):	Transportation support for supervision from RHT to MCH: supervision of GAVI MCH clinics as well as supervision of LHWs and their supervisors has been an ongoing activity since the deployment of the LHWs, supported by the NPO at each zone. Similar as under 1.12. applies to this activity
Activity 1.14. (WHO):	Incentives for MCH staff: The level of incentives has been agreed upon with the SHAs; they are provisioned on top of the staff salaries and are in line with adopted middle scenario adopted by the SHA to pay for and incentivize health workers; these incentives motivatedand improved the health workers performance since the salary from the Ministry of Health is either irregular or very less. • PL: staff teams from 12 MCHs receive top ups of their salaries as of January 2014; • SL: staff teams from 13 MCH receiving top up of their salaries as of March 2013 (40 MCH staff; 28 HP staff);
Activity 1.15. (WHO):	Provision of incentives for MoH focal points has been ongoing since 2012; FPs coordinate the oversight of the programme by stakeholders and engage in all relevant activities of the grant. Central PFs are participating in national / regional / international meetings on GHI and HSS relevant aspects as part of increasing their knowledge and to serve at the zonal MoH as a resource person for these issues. Regional focal points have been included to contribute to their professional development and to the success of the programme at regional and district and as such facility level.
Activity 2.2.(WHO):	Completed (200 LHWs recruited); new recruitment planned Q2 2014/15 to account for drop outs;

Activity	Status
Activity 2.3. (WHO):	Completed; revision of curriculum planned for Q3 in 2014/15;
Activity 2.4. (WHO	Completed
Activity 2.5.(WHO):	Completed; planned for Q4 2014-Q2 2015 for new comers and as refreshment
Activity 2.6.(WHO):	idem
Activity 2.7. (WHO):	Supervision of LHWs: Lady Health Workers are regularly supervised on monthly basis by specifically trained supervisors; the style of the supervision is a supportive and at the same time an on-the-job training with guidance provided to the LHWs at field level; during this engagement, supervisors ensure that links are being established between MCH and LHWs; this supports the establishment and functioning of the referral system mechanism, addressing mother and children to receive their vaccination services, antenatal and postnatal care as well as curative care. Supervisors look at data collected through the community HIS form and reports on activities conducted within their communities. Although LHW's data and report are not yet integrated with MOH HIMS but LHS document all these data and activities in respective MCHs and Regional office. LHS also assess performance of LHWs for every month and take action against the result of supervision and performance assessment. In PL, five LHW supervisors provide supportive supervision for 10-15 LHWs on monthly basis; In SL, four LHW supervisors work with 65 LHWs;
Activity 2.8.(WHO):	Community based HIS forms have been developed, printed and disseminated to LHWs; discussion are ongoing on how to integrate data into the HMIS;
Activity 2.9.(WHO):	Completed.
Activity 2.10.(UNICEF/WHO):	Funds for this activity have been transferred to WHO; WHO has procured kits for all LHWs sufficient to cover 6 months;
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):	Complements activity 2.2. and 2.3; foreseen for 2015
Activity 2.13. (WHO):	Incentives CHWs: the programme, complementing the provision of incentives for MCH staff, provides incentives for staff based at HP level. SL: 28 HP, staffed with one CHW since March 2013; PL: not yet; SC: no HPs included. Under the Global Fund Grant for Malaria, a specific assessment is foreseen to look at HPs; many HPs are inappropriately staffed and equipped and their contribution to the PHC system is under revision. In the EPHS, their roles and scope of work have been made clearer; however, EPHS implementation without substantial support or only implemented by the SHAs is a challenge.
Activity 2.14. (WHO):	Incentives LHWs: ongoing; • SL: start in April 2013; • PL: started May 2013 ; • SC: started in October 2013; Monthly incentive of 80 US$; amount udner revision and exploring budget balance to increase to 100 USD;
Activity 3.1.(UNICEF):	Formative Research: Data collected for NWZ has been conducted and analyzed. In NEZ the Ministry of Health recommended that there was no need to conduct a KAP because Save the Children Fund had already conducted on in Karkar which results could be used for GAVI areas. The consultant used the data from SC to write a report on the key areas required in under GAVI. Draft formative research reports for NWZ and NEZ have been presented to partners and zones. Based on comments received reports are being revised. Final reports will be ready by end of April.

	In SCZ training of data collectors has been conducted and data collection on-going. Final report expected end of May 2014
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. Terms of reference for developing zonal strategies have been developed with input from all partners. A consultant is being identified to support the process starting with NEZ and NWZ where the reports for the formative research are being finalized.
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. 50 copies of the video have been produced and distributed to each of the three zones. A training plan on IPC has been developed and the videos will be used during these sessions. 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 programs. A total of 96 interactive radio program is produced and broadcast covering ACSD topics child health, immunization nutrition, maternal health and hygiene, in the 3 Zones SCZ: radio Mogadishu and Kulmiye, NEZ: Radio Daljir and NWZ: Radio Hageisa. .The programs cover the following topics: immunization, danger signs of childhood illnesses, Antenatal Care (ANC), pregnancy danger signs, exclusive and complementary breast feeding.
Activity 3.5.(UNICEF)	The activity was not conducted in 2013 as planned because the funds were not adequate. During the reprogramming, funds under this activity were increased. One partner, Save the Children, has confirmed participation and will commence work in June 2014. A second partner for NEZ is being assessed before being included in the program.
Activity 3.6. (UNICEF):	A total of 150 religious leaders in the three zones have been trained to work closely with the health workers and communities to promote MCH. In 2014 the religious leaders will be supporting outreach activities in their areas of operation using the mosques and the MCH as the epic entre. Each religious leader will work with the MCH in their catchment area to support child survival initiatives. A mapping exercise of the catchment area is planned for the second quarter of 2014.
Activity 3.7. (UNICEF):	In partnership with local NGO (PSCA in NEZ, KMC in NWZ), 15 primary school children has been reached with key immunization and other child health messages using knowledge competition, games, puppetry and mobile cinema show. A total of 600 children were reached 240 of whom were girls. 40 teachers (20 per zone) were trained on health related practices that include: vaccination, hygiene and nutrition. The teachers are to support health promotion activities in their schools through the school clubs. In 2014 more support will be given to the school clubs so they can continue to participate in health promotion activities in schools.
Activity 3.8. (UNICEF):	A total of 300 grain sacks for FCHWs are being printed, 8 posters are being developed to enable them conduct community dialogues in the community on: 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. In 2014 efforts will be on training the FCHWs on how to use the grain sacks and how to conduct community dialogues.
Activity 3.9. (UNICEF):	In NWZ in partnership with TELSOM a phone service provider mothers have been registered from the GAVI health facilities to received mother reminder messages on vaccination, ANC, immunization for their children and exclusive breast feeding. This partnerships aims at increasing the number of children who are fully protected against six vaccine preventable diseases, mothers who complete TT vaccination and give birth with skilled labor support. To date a total of 350 mothers with under 1 year children are registered the program is targeting 500 participants. The program will also have interactive health messages where giving a correct answer will earn the participant airtime/phone credit worth 1USD and those who participate will get 0.5 worth air time. The interactive questions have been developed and pretested. In NEZ and CSZ it has been a challenge implementing this activity directly with the phone companies. In 2014 a company already involved with use of SMS will be partnered with to provide support to the two zones.
Activity 4.1. (UNICEF):	Ongoing activity One consultant has been hired to analyze the HMIS data; another consultant is expected to be soon onboard to complete the HMIS data analysis with desk review of available relevant surveys and related key reports i.e. MICS-2011, MIS, EPHS baseline, formative research report, SC KAP study in Puntland.
Activity 4.2. (WHO):	Establish and support operational research committees: • In SL, a Health Systems Research Unit has been established; the Research Commitees in Somaliland are established and active consists of six members from the GAVI/HSS partners chaired by Ministry of Health; the committee has supported the formative research conducted by UNICEF. • In PL, a Health Research Unit has been established; the committee members have been nominated by the MoH; WHO has deployed national experts as part of the Health Systems Analysis Team (HSAT)at each zone to support the analysis and research function (JHNP funded) in support to decision making processes of the health sector coordination committee; ToRs for research committees have been developed; HSAT will also support the SHAs to identify a prioritized research agenda;
Activity 4.3. (WHO):	Has been reprogrammed for 2014 and will pick up with the presence of HSAT;
Activity 4.4. (UNICEF):	Conduct focus groups for operational research (refer to activity 3.1.)
Activity 4.5. (WHO):	Idem as 4.3.
Activity 4.6. (WHO):	Idem
Activity 4.8. (WHO):	Idem as 4.3.

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

The activities listed in table 9.2.1. reflect the reprogramming that was approved in 2013; <?xml:namespace prefix = o />

For activities under objective 4 (operational research) no progress had been made in 2012 and 2013 and activities had been reprogrammed as the required institutional framework at the Ministry of Health level (units established) and human resources (designated MoH staff to lead research committee, supported by experts (HSAT) and national advisors (M&E)) have been set in place late 2013 and early 2014.

The main activity delayed was the formative research and this was because it was difficult to get a consultant to lead the process. Advertisement was made three times before a consultant who was willing to support data collection in SCZ was identified. Even after identification it was not possible to conduct the training of data collectors in SCZ because of security reasons. The training was finally held in Hargeisa and data collection is ongoing.

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?

As part of the GAVI HSS grant, incentives are paid to a number of MoH staff involved in the implementation of the grant. These include management staff from the central Ministry, some Regional and District Health Management Team. In addition, staffs at HP and MCH clinics receive a modest level of incentives. These cadres are employees of the Government. Following a "review of compensation, salaries, incentives and benefits for health personnel" carried out in late 2012, the Ministry of Health has adopted a middle scenario that is below the foreseen costing of the Health Sector Strategic Plan. <?xml:namespace prefix = o />

The applied incentives complement government salaries; at this point SHAs are not yet in the full position to provide the middle scenario salary level to its entire staff.

The newly introduce cadres of Lady Health Workers receive a monthly remuneration of 80 US $, their supervisors 300 US $. We are conscientious about the sustainability of the programme and are committed to take these new staff on board in the future. Especially for these health workers who carry the load of the programme, given the scope of work and the expectations they need to meet in the communities as well as the very long distances between the communities, a revision of current levels of incentives is required.

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 2012 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	2013 Target						Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2009	2010	2011	2012	2013		
# of MCH centres providing routine immunization services including outreach;	SL: 6 /12;	monitoring and supervision visits;	100%	36						SARA	Following the reprogramming exercise, a revision of the M&E framework was requested that was sent to GAVI secretariat in April 2014; the baseline survey is planned to be finalized by June 2014; as such, for most of the indicators related to the four objectives of the grant, some of the baseline values, including for 2013 still need to be determined.
DTP3 coverage: % of surviving infants recieveing three	42	Adminstrative data	80	60							

doses of Diphtheria-tetanus-pertusis											
DTP3 coverage numerator (number of doses administered through routine services)	89788	Adminstrative data									
DTP3 coverage denominator (number in target group)	270981	UNDP projection									
MCV1 coverage - % of surviving infants receiving first dose of measles containing vaccine	100564										
MCV1 coverage numerator (number of doses administered through routine services)											
MCV1 coverage denominator (number in target group)											
Geographic equity of DTP 3 coverage - % of districts that have at or above 80% DTP3 coverage	SL: 39% PL: 26 SC: 14										
Socio-economic equity in immunisation coverage - DTP3 coverage in the lowest wealth quintile is +/- X % points of the coverage in the highest wealth quintile	NA										
Drop out rate - percentage point difference between DTP1 and DTP3 coverage		13		7							
Proportion of children fully immunised - % of children aged 12-23 months who receive all basic vaccinations in a country's routine immunisation program		MICS									
Vitamin A supplementation coverage among 6 months to under five children	24%	MICS	60	45							
ANC coverage (% of women 15-49, one or more during	26%	MICS	50	35							

pregnancy) from health facility											
# of MCH clinics offering immunisation services that have tracer items for delivery of immunisation including:	tbd	SARA; baseline survey,	100	NA						SARA	Monitoring and supervision of the MCH clinics according to agreed upon standards have only started in Q1/2014;
Availability of vaccinators in the selected MCH clinics with good knowledge and skills;	tbd	Baseline survey (pre- and post test);	100	NA						SARA	Baseline survey (pre- and post test);
Vaccine wastage rates;	tbd	EPI HMIS records;	tbd	NA						EPI HMIS records;	MOH HMIS does not yet include indicators such as vaccine wastage rate but is under revision;
% of target population (pregnant women, children < 1) in LHW catchment area fully immunized;	tbd	Household Survey; family register (community based HIS);	>95%	NA						Household Survey; family register (community based HIS);	Baseline survey not yet conducted; community based HIS only introduced in Q4/2013
# of persons referred to the next MCH, disaggregated by gender and age;	nil	Community based HMIS reports (referral slips)	0	tbd						Community based HMIS reports; referral slips	idem
% of mot % of mothers and fathers having knowledge about immunization and danger signs of pregnancy and childhood illnesses;	tbd	Formative research	29% of mothers know pregnancy danger signs 60% know the importance of vaccination 37% know the childhood danger signs (Average for NEZ and NWZ)							end line survey	
Annual production of operational research reports on programme relevant topics;	0	HSAT activity reports;	4/y							HSAT activity reports	Achievements on objective 4, operational research are lacking behind. See table 9.2.1.
DPT3 data verification	NA	Monitoring and supervision visits;	tbd							Monitoring and supervision visits;	
Timeliness and completeness of facility reporting	NA	Monitoring and supervision visits; compiled HIS reports zonal level;	100%							Monitoring and supervision visits; compiled HIS reports zonal level;	

9.4. Programme implementation in 2013

9.4.1. Please provide a narrative on major accomplishments in 2013, especially impacts on health service programmes, and how the HSS funds benefited the immunisation programme

In October 2013, reprogramming of the grant was submitted for the remaining implementation period that

comes to an end in December 2015. More emphasis was given to improve the availability and quality of vaccination activities, their data processing and analysis and demand for them. <?xml:namespace prefix = o />

The four objectives of the programme remained unchanged, mainly due to the fact that the start-off of programme implementation was substantially delayed and processes that needed to be established in collaboration with the Somali Health Authorities require a lot of technical input and time. At the same time, implementation is prone to delays due to the fact that the fund receiving UN agencies are located in Nairobi and have to oversee programme implementation at three zones.

However, 2013 was a year of acceleration of programme implementation and increased ownership by the Somali Health Authorities. A lot of processes could be set off from the ground that posed big obstacles in the implementation.

Systems for providing the incentives were established:

for 200 LHWs and their 16 as well upervisors,

- in SL for 40 MCH staff and 28 HP as well as for 5 HSS focal points;
- in PL for 62 MCH staff as well as 8 HSS focal points
- in SC for ...MCH staff as well as 2 HSS focal poins.

have been established, with growing taking over of responsibilities and management by the Ministry teams.

Foundations were laid for the successful continuation and finalization of this grant but for any other programme in support to HSS targeting the improvement of immunization coverage.

Main accomplishments in 2013 included:

– Deployment of all 200 Lady Health Workers to their communities: the ladies, following their 3 months training, have been equipped with basic supplies according to their areas of intervention including HIS forms for registering the families in their catchment areas, documenting their work and preparing mothers, children and those in need for referrals to the respective MCH clinic; these ladies play a vital role in increasing demand for immunization services and ensuring that mothers and children receive their appropriate vaccination at the next facility; the 200 ladies are being supervised by a new and specifically trained cadre of LHW supervisor (PL: 5) total of 16) who support the activities of the ladies;

– Support to selected MCH clinics: in the 3 Zones, selected MCH clinics have been rehabilitated; upon completion of the rehabilitation, the MoH engineer together with UNICEF conducted certification of the rehabilitation;

– Procurement and quarterly supply of essential medicines and equipment for MCH services (based on gaps): UNICEF has provided quarterly supplies of essential medicines to the MCH clinics. The supplies are MCH kits; the contents of the supplies was previously discussed and agreed by the Zonal MoH.

– Procure and distribute/re-supply medicines for Health posts (50%): UNICEF has provided quarterly supplies of essential medicines to the PHUs. The supplies are PHU kits; the contents of the supplies was previously discussed and agreed by the Zonal MoH

– Rehabilitation of Cold chain equipment: UNICEF conducted the renovation of cold chain equipment in all 40 health facilities. The MoHs deployed staff according to EPHS requirements; a number of MCH clinics had been up-graded from a previous health post level;

– τhe grant provides incentives to all these staff in accordance with the results of the remuneration study and in complementarity of actual payment made by the MoH or NGOs;

– In those clinics that are not supported by NGOs, the MoHs deployed staff according to EPHS requirements; a number of MCH clinics had been up-graded from a previous health post level; the grant provides incentives to all staff working in these facilities; the level of payment is in accordance with the results of the remuneration study and in complementarity of actual payment made by the MoH or NGOs;

– In SL: 6 health posts have been upgraded to MCH centres due to size of the catchment population

and to increase of EPI access to those mother and children living in the catchment areas who do not have a chance for immunization, these upgraded MCH are regularly providing immunization services routinely, the grant provides incentives to all these staff 40 staff members with different qualifications (Nurses, Midwives, Auxillary etc.)

–□□□□□□□□ In PL: 60 MCH staff; 8 HSS FP; four health post were upgraded to MCH I Puntland; 36 MCH staff and 24 support staff in Puntalnd

–□□□□□□□□ Conducting of the formative research in NWZ and NEZ which will guide the development of zone specific communication strategies.

–□□□□□□□□ Working with 48 trained religious leaders in Somaliland from catchment areas of six MCHs in Gebile District who worked closely with the health workers and community in promoting and educate communities and families on child health, immunization, nutrition, maternal health and hygiene topics.

–□□□□□□□□ 96 interactive radio program were produced and broadcast covering topics on child health, immunization nutrition, maternal health and hygiene, in the 3 Zones SCZ: radio Mogadishu and Kulmiye, NEZ: Radio Daljir and NWZ: Radio Hageisa

–□□□□□□□□ 40 teachers (20 per zone) were trained on health related practices that include: vaccination, hygiene and nutrition. The teachers are expected to support health education activities through the school health clubs.

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

Substantial delay still occurs due to the fact that the programme is being implemented in three zones far away from where the programme management team is located. This is resulting in a substantial work load linked to the fact that three Ministries of Health are the implementing partners. At the same time, the Ministry teams need to be more delinquent if it comes to technical and financial reporting. Both factors have caused substantial delay in the timely release of funds for incentives. WHO’s team leader for administration and finance provided training sessions to MoH team in Somai- and Puntland on WHO procedures and reporting requirements. It is planned to transfer more of these functions to the health authorities with capacities and skills being increased at WHO zonal office level. Processes have now been established to remunerate (lady) health workers involved in the programme via payment through mobile phone system (Dahabschil).
<?xml:namespace prefix = o />

Technical support and assistance is required to be provided to zonal partners (both UN sub-office staff and MoH) which is a challenge due to geographical distance and security constraints to visit the implementation sites in South Central. National officers as well as MoH technical staff were able to participate in regional meetings for increasing their knowledge on GAVI and HSS related issues, however obtaining visa for Somali citizen in most of the time is problematic and many opportunities were missed. UN technical management team travels as often as possible to the zones to provide technical support and guidance, to visit implementation sites and to participate in GAVI HSS coordination and review meetings.

In September 2013 the arrangements for the Health Sector Coordination Committee was put on hold as the SHAs desired a mechanisms for strengthened in-country coordination. At the same time the contracts of staff working at the HSC office came to an end. The HSC, and as such only as an ad-hoc arrangement, only met in late February 2014. The lack of an overall forum to discuss strategic issues of the grant implementation affected especially the perception of ownership by the SHAs negatively.

A HSC task force was established to prepare a strategy for strengthened in country coordination and, in accordance with a communique developed and agreed upon by all parties, a Health Information Liaison Officer recruited by WHO to ensure that relevant information is being shared, disseminated and reviewed. The HSC task force was informed that a regular forum is required to discuss and review issues not only related to GAVI HSS but to the GHI interventions to ensure synergy and complementarity among interventions but also for ensuring alignment to the health Sector Strategic Plans (HSSPs).

Despite the inclusion of the provision of equipment and supplies at the 40 selected MCH clinics and their adjacent health posts, there are frequent stock outs in all clinics. The composition of kits provided to the MoH does not meet EPHS requirements and are not delivered to the clinics on regular basis. The SHAs have included the move from the current push system to a proper pull as part of a supply chain management system. Currently there is no system in place to regularly and appropriately provide facilities with supplies.

Implementing partners will examine options for improved forecasting and use of supplies at the supported clinics and seek synergies with other programmes addressing supply chain management.

The content will be reviewed by the SHAS at zonal level and collaboration will be sought with those NGOs that are supporting some of the clinics.

The project involves MoH staff at regional and district level as focal points to ensure supervision and monitoring the implementation of the programme. The RHO and DHO do not have any operational budget on hand to ensure that they can carry out their routine duties. In terms of supervision, the SHAs and partners decided that to utilize the supervision tool that had been developed by the programme should be utilized across the country for the supervision of the EPHS implementation. As such, resources for supervision should be pooled.

Implementation sites of this grant are scattered and in most of the cases located in remote areas and not covering an entire geographical area such as district or region. It is therefore almost impossible to attribute improved health outputs to the intervention. Efforts are ongoing to include for some of activities such as training of vaccinators facilities that are not part of the programme to ensure geographical continuity. In any future grant this issue needs to be rectified.

Work on health information and operation research is still in an early stage. However, progress in this areas is taking up with the recruitment of M&E advisors and HSAT (Health Systems Analysis Team) experts at all zones supported by the JHNP and HIS focal points supported by GF.

The formative research has been conducted in NWZ in four districts of Burao, Boroma, El-Afwayn and Hergeisa. In Puntland the Government opted to use the formative research findings conducted by Save the Children in Karkaar Region. A presentation was made to the Somaliland technical teams on the major findings and report reviewed according. Review findings for Puntland have been shared electronically and will be presented to the zone in May 2014. Data collection is on-going in SCZ and it is hoped will be completed in May 2014. The final report will be completed by April 2014.

The security situation in Somalia, mainly in SCZ, has been a main challenge in conducting the baseline as per the timeline. It has been difficult to find a consultant who was willing to go to Somalia for the field implementation of the baseline.

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

Following the reprogramming of this grant, a revision of the M&E framework was requested. Challenges arose from the fact that the implementation of the base line survey had not been conducted until now and the lack of a national M&E framework. <?xml:namespace prefix = o />

However, supported through the JHNP, the development of a national M&E framework is in progress that will include national targets for impact indicators such as maternal and child mortality. The framework will also include indictors that are relevant for the implementation of this grant and layout mechanisms and processes for regular data collection, processing and analysis. The recruitment of national M&E advisors early 2014 who are supported by the HSAT consultants has been an important step to ensure that M&E of this grant does not stand alone but will be integrated into zonal M&E work. The common supervision system will similarly ensure that resources are pooled and activities integrated. Information from the community based information system that has been introduced by the programme and is being implemented by the LHWs will be integrated into the national HIS and reflected in the development of a community based health strategy that is being planned to be developed in 2014.

Currently, a Joint Annual Review of the HSSP Annual Work Plans (AWPs) and development of 2014 AWPs is under way that will also examine the contribution of GAVI funded HSS activities to the implementation of the plan. A JANS is being planned for later this year. An inventory for HSS activities is being developed and HSS working groups at zonal level will be revitalized to ensure that synergies and complementarity are being created and problems in implementation are being jointly discussed and addressed.

The HSAT which has been recruited by WHO with presence in all zones, led by an international expert plays an important role to support the monitoring and evaluation of GAVI funded HSS activities and to review ongoing interventions and identify flaws and gaps.

HSAT is also supporting units for operational research that have been established at MoH levels and that will

examine the efficiency of GAVI funded interventions.

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.

As said above, the GAVI HSS M&E framework will be integrated into the national framework. The grants interventions are being included in the JAR of the AWP 2013 and will be reflected in the AWP 2014. <?xml:namespace prefix = o />

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 main implementation partner of this grant are the three zonal Ministries of Health.<?xml:namespace prefix = o />

As for CSOs, it is Kow Media Corp (KMC), IHSAN religious network Puntland, Puntland Students Consultancy Association, Radio Daljir, Telsom media and Radio Hargeisa.

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.

Kow Media Corp (KMC) and Puntland Students Consultancy Association supported the school education events through parapet shows and essay competitions.<?xml:namespace prefix = o />

IHSAN religious network Puntland: support community mobilization activities on maternal child health in partnership with the MCHs in Puntland.

Radio Daljir and Hargeisa produced and aired 30-minute radio programmes on child survival

Telsom media involved in the use of interactive SMS on maternal child health

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

9.5. Planned HSS activities for 2014

Please use **Table 9.5** to provide information on progress on activities in 2014. If you are proposing changes to your activities and budget in 2014 please explain these changes in the table below and provide explanations for these changes.

Table 9.5: Planned 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)	**2014 actual expenditure** (as at April 2014)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2014** (if relevant)
1.1.	Develop list of priority health facilities and conduct survey to identify gaps in 40 MCH centres				Completed in 2012	
1.2.	Rehabilitation of selected MCH centres				Completed in 2013	

	(based on assessment)					
1.3.	Procurement and supply of essential medicines and equipment for MCH services	98000	25238			
2.13	Icentives CHWs	86400	21000			
2.8.	Implement comm HIS					
1.4.	Provide comprehensive support for BEMONC in selected MCH centres (3)	102000	15000			
1.5.	Training curriculum EPI	15000				
1.6.	Training in EPI	65000	35000			
1.8.	Training of MCH staff	65000	35000			
1.7.	Develop curr trainig MCH staff					
1.10.	Develop/implement EPI outreach	130000				
1.8.	Training MCH staff	65000	35000			
1.12.	Transport supervision of RHTs	26400	10000			
1.13.	Transport supervision of MCH clinics	81000	25000			
1.14.	Incentives MCH staff	288000	72000			
1.15.	Incentives for MoH focal points	120000	30000			
2.2.	Recruitment of LHWs (to account for those pulled out)	15000				
2.3.	Curriculum for LHWs (revision)	10000				
2.5.	Training of LHWs (refresher)	100000	25000			
2.6.	Training of supervisors (idem)	40142	10000			
2.7.	Develop and implement supervision system	250000	25000			
2.10.	Procurement of supplies for LHWs	80000				
2.11.	Procure and distribute/re-supply medicines for Health posts (50%)		40586			
2.14.	Incentives for LHWs	207360	51840			
3.1.	Formative research to identify key maternal and child caring behaviors and barriers	50000	58256			
3.2.	Develop five year strategic communication plan	16000				
3.3.	Develop print, audio-visual and IPC package for health workers	60000				
3.4.	Develop and broadcast radio programme on key child caring and health practices	60000				
3.5.	Identify three strong communication NGOs to build capacity of existing NGOs and to scale up public awareness at	20000				

	community level					
3.6.	Strengthen and establishing structured/systematized partnership with religious leaders, religious organizations, clan leaders, community elders and networks	20000	2572			
3.7.	Work with school structures to increase dialogue on key child survival and development messages	20000				
3.8.	Develop community friendly materials (discussion guides etc) with key iccm messages for FCHWs, CHWs, TBAs for home based family promotion	20000				
3.9.	Partner for m-health videos to remind on key child survival messages	60000				
4.1.	Conduct baseline and end-line surveys	0			Has not yet been implemented	
4.2.	Support to operational research committees	18000	10803			
4.3.	Commission OR studies	37500				
4.4.	Conduct focus groups for operational research	36000				
4.5.	Support to data analysis and use	35000				
4.6.	Training of MoH managers in OR	70000				
4.8.	TA for OR	47741				
	Management Operational/managemnt Costs	102000	205659			
	M&E support costs - UNICEF	157022				
	Technical Support - WHO	513280	599586			
	Technical Support - UNICEF	487670	194429			
		3674515	1526969			0

9.6. Planned HSS activities for 2015

Please use **Table 9.6** to outline planned activities for 2015. 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 2015

Major Activities (insert as many rows as necessary)	**Planned Activity for 2015**	**Original budget for 2015** (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 2015** (if relevant)

1.3.	Continue procurement and supply of essential medicines and equipment for MCH services	98000			
1.4.	Continue providing comprehensive support for BEMONC in selected MCH centres (3)	102000			
1.6.	Training in EPI (refresher)	65000			
1.8.	Training of MCH staff (refresher)	65000			
1.10.	Develop/implement EPI outreach	130000			
1.12.	Transport supervision of RHTs by zonal teams	26400			
1.13.	Transport supervision of MCH clinics	81000			
1.14.	Incentives MCH staff	288000			
1.15.	Incentives for MoH focal points	120000			
2.2.	Recruitment of LHWs (to account for those dropped out)	15000			
2.3.	Curriculum for LHWs (revision)	10000			
2.7.	Implement supervision system	250000			
2.10.	Procurement of supplies for LHWs (is being done on 6-monthly basis)	80000			
2.11.	Continue procuring and distribute/re-supply medicines for Health posts (50%)	50000			
2.12.	Refresher training for FCHWs and Supervisors	100000			
2.13.	Incentives for CHWs	93312			
2.14.	Incentives for LHWs	223949			
3.4.	Develop and broadcast radio programme on key child caring and health practices	60000			
3.5.	Identify three strong communication NGOs to build capacity of existing NGOs and to scale up public awareness at community level	20000			
3.6.	Strengthen and establishing structured/systematized partnership with religious leaders, religious organizations, clan leaders, community elders and networks	20000			
3.7.	Work with school structures to increase dialogue on key child survival and development messages	20000			
3.8.	Develop community friendly materials (discussion guides etc)	20000			

	with key iccm messages for FCHWs, CHWs, TBAs for home based family promotion				
3.10.	Evaluation of C4D interventions	50000			
4.1.	Conduct baseline and end-line surveys	30000			
4.2.	Support to operational research committees	18000			
4.3.	Commission OR studies	37500			
4.4.	Conduct focus groups for operational research	36000			
4.5.	Support to data analysis and use	41416			
4.6.	Training of MoH managers in OR	65000			
4.8.	TA for OR	47741			
Management costs		102000			
M&E support costs - UNICEF		153140			
Technical Support - WHO		553544			
Technical Support - UNICEF		422212			
Agencies 7%		244595			
		3738809			

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
JHNP: DFID, SIDA, USAID, SDC, Global Fund Health Consortium for Somalia	60365652	5 years; GF: 3 years HCS: 2013-14	In support to HSSP and HSS, multi donor programme, implemented by three UN agencies; planned amount includes EPHS roll out; planned funds 236 mill US$; 48,272,324 disbursed so far. GF: Includes all three diseases and HSS; decision on the split (and HSS) is imminent and due by end May 2014; total allocation 112.1 mill. Consortium: servcie iplementation by four NGOs

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
1) GAVI HSS review meeting minutes 2) WHO supervision / monthly reporting / mission report 3) WHO/UNICEF financial system (Vision) 4) Zonal monitoring and supervision system, prepared by MoH and WHO 5) Field visits 6) HIS	ad1) Endorsed by zonal Directors P&P; ad2) Reviewed by zonal NPO; endorsed by Head of WHO office ad3) Internal administrative and financial system (GSM); ad4) To be signed by MOH and WHO together for all financial and technical activities that have been under taken ad5) Mission reports approved by grant manager; ad6) Community based HIS reviewed by MoH / WHO team	ad1) Meeting minutes irregularly prepared with delays; ad2) none ad3) Expenditures at a specific point cannot be made as the system accounts for encumbered amounts; ad4) Prone to delays ad6) Process just started;

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.

Geographical distance to the sites of implementation, limitation in e-mail communication where direct discussion would be more fruitful.<?xml:namespace prefix = o />

Lack of fully functioning HSC and no structure opportunity to jointly discuss the APR; no feedback from zonal teams, first draft was sent to WHO sub-offices ahead of time.

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2013?3

Please attach:

1. The minutes from the HSCC meetings in 2014 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**

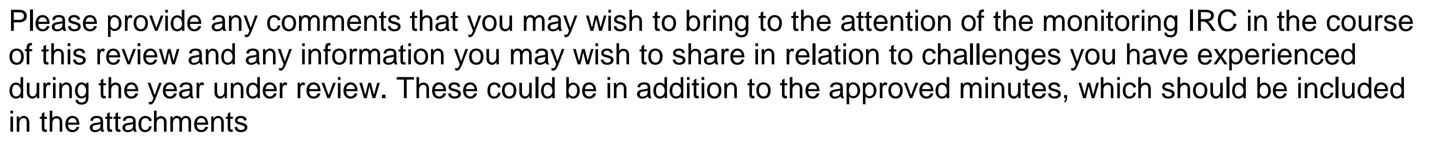
Somalia is not reporting on GAVI TYPE A CSO support for 2013

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 2013

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 2013 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2013, 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 2013 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 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

c. Other income received during 2013 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, 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 2013 (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 2013 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 2012 (balance as of *31Decembre 2012*)	25,392,830	53,000
Summary of income received during 2013		
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 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, 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 2013	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 2013 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2013, 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 2013 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 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

c. Other income received during 2013 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, 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 2013 (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 2013 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 2012 (balance as of *31Decembre 2012*)	25,392,830	53,000
Summary of income received during 2013		
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 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, 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 2013	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 2013 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2013, 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 2013 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 2012 calendar year (opening balance as of 1 January 2013)

b. Income received from GAVI during 2013

c. Other income received during 2013 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2013

f. A detailed analysis of expenditures during 2013, 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 2013 (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 2013 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 2012 (balance as of *31Decembre 2012*)	25,392,830	53,000
Summary of income received during 2013		
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 2013	30,592,132	63,852
Balance as of 31 December 2013 (balance carried forward to 2014)	60,139,325	125,523

* Indicate the exchange rate at opening 01.01.2013, the exchange rate at closing 31.12.2013, 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 2013	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	✔	Signature will be sent ASAP.docx **File desc:** **Date/time :** 27/04/2014 04:43:20 **Size:** 12 KB
2	Signature of Minister of Finance (or delegated authority)	2.1	✔	Signature will be sent ASAP.docx **File desc:** **Date/time :** 27/04/2014 04:44:11 **Size:** 12 KB
3	Signatures of members of ICC	2.2	✔	Signature will be sent ASAP.docx **File desc:** **Date/time :** 27/04/2014 04:44:53 **Size:** 12 KB
4	Minutes of ICC meeting in 2014 endorsing the APR 2013	5.7	✔	Minute will be sent ASAP.docx **File desc:** **Date/time :** 27/04/2014 04:55:29 **Size:** 12 KB
5	Signatures of members of HSCC	2.3	✔	Signature will be sent ASAP.docx **File desc:** **Date/time :** 27/04/2014 04:45:32 **Size:** 12 KB
6	Minutes of HSCC meeting in 2014 endorsing the APR 2013	9.9.3	✔	Endorsed minutes HSC ad hoc Feb 28 2014.pdf **File desc:** not yet done but issue was discussed. **Date/time :** 26/04/2014 03:21:02 **Size:** 433 KB
7	Financial statement for ISS grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	6.2.1	✗	Not applicable.docx **File desc:** **Date/time :** 27/04/2014 04:57:01 **Size:** 12 KB
8	External audit report for ISS grant (Fiscal Year 2013)	6.2.3	✗	Not applicable.docx **File desc:** **Date/time :** 27/04/2014 04:57:45 **Size:** 12 KB
9	Post Introduction Evaluation Report	7.2.2	✔	Not applicable.docx **File desc:** **Date/time :** 27/04/2014 04:49:26

				Size: 12 KB
10	Financial statement for NVS introduction grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	7.3.1	✔	Signature will be sent ASAP.docx **File desc:** **Date/time :** 27/04/2014 04:58:25 **Size:** 12 KB
11	External audit report for NVS introduction grant (Fiscal year 2013) if total expenditures in 2013 is greater than US$ 250,000	7.3.1	✔	Signature will be sent ASAP.docx **File desc:** **Date/time :** 27/04/2014 04:59:03 **Size:** 12 KB
12	Latest EVSM/VMA/EVM report	7.5	✔	EVM_Somalia report_v7.zip **File desc:** **Date/time :** 27/04/2014 03:41:24 **Size:** 4 MB
13	Latest EVSM/VMA/EVM improvement plan	7.5	✔	EVM_improvement_plan_Somalia 2013.xls **File desc:** **Date/time :** 27/04/2014 03:42:56 **Size:** 194 KB
14	EVSM/VMA/EVM improvement plan implementation status	7.5	✔	EVM Implementation status.docx **File desc:** **Date/time :** 30/05/2014 10:10:35 **Size:** 12 KB
16	Valid cMYP if requesting extension of support	7.8	✗	Somalia cMYP.docx **File desc:** **Date/time :** 27/04/2014 04:52:20 **Size:** 457 KB
17	Valid cMYP costing tool if requesting extension of support	7.8	✗	cMYP_Costing_Tool_Vs.2.5_EN somalia alternative 16Apr.xls **File desc:** **Date/time :** 27/04/2014 05:01:23 **Size:** 3 MB
18	Minutes of ICC meeting endorsing extension of vaccine support if applicable	7.8	✗	Minute will be sent ASAP.docx **File desc:** **Date/time :** 27/04/2014 05:03:15 **Size:** 12 KB
19	Financial statement for HSS grant (Fiscal year 2013) signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✔	Financial statement.pdf **File desc:** **Date/time :** 30/05/2014 07:20:48 **Size:** 70 KB

20	Financial statement for HSS grant for January-April 2014 signed by the Chief Accountant or Permanent Secretary in the Ministry of Health	9.1.3	✔	Financial statement for HSS grant 2014.docx **File desc:** **Date/time :** 30/05/2014 07:58:02 **Size:** 12 KB
21	External audit report for HSS grant (Fiscal Year 2013)	9.1.3	✔	External Audit report.docx **File desc:** **Date/time :** 30/05/2014 07:59:36 **Size:** 12 KB
22	HSS Health Sector review report	9.9.3	✔	HSS Health Sector Review Report.docx **File desc:** **Date/time :** 30/05/2014 08:01:26 **Size:** 12 KB
23	Report for Mapping Exercise CSO Type A	10.1.1	✘	No file loaded
24	Financial statement for CSO Type B grant (Fiscal year 2013)	10.2.4	✘	No file loaded
25	External audit report for CSO Type B (Fiscal Year 2013)	10.2.4	✘	No file loaded
26	Bank statements for each cash programme or consolidated bank statements for all existing cash programmes if funds are comingled in the same bank account, showing the opening and closing balance for year 2013 on (i) 1st January 2013 and (ii) 31st December 2013	0	✔	Bank statement for each cash programme.docx **File desc:** **Date/time :** 30/05/2014 08:29:04 **Size:** 12 KB
27	Minutes ICC meeting endorsing change of vaccine prensentation	7.7	✘	No file loaded

			×	EPI Performance Assessment _26_ Sep.doc **File desc:** **Date/time :** 27/04/2014 04:02:36 **Size:** 1 MB
				GAVI SC110552 - Somalia HSS Statement of Account as of 31st December 2011.pdf **File desc:** **Date/time :** 30/05/2014 09:14:01 **Size:** 80 KB
	Other			GAVI SC110552- Somalia HSS Statement of Account as of 31st December 2012.pdf **File desc:** **Date/time :** 30/05/2014 09:14:13 **Size:** 302 KB
				GAVI SC110552- Somalia HSS Statement of Account as of 31st December 2013.pdf **File desc:** **Date/time :** 30/05/2014 09:14:21 **Size:** 168 KB
				Somalia coverage improvement plan 2014-2015 .doc **File desc:** **Date/time :** 27/04/2014 04:06:44 **Size:** 422 KB