GAVI Alliance

Annual Progress Report 2011

Submitted by

The Government of

Somalia

Reporting on year: **2011**
Requesting for support year: **2013**
Date of submission: **5/29/2012**

Deadline for submission: 5/22/2012

Please submit the APR 2011 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: **2011**

Requesting for support year: **2013**

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

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 2011	Request for Approval of
ISS	Yes	ISS reward for 2011 achievement: Yes
HSS	Yes	next tranche of HSS Grant Yes
CSO Type A	No	Not applicable N/A
CSO Type B	No	CSO Type B extension per GAVI Board Decision in July 2011: N/A

1.4. Previous Monitoring IRC Report

APR Monitoring IRC Report for year 2010 is available here.

2. Signatures

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

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

For the Government of Somalia

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

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Duale Adam/Director General TFG MoH	**Name**	N/A
Date		**Date**	
Signature		**Signature**	

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

Full name	Position	Telephone	Email
Assegid Kebede	EPI Medical Officef, WHO Somalia	+254 734 600 608	kebedea@nbo.emro.who.int
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2.2. ICC signatures page

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

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

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

2.2.1. ICC report endorsement

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

Name/Title	Agency/Organization	Signature	Date

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

All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

2.3. HSCC signatures page

We, the undersigned members of the National Health Sector Coordinating Committee (HSCC), Marina Madeo/Somali Health Sector Coordinator andJohn Agbor/UN Representative to HSC , endorse this report on the Health Systems Strengthening Programme. Signature of endorsement of this document does not imply any financial (or legal) commitment on the part of the partner agency or individual.

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

Name/Title	Agency/Organization	Signature	Date
John Agbor/UN Representative to HSC	UN		
Marina Madeo/Somali Health Sector Coordinator	Somali Health Sector Committee		

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

All comments will be treated confidentially

Comments from Partners:

Comments from the Regional Working Group:

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

Somalia is not reporting on CSO (Type A & B) fund utilisation in 2012

3. Table of Contents

This APR reports on Somalia's activities between January – December 2011 and specifies the requests for the period of January – December 2013

Sections

4. Baseline & annual targets

Number	Achievements as per JRF		Targets (preferred presentation)							
	2011		2012		2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation
Total births	358,341	358,341	369,091	369,091	380,164	380,164	391,569	391,569		403,316
Total infants' deaths	39,059	39,059	40,231	40,231	41,438	41,438	42,681	42,681		43,961
Total surviving infants	319282	319,282	328,860	328,860	338,726	338,726	348,888	348,888		359,355
Total pregnant women	358,341	358,341	369,091	369,091	380,164	380,164	391,569	391,569		403,316
Number of infants vaccinated (to be vaccinated) with BCG	164,837	184,835	184,546	184,546	209,090	209,090	234,941	234,941	282,321	282,321
BCG coverage	46 %	52 %	50 %	50 %	55 %	55 %	60 %	60 %	70 %	70 %
Number of infants vaccinated (to be vaccinated) with OPV3	223,497	156,624	246,645	246,645	270,981	270,981	296,555	296,555	323,420	323,420
OPV3 coverage	70 %	49 %	75 %	75 %	80 %	80 %	85 %	85 %	90 %	90 %
Number of infants vaccinated (to be vaccinated) with DTP1	274,583	241,857	295,974	295,974	311,628	311,628	327,955	327,955	348,574	348,574
Number of infants vaccinated (to be vaccinated) with DTP3	223,497	193,163	246,645	246,645	270,981	270,981	296,555	296,555	323,420	323,420
DTP3 coverage	70 %	60 %	75 %	75 %	80 %	80 %	85 %	85 %	90 %	90 %
Wastage[1] rate in base-year and planned thereafter (%) for DTP	0	40	0	0	0	0	0	0	0	0
Wastage[1] factor in base-year and planned thereafter for DTP	1.00	1.67	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Number of infants vaccinated (to be vaccinated) with 1st dose of DTP-HepB-Hib		0		0	311,628	311,628	327,955	327,955	348,574	348,574
Number of infants vaccinated (to be vaccinated) with 3rd dose of DTP-HepB-Hib		0		0	270,981	270,981	296,555	296,555	323,420	323,420
DTP-HepB-Hib coverage		0 %		0 %	80 %	80 %	85 %	85 %	90 %	90 %
Wastage[1] rate in base-year and planned thereafter (%)		25	0	25	0	25	0	25	0	20
Wastage[1] factor in base-year and planned thereafter (%)		1.33	1	1.33	1	1.33	1	1.33	1	1.25
Maximum wastage rate value for DTP-HepB-Hib, 10 doses/vial, Liquid	25 %	25 %	25 %	25 %	25 %	25 %	25 %	25 %	25 %	25 %
Number of infants vaccinated (to be vaccinated) with 1st dose of Measles	239,462	251,326	263,088	263,088	287,917	287,917	313,999	313,999	341,387	341,387
Measles coverage	75 %	79 %	80 %	80 %	85 %	85 %	90 %	90 %	95 %	95 %
Pregnant women vaccinated with TT+	125,419	208,578	166,091	166,091	209,090	209,090	254,520	254,520	282,321	282,321
TT+ coverage	35 %	58 %	45 %	45 %	55 %	55 %	65 %	65 %	70 %	70 %
Vit A supplement to mothers within 6 weeks from delivery	0	0	0	0	0	0	0	0	0	0
Vit A supplement to infants after 6 months	N/A	251,326	N/A	263,088	N/A	287,917	N/A	313,999	N/A	341,387

Number	Achievements as per JRF		Targets (preferred presentation)							
	2011		2012		2013		2014		2015	
	Original approved target according to Decision Letter	Reported	Original approved target according to Decision Letter	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation	Previous estimates in 2011	Current estimation
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	19 %	20 %	17 %	17 %	13 %	13 %	10 %	10 %	7 %	7 %

*

** Number of infants vaccinated out of total surviving infants

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

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

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

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 2011 must be consistent with those that the country reported in the **WHO/UNICEF Joint Reporting Form (JRF) for 2011.** The numbers for 2012 - 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**

  No change
- Justification for any changes in **wastage by vaccine**

  No change

5.2. Immunisation achievements in 2011

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 2011 and how these were addressed:

- Program Management
  - The country's cMYP developed for the years 2011 - 2015
  - EPI Units of Somaliland and Puntland supported technically and financially; and EPI Unit of MOH/TFG established
  - Zonal coordination meeetings in Somaliland and and Puntland supported
- Service Delivery
  - Expanded outreach activities of 14 MCHs in Mogadishu
  - More than 250 MCHs were provided with supplies by UNICEF
  - Despite continued civil war and a major famine experienced by the country that resulted in huge displacement, partners were able to continue immunization activities in many areas of the country.
- VPD Surveillance
  - Measles laboratory established in Mogadishu
  - Provided technical, financial and logistics support to measels laboratories in Somaliland and Puntland
  - Measles surveillance guideline translated into Somali language
- Advocacy and Communications
  - Conducted annual Vaccination Week in Somaliland, Puntland and Mogadishu
  - Carried out social mobilization activities in all outreach activities
  - UNICEF has started development of communication strategy for immunization (with special emphasis on Pentavalent Vaccine)
- New Vaccine Introduction
  - Successful application for Pentavalent Vaccine introduction was made

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

Immunization targets for 2011 were not reached, due to the mass displacement of population after the drought and famine the country has experienced.

5.3. Monitoring the Implementation of GAVI Gender Policy

In the past three years, were the sex-disaggregated data on immunisation services access available in your country? Choose one of the three: **no, not available**

If yes, please report all the data available from 2009 to 2011

Data Source	Timeframe of the data	Coverage estimate
NA	NA	NA

How have you been using the above data to address gender-related barrier to immunisation access?

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

If no sex-disaggregated data is available at the moment, do you plan in the future to collect sex-disaggregated data on routine immunisation reporting? **No**

What action have you taken to achieve this goal?

With GAVI HSS support, data will be collected at community level with the support of Female Community Health Workers. This will help achieve the goal of collection of sex-disaggregated data. In addition to data on routine immunization, the newly started surveillance system collectes 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 through Child Health Days (CHD) and Reaching Every Child (RED) approach. Data are collected and transferred, to UNICEF, by partners through the HMIS system of UNICEF, and coverage calculated by UNICEF and WHO, and endorsed by local health authorities. These same figures are reported as the Official Estimates for Somalia.

Over the last three years, there has been discrepancy between the official estimates of the country and the estimates made by WHO/UNICEF through the Joint Reporting Format (JRF). The discrepancy is due to the figure coming from CHD, a strategy not considered as a component of routine activity by JRF task force, though all routine doses in CHD are administered based on routine EPI schedule.

As a result of this discrepancy, the JRF task force, has started publishing Somalia's Estimate in two line graphs: one indicating the number vaccinated through *'classical routine'* and another indicating the number vaccinated through *'CHD Strategy'*.

* Please note that the WHO UNICEF estimates for 2011 will only be available in July 2012 and can have retrospective changes on the time series.

5.4.2. Have any assessments of administrative data systems been conducted from 2010 to the present? **No**

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

NA

5.4.3. Please describe any major activities undertaken to improve administrative data systems from 2009 to the present.

Training on data quality has been conducted before each Child Health Days, twice a year since 2009.

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.

An EPI review is planned for 2012 along with EPI cluster coverage survey, with administrative support of UNICEF and technical support from CDC, Atlanta

5.5. Overall Expenditures and Financing for Immunisation

The purpose of **Table 5.5a** and **Table 5.5b** 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$ = 24000	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 2011**	**Source of funding**						
		Country	**GAVI**	**UNICEF**	**WHO**	**DFID**	**NGOs**	**Other**
Traditional Vaccines*	2,165,575	0	0	2,165,575	0	0	0	0
New and underused Vaccines**	0	0	0	0	0	0	0	0
Injection supplies (both AD syringes and syringes other than ADs)	433,942	0	0	433,942	0	0	0	0
Cold Chain equipment	479,848	0	0	479,848	0	0	0	0
Personnel	3,175,851	43,200	0	1,255,001	1,140,802	0	736,848	0
Other routine recurrent costs	715,214	0	0	357,607	357,607	0	0	0
Other Capital Costs	19,890	0	0	0	19,890	0	0	0
Campaigns costs	6,704,229	0	0	0	4,620,772	2,083,457	0	0
Training, supervision		0	323,820	0	0	0	0	0
Total Expenditures for Immunisation	13,694,549							
Total Government Health		43,200	323,820	4,691,973	6,139,071	2,083,457	736,848	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.

Please state if an Annual Action Plan for the year 2011, based on the cMYP, was developed and costed.

5.5.1. If there are differences between available funding and expenditures for the reporting year, please clarify what are the reasons for it.

Annual plan of action was developed, based on cMYP, but not costed. The plan was implemented partially, due to the drought and famine that hit Somalia. Delivery of *Emeregency Health Response*, including control of outbreaks of measles, had kept partners busy for the good part of the last two quarters of 2011.

In Somalia, there are about 40 immunization partners. The major financiers are UNICEF, WHO, NGOs and local governments. It is difficult, for a lot of resons, to obtain all the expenses from each partners. As a result, the above figures on *Overall Expenditure and Financing for Immunization*, do not reflect the entire funding situation of immunization. (In 2010, for instance, UNICEF was the major financier of routine immunization, financing about 46% of all the routine expenditures. The second major financier was WHO financing about 29%; and NGOs financed about 24% of total immunization cost. The contribution of sub-national governments was about 1% of routine immunization expenditure)

<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />*NOTE: The fields in the above form are formatted in such a way that a 'NA' (Not Available) response is not allowed. Unfortunatelly, blank fields are also not allowed, upon submission of the APR. So, we had to populate the fields with 'zero'. So, some 'zeros' might mean 'NA'*

5.5.2. If less funding was received and spent than originally budgeted, please clarify the reasons and specify which areas were underfunded.

No costing of activities was done for the plan, nor all planned activities been implemented, in 2011. As a result, the exact funding gap, for planned activities, were not identified. But, there had not been a major financial problem, that hampered routine immunization activities.

5.5.3. If there are no government funding allocated to traditional vaccines, please state the reasons and plans for the expected sources of funding for 2012 and 2013

Somalia has not had a functioning central government for the last 21 years. As a result, all immunization activities are financed by UNICEF, WHO and other donors.

Table 5.5b: Overall Budgeted Expenditures for Immunisation from all sources (Government and donors) in US$.

Expenditure by category	Budgeted Year 2012	Budgeted Year 2013
Traditional Vaccines*	697,717	475,240
New and underused Vaccines**	0	3,411,518
Injection supplies (both AD syringes and syringes other than ADs)	138,701	156,212
Injection supply with syringes other than ADs	0	0
Cold Chain equipment	329,969	345,373
Personnel	3,305,914	3,405,749
Other routine recurrent costs	7,912,508	11,476,541
Supplemental Immunisation Activities	19,008,510	19,616,983
Total Expenditures for Immunisation	31,393,319	38,887,616

* 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.

If there are major differences between the cMYP projections and the budgeted figures above, please clarify the main reasons for it.

5.5.4. Are you expecting to receive all funds that were budgeted for 2012 ? If not, please explain the reasons for the shortfall and which expenditure categories will be affected.

The country expectes to receive most of the funds budgeted for 2012. But, if there will be a shortfall in the expected fund, it will be the SIA activities that are likely to be affected most.

5.5.5. Are you expecting any financing gaps for 2013 ? If yes, please explain the reasons for the gaps and strategies being pursued to address those gaps.

About half of the population of Somalia, has been under the control of militant groups, that have limited most immunization activities. These groups are fleeing from most of the areas that they have controlled. If this trend continues, more and more areas will be opened and partners will be able to implement all immunization activites. This will call for scaling-up of immunization activities, including conduct of supplemental immunization activities. As a result of increased activities, the country might face relative funding gap. The strategies pursued to address this gap include: raising funding issue in all partners' meeting, appealing for more fund, approach non-traditional donors, use locally available funding mechanism like that of the CERF.

5.6. Financial Management

5.6.1. Has a GAVI Financial Management Assessment (FMA) been conducted prior to, or during the 2011 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?
NA	No

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

NA

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

NA

5.7. Interagency Coordinating Committee (ICC)

How many times did the ICC meet in 2011? **12**

Please attach the minutes **(Document N°)** from all the ICC meetings held in 2011, including those of the meeting 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

One of the key concerns, that has been discussed over and over, relate with absense of good population estimates in Somalia.

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

If Yes, which ones?

List CSO member organisations:
SRCS
Trocaire
World Vision
COOPI
Merlin
SAF
SAACID
CISP
COSV
SAACID/ Oxfam Novib
SAFUK

5.8. Priority actions in 2012 to 2013

What are the country's main objectives and priority actions for its EPI programme for 2012 to 2013?

1. Routine Immunization Coverage<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

a. Improving routine immunization coverage by increasing access and utilization of immunization services through:

i. Implementation of RED approach in all accessible districts of Somalia.

ii. Conducting two rounds of CHDs

2. Accelerated Disease Control

a. Maintaining the polio free status by conducting quality SIA.

b. Activities towards achieving elimination of measles by 2015, through two rounds of Child Health Days and improved measles surveillance

c. Activities towards achieving elimination of MNT through two rounds of Child Health Days, in 2012.

3. Programme Management

a. Supporting EPI units within existing ministries in all zones.

b. Strengthening of supportive supervision especially from zone to district and MCH levels.

4. Introduction of new vaccine: Preparation for Pentavalent vaccine completed, by end of 2012; and Pentavalent vaccine introduced by Jan, 2013

5. Advocacy and communication: communication strategy for pentavalent vaccine developed.

6. Disease surveillance: Improved aggregate VPD surveillance, and measles case-based surveillance in place by the end of 2012.

Are they linked with cMYP? **Yes**

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 2011

Vaccine	Types of syringe used in 2011 routine EPI	Funding sources of 2011
BCG	0.05ml	UNICEF
Measles	0.5ml	UNICEF
TT	0.5ml	UNICEF
DTP-containing vaccine	0.5ml	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)

Though the country does not have a policy on injection safety, training on injection safety has been conducted to all health workers, and injection safety procedures are observed in all immunization activities. Somalia, will develop its injection safety policy by the end of 2012.

Please explain in 2011 how sharps waste is being disposed of, problems encountered, etc.

All sharp wastes are collected in safety boxes, and later on incinerated and buried. No problem had been encountered regarding sharp waste disposal.

6. Immunisation Services Support (ISS)

6.1. Report on the use of ISS funds in 2011

	Amount US$	Amount local currency
Funds received during 2011 *(A)*	0	0
Remaining funds (carry over) from 2010 *(B)*	229,987	229,987
Total funds available in 2011 *(C=A+B)*	229,987	229,987
Total Expenditures in 2011 *(D)*	229,987	229,987
Balance carried over to 2012 *(E=C-D)*	0	0

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

Somalia had not recieved *GAVI ISS* award in 2011. But, WHO Somalia had a remaining balance of US$ 229,987 from the last tranche of the ISS award that was transferred in 2009. This fund was used in 2011 for training and supervision activities. There was no transfer of fund to local health authorities; nor inclusion of funds in the National Health Sector Plan, as there is none. No problem encountered involving the use of ISS fund.

6.1.2. 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 ICC in this process

WHO uses an online system of financial management, in which funds received at HQ level are channelled to country offices. In the case of WHO Somalia, funds are utilized by sub-offices for training, supervision and other immunization activities, with the approval of EPI manager.

6.1.3. Please report on major activities conducted to strengthen immunisation using ISS funds in 2011

Major immunization activities conducted using ISS fund in 2011 include:

- Training of health workers in all accessible areas of Somalia
- Conduct of supervision by from zone to health facilities
- Outreach activities for 14 MCHs in Mogadishu

6.1.4. Is GAVI's ISS support reported on the national health sector budget? **No**

6.2. Detailed expenditure of ISS funds during the 2011 calendar year

6.2.1. Please attach a detailed financial statement for the use of ISS funds during the 2011 calendar year (Document Number 13) (Terms of reference for this financial statement are attached in Annexe 2). Financial statements should be signed by the Chief Accountant or by the Permanent Secretary of Ministry of Health.

6.2.2. Has an external audit been conducted? **No**

6.2.3. External audit reports for ISS, HSS, CSO Type B programmes are due to the GAVI Secretariat six months following the close of your governments fiscal year. If an external audit report is available for your ISS programme during your governments most recent fiscal year, this must also be attached (Document Number 19).

6.3. Request for ISS reward

In June 2009, the GAVI Board decided to improve the system to monitor performance of immunisation programmes and the related calculation of performance based rewards. Starting from 2008 reporting year, a country is entitled to a reward:

a) if the number of children vaccinated with DTP3 is higher than the previous year's achievement (or the original target set in the approved ISS proposal), and

b) if the reported administrative coverage of DTP3 (reported in the JRF) is in line with the WHO/UNICEF coverage estimate for the same year, which will be published at http://apps.who.int/immunization_monitoring/en/globalsummary/timeseries/tscoveragedtp3.htm

If you may be eligible for ISS reward based on DTP3 achievements in 2011 immunisation programme, estimate the $ amount by filling **Table 6.3** below

The estimated ISS reward based on 2011 DTP3 achievement is shown in Table 6.3

Table 6.3: Calculation of expected ISS reward

				Base Year**	2011
				A	B***
1	Number of infants vaccinated with DTP3* (from JRF) **specify**			143184	193163
2	Number of **additional** infants that are reported to be vaccinated with DTP3				49979
3	Calculating	$20	per additional child vaccinated with DTP3		999580
4	**Rounded-up estimate of expected reward**				1000000

* Number of DTP3: total number of infants vaccinated with DTP3 alone plus the number of those vaccinated with combined DTP-HepB3, DTP-HepB-Hib3.

** Base-year is the previous year with the highest DTP3 achievement or the original target set in the approved ISS proposal, whichever is higher. Please specify the year and the number of infants vaccinated with DTP3 and reported in JRF.

*** Please note that value B1 is 0 (zero) until **Number of infants vaccinated (to be vaccinated) with DTP3** in section 4. Baseline & annual targets is filled-in

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

7.1. Receipt of new & under-used vaccines for 2011 vaccine programme

7.1.1. Did you receive the approved amount of vaccine doses for 2011 Immunisation Programme that GAVI communicated to you in its Decision Letter (DL)? Fill-in table below **Table 7.1**

Table 7.1: Vaccines received for 2011 vaccinations against approvals for 2011

	[A]	[B]	
Vaccine type	**Total doses for 2011 in Decision Letter**	**Total doses received by 31 December 2011**	**Total doses of postponed deliveries in 2012**
DTP-HepB-Hib		0	0

**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? ...)

  NA
- 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)

  NA

7.1.2. For the vaccines in the **Table 7.1**, has your country faced stock-out situation in 2011? **No**

If **Yes**, how long did the stock-out last?

NA

Please describe the reason and impact of stock-out, including if the stock-out was at the central level only or at lower levels.

NA

7.2. Introduction of a New Vaccine in 2011

7.2.1. If you have been approved by GAVI to introduce a new vaccine in 2011, please refer to the vaccine introduction plan in the proposal approved and report on achievements:

Vaccine introduced	NA	
Phased introduction	No	
Nationwide introduction	No	
The time and scale of introduction was as planned in the proposal? If No, Why ?	No	NA

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° 20))

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**

7.3. New Vaccine Introduction Grant lump sums 2011

7.3.1. Financial Management Reporting

	Amount US$	Amount local currency
Funds received during 2011 (A)	0	0
Remaining funds (carry over) from 2010 (B)	0	0
Total funds available in 2011 (C=A+B)	0	0
Total Expenditures in 2011 (D)	0	0
Balance carried over to 2012 (E=C-D)	0	0

Detailed expenditure of New Vaccines Introduction Grant funds during the 2011 calendar year

Please attach a detailed financial statement for the use of New Vaccines Introduction Grant funds in the 2011 calendar year (Document No 14) . 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

NA

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

NA

Please describe the activities that will be undertaken with any remaining balance of funds for 2012 onwards

NA

7.4. Report on country co-financing in 2011

Table 7.4 : Five questions on country co-financing

	Q.1: What were the actual co-financed amounts and doses in 2011?	
Co-Financed Payments	**Total Amount in US$**	**Total Amount in Doses**
1st Awarded Vaccine DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	0	0
	Q.2: Which were the sources of funding for co-financing in reporting year 2011?	
Government	NA	
Donor	NA	
Other	NA	
	Q.3: Did you procure related injections supplies for the co-financing vaccines? What were the amounts in US$ and supplies?	
1st Awarded Vaccine DTP-HepB-Hib, 10 dose(s) per vial, LIQUID		
	Q.4: When do you intend to transfer funds for co-financing in 2013 and what is the expected source of this funding	
Schedule of Co-Financing Payments	Proposed Payment Date for 2013	Source of funding

1st Awarded Vaccine DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	November	UNICEF
	Q.5: Please state any Technical Assistance needs for developing financial sustainability strategies, mobilising funding for immunization, including for co-financing	
	Visit by a team from GAVI secretariat and VPI EMRO	

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 GAVI's new vaccine support reported on the national health sector budget? **No**

7.5. Vaccine Management (EVSM/VMA/EVM)

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

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

When was the latest Effective Vaccine Management (EVM) or an alternative assessment (EVSM/VMA) carried out? **September 2007**

Please attach:

(a) EVM assessment **(Document No 15)**

(b) Improvement plan after EVM **(Document No 16)**

(c) Progress report on the activities implemented during the year and status of implementation of recommendations from the Improvement Plan **(Document No 17)**

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

Kindly provide a summary of actions taken in the following table:

Deficiency noted in EVM assessment	Action recommended in the Improvement plan	Implementation status and reasons for for delay, if any

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

If yes, provide details

After the last EVM of 2007, no formal EVM was conducted. But, activities related with EVSM were carried out as part of internal quality assurance activities for all UNICEF sub-offices, in March 2011. EVM was planned for September, 2011, but could not be implemented due to the humanitarian crisis. This activity is re-planned for September 2012.

When is the next Effective Vaccine Management (EVM) assessment planned? **September 2012**

7.6. Monitoring GAVI Support for Preventive Campaigns in 2011

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 2012

Renewal of multi-year vaccines support for Somalia is not available in 2012

7.9. Request for continued support for vaccines for 2013 vaccination programme

In order to request NVS support for 2013 vaccination do the following

Confirm here below that your request for 2013 vaccines support is as per 7.11 Calculation of requirements
Yes

If you don't confirm, please explain

NA

7.10. Weighted average prices of supply and related freight cost

Table 7.10.1: Commodities Cost

Estimated prices of supply and related freight cost: 2011 from UNICEF Supply Division; 2012 onwards: GAVI Secretariat

Vaccine	Presentation	2013	2014	2015
DTP-HepB, 10 dose(s) per vial, LIQUID	10			
DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	1	2.017	1.986	1.933
DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	10	2.017	1.986	1.933
DTP-HepB-Hib, 2 dose(s) per vial, LYOPHILISED	2	2.017	1.986	1.933
HPV bivalent, 2 dose(s) per vial, LIQUID	2	5.000	5.000	5.000
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	5.000	5.000	5.000
Measles, 10 dose(s) per vial, LYOPHILISED	10	0.242	0.242	0.242
Meningogoccal, 10 dose(s) per vial, LIQUID	10	0.520	0.520	0.520
MR, 10 dose(s) per vial, LYOPHILISED	10	0.494	0.494	0.494
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2	3.500	3.500	3.500
Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	1	3.500	3.500	3.500
Yellow Fever, 10 dose(s) per vial, LYOPHILISED	10	0.900	0.900	0.900
Yellow Fever, 5 dose(s) per vial, LYOPHILISED	5	0.900	0.900	0.900
Rotavirus, 2-dose schedule	1	2.550	2.550	2.550
Rotavirus, 3-dose schedule	1	3.500	3.500	3.500
AD-SYRINGE	0	0.047	0.047	0.047
RECONSTIT-SYRINGE-PENTAVAL	0	0.047	0.047	0.047
RECONSTIT-SYRINGE-YF	0	0.004	0.004	0.004
SAFETY-BOX	0	0.006	0.006	0.006

Note: WAP weighted average price (to be used for any presentation: For DTP-HepB-Hib, it applies to 1 dose liquid, 2 dose lyophilised and 10 dose liquid. For Yellow Fever, it applies to 5 dose lyophilised and 10 dose lyophilised)

Table 7.10.1: Commodities Cost

Estimated prices of supply and related freight cost: 2011 from UNICEF Supply Division; 2012 onwards: GAVI Secretariat

Vaccine	Presentation	2016
DTP-HepB, 10 dose(s) per vial, LIQUID	10	
DTP-HepB-Hib, 1 dose(s) per vial, LIQUID	1	1.927
DTP-HepB-Hib, 10 dose(s) per vial, LIQUID	10	1.927
DTP-HepB-Hib, 2 dose(s) per vial, LYOPHILISED	2	1.927
HPV bivalent, 2 dose(s) per vial, LIQUID	2	5.000
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	5.000
Measles, 10 dose(s) per vial, LYOPHILISED	10	0.242
Meningogoccal, 10 dose(s) per vial, LIQUID	10	0.520
MR, 10 dose(s) per vial, LYOPHILISED	10	0.494
Pneumococcal (PCV10), 2 dose(s) per vial, LIQUID	2	3.500
Pneumococcal (PCV13), 1 dose(s) per vial, LIQUID	1	3.500
Yellow Fever, 10 dose(s) per vial, LYOPHILISED	10	0.900
Yellow Fever, 5 dose(s) per vial, LYOPHILISED	5	0.900
Rotavirus, 2-dose schedule	1	2.550
Rotavirus, 3-dose schedule	1	3.500
AD-SYRINGE	0	0.047
RECONSTIT-SYRINGE-PENTAVAL	0	0.047
RECONSTIT-SYRINGE-YF	0	0.004
SAFETY-BOX	0	0.006

Note: WAP weighted average price (to be used for any presentation: For DTP-HepB-Hib, it applies to 1 dose liquid, 2 dose lyophilised and 10 dose liquid. For Yellow Fever, it applies to 5 dose lyophilised and 10 dose lyophilised)

Table 7.10.2: Freight Cost

Vaccine Antigens	VaccineTypes	No Threshold	500,000$	
			<=	>
DTP-HepB	HEPBHIB	2.00 %		
DTP-HepB-Hib	HEPBHIB		23.80 %	6.00 %
Measles	MEASLES	14.00 %		
Meningogoccal	MENINACONJUGATE	10.20 %		
Pneumococcal (PCV10)	PNEUMO	3.00 %		
Pneumococcal (PCV13)	PNEUMO	6.00 %		
Rotavirus	ROTA	5.00 %		
Yellow Fever	YF	7.80 %		

7.11. Calculation of requirements

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

ID		Source		2011	2012	2013	2014	2015	TOTAL
	Number of surviving infants	Table 4	#	319,282	328,860	338,726	348,888	359,355	1,695,111
	Number of children to be vaccinated with the first dose	Table 4	#	0	0	311,628	327,955	348,574	988,157
	Number of children to be vaccinated with the third dose	Table 4	#	0	0	270,981	296,555	323,420	890,956
	Immunisation coverage with the third dose	Table 4	%	0.00 %	0.00 %	80.00 %	85.00 %	90.00 %	
	Number of doses per child	Parameter	#	3	3	3	3	3	
	Estimated vaccine wastage factor	Table 4	#	1.33	1.33	1.33	1.33	1.25	
	Vaccine stock on 1 January 2012		#	0					
	Number of doses per vial	Parameter	#		10	10	10	10	
	AD syringes required	Parameter	#		Yes	Yes	Yes	Yes	
	Reconstitution syringes required	Parameter	#		No	No	No	No	
	Safety boxes required	Parameter	#		Yes	Yes	Yes	Yes	
g	**Vaccine price per dose**	Table 7.10.1	$		2.18	2.02	1.99	1.93	
cc	**Country co-financing per dose**	Co-financing table	$		0.00	0.20	0.20	0.20	
ca	**AD syringe price per unit**	Table 7.10.1	$		0.0465	0.0465	0.0465	0.0465	
cr	**Reconstitution syringe price per unit**	Table 7.10.1	$		0	0	0	0	
cs	**Safety box price per unit**	Table 7.10.1	$		0.0058	0.0058	0.0058	0.0058	
fv	**Freight cost as % of vaccines value**	Table 7.10.2	%		23.80 %	6.00 %	6.00 %	6.00 %	
fd	**Freight cost as % of devices value**	Parameter	%		10.00 %	10.00 %	10.00 %	10.00 %	

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

Co-financing group	Low

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

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

		2012	2013	2014	2015
Number of vaccine doses	#	0	1,408,900	1,199,000	1,179,600
Number of AD syringes	#	0	1,382,800	1,110,200	1,160,800
Number of re-constitution syringes	#	0	0	0	0
Number of safety boxes	#	0	15,350	12,325	12,900
Total value to be co-financed by GAVI	$	0	3,083,000	2,581,000	2,476,500

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

		2012	2013	2014	2015
Number of vaccine doses	#	0	145,400	125,900	127,600
Number of AD syringes	#	0	0	0	0
Number of re-constitution syringes	#	0	0	0	0

Number of safety boxes	#	0	0	0	0
Total value to be co-financed by the Country	$	0	311,000	265,000	261,500

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

		Formula	2011	2012		
			Total	Total	Government	GAVI
A	**Country co-finance**	*V*	0.00 %	0.00 %		
B	**Number of children to be vaccinated with the first dose**	*Table 5.2.1*	0	0	0	0
C	**Number of doses per child**	*Vaccine parameter (schedule)*	3	3		
D	**Number of doses needed**	*B X C*	0	0	0	0
E	**Estimated vaccine wastage factor**	*Table 4*	1.33	1.33		
F	**Number of doses needed including wastage**	*D X E*	0	0	0	0
G	**Vaccines buffer stock**	*(F – F of previous year) * 0.25*		0	0	0
H	**Stock on 1 January 2012**	*Table 7.11.1*	0			
I	**Total vaccine doses needed**	*F + G – H*		0	0	0
J	**Number of doses per vial**	*Vaccine Parameter*		10		
K	**Number of AD syringes (+ 10% wastage) needed**	*(D + G – H) * 1.11*		0	0	0
L	**Reconstitution syringes (+ 10% wastage) needed**	*I / J * 1.11*		0	0	0
M	**Total of safety boxes (+ 10% of extra need) needed**	*(K + L) /100 * 1.11*		0	0	0
N	**Cost of vaccines needed**	*I x vaccine price per dose (g)*		0	0	0
O	**Cost of AD syringes needed**	*K x AD syringe price per unit (ca)*		0	0	0
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)*		0	0	0
R	**Freight cost for vaccines needed**	*N x freight cost as of % of vaccines value (fv)*		0	0	0
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)*		0	0	0
U	**Total country co-financing**	*I x country co-financing per dose (cc)*		0		
V	**Country co-financing % of GAVI supported proportion**	*U / (N + R)*		0.00 %		

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

		Formula	2013			2014		
			Total	Government	GAVI	Total	Government	GAVI
A	Country co-finance	*V*	9.35 %			9.50 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	311,628	29,152	282,476	327,955	31,158	296,797
C	Number of doses per child	*Vaccine parameter (schedule)*	3			3		
D	Number of doses needed	*B X C*	934,884	87,454	847,430	983,865	93,472	890,393
E	Estimated vaccine wastage factor	*Table 4*	1.33			1.33		
F	Number of doses needed including wastage	*D X E*	1,243,396	116,313	1,127,083	1,308,541	124,318	1,184,223
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	310,849	29,079	281,770	16,287	1,548	14,739
H	Stock on 1 January 2012	*Table 7.11.1*						
I	Total vaccine doses needed	*F + G – H*	1,554,245	145,392	1,408,853	1,324,828	125,865	1,198,963
J	Number of doses per vial	*Vaccine Parameter*	10			10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	1,382,764	0	1,382,764	1,110,169	0	1,110,169
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	0	0	0	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	15,349	0	15,349	12,323	0	12,323
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	3,134,913	293,254	2,841,659	2,631,109	249,968	2,381,141
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	3,134,913	0	64,299	2,631,109	0	51,623
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	90	0	90	72	0	72
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	188,095	17,596	170,499	157,867	14,999	142,868
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	6,439	0	6,439	5,170	0	5,170
T	Total fund needed	*(N+O+P+Q+R+S)*	3,393,836	310,850	3,082,986	2,845,841	264,966	2,580,875
U	Total country co-financing	*I x country co-financing per dose (cc)*	310,849			264,966		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	9.35 %			9.50 %		

Table 7.11.4: Calculation of requirements for DTP-HepB-Hib, 10 dose(s) per vial, LIQUID (part 3)

		Formula	2015		
			Total	Government	GAVI
A	Country co-finance	*V*	9.76 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2.1*	348,574	34,025	314,549
C	Number of doses per child	*Vaccine parameter (schedule)*	3		
D	Number of doses needed	*B X C*	1,045,722	102,073	943,649
E	Estimated vaccine wastage factor	*Table 4*	1.25		
F	Number of doses needed including wastage	*D X E*	1,307,153	127,591	1,179,562
G	Vaccines buffer stock	*(F – F of previous year) * 0.25*	0	0	0
H	Stock on 1 January 2012	*Table 7.11.1*			
I	Total vaccine doses needed	*F + G – H*	1,307,153	127,591	1,179,562
J	Number of doses per vial	*Vaccine Parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G – H) * 1.11*	1,160,752	0	1,160,752
L	Reconstitution syringes (+ 10% wastage) needed	*I / J * 1.11*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) /100 * 1.11*	12,885	0	12,885
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	2,526,727	246,633	2,280,094
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	53,975	0	53,975
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)*	75	0	75
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	151,604	14,799	136,805
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	5,405	0	5,405
T	Total fund needed	*(N+O+P+Q+R+S)*	2,737,786	261,431	2,476,355
U	Total country co-financing	*I x country co-financing per dose (cc)*	261,431		
V	Country co-financing % of GAVI supported proportion	*U / (N + R)*	9.76 %		

8. Injection Safety Support (INS)

Somalia is not reporting on Injection Safety Support (INS) in 2012

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 and received HSS funds before or during January to December 2011**. All countries are expected to report on:

   a. Progress achieved in 2011

   b. HSS implementation during January – April 2012 (interim reporting)

   c. Plans for 2013

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

For countries that received HSS funds within the last 3 months of 2011, or experienced other delays that limited implementation in 2011, 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 2011 fiscal year starts in January 2011 and ends in December 2011, HSS reports should be received by the GAVI Alliance before **15th May 2012**. 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 2012, the HSS reports are expected by GAVI Alliance by September 2012.

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 activities and budget (reprogramming) please explain these changes in this report (Table/Section 9.5, 9.6 and 9.7) and provide explanations for each change so that the IRC can approve 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. The changes must have been discussed and documented in the HSCC minutes (or equivalent).**

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 2011

   b. Minutes of the HSCC meeting in 2012 that endorses the submission of this report

   c. Latest Health Sector Review Report

   d. Financial statement for the use of HSS funds in the 2011 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 2011 and request of a new tranche

9.1.1. Report on the use of HSS funds in **2011**

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: **3037862** US$

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

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

Table 9.1.3a (US)$

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)	0	0	0	0	2786791	2476727
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0	0	0	0	136949	2654506
Total funds received from GAVI during the calendar year (*A*)	0	0	0	0	2696455	0
Remaining funds (carry over) from previous year (*B*)	0	0	0	0	0	2559506
Total Funds available during the calendar year (*C=A+B*)	0	0	0	0	2604506	2559506
Total expenditure during the calendar year (*D*)	0	0	0	0	136949	
Balance carried forward to next calendar year (*E=C-D*)	0	0	0	0	2559506	
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	3037862

Table 9.1.3b (Local currency)

	2007	2008	2009	2010	2011	2012
Original annual budgets (*as per the originally approved HSS proposal*)	0	0	0	0	0	0
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	0	0	0	0	0	0
Total funds received from GAVI during the calendar year (*A*)	0	0	0	0	0	0

Remaining funds (carry over) from previous year (*B*)	0	0	0	0	0	0
Total Funds available during the calendar year (*C=A+B*)	0	0	0	0	0	0
Total expenditure during the calendar year (*D*)	0	0	0	0	0	0
Balance carried forward to next calendar year (*E=C-D*)	0	0	0	0	0	0
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

Report of Exchange Rate Fluctuation

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

Table 9.1.3.c

Exchange Rate	2007	2008	2009	2010	2011	2012
Opening on 1 January	0	0	0	0	0	0
Closing on 31 December	0	0	0	0	0	0

Detailed expenditure of HSS funds during the 2011 calendar year

Please attach a detailed financial statement for the use of HSS funds during the 2011 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: 9)**

If any expenditures for the January April 2012 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: 22)**

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.

WHO Managed Portion of GAVI HSS<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

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

Please note that the year parameters in the above table 9.1.3a are not updated/compatible with Somalia APR requirements and do not allow us to complete them appropriately. Therefore, in respect of the new tranche requests and revised budget, please consider the two separate tables (below) for Unicef & WHO.

9.1.1. Report on the use of HSS funds in 2011

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:

WHO needs additional amount of USD48,234 to finalize activities planned for 2012 and USD1,980,776.6 to implement activities planned for 2013. Therefore, WHO would like to request total amount of USD2,029,010.6 in the next tranche of funding.

UNICEF requires a new tranche that amounts to USD1,008,851 for year 2013.

9.1.3. Is GAVI's HSS support reported on the national health sector budget?

Not applicable for Somalia as there is no national health sector budget.

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

Table 9.1.3a (US)$ UNICEF

	2010	2011	2012	2013	2014	2015
Original annual budgets (*as per the originally approved HSS proposal*)		1,381,282	1,015,191	603,070	583,070	622,989
Revised annual budgets (*if revised by previous Annual Progress Reviews*)		1,337,712	1,008,851	1,012,729	846,310	
Total funds received from GAVI during the calendar year (*A*)		**$1,290,946.16**				
		(Programmable)				
Remaining funds (carry over) from previous year (*B*)		Nil				
Total Funds available during the calendar year (*C=A+B*)						

$1,290,946.16

Total expenditure during the calendar year (*D*)

Nil

Balance carried forward to next calendar year (*E=C-D*)

$1,290,946.16

Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]

1,008,851

1,012,729

846,310

Table 9.1.3a (US)$ WHO

	2010	2011	2012	2013	2014	2015
Original annual budgets (*as per the originally approved HSS proposal*)	1,405,509	1,461,536	1,619,832	1,434,152	1,417,549	
Revised annual budgets (*if revised by previous Annual Progress Reviews*)	136,949	1,316,794	1,980,776.6	1,958,330.7	1,945,728.7	
Total funds received from GAVI during the calendar year (*A*)	1,405,509					
Remaining funds (carry over) from previous year (*B*)						
Total Funds available during the calendar year (*C=A+B*)	1,313,560					
Total expenditure during the calendar year (*D*)	136,949					

Balance carried forward to next calendar year (*E=C-D*)

1,268,560

Amount of funding requested for future calendar year(s) [please ensure you complete this row if you are requesting a new tranche]

2,029,010.6

(48,234 $ to finalize activities planned for 2012 and 1,980,776.6

$ for activities planned for 2013).

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: 26)

9.2. Progress on HSS activities in the 2011 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 2011 reporting year

Major Activities (insert as many rows as necessary)	**Planned Activity for 2011**	**Percentage of Activity completed (annual)** (where applicable)	**Source of information/data** (if relevant)
Unicef Activity 1.2	Rehabilitation of selected MCH centres (based on assessment)	0	
Unicef Activity 1.3:	Procurement and supply of essential equipment for MCH services (based on gaps)	0	
Unicef Activity 1.4:	Provide comprehensive support for BEMONC in selected MCH centres (6)	0	
Unicef Activity 1.9:	Renovation of cold chain equipment in all MCH centres	0	
Unicef Activity 2.8:	Develop and implement a community based HMIS	0	
Unicef Activity 2.9:	Printing and distribution of HMIS tools	0	
Unicef Activity 2.10:	Procure and distribute/resupply FCHW kits	0	
Unicef Activity 2.11:	Procure and distribute/re-supply equipment for Health posts	0	
Unicef Activity 3.1:	Formative research to identify key behaviours and barriers	0	
Unicef Activity 3.2:	Develop National BCC strategy	0	
Unicef Activity 3.3:	Develop, print and distribute IEC material (MCH centres, health posts)	0	
Unicef Activity 3.4:	Develop video programs	0	

Unicef Activity 3.5:	Disseminate video messages through cable	0	
Unicef Activity 3.6:	Develop radio programs	0	
Unicef Activity 3.7:	Disseminate BCC messages through radio	0	
Unicef Activity 3.8:	Increase public awareness through print media	0	
Unicef Activity 3.9:	Organise advocacy/BCC events for community elders and religious leaders	0	
Unicef Activity 3.10:	Organise school events on key messages	0	
Unicef Activity 3.11	Produce and distribute IEC material to private pharmacies	0	
Unicef Activity 3.12:	Produce and distribute IEC material (flipcharts) to FCHWs and CHWs	0	
Unicef Activity 3.13:	SMS text messaging for BCC	0	
Unicef Activity 4.1:	Conduct baseline and end-line surveys	0	
WHO Activity 1.1:	Develop list of priority health facilities and conduct survey to identify gaps in 40 MCH centres	50	List of selected / recommended health facilities
WHO Activity 1.5:	Development / adapt curriculum for training of MCH and EPI staff in supervision, outreach and HMIS	0	
WHO Activity 1.6:	Conduct training of MCH and EPI staff (in 40 MCH centres)	0	
WHO Activity 1.7:	Develop curriculum for training of all MCH staff in EPI injection safety and vaccine management	0	
WHO Activity 1.8:	Training of all MCH centres staff (EPI, injection safety and vaccine management)	0	
WHO Activity 1.10:	Develop and implement a system of regular EPI outreach from MCH centres to the catchment areas of health posts and FHWs	0	
WHO Activity 1.11:	Develop a system for regular supervision for MCH centres from regional and zonal MOH	0	
WHO Activity 1.12:	Provide transport support to MOH for supervision of regional offices	0	
WHO Activity 1.13:	Provide transport support to regional managers for supervision of MCH centres	0	
WHO Activity 1.14:	Provide incentives for EPI outreach and RH staff at MCH centres	0	
WHO Activity 2.1:	Developing scope of work, incentives and criteria for selection, plan of supervision of FHWs and Health Posts	100	Compendium Document attached to this report;
WHO Activity 2.2:	Recruitment of FHWs	0	
WHO Activity 2.3:	Development/adapt curriculum for FHWs and supervisors	75	Inception Report attached to this report;
WHO Activity 2.4:	Training of trainers	0	
WHO Activity 2.5:	Training of FHWs	0	
WHO Activity 2.6:	Training of supervisors	0	

WHO Activity 2.7:	Develop and implement a system of supportive supervision for health posts and FHWs and outreach activities	0	
WHO Activity 2.14:	Provide incentives to FHWs	0	
WHO Activity 4.1:	Establish and support operational research committee	0	
WHO Activity 4.3:	Commission operational research studies	0	
WHO Activity 4.5:	Support data analysis and use	0	
WHO Activity 4.6:	Training of MOH managers in operational research	0	
WHO Activity 4.7	Organize study tour for health authorities	100	
WHO Activity 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**
Unicef Activity 1.2: Rehabilitation of selected MC	This activity was pending selection and finalization of GAVI-HSS supported facilities by MOH and WHO. Facilities have been finalized by three zonal Ministries in February/ March 2012, and rehabilitation will be done during 2nd quarter of 2012.
Unicef Activity 1.3: Procurement and supply of ess	UNICEF has already procured regular supplies for MCH facilities from other funding resources.
Unicef Activity 1.4: Provide comprehensive support	Awaiting selection of BEMOC facilities by zonal Ministries
Unicef Activity 1.9: Renovation of cold chain equi	Most of the GAVI-HSS selected facilities have cold chain equipment. For new facilities procurement of equipment is in progress.
Unicef Activity 2.8: Develop and implement a commu	Several preparatory meetings have been held between UNICEF and the Somali Health Authorities. Development of community based HMIS tools is in progress.
Unicef Activity 2.9: Printing and distribution of	Pending finalization of tools
Unicef Activity 2.10: Procure and distribute/resup	Three consultants from WHO developed compendium explaining the scope of FCHWs work and system components of the FCHWs' intervention in January 2012. Ministries have not yet confirm proposed supplies to be used by FCHWs. Procurement will be started as soon as three zonal ministries will confirm the kit's contents.
Unicef Activity 2.11: Procure and distribute/re-su	UNICEF has already procured regular supplies for health posts from other funding resources
Unicef Objective 3: Improved awareness and demand	A full time BCC/C4D specialist has been appointed to plan and implement various BCC related activities. Most of the planned activities under objective 3 will be revised during 2012 after consultation with health authorities depending upon results of formative research findings and national BCC strategy document.
Unicef Activity 3.1: Formative research to identif	Planned for 2012
Unicef Activity 3.2: Develop National BCC strategy	Planned for 2012
Unicef Activity 3.3: Develop, print and distribute	Planned for 2013 based on formative research findings and national BCC strategy document - Develop print, audio-visual and IPC package for health workers
Unicef Activity 3.4: Develop video programs	Cancelled and merged with activity 3.3
Unicef Activity 3.5: Disseminate video messages th	Cancelled and merged with activity 3.3
Unicef Activity 3.6: Develop radio programs	Activity 3.4: Develop and broadcast radio programme on key child caring and health practices
Unicef Activity 3.7: Disseminate BCC messages thro	Cancelled and merged with activity 3.4 – planned in 2013

Unicef Activity 3.8: Increase public awareness thr	Changed to “Identify three strong communication NGOs to build capacity of existing NGOs and to scale up public awareness at community level” – Planned for 2012
Unicef Activity 3.9: Organise advocacy/BCC events	Changed to “Strengthen and establishing structured/systematized partnership with religious leaders, religious organizations, clan leaders, community elders and networks” – planned for 2012
Unicef Activity 3.10: Organise school events on ke	Changed to “Work with school structures to increase dialogue on key child survival and development messages” Planned for 2012
Unicef Activity 3.11 Produce and distribute IEC ma	Cancelled and merged with activity 3.8
Unicef Activity 3.12: Produce and distribute IEC m	Changed to “Develop community friendly materials (discussion guides etc) with key ICCM messages for FCHWs, CHWs, TBAs for home based family promotion” Planned for 2012
Unicef Activity 3.13: SMS text messaging for BCC	Changed to “Partner with Text to Change company to use interactive SMS text messaging to remind on key child survival messages” Planned for 2012
Unicef Activity 4.1: Conduct baseline and end-line	Consultative meetings were held with MOH and base line survey will be conducted during 3rd quarter of 2012 on selected indicators. Minutes of the meetings with SCZ and NWZ Health Authorities are attached to this report
WHO Activity 1.1: Develop list of priority health	40 health facilities identified in three zones in consultation with Health Authorities and basic information about the health facilities collected. ToRs and tools for comprehensive health facility assessment have been finalized as aligned activity of the baseline survey.
WHO Activity 1.5: Development/adapt curriculum for	Planned for 2012 as funds have been received during the last quarter of 2011.
WHO Activity 1.6: Conduct training of MCH and EPI	Planned for 2013
WHO Activity 1.7: Develop curriculum for training	Planned for 2012
WHO Activity 1.8: Training of all MCH centres staf	Planned for 2013
WHO Activity 1.10: Develop and implement a system	Planned for 2012
WHO Activity 1.11: Develop a system for regular su	Started initial discussions with MOH. Need to finalize and tools to be developed in 2012.
WHO Activity 1.12: Provide transport support to MO	Will be implemented after the system has been developed.
WHO Activity 1.13: Provide transport support to re	Will be implemented after the system has been developed
WHO Activity 1.14: Provide incentives for EPI outr	Will be implemented after the training and strengthening of MCH centres.
WHO Activity 2.1: Developing scope of work, incent	HSS Strategic plan (2011-15) and a compendium relevant to the FHW component has been developed in 2011 and officially endorsed by Somali Health Authorities in February 2012. These documents contain information relevant to scope of work, selection criteria, activities plan and explanation about different system’s component etc. and are attached to this report.
WHO Activity 2.2: Recruitment of FHWs	Preparatory works for recruitment have started and the recruitment is to be completed in June 2012.
WHO Activity 2.3: Development/ adapt curriculum fo	Inception report produced as an output of the phase I of the process. Phase II started in February 2012 and draft curriculum developed and needs will be finalized in May 2012.
WHO Activity 2.4: Training of trainers	Process to start on availability of curriculum.
WHO Activity 2.5: Training of FHWs	Process to start after availability of curriculum and training of trainers.
WHO Activity 2.6: Training of supervisors	Process to start on availability of curriculum and selection of supervisors.
WHO Activity 2.7: Develop and implement a system o	Process will start after the training of supervisors.
WHO Activity 2.12: Refresher training for FHWs and	Planned for 2014
WHO Activity 2.13: Provide incentives to CHWs	Planned for second half of 2012
WHO Activity 2.14: Provide incentives to FHWs	Selection of FHWs planned to start in June 2012.
WHO Activity 4.2: Establish and support operationa	ToRs of the operational research (ORC) committees are currently being drafted.
WHO Activity 4.3: Commission operational research	Planned for end of 2012 after implementation of program
WHO Activity 4.5: Support data analysis and use	Will be done after the operational research studies

WHO Activity 4.6: Training of MOH managers in oper	Planned for 2013
WHO Activity 4.7: Organize study tour for health a	In April 2012 WHO organized a study tour to Pakistan where Somali Health Authorities (including GAVI focal points identified by three Somali MoHs) had an opportunity to familiarize themselves with the Lady Health Workers Programme. As a similar program has been proposed for Somalia, the tour helped the team to identify key issues and lessons learnt that can be applied in the context of Somalia.
WHO Activity 4.8: Technical assistance for operati	Planned for 2012

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

The grant agreement was signed after a significant delay resulting in both WHO and UNICEF receiving funds only in the last quarter of 2011. It has been agreed by two organizations to revisit their activity plans and budget lines and inform the GAVI secretariat of any modifications to the plans.<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

As funds were received during last quarter of 2011, during declared famine and level three emergency in Somalia, as well as UNICEF was moving to its new financial system, therefore no GAVI-HSS related activity was carried out by UNICEF in 2011. Preparatory work including the drafting of work plans was carried out in 2011 and first quarter of 2012.

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

Not applicable for UNICEF<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

There is no one national human resource policy or guidelines in Somalia, however, standardized level of salaries and incentives for health staff was agreed by UN agencies in a document developed in 2008 that needs revision.

WHO did not yet begin to pay incentives to FCHW and MCH staff. WHO plan to start paying incentives in the second half of 2012 based on standardized and agreed levels, once the training of FCHW begins.

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 2010 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	2011 Target					Data Source	Explanation if any targets were not achieved
	Baseline value	Baseline source/date			2007	2008	2009	2010	2011	
National DTP3 coverage (%)	36%	UNICEF 2006	55%, original target date 2014 but reprogrammed for 2015	N/A	N/A	N/A	N/A	N/A	N/A	JRF	Even in the original proposal there was no target for 2011. Both WHO and Unicef received first instalments only in the last quarter of 2011, that is why reprogramming was done moving the date targets from the fourth column accordingly.

Number/% of regions achieving >/= 80% DTP3 coverag	0%	UNICEF 2006	30%, original target date 2014 but reprogrammed for 2015	N/A						MICS	Even in the original proposal there was no target for 2011. Both WHO and Unicef received first instalments only in the last quarter of 2011, that is why reprogramming was done moving the date targets from the fourth column accordingly.
Under five mortality rate (per 1000)	145	UNICEF 2007	125, original target 2014 but reprogrammed for 2015	N/A						State of Worlds Children 2009	Even in the original proposal there was no target for 2011. Both WHO and Unicef received first instalments only in the last quarter of 2011, that is why reprogramming was done moving the date targets from the fourth column accordingly.
Measles immunization coverage (%)	19%	UNICEF 2006	60%, original target date 2014 but reprogrammed for 2015	N/A						MICS	Even in the original proposal there was no target for 2011. Both WHO and Unicef received first instalments only in the last quarter of 2011, that is why reprogramming was done moving the date targets from the fourth column accordingly.
ANC coverage (% women 15-49, one visit or > during	26%	UNICEF 2006	50%, original target date 2014 but reprogrammed for 2015	N/A						MICS	Even in the original proposal there was no target for 2011. Both WHO and Unicef received first instalments only in the last quarter of 2011, that is why reprogramming was done moving the date targets from the fourth column accordingly.
Vitamin A supplementation (under-fives) (%)	24%	UNICEF 2006	60%, original target date 2014 but reprogrammed for 2015	N/A						MICS	Even in the original proposal there was no target for 2011. Both WHO and Unicef received first instalments only in the last quarter of 2011, that is why reprogramming was done moving the date targets from the fourth column accordingly.

% MCH centres providing outreach immunization ser	N/A	N/A	100%, original target date 2012 but reprogrammed for 2013	N/A						EPI records Report of supervisory visits	Even in the original proposal there was no target for 2011. Both WHO and Unicef received first instalments only in the last quarter of 2011, that is why reprogramming was done moving the date targets from the fourth column accordingly.
Improved supervision of MCH centres	N/A	N/A	80%, original target date 2012 but reprogrammed for 2013	N/A						Supervision records at regional health offices	Even in the original proposal there was no target for 2011. Both WHO and Unicef received first instalments only in the last quarter of 2011, that is why reprogramming was done moving the date targets from the fourth column accordingly.
% of FCHWs carrying out regular home visits (5-7 p	N/A	N/A	90%, original target 2012 but reprogrammed for 2013	N/A						Supervision records at MCH centres	Even in the original proposal there was no target for 2011. Both WHO and Unicef received first instalments only in the last quarter of 2011, that is why reprogramming was done moving the date targets from the fourth column accordingly.
Community based information system in place and fu	N/A	N/A	90%, original target date 2013 but reprogrammed for 2014	N/A						MCH centres records	Even in the original proposal there was no target for 2011. Both WHO and Unicef received first instalments only in the last quarter of 2011, that is why reprogramming was done moving the date targets from the fourth column accordingly.
% of school events held to improve awareness of ke	N/A	N/A	80%, original target date 2014 but reprogrammed for 2015	N/A						FCHW monthly report	Even in the original proposal there was no target for 2011. Both WHO and Unicef received first instalments only in the last quarter of 2011, that is why reprogramming was done moving the date targets from the fourth column accordingly.

M&E system in place for routine data collection as	N/A	N/A	80%, original target date 2014 but reprogrammed for 2015	N/A						Regional office records	Even in the original proposal there was no target for 2011. Both WHO and Unicef received first instalments only in the last quarter of 2011, that is why reprogramming was done moving the date targets from the fourth column accordingly.
% of MCH centres rehabilitated and equipped	N/A	N/A	100%, original target date 2012 but reprogrammed for 2013	N/A						Regional office reports	Even in the original proposal there was no target for 2011. Both WHO and Unicef received first instalments only in the last quarter of 2011, that is why reprogramming was done moving the date targets from the fourth column accordingly.
% of MCH centres having a functional cold chain eq	N/A	N/A	100%, original target date 2012 but reprogrammed for 2013	N/A						Regional office reports	Even in the original proposal there was no target for 2011. Both WHO and Unicef received first instalments only in the last quarter of 2011, that is why reprogramming was done moving the date targets from the fourth column accordingly.
No. of FCHWs trained	N/A	N/A	Originally planned 240 but revised to 200 and original target date - 2012 reprogrammed for 2013	N/A						Contracted NGO's report	Even in the original proposal there was no target for 2011. Both WHO and Unicef received first instalments only in the last quarter of 2011, that is why reprogramming was done moving the date targets from the fourth column accordingly.
% of FCHWs with regular supply of essentials kit i	N/A	N/A	100%, original target date 2012 but reprogrammed for 2013	N/A						UNICEF	Even in the original proposal there was no target for 2011. Both WHO and Unicef received first instalments only in the last quarter of 2011, that is why reprogramming was done moving the date targets from the fourth column accordingly.

IEC material developed and distributed	N/A	N/A	90%, original target date 2012 but reprogrammed for 2013	N/A						UNICEF	Even in the original proposal there was no target for 2011. Both WHO and Unicef received first instalments only in the last quarter of 2011, that is why reprogramming was done moving the date targets from the fourth column accordingly.
% of health managers trained in operational resear	N/A	N/A	100%, original target date 2010 but reprogrammed for 2013	N/A						WHO	Even in the original proposal there was no target for 2011. Both WHO and Unicef received first instalments only in the last quarter of 2011, that is why reprogramming was done moving the date targets from the fourth column accordingly.

9.4. Programme implementation in 2011

9.4.1. Please provide a narrative on major accomplishments in 2011, especially impacts on health service programs, notably the organization program

Financial Management Assessment (FMA) was completed in 2011, followed by signing of the Aide Memoire of the HSS grant on 26 May 2011. Later on, the Grant Agreement between GAVI secretariat and WHO was signed on 29 September 2011.<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

The grant agreement was signed after a significant delay resulting in both WHO and UNICEF receiving funds only in the last quarter of 2011. It was agreed that the two organizations will revisit their activity plans and budget lines and inform the GAVI secretariat of any modifications to the plans. This was completed in March/April 2012 when WHO held operational planning exercise with Somali health authorities.

Earlier WHO launched a mission to hold consultations with different stakeholders and to develop a strategic plan for GAVI health system strengthening program. The strategic plan (2011-15) was finalized in December 2011, which is based on a conceptual framework to strengthen health system in the Somali context and describes different strategic areas of the HSS programme aligned to this framework. Governance mechanism of the programme, different criteria for selection, broader roles and responsibilities along with revised activity plan have been included. The plan was shared with health authorities for their comments and the final version is presented to HSCC and HAB and officially approved and signed by Somali Health Authorities during Health advisory board meeting in February 2012. The Strategic Plan 2011-2015 is attached as an annex to this report, Document Number 8.

Along with strategic plan, WHO also developed a compendium describing roles and responsibilities, explaining different systems of the Female Health Workers intervention including training, supervision, logistics, and reporting. This will help the health authorities and managers to implement the intervention in a systematic way.

WHO has started development of training curriculum for FHWs, master trainers of FHWs and supervisors of FHWs and phase I of this activity has been completed. The output of the phase I is an inception report describing the situation, suggesting services delivery activities of FHWs based on global scientific evidence and accordingly suggesting topic to be included in different training modules of FHW's component. The inception report also suggests the methodology to be used in the trainings. A follow up plan to develop and finalize the training materials have been suggested in different phases which are expected to be completed in June 2012. The draft curriculum have been developed. These will be finalized with involvement of four experts (nominated by the health authorities) from each zone, who will later on act as the master trainers.

Health Sector Coordination office is also working to form a “Curriculum technical committee” under the Health System Working Group (HSWG) to review all training materials to be used in future in order to standardise trainings by different stakeholders. First task of this committee will be to review the training material for the FHW intervention. Minutes of three HSWG meetings held in 2011 together with the signed list of participants are attached as annexes to this report.

WHO drafted ToRs for the “Operational Research Committee”. This committee is expected to be linked with the Health Sector Analysis Team (HSAT) in order to use evidence generated by the HSS programme to influence policies and practices and build capacity of health authorities in evidence based decision planning and making.

As part of planned WHO activity to develop a list of priority health facilities, a preliminary assessments were conducted in Somaliland, Puntland and South Central Somalia. The purpose was to ensure the selected facilities meet the criteria, have the essential staff and to identify catchment areas/villages for selection of Female Community Based Health Workers.

Given the importance of the Health Advisory Board (HAB) and the Health Sector Committee (HSC) in playing an oversight role for the programme, it has been agreed that meetings of the HAB shall be convened twice yearly whereas the HSC will meet to discuss HSS implementation on quarterly basis. The meetings of the HSC and HAB were due to be held in December 2011 but were postponed as the health authorities were unable to get the necessary visas for Kenya.

The revised strategic plan was approved and signed by three Zonal Health Authorities in February 2012, during HAB and HSC meetings. The minutes of this meeting can be submitted after official endorsement during the next HSC meeting expected on 22 May 2012.

GAVI delegation visited the WHO Office in Nairobi in February 2012 and had a discussion about a number of modifications to work plan and budget that needed to be made as the activities originally planned to be carried out over a five year period, now planned to be implemented in four years.

WHO Somalia organized an operational planning exercise with all three Somali health authorities. The purpose of this exercise was to further familiarize health authorities with the GAVI HSS, and jointly re-programme activities which subsequently resulted in the reprogramming submitted with this report.

An MOU between WHO and UNICEF specifying the planning and coordination arrangements for the implementation of the HSS programme has been finalized and signed in March 2012 as specified in the Aide Memoire.

In April 2012 WHO organized a study tour to Pakistan where Somali Health Authorities (including GAVI focal points identified by three Somali MoHs) had an opportunity to familiarize themselves with the Lady Health Workers Programme. As a similar program has been proposed for Somalia, the tour helped the team to identify key issues and lessons learnt that can be applied in the context of Somalia.

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

The HSS Programme has faced significant delays since approval of the HSS proposal and actual signing of the grant agreement. Soon after receiving the first tranche, WHO office had no other option but to review the activity plan and budget keeping in view the increase in prices, cost of living and impact of inflation on the Programme. GAVI should consider shortening the delay by speeding up the processes and simplifying funds transfer mechanisms. On the other hand GAVI may provide some interim technical assistance to start early activities, which are critical to achieve objectives and targets of the programme. <?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

Majority of countries furthest from reaching the MDGs are in the midst of or emerging from a violent conflict. The challenges faced by such countries are immense and implementation of health system strengthening interventions in a conflicted affected country is not an easy task. GAVI should prioritise and enhance investment for successful interventions in such countries. Limited financing to pilot interventions at small scale generate demand for provision of services in other parts of the country. To address equity issues, it is important that GAVI should develop a mechanism to provide additional funds to expand successful interventions.

Coordination is perhaps the most important challenge in the implementation of any intervention in the Somali context. However, using the mechanisms of Health Advisory Board and Health Sector Coordination Committee is perhaps the only option. Unfortunately, these committees are supposed to meet in Nairobi, Kenya. Getting visa for health authorities to visit Kenya is a major challenge especially during the time, when tensions are high among the neighbouring countries. GAVI is expected to be flexible in strictly following all the rules and procedures. HSS Programme is a good case study to learn lessons on how to implement health sector interventions in a country affected by conflict and crisis.

Given the original proposal and budget were drafted in 2009, with funds received in the last quarter of 2011, a number of modifications to both work plan and budget needed to be made, budget lines have been modified, with activities originally planned to be carried out over a 5 year period, now planned to implemented in 4 years.

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

GAVI HSS resources will be used to strengthen the monitoring and evaluation mechanisms. At present, WHO and Unicef are working together to conduct a baseline survey and health facility assessment in second quarter of 2012. This will help to monitor the progress and assess outcome and impact of the programme by the end of HSS support. <?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

The programme will also strengthen routine monitoring system by building capacity and integrating different reporting lines. The major focus of GAVI is on the interventions at the district and sub-district level, whereas a harmonised approach has been adopted to strengthen the information system at higher level through the GFATM support. Efforts are being made to simplify data forms and maintaining a single centralised data base for different programmatic interventions. WHO and Unicef are exploring further support to strengthen the monitoring & evaluation mechanism through other funding support.

Developing and integrating supervision and monitoring mechanism for the new cadre of FHWs is a challenging job. An initial work has been done by developing a compendium for this intervention by describing different systems including supervision and monitoring.

WHO and UNICEF will lead the implementation in close collaboration with health authorities. For the implementation, monitoring and evaluation of HSS interventions, roles and responsibilities have been clearly outlined (see GAVI-HSS Strategic Plan 2011-2015 attached to this report).

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

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

Use of agreed governance mechanism of HSWG, HSC and HAB will enable the Programme to follow an integrated approach for evidence based decision making process. Some gaps in the M&E mechanism will be covered through the operational research component of the HSS programme. Again, all such research activities will be linked with the work of “HSAT”, thus avoiding any duplication of activities.

The Zonal and Regional Health Authorities will be responsible for monthly joint supervision activities with implementing partners. Zonal Health Authorities will also organize joint annual review in which different development and implementing partners and health authorities from others zones will participate to review progress and learn lessons.

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

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

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

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

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

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

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

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

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

CSOs were involved in the planning process and will be responsible for implementation of selected GAVI-HSS activities. Names of organisations, type of activities and funding provided to these organisations from the HSS funding, will be provided later, once agreements are finalized and signed.

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

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

The HSS funds were disbursed during the last quarter of 2011 which resulted in delayed implementation of activities. So far, there are no other issues regarding the management of HSS funds. There are no planned changes to management processes of the HSS funds in the coming year. <?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

MOUs have been signed with WHO and UNICEF to implement the programme with the Somali Health authorities. Disbursement through tranches will be made directly to WHO and UNICEF through their corporate agreements with GAVI.

The Somali Health Sector Committee (HSC) will be involved in approval, oversight, and submission of GAVI APR reports.

9.5. Planned HSS activities for 2012

Please use **Table 9.5** to provide information on progress on activities in 2012. If you are proposing changes to your activities and budget in 2012 please explain these changes in the table below and provide explanations for these changes.

Table 9.5: Planned activities for 2012

Major Activities (insert as many rows as necessary)	**Planned Activity for 2012**	**Original budget for 2012** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**2012 actual expenditure** (as at April 2012)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2012** (if relevant)
Unicef Activity 1.2: Rehabilitation of selected MC	Activity 1.2: Rehabilitation of selected MCH centres (based on assessment)	100000	0		All facilities will be rehabilitated in 2012	200000
Unicef Activity 1.3: Procurement and supply of ess	Activity 1.3: Procurement and supply of essential medicines and equipment for MCH services (based on gaps)	200000		Activity 1.3: Procurement and supply of essential medicines and equipment for MCH services (based on gaps)	In original budget essential medicines component was missing, total budget has been increased to USD 392,000 (with $98,000 providing these supplies for 2012)	98000
Unicef Activity 1.4: Provide comprehensiv e support	Activity 1.4: Provide comprehensiv e support for BEMOC in selected MCH centres	150000			Budget has been distributed by year with the same total cost.	84000
Unicef Activity 1.9: Renovation of cold chain equi	Activity 1.9: Renovation of cold chain equipment in all MCH centres	160000			Budget has been reduced to USD 80,000, as majority of health facilities already have cold chain equipment (activity planned for 2012 only)	80000
Unicef Activity 2.8: Develop and implement a commu	Activity 2.8: Develop and implement a community based HMIS	36000			Unit cost has been reduced	24000
Unicef Activity 2.9: Printing and distribution of	Activity 2.9: Printing and distribution of HMIS tools	20000				20000
Unicef Activity 2.10: Procure and distribute/resu p	Activity 2.10: Procure and distribute/resu pply FCHW kits	15000			Unit cost of FCHWs supplies has been increased	20000

Unicef Activity 2.11: Procure and distribute/re-su	Activity 2.11: Procure and distribute/re-supply medicines for Health posts	8000			Unit cost was calculated in 2008. Kits cost as per EPHS criteria is high.	48000
Unicef Activity 3.1: Formative research to identif	Activity 3.1: Formative research to identify key behaviours and barriers	30000		Activity 3.1: Formative research to identify key maternal and child caring behaviours and barriers	Cost has been increased as compared to 2008 plans	60000
Unicef Activity 3.2: Develop National BCC strategy	Activity 3.2: Develop National BCC strategy	36000		Activity 3.2: Develop five year strategic communication plan		36000
Unicef Activity 3.3: Develop, print and distribute	Activity 3.3: Develop, print and distribute IEC material (MCH centres, health posts)	6000		Activity 3.3: Develop print, audio-visual and IPC package for health workers	Unit cost has been increased as compared to 2008 plans	10000
Unicef Activity 3.4: Develop video programs	Activity 3.4: Develop video programs	15000			Cancelled and merged with activity 3.3	
Unicef Activity 3.5: Disseminate video messages th	Activity 3.5: Disseminate video messages through cable	5000			Cancelled and merged with activity 3.3	
Unicef Activity 3.6: Develop radio programs	Activity 3.6: Develop radio programs	20000		Activity 3.4: Develop and broadcast radio programme on key child caring and health practices	Unit cost has been reduced but funds will be required for three zones every year	30000
Unicef Activity 3.7: Disseminate BCC messages thro	Activity 3.7: Disseminate BCC messages through radio	104000		Cancelled and merged with activity 3.4		
Unicef Activity 3.9: Organise advocacy/BCC events	Activity 3.9: Organise advocacy/BCC events for community elders and religious leaders	96000		Activity 3.6: Strengthen and establishing structured/systematized partnership with religious leaders, religious organizations, clan leaders, community elders and networks	Cost is reduced	15000
Unicef Activity 3.10: Organise school events on ke	Activity 3.10: Organise school events on key messages	48000		Activity 3.7: Work with school structures to increase dialogue on key child survival and development messages	Unit cost is increased however activity has been narrowed to schools related to GAVI facilities only	20000
Unicef Activity 3.11 Produce and distribute IEC ma	Activity 3.11 Produce and distribute IEC material to private pharmacies	27000		Cancelled and merged with activity 3.8		

Unicef Activity 3.12: Produce and distribute IEC m	Activity 3.12: Produce and distribute IEC material (flipcharts) to FCHWs and CHWs	25000		Activity 3.8: Develop community friendly materials (discussion guides etc) with key iCCM messages for FCHWs, CHWs, TBAs for home based family promotion	Unit cost has been increased but will be produced for GAVI-HSS facilities	15000
Unicef Activity 3.13: SMS text messaging for BCC	Activity 3.13: SMS text messaging for BCC	9000		Activity 3.9: Partner with Text to Change company to use interactive SMS text messaging to remind on key child survival messages	Unit cost has been increased.	20000
Unicef New Activity 3.16				Activity 3.16 Technical Assistance for BCC/C4D activities	New activity	174606
Unicef Activity 4.1: Conduct baseline and end-line	Activity 4.1: Conduct baseline and end-line surveys	60000				60000
Unicef Activity 4.4: Conduct focus groups for oper	Activity 4.4: Conduct focus groups for operational research	36000				36000
Unicef Management costs (7%)		90364			Costs has been adjusted to four years	87514
Unicef M&E support costs		44569			Costs has been adjusted to four years	66650
Unicef Technical support		50349			Costs has been adjusted to four years	132942
WHO Activity 1.1: Develop list of priority health	Activity 1.1: Develop list of priority health facilities and conduct survey to identify gaps in 40 MCH centres	45000				45000
WHO Activity 1.1: Develop list of priority health	Activity 1.1: Develop list of priority health facilities and conduct survey to identify gaps in 40 MCH centres	45000				45000
WHO Activity 1.5: Development / adapt curriculum f	Activity 1.5: Development / adapt curriculum for training of MCH and EPI staff in supervision, outreach and HMIS	15000			Budget increased as adaptation of IMNCI guidelines needed more resources. IMPAC guidelines to be adopted with AusAID support.	45000
WHO Activity 1.6: Conduct training of MCH and EPI	Activity 1.6 is re-planned for 2013	30000			Activity 1.6 is re-planned for 2013	

WHO Activity 1.7: Develop curriculum for training	Activity 1.7: Develop curriculum for training of all MCH staff in EPI injection safety and vaccine management	15000			Requires 9,000 less than originally planned.	6000
WHO Activity 1.8: Training of all MCH centre staff	Activity 1.8 is re-planned for 2013	60000			Activity 1.8 is re-planned for 2013	
WHO Activity 1.10: Develop and implement a system	Activity 1.10: Develop and implement a system of regular EPI outreach from MCH centres to the catchment areas of health posts and FHWs	15000				15000
WHO Activity 1.11: Develop a system for regular su	Activity 1.11: Develop a system for regular supervision for MCH centres from regional and zonal MOH	15000		1.11 Develop integrated system of regular supervision at all levels and tools and organize training for supervisors.	Cost increased for review and development of supervision for MCHC and addition of cost for training of Zonal, Regional and District Authorities.	35000
WHO Activity 1.12: Provide transport support to MO	Activity 1.12: Provide transport support to MOH for supervision of regional offices, facilities and communities	22500		Activity 1.12: Provide transport support to MOH for supervision of regional offices, facilities and communities	Overall cost saved for no activity in year 1. Each zonal team consisting of 3 team members (WHO, 2MOH) will have 3 days- visit for HSS Programme - Quarterly visits (Per diem: $100/person/day; Transport:$200/day +100Misc)	19800
WHO Activity 1.13: Provide transport support to re	Activity 1.13: Provide transport support to regional and district managers for supervision of MCH centres	77100		Activity 1.13: Provide transport support to regional and district managers for supervision of MCH centres	As supervision of MCH centres will start later than initially planned in the original proposal, only USD25,000 is required for transport costs of regional and district managers in 2012. Savings from 2012 will contribute to anticipated transport cost increase in the three subsequent years (included in reprogramming).	25000
WHO Activity 1.14: Provide incentives for EPI outr	Activity 1.14: Provide incentives for EPI outreach and RH staff at MCH centres	12000			Overall cost saved for no activity in year 1. Currently $500 for 5 facility staff per month is paid by Unicef. In case of top-up, the rate is $250 for 5 facility staff per month. An increase is expected and therefore a rate of $600 for five persons per month is used. Contract to start by May 2012	176200

WHO Activity 2.1: Developing scope of work, incent	Activity 2.1: Developing scope of work, incentives and criteria for selection, plan of supervision of FHWs.	36000	15000	Activity 2.1: Developing scope of work, incentives and criteria for selection, plan of supervision of FHWs.	Every year, in December, three zonal workshops will be held to develop Annual Zonal Plan for next year. The funds are redistributed accordingly (included in reprogramming).	15000
WHO Activity 2.2: Recruitment of FHWs	Activity 2.2: Recruitment of FHWs and supervisors.	14400		Activity 2.2: Recruitment of FHWs and supervisors.	This includes the recruitment of supervisors combined with the new, orientation of the facility staff and community. 2 visits of DPO (1 interview and 1 verification) and 1 visit of DMO/ RMO for verification + 1 zonal WHO staff	30000
WHO Activity 2.3: Development/ adapt curriculum fo	Activity 2.3: Development/ adapt curriculum for FHWs and supervisors	36000	30000		This is comprised of two phases, first phase is completed in 2011 where 30,000 was spent while additional 26,000 (including balance of 6000) is needed for workshop to develop curriculum, its translation and printing.	26000
WHO Activity 2.4: Training of trainers	Activity 2.4: Training of trainers	27000			This includes Training of Master Trainers not foreseen in the original budget.	103000
WHO Activity 2.5: Training of FHWs	Activity 2.5: Training of FHWs	100000				100000
WHO Activity 2.6: Training of supervisors	Activity 2.6: Training of supervisors	60000			After consultations with health authorities during the re-programming, costs for 2012 were revised as turned to be less than originally foreseen due to the late start.	32760
WHO Activity 2.7: Develop and implement a system o	Activity 2.7: Develop and implement a system of supportive supervision for health posts and FHWs and outreach activities	153600		Activity 2.7: Develop and implement a system of supportive supervision for health posts and FHWs and outreach activities	Due to late start for 2012 is needed less funds for this activity.	65000
WHO Activity 2.13: Provide incentives to CHWs	Activity 2.13: Provide incentives to CHWs	38400			Due to late start for 2012 is needed less funds for this activity	18240
WHO Activity 2.14: Provide incentives to FHWs	Activity 2.14: Provide incentives to FHWs	86400			The level of incentives was increased from originally planned due to increased cost of living.	96000
WHO Activity 4.2: Establish and support operationa	Activity 4.2: Establish and support operational research committee	24000			The committee will meet only once in 2012 instead of 12 times as originally foreseen. This will require less funds in 2012.	1000
WHO Activity 4.3: Commission operational research	Activity 4.3: Commission operational research studies	15000			This is revised budget estimation taking into account an overall increase in costs.	24000
WHO Activity 4.5: Support data analysis and use	Activity 4.5 is re-planned for 2013	6000			Activity 4.5 is re-planned for 2013	

WHO Activity 4.6: Training of MoH managers in oper	Activity 4.6 is re-planned for 2013	15000			Activity 4.6 is re-planned for 2013	
WHO 4.7: Organize study tours for health authoriti	4.7: Organize study tours for health authorities	20000	60484		Study tour to Pakistan required USD60,484. This included originally planned USD20,000 from year 1 and USD20,000 for year 2 as after revision this was planned to be done only once during the five year period. Additional USD20,484 was required.	60484
WHO Activity 4.8: Technical assistance for operati	Activity 4.8 is re-planned for 2013	22500			Activity 4.8 is re-planned for 2013	
WHO Management Cost		151240				145310
WHO Technical Support		190629			The total 7% of agency cost was originally deducted on the expense of TA section leaving insufficient amount to cover for 1 P5, 3 NOB and Admin Assistance positions. Also the P4 position was replaced with P5 as required by the scope of work and qualifications needed.	233000
WHO 7% Agency Cost		102740	91949		Agency costs are adjusted to four disbursements. 7% agency charge of the first disbursement was deducted in 2011.	
		2841791	197433			2699506

9.6. Planned HSS activities for 2013

Please use **Table 9.6** to outline planned activities for 2013. If you are proposing changes to your activities and budget (reprogramming) please explain these changes in the table below and provide explanations for each change so that the IRC can approve 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 2013

Major Activities (insert as many rows as necessary)	**Planned Activity for 2013**	**Original budget for 2013** (as approved in the HSS proposal or as adjusted during past annual progress reviews)	**Revised activity** (if relevant)	**Explanation for proposed changes to activities or budget** (if relevant)	**Revised budget for 2013** (if relevant)
UNICEF	Activity 1.3: Procurement and supply of essential medicines and equipment for MCH services (based on gaps)	100000	Activity 1.3: Procurement and supply of essential medicines and equipment for MCH services (based on gaps	In original budget essential medicines component was missing, total budget has been increased to USD 392,000 (with $98,000 providing these supplies for 2013)	98,000

UNICEF	Activity 1.4: Provide comprehensive support for BEMONC in selected MCH centres (6)	150000	Activity 1.4: Provide comprehensive support for BEMOC in selected MCH centres (3)	Budget has been distributed by year with the same total cost.	72,000
UNICEF	Activity 1.9: Renovation of cold chain equipment in all MCH centres	160000		All facilities will be equipped with cold chain in year 1 (2012) of implementation	
UNICEF	Activity 2.10: Procure and distribute/resupply FCHW kits	12000		Unit cost of FCHWs supplies has been increased	80,000
UNICEF	Activity 2.11: Procure and distribute/re-supply medicines for Health posts	4000		Unit cost was calculated in 2008. Kits cost as per EPHS criteria is high	48,000
UNICEF	Activity 3.3: Develop, print and distribute IEC material (MCH centres, health posts)	6000	Activity 3.3: Develop print, audio-visual and IPC package for health workers	Unit cost has been increased as compared to 2008 plans	10,000
UNICEF	Activity 3.6: Develop radio programs		Activity 3.4: Develop and broadcast radio programme on key child caring and health practices	Unit cost has been reduced but funds will be required for three zones every year	30,000
UNICEF	Activity 3.8: Increase public awareness through print media	26000	Activity 3.5. Identify three strong communication NGOs to build capacity of existing NGOs and to scale up public awareness at community level	Unit cost has been increased	60,000
UNICEF	Activity 3.9: Organise advocacy/BCC events for community elders and religious leaders	96000	Activity 3.6: Strengthen and establishing structured/systematized partnership with religious leaders, religious organizations, clan leaders, community elders and networks	Unit cost has been reduced	15,000
UNICEF	Activity 3.10: Organise school events on key messages	48000	Activity 3.7: Work with school structures to increase dialogue on key child survival and development messages	Unit cost is increased however activity has been narrowed to schools related to GAVI facilities only	20,000
UNICEF	Activity 3.12: Produce and distribute IEC material (flipcharts) to FCHWs and CHWs	25000	Activity 3.8: Develop community friendly materials (discussion guides etc) with key ICCM messages for FCHWs, CHWs, TBAs for home based family promotion	Unit cost has been increased but will be produced for GAVI-HSS facilities only	15,000
UNICEF	Activity 3.13: SMS text messaging for BCC	9000	Activity 3.9: Partner with Text to Change company to use interactive SMS text messaging to remind on key child survival messages	Unit cost has been increased	10,000
UNICEF			Activity3.11: Technical Assistance for BCC/C4D activities	New activity	261,909

UNICEF	Activity 4.4: Conduct focus groups for operational research	36000			36,000
UNICEF	Management costs (7%)			Costs has been adjusted to four years	66,000
UNICEF	M&E support costs	35340		Costs has been adjusted to four years	54,000
UNICEF	Technical support	90437		Costs has been adjusted to four years	132,942
WHO 1.6 Conduct training of MCH/EPI staff	1.6 Conduct training of MCH and EPI staff (in 40 MCH centres)			Activity 1.6 was initially planned for year 1 but was moved to 2013 during the reprogramming. The revised budget for 2013 reflects applied changes both in costs and timeframe planned for implementation.	24,000
WHO 1.8 Training of all MCH centre staff (EPI, IS,	1.8 Training of all MCH centres staff (EPI, injection safety and vaccine management)			Activity 1.8 was initially planned for year 1 but was moved to 2013 during the reprogramming. The revised budget for 2013 reflects applied changes both in costs and timeframe planned for implementation.	20,000
WHO 1.11 Develop a system for regular supervision	1.11 Develop a system for regular supervision for MCH centres from regional and zonal MOH		1.11 Develop integrated system of regular supervision at all levels and tools and organize training for supervisors	Activity 1.11 was not originally planned for 2013. This was changed during the reprogramming. Additional cost was needed for refresher training of Zonal, Regional and District Supervisors.	35,000
WHO 1.12 Provide transport support to MOH for supe	1.12 Provide transport support to MOH for supervision of regional offices	22500		Increase in transport cost.	26,400
WHO 1.13 Provide transport support to RM for super	1.13 Provide transport support to regional and district managers for supervision of MCH centres	77100	1.13 Provide transport support to regional and district managers for supervision of MCH centres	Increase in transport cost and additional district level supervision in Somaliland.	81,000
WHO 1.14 Provide performance based incentives to M	1.14 Provide incentives for EPI outreach and RH staff at MCH centres	216000		Increased level of incentives due to increased cost of living.	288,000
WHO 2.1 Developing scope of work, incentives and c	2.1 Developing scope of work, incentives and criteria for selection, plan of supervision of FHWs and Health Posts		Activity 2.1: Developing scope of work, incentives and criteria for selection, plan of supervision of FHWs		30,000
WHO Activity 2.2: recruitment of FCHWs	Activity 2.2: recruitment of FCHWs	14400	Activity 2.2: recruitment of FCHWs and Supervisors	Activity 2.2 was after reprogramming planned only for 2012 as this is when all FCHW are going to be recruited.	
WHO 2.3 Development/ adapt curriculum for FHWs and	2.3 Development/ adapt curriculum for FHWs and supervisors			It was agreed during the reprogramming to do a revision of curriculum after the first training was done in 2012. This will include printing costs as originally not foreseen.	20,000
WHO 2.5 Training of FHWs	2.5 Training of FHWs	100000		The second year training includes ongoing training for one week every month. This will require less funds in 2013.	53,600

WHO 2.6 Training of supervisors	2.6 Training of supervisors	30000		The training will be combined with FHWs and will require less funds.	28,200
WHO 2.7 Develop and implement a system of supporti	2.7 Develop and implement a system of supportive supervision for health posts and FHWs and outreach activities	153600	2.7 Develop and implement a system of supportive supervision for FHWs and outreach activities.	Includes increase in transport costs and 8% annual increase in stipends for supervisors.	208,768
WHO 2.13 Incentives for CHWs	2.13 Incentives for CHWs	57600			53,568
WHO 2.14 Incentives for FCHWs	2.14 Incentives for FCHWs	172800		Increased incentives for FCHWs and 8% annual increase.	207,360
WHO 4.2 Establish and support operational research	4.2 Establish and support operational research committee	9000		Number of meetings increased than originally planned	12,000
WHO 4.3 Commission operational research studies	4.3 Commission operational research studies	15000		Minimum one operational research in each zone. More than originally planned.	36,000
WHO 4.5 Support data analyses and use	4.5 Support data analyses and use	6000		Activity 4.5 was initially planned for year 1 but was moved to 2013 during reprogramming. Increase in cost since the development of the original proposal.	10,000
WHO 4.6 Training of MoH Managers in operational re	4.6 Training of MoH Managers in operational research	15000		Activity 4.6 was initially planned for year 1 but was moved to 2013 during reprogramming.	15,000
WHO 4.8 Technical Assistance for Operational Resea	4.8 Technical Assistance for Operational Research	22500		Activity 4.8 was initially planned for year 1 but was moved to 2013 during reprogramming. Increase in cost since the development of the original proposal.	36,000
WHO Management Cost		158080			152,017
WHO Technical Assistance		304216		The total 7% of agency cost was originally deducted on the expense of TA section leaving insufficient amount to cover for 1 P5, 3 NOB and Admin. Assistance positions. Also the P4 position was replaced with P5 as required by the scope of work and qualifications needed.	503,280
WHO Agency Cost (7%)		102740		Agency costs are adjusted to four disbursements. As 7% agency charge of the first disbursement was 91,949 the estimated charge for every subsequent disbursement amounts to 140,583.7	140,583.6
		2274313			

9.6.1. If you are reprogramming, please justify why you are doing so.

The HSS Programme has faced significant delays since approval of the HSS proposal and actual signing of the grant agreement. Soon after receiving the first tranche, WHO office had no other option but to review the activity plan and budget keeping in view the increase in prices, cost of living and impact of inflation on the Programme. <?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

Given the original proposal and budget were drafted in 2009, with funds received in 2011, a number of modifications to both work plan and budget needed to be made, budget lines have been modified, with activities originally planned to be carried out over a 5 year period, now planned to implemented in 4 years.

9.6.2. If you are reprogramming, please outline the decision making process for any proposed changes

Activities are revised in consultation with respective health authorities, WHO and UNICEF and after getting final approval of Health Advisory Board (HAB). <?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

After consultations with the GAVI delegation who visited the WHO Office in Nairobi in February 2012, WHO Somalia organized an operational planning exercise with all three Somali health authorities. Operational planning exercise with the health authorities from South Central Somalia took place in Nairobi in March 2012. A WHO delegation visited Puntland and Somaliland to hold a GAVI HSS operational planning with the two health authorities at the end of March 2012. The purpose of this exercise was to further familiarize health authorities with the GAVI HSS, and jointly re-programme activities originally planned to be carried out over a 5 year period into a 4 year implementation period which subsequently resulted in the reprogramming submitted with this report. A special mention go out to the three health authorities for their commitment, dedication and perseverance which they demonstrated during this planning exercise.

9.6.3. Did you propose changes to your planned activities and/or budget for 2013 in **Table 9.6** ? **Yes**

9.7. Revised indicators in case of reprogramming

If the proposed changes to your activities and budget for 2013 affect the indicators used to measure progress, please use **Table 9.7** to propose revised indicators for the remainder of your HSS grant for IRC approval.

Table 9.7: Revised indicators for HSS grant in case of reprogramming

Name of Objective or Indicator (Insert as many rows as necessary)	Numerator	Denominator	Data Source	Baseline value and date	Baseline Source	Agreed target till end of support in original HSS application	2013 Target

9.7.1. Please provide justification for proposed changes in the **definition, denominator and data source of the indicators** proposed in Table 9.6

Proposed changes are based on agreed Logical Framework of GAVI HSS Strategic Plan (attached to this report) and its strategic objectives and mechanisms for effective service provision, coordination and governance. The Logical Framework includes new key performance indicators and means of verification which are planned to be revised again in 2012 upon availability of latest MICS and information from Baseline Survey and Health Facility Assessment.

9.7.2. Please explain how the changes in indicators outlined in Table 9.7 will allow you to achieve your targets

Process of achieving targets is presented in the table with revised indicators in the Annex A - the Logical Framework of GAVI HSS Strategic Plan, attached to this report. However, as mentioned above, the indicators are planned to be revised again in 2012 after availability of MICS data and information from Baseline Survey and Health Facility Assessment.

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
Global Fund HSS	2439903	October 2010 - March 2012	HSS support through strengthening following components of health care: • Laboratory & Blood Safety Component; • Management Capacity Building; • Essential Medicines & Quality Control Component.

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
Compendium to Implement Community Based Female Health Workers' Intervention	The Compendium Document is attached to the APR.	N/A
Financial Statements of Expenditures from the GSM	The Financial Statements are attached to the APR.	N/A
Inception Report to Develop Training Material for Community Based Female Health Workers Intervention Under GAVI HSS Support for Somalis	The Inception Report is attached to the APR.	N/A
List of Selected/Recommended Health Facilities	The Lists were sent to WHO by all three MoHs.	N/A
Strategic Plan 2011-2015	The signed scanned copy of the Strategic Plan is attached to the APR.	N/A

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.

The year parameters in the table 9.1.3a are not updated/compatible with Somalia APR requirements and do not allow us to complete them appropriately. <?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

This APR was intended for requesting support for 2013 and the mentioned table does not have a column for 2013 (it is from 2007 till 2012 instead of 2011-2015). We also need two of these tables in order to have separate requests for Unicef and WHO.

Therefore, in respect of the new tranche requests and revised budget, please consider the two separate tables for Unicef & WHO from the word version of the APR Section 9 – HSS attached to this report.

9.9.3. How many times did the Health Sector Coordinating Committee (HSCC) meet in 2010?? 3

Please attach:

1. The minutes from all the HSCC meetings held in 2010, including those of the meeting which discussed/endorsed this report **(Document Number: 8)**
2. The latest Health Sector Review report **(Document Number: 23)**

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 is not reporting on GAVI TYPE A CSO support for 2012

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

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

11. Comments from ICC/HSCC Chairs

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

12. Annexes

12.1. Annex 1 – Terms of reference ISS

TERMS OF REFERENCE:

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

I. All countries that have received ISS /new vaccine introduction grants during the 2011 calendar year, or had balances of funding remaining from previously disbursed ISS/new vaccine introduction grants in 2011, 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 2011 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 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, 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 2011 (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 2011 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 2010 (balance as of *31Decembre 2010*)	25,392,830	53,000
Summary of income received during 2011		
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 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** – GAVI ISS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2011	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 2011 calendar year, or had balances of funding remaining from previously disbursed HSS grants in 2011, 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 2011 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 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, 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 2011 (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 2011 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 2010 (balance as of *31Decembre 2010*)	25,392,830	53,000
Summary of income received during 2011		
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 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** - GAVI HSS						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2011	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 2011 calendar year, or had balances of funding remaining from previously disbursed CSO 'Type B' grants in 2011, 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 2011 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 2010 calendar year (opening balance as of 1 January 2011)

b. Income received from GAVI during 2011

c. Other income received during 2011 (interest, fees, etc)

d. Total expenditure during the calendar year

e. Closing balance as of 31 December 2011

f. A detailed analysis of expenditures during 2011, 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 2011 (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 2011 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 2010 (balance as of *31Decembre 2010*)	25,392,830	53,000
Summary of income received during 2011		
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 2011	30,592,132	63,852
Balance as of 31 December 2011 (balance carried forward to 2012)	60,139,325	125,523

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

Detailed analysis of expenditure by economic classification ** - GAVI CSO						
	Budget in CFA	**Budget in USD**	**Actual in CFA**	**Actual in USD**	**Variance in CFA**	**Variance in USD**
Salary expenditure						
Wedges & salaries	2,000,000	4,174	0	0	2,000,000	4,174
Per diem payments	9,000,000	18,785	6,150,000	12,836	2,850,000	5,949
Non-salary expenditure						
Training	13,000,000	27,134	12,650,000	26,403	350,000	731
Fuel	3,000,000	6,262	4,000,000	8,349	-1,000,000	-2,087
Maintenance & overheads	2,500,000	5,218	1,000,000	2,087	1,500,000	3,131
Other expenditures						
Vehicles	12,500,000	26,090	6,792,132	14,177	5,707,868	11,913
TOTALS FOR 2011	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 Page, MoH (Delegated Authority) and HSCC.pdf File desc: File description... Date/time: 5/24/2012 7:38:47 AM Size: 531084
2	Signature of Minister of Finance (or delegated authority)	2.1	✓	Not Applicable for Somalia.docx File desc: File description... Date/time: 5/28/2012 3:25:26 AM Size: 10030
3	Signatures of members of ICC	2.2	✓	Signatures of ICC members.docx File desc: File description... Date/time: 5/29/2012 3:25:07 AM Size: 10185
4	Signatures of members of HSCC	2.3	✗	Signature Page, MoH (Delegated Authority) and HSCC.pdf File desc: File description... Date/time: 5/25/2012 1:48:38 AM Size: 531084
5	Minutes of ICC meetings in 2011	2.2	✓	Document 11. Minutes of the Health Sector Committee Meeting October 2011.pdf File desc: File description... Date/time: 5/29/2012 3:28:58 AM Size: 280579
6	Minutes of ICC meeting in 2012 endorsing APR 2011	2.2	✓	Minutes endorsing APR 2011.docx File desc: File description... Date/time: 5/29/2012 3:22:37 AM Size: 10069
7	Minutes of HSCC meetings in 2011	2.3	✗	Minutes of the Health Sector Committee Meetings in 2011.pdf File desc: File description... Date/time: 5/24/2012 8:40:31 AM Size: 828286
8	Minutes of HSCC meeting in 2012 endorsing APR 2011	9.9.3	✗	Signature List of Participants, HSC Meeting 21 May 2012, APR Endorsment.pdf File desc: The minutes of the meeting which discussed/endorsed this report will be submitted with the next APR as it first need to be approved during the next HSC meeting. The list of participants in the HSC meeting which discusses/endorses this report is attached. Date/time: 5/24/2012 8:46:35 AM Size: 2105514
9	Financial Statement for HSS grant APR 2011	9.1.3	✗	GAVI HSS Financial Information on Expenditures in 2011.pdf File desc: File description...

				Date/time: 5/24/2012 8:22:33 AM Size: 393778
10	new cMYP APR 2011	7.7	✓	Somalia cMYP.pdf File desc: File description... Date/time: 5/22/2012 10:36:40 AM Size: 638354
11	new cMYP costing tool APR 2011	7.8	✓	cMYP_Costing_Tool_Vs.2.5_EN somalia alternative 16Apr.xlsx File desc: File description... Date/time: 5/22/2012 10:44:27 AM Size: 1480596
13	Financial Statement for ISS grant APR 2011	6.2.1	✗	ISS Financial Statement.pdf File desc: File description... Date/time: 5/22/2012 11:34:57 AM Size: 130868
14	Financial Statement for NVS introduction grant in 2011 APR 2011	7.3.1	✓	Not applicable for Soamlia.docx File desc: File description... Date/time: 5/29/2012 2:55:05 AM Size: 10051
15	EVSM/VMA/EVM report APR 2011	7.5	✓	EVSM Assessment_questionnaire_final-UNICEF-Harg.pdf File desc: File description... Date/time: 5/22/2012 11:54:51 AM Size: 126300
16	EVSM/VMA/EVM improvement plan APR 2011	7.5	✓	EVM not done.docx File desc: File description... Date/time: 5/29/2012 2:56:12 AM Size: 10069
17	EVSM/VMA/EVM improvement implementation status APR 2011	7.5	✓	EVM not done.docx File desc: File description... Date/time: 5/29/2012 2:56:53 AM Size: 10069
18	new cMYP starting 2012	7.8	✗	Not applicable for Soamlia.docx File desc: File description... Date/time: 5/29/2012 2:59:50 AM Size: 10051
19	External Audit Report (Fiscal Year 2011) for ISS grant	6.2.3	✗	No external audit done.docx File desc: File description... Date/time: 5/29/2012 2:59:07 AM Size: 10076
20	Post Introduction Evaluation Report	7.2.2	✓	Not applicable for Soamlia.docx File desc: File description... Date/time: 5/29/2012 3:00:19 AM Size: 10051

21	Minutes ICC meeting endorsing extension of vaccine support	7.8	✓	Not applicable for Soamlia.docx File desc: File description... Date/time: 5/29/2012 3:02:05 AM Size: 10051
22	External Audit Report (Fiscal Year 2011) for HSS grant	9.1.3	✗	Not Applicable for Somalia.docx File desc: File description... Date/time: 5/28/2012 3:26:12 AM Size: 10030
23	HSS Health Sector review report	9.9.3	✗	Not Applicable for Somalia.docx File desc: File description... Date/time: 5/28/2012 3:26:58 AM Size: 10030
26	HSS expenditures for the January-April 2012 period	9.1.3	✗	GAVI HSS Financial Information on Expenditures in January-April 2012.pdf File desc: File description... Date/time: 5/24/2012 8:42:13 AM Size: 635090