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| GAVI White **Guidelines and Form for Reprogramming Submission for** **GAVI health system strengthening (HSS) cash support for 2013 Submissions****Health System Strengthening (HSS) Cash Support** |  |  |  |
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This document is for use by applicants seeking to submit a reprogramming request for health system strengthening (HSS) cash support from the GAVI Alliance. Countries are encouraged to participate in an iterative process with GAVI Alliance partners, including civil society organisations (CSOs), in the development of HSS reprogramming requests prior to submission.

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# SUMMARY OF A COMPLETE REPROGRAMMING SUBMISSION

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| **HSS Reprogramming Submission Forms - Mandatory attachments***→ Please place an ‘X’ in the box when the attachment is included* |
| *No.* | *Attachment* | ***X*** |
| 1.
 | Complete HSS Reprogramming Submission Form  |  |
| 1.
 | Signatures of the HSCC (or equivalent body) and the Ministry of Health (or delegated authority) |  |
| 1.
 | Revised HSS Monitoring & Evaluation Framework (this should include all indicators to be used for the remainder of the grant) |  |
| 1.
 | Revised work plan and detailed budget  |  |
|  | Latest National health strategy, plan or national health policy, if different from what was submitted with the original proposal |  |
|  | Latest cMYP, if different from what was last submitted with an Annual Progress Report (APR) |  |
|  | Latest Health Sector Review Report, if different from what was last submitted with an Annual Progress Report (APR) |  |
|  | The most recent interim unaudited financial report (IFR) for use of HSS funds in the current calendar year (2013). This should illustrate how much has been received from GAVI, the level of in-country expenditure, funds remaining to be disbursed by GAVI and annual budget amounts for future years. |  |
|  | External audit report for HSS funds during the most recent fiscal year (as available) |  |
|  | Any other documents to support or justify reprogramming (please list them here) |  |

# ACRONYMS

AEFI Adverse events following immunisation

APR Annual Progress Report

AWPB Annual Work plan and Budget

CMYP Comprehensive Multi-Year Plan for Immunisation

CSO Civil society organisation

DHS Demographic and Health Surveys

DQRC Data Quality Report Card

DTP Diphtheria-tetanus-pertussis

EPI Extended Programme of Immunisation

EVM Effective Vaccine Management

FMA Financial Management Assessment

GAVI GAVI Alliance (Formerly the Global Alliance for Vaccines and Immunisation)

HIS Health Information System

HMIS Health Management Information Systems

HSCC Health Sector Coordinating Committee

HSS Health system strengthening

HRH Human Resources for Health

ICC Inter-Agency Coordinating Committee for Immunisation

IDQA Immunisation Data Quality Assessment

IFR Interim unaudited Financial Reporting

IHP International Health Partnership

IMCI Integrated Management of Childhood Illness

IRC Independent Review Committee (GAVI)

ISS Immunisation Services Support

JANS Joint Assessment of National Health Strategies

JAR Joint Annual Review

LMIS Logistics Management Information Systems

MCV Measles Containing Vaccine

M&E Monitoring and Evaluation

MICS Multi indicator cluster surveys

MNCH Maternal, Neonatal and Child Health

MOH Ministry of Health

NGO Non-governmental organisation

NHP National Health Plan

NIP National Immunisation Plan

OECD-DAC Organisation for Economic Co-operation and Development - Development Assistance Committee

PBF Performance based funding

PIE Post Introduction Evaluation

PFA Partnership Framework Agreement

PSM Procurement and supply management

SAGE Strategic Advisory Group of Experts (WHO)

SARA Service Availability and Readiness Assessment

TA Technical Assistance

TAP Transparency and Accountability Policy

THE Total Health Expenditure

TOR Terms of Reference

UNICEF United Nations Children’s Fund

VPD Vaccine Preventable Diseases

WHO World Health Organization

# INSTRUCTIONS

**WHEN TO MAKE A REQUEST FOR REPROGRAMMING OF A PREVIOUSLY APPROVED GAVI HSS GRANT:**

1. Request for reprogramming of a previously approved GAVI HSS grant should be made when either one or both of the following are true:
	* New objectives are being proposed for a previously approved GAVI HSS grant; or
	* Proposed revised activities will result in a budget change greater than 15% of the total approved budget of the original grant.
2. If no new objectives are proposed and changes in activities are less than 15% of the total budget, GAVI considers this a reallocation which does not need to be submitted to GAVI’s Independent Review Committee (IRC) for approval. However, these reallocation changes will need to be discussed in country and reviewed by the HSCC or equivalent. A notification should then be sent to GAVI stating this change, with the new workplan and budget following reallocation.
3. Country may make a reprogramming request if there have been delays to programme implementation requiring revision of activities, if HSS analysis suggests new objectives to improve immunisation outcomes, or to align a previously approved HSS grant with the GAVI Alliance Strategy 2011 – 2015 which has a focus on strengthening the capacity of integrated health systems to deliver immunisation outcomes. Please note that if timelines have simply shifted and activities are unchanged but will now be implemented in future years, this does not constitute a reprogramming – in such cases a no-cost extension may be sought.
4. A reprogramming request is for all the remaining years of the grant. The full budget provided as an attachment in support of the reprogramming request should be for the entire unspent amount of the remaining grant budget – even if budgets for some activities remain the same as before. This is to be clear to the IRC how the total remaining funds will be spent by the Country. In Section 7, only the budget for new/revised activities is sought.
5. Country may use reprogramming request to propose a faster timeline for spending HSS funds than in the original proposal as long as Country is able to justify that adequate implementation arrangements are in place.

**HOW THE DECISION WILL BE MADE BY GAVI:**

1. Reprogramming requests must be submitted to the IRC. The changes must have been discussed, documented and endorsed by the Health Sector Coordinating Committee (HSCC) or equivalent.
2. The information required by the IRC and how it will use it in order to approve reprogramming is as follows:
	* Re-programming requests with greater than 15% change in the total approved budget because of revised activities: the IRC is making a recommendation on whether the revised activities and budget proposed will result in the achievement of the programme targets at outcome, intermediate result and output level. The IRC will use the revised workplan and budget, Results Chain, M&E framework and justification for proposed changes as evidence to make this recommendation to GAVI.
	* Re-programming requests with new objectives or modified objectives: the IRC is making a recommendation on whether the proposed objectives will address the identified HSS bottlenecks and therefore result in improved immunisation outcomes. The IRC will require justification that the new proposed objectives are supported by sound analysis of HSS bottlenecks to achieving improved immunisation outcomes, have a clear results chain with linkage to improving immunisation outcomes, and are aligned with national health and immunisation plans and strategies.
3. Inaccurate, incomplete or unsubstantiated reporting may lead the IRC to either send this request back to your country for clarifications (which may cause delays in the release of further HSS funds), or to recommend a full resubmission of the reprogramming request.

**HOW TO MAKE A REQUEST FOR REPROGRAMMING:**

Countries proposing new objectives for the HSS grant will need to complete the full reprogramming form. Countries that are only proposing new/revised activities and are not proposing any new objectives may skip Part B Sections 2 – 5.

1. Please explain proposed changes in this reprogramming form and provide explanations for each change so that the IRC can approve the revised budget and activities.
2. Please ensure that, **prior to its submission to the GAVI Alliance Secretariat, this reprogramming request 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. The reprogramming submission must also be signed by the Minister of Health.
3. The following bullet points outline GAVI’s approach to health system strengthening and should be reflected in an HSS reprogramming request:
* One of GAVI’s strategic goals is to *“contribute to strengthening the capacity of integrated health systems to deliver immunisation”.* The objective of GAVI HSS support is to address system bottlenecks to achieve better immunisation outcomes, including coverage and equity. As such, it is necessary for the reprogramming submission to be based on a strong bottleneck and gap analysis, and present a clear results chain demonstrating the link between new/revised activities and improved immunisation outcomes.
* GAVI’s approach intends to deliver and document results. The performance of the HSS grant will be measured through intermediate results as well as immunisation outcomes such as diphtheria-tetanus-pertussis (DTP3) coverage, measles coverage, and percent of districts reporting at least 80% coverage. Therefore the reprogramming submission must include a strong M&E framework aligned with the national M&E plan or national M&E processes.
* Performance based funding (PBF) is a core approach of GAVI HSS support, and applies to all countries approved for HSS grants in 2012 onwards. However, PBF is not applicable for countries that are reprogramming HSS grants that were previously approved before 2012. Please see the GAVI website for additional information on PBF.
* GAVI supports the principles of alignment and harmonization (in keeping with Paris, Accra and Busan declarations and the International Health Partnership, IHP+). The reprogramming must demonstrate how GAVI support is aligned with country health plans and processes, complementary to other donor funding, and how GAVI support is based on existing country systems, such as for financial management and M&E. The IHP+ Common Monitoring and Evaluation Framework is used as a reference framework in these guidelines.
* GAVI supports the use of Joint Assessment of National Strategies (JANS). A JANS assessment is not a requirement for a GAVI HSS reprogramming. If a country has conducted a JANS assessment, the findings can be included in the HSS reprogramming submission. The IRC will use the findings of a JANS assessment to gain an understanding of the policy and health sector context that will inform their assessment of the credibility and feasibility of the HSS reprogramming submission.
* GAVI encourages a consultative and participatory approach for developing this HSS reprogramming proposal, particularly across relevant departments in the Ministry of Health (including Planning, EPI, HMIS, M&E), across development partners and civil society. While the HSCC (or equivalent) is required to sign off on this reprogramming submission, the Inter-Agency Coordinating Committee for Immunisation (ICC), or equivalent, should also be consulted and involved in the reprogramming development process.
* GAVI encourages countries to identify and build linkages between HSS support and new vaccine introduction support (such as GAVI New Vaccines Support). These linkages should be demonstrated in the reprogramming submission. Countries will need to demonstrate systems readiness for new vaccine introductions in the context of routine immunisation services. GAVI HSS support will be for strengthening these routine immunisation services.
* GAVI’s approach to HSS includes support for strengthening information systems and improving data quality. Strong information systems are of fundamental importance both to countries and to GAVI. Countries are strongly encouraged to include in their reprogramming requests actions to strengthen data systems, including surveys and the institutionalization of routine mechanisms to track data quality improvements over time.
* GAVI supports innovation. Countries are encouraged to be innovative in their identification of activities which will have a catalytic effect on addressing HSS bottlenecks to improving immunisation outcomes.
* GAVI encourages applicants to include funding for CSOs in implementation of HSS support to improve immunisation outcomes. CSOs can receive GAVI funding through two channels: (i) funding from GAVI to Ministry of Health (MOH) and then transferred to CSO, or (ii) direct from GAVI to CSO. Please refer to [GAVI website CSO pages](http://www.gavialliance.org/support/cso/) for more information.
* Reprogramming submissions must include information on how sustainability and equity (including geographic, socio-economic, and gender equity) will be addressed.
* Cash disbursed for HSS support must be used solely to fund HSS Programme Activities. These funds may not be used to purchase vaccines or meet GAVI’s requirements to co-finance vaccine purchases, and shall not be used to pay any taxes, customs, duties, toll or other charges imposed on the importation of vaccines and related supplies.

*This reprogramming request draws upon the HSS application materials. For more information, please refer to the* [*GAVI HSS application guidelines*](http://www.gavialliance.org/support/apply/hsfp/) *on the GAVI website.*

# PART A - SUMMARY OF ORIGINAL SUPPORT REQUESTED AND APPLICANT INFORMATION

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| **Country:** | ***Somalia*** |
| **Original proposed start date:** | ***September 1, 2011*** |
| **Original proposed end date:** | ***31 December 2015*** |
| **Original duration of support requested:** | ***4.25 years[[1]](#footnote-2)*** |
| **Revised new end date, based on this reprogramming request:** | ***31 December 2015*** |
|  |  |  |  |
| **Original GAVI HSS grant budget** **(in $ USD):** | **(A) Total grant amount originally approved by GAVI**  | **(B) Amount spent to date (Oct 23): [[2]](#footnote-3)** | **(C) Amount remaining for reprogramming (A – B)** |
| **11,545,500 US $**  | **2,934,621 US $** | **8,610,880 US $** |
|  |  |  |  |
| **Annual breakdown for total reprogramming request (in $ USD).** *Please use the total value from column (C) above and allocate for each remaining year of the grant.*  | **2013** | **2014** | **2015** |
| **972,441**  | **3,899,631 US $** | **3,738,808 US $** |

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| --- | --- | --- |
|  | **Primary contact** | **Secondary contact** |
| **Name** | Katja Schemionek | Mirza, Imran Raza  |
| **Organisation & Title** | WHO Somalia, HSS Country Programme Advisor | Maternal, Newborn and Child Health Manager |
| **Mailing address** | WHO SomaliaWarwick Centre, UN Avenue, GigiriP.O. Box 63565-00619 Nairobi, Kenya | UNICEF Somalia Support Center (USSC)Block Q, United Nations Office at Nairobi (UNON)UN Avenue, Gigiri.P.O. Box 44145-00100 Nairobi, Kenya |
| **Telephone** | +254(0)733770212 | +254(0)724255654 |
| **Fax** |  |  |
| **E-mail address** | schemionekk@nbo.emro.who.int | imirza@unicef.org |
| **Alternative e-mail address** | wroffice@nbo.emro.who.int |  |

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# PART B – REPROGRAMMING DETAILS

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| Background Information |

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| * 1. Since the original GAVI HSS grant was approved, has your country developed a new National Health Plan or any other strategy or plan relevant to immunisation (such as routine immunisation strategy, maternal and child health strategy, etc.)?

YES. The three zones have developed their health sector strategic plans (HSSP) early 2013 and Annual Work Plans (AWP) (documents are attached). It is the first time that the three Zonal Ministries of Health have produced strategic plans. They cover 2013 to 2016 and include an annual work plan (AWP) for 2013. It is planned to conduct a review of these plans before the end of the year and to produce AWPs for 2014. In complementarity, a national M&E framework will be developed that will include targets and indicators specific to immunization. An EPI situation analysis and recommendations on Improving Immunization Coverage had been produced in September 2013 (attached). * 1. Please explain why you are reprogramming. Provide a summary of whether you are changing programme objectives, planning additional activities, accelerating existing activities or reducing existing activities. Please attach any new country documents that support this reprogramming request. For example, National Health Plan, EPI plan, cMYP, etc.
 |  |  |  |  |  |
| This grant faced significant delays in starting implementation as the actual signing of the grant happened much later than the approval of the grant. Therefore, after having received the first tranche of funds in November 2011, WHO and UNICEF reviewed the original activity plan including budget allocations that had been produced in 2009 to account for the natural increase of costs and a fast changing environment typical for a complex emergency context. However, implementation of activities in 2012 continued to be delayed; the security situation in South Central hampered the recruitment of the Lady Health Workers. Also in the two other zones, this first but critical step in getting activities off from the ground was delayed. The geographical distance between project management situated in Nairobi and the implementation being carried forward by the three zonal Somali Health Authorities (SHAs) pose additional, constant constraints to a speedy implementation. For this new reprogramming, implementing agencies and partners involved decided NOT to re-programme planned objectives, but to suggest some changes of activities and, more importantly, increase the various budget allocations as to a) intensify implementation of activities; b) account for increased unit costs and c) accommodate the substantial amount of carry-over from previous years. In 2013 huge efforts were dedicated to establish systems and processes for incentivizing the ladies, their supervisors, health workers and public health managers involved as GAVI/HSS focal points and for transferring funds for other MoH led activities. Mechanisms for improved communication, coordination and cooperation have been established and responsibilities of implementing partners were clarified. The former, in conjunction with more technical presence and attention to the programme implementation at zonal level revealed a number of bottle necks that need to be tackled if implementation should be successful. The programme picked up on speed but is still facing delays, often unforeseen, in implementing planned activities. Most of mentioned challenges do not require adding new activities or funding but to the provision of stronger guidance, technical assistance and hands-on-transfer of knowledge and skills from the programme management team at Nairobi and zonal level (WHO and UNICEF) to SHAs. Similarly, coordination, communication and cooperation need to be enhanced and strategized; opportunities for synergies and complementarity need to be explored. Accruing costs for travel and coordination activities will be bared under the operational cost budget. Some of these issues do not necessarily have to be taken up within this grant but require attention by other programmes such as EPI and can be easily address through improved communication, coordination and creation of synergies and complementarity. *Service delivery*: designated staff at selected MCH clinics and HPs often does not have the required qualifications as required by the EPHS; it is recognized that the process to building an appropriate health work force in Somalia requires a long term strategic approach; however, in relation to the success of this programme training activities especially for vaccinators need to be beefed up and start with the transfer of basic knowledge. A positive and certainly to the success of this programme contributing result is the determination of the SHAs to finalize an EPI policy and strategy and the production of a vaccinator manual. Substantial ground work also needs to be put into building skills for monitoring and supportive supervision of MCH staff as well as using health information data collected by the Lady Health Workers. *Public health management*: appropriate monitoring and supervision but also the provision of strategic directions at district and regional level is important for the success of the programme; at present district health and regional health management teams are only partially functional with little staff whose job description still need to be developed in accordance with defined roles and responsibilities that sub zonal health management teams perform. Their budget is limited and means for transportation for field visits are largely not available. Capacities for planning, coordination and public health management are weak. Building public health management functions at these levels will be addressed by the Joint Health & Nutrition Programme (JHNP). At the same time, UNDP is supporting strengthening local governance functions. The grant provides for support to carry out monitoring and supervision activities and incentives for central, regional and district MoH teams. These staff are critical for supervising and monitoring the facilities and, overall, the implementation of the programme. The grant management team and WHO technical officers at zonal level will work on building and transferring skills and knowledge to district and regional health managers and explore further technical assistance within this grant (e.g. TA for conducting operational research). *Supplies****:*** the grant includes the provision of equipment and supplies at facilities (MCH and HPs); UNICEF provides vaccines and cold chain equipment across Somalia and covers operational costs for the transportation of these supplies to facilities; however, at present the operational capacities at the Ministry level are limited and result in frequent stock-outs; the programme needs to address this serious bottle necks. These constraints have been revealed by an EPI review conducted in mid-2013 and been discussed by the Health Sector Committee (HSC). Stakeholders agreed to establish, enlarge and further strengthen EPI working groups and discuss approaches for an improved national EPI programme as a standing agenda at each HSC coordination meeting. Processes for improved communication and information sharing at zonal and Nairobi level between the implementing partners have been set in place. Regular GAVI / HSS coordination meetings include the participation of MoH EPI management teams and EPI is included in their respective operational work plans. *Coordination*: in addition to the above, coordination activities need to happen more regularly and be carried out more strategically, involving focal points from regions and districts (increases cost for transportation); in addition to the participation of MoH technical and UNICEF/WHO zonal staff, the presence of the management team based in Nairobi, at least in an initial phase, should be more frequent to provide specific technical guidance and to revise operational plans. Terms of reference (ToRs) for all GAVI/HSS MoH focal points need to be developed and monthly work plans to be produced accordingly (and costed). Emphasis should be given to discuss findings from supervisory field visits to address identified bottle necks and to facilitate discussion and sharing of lessons learnt across the country. The latter is important as SHAs are planning to expand the number of Lady Health Workers with support from other programmes. The provision of technical and logistical support to MoH GAVI/HSS focal points is equally required to carry out effective coordination functions. *Training*: in addition to providing comprehensive basic training in line with national standards, training venues need to be prepared and equipped; trainees need to reside in the proximity of the training centre as they live in villages far away and cannot return on daily basis. This factor largely attributes to increased costs for accommodation which are included under training related activities. The programme envisions to contribute to establishing national standards for training curricula, the development of a strategic training plan and at long terms to the process of accrediting training institutes and registration of health workers. Synergies have already been created with related activities carried out under the JHNP. *Health information and operational research*: activities around this objective are important if the programme is meant to be expanded and are also meant to contribute to build national research capacities. Consultative meetings were held between MoH teams and UN agencies and an agreement was made to combine the planned baseline survey with funds allocated to formative research.As part of the support to HSS through other programmes, a national M&E framework will be developed that will include key indicators as addressed in this grant M&E framework. At each zonal Ministry of Health a national M&E advisor will be recruited to support this work and to contribute to strengthening M&E functions of the health sector as well as of the implementation of the Health Sector Strategic Plans (HSSPs). A review of the HSSPs (this would be the first review) and the development of new Annual Work Plans (AWP) for 2014 are planned to take place before the end of the year and will also address the need for producing better health information and its use for decision making processes. Members of the Health System Analysis Team (HSAT) are currently being recruited by WHO to conduct assigned analysis of key health system areas. GAVI/HSS support to operational health system research will complement these activities and contribute to the development and strengthening of core health information related functions such as data production (through routine and research data) and analysis. The work will be overseen by the respective MoH Director for Policy & Planning and technically assisted by the international HSS country programme advisor.  |
| * 1. Please outline the decision making process for any proposed changes in the reprogramming. Clearly describe the roles of the HSCC including the government, development partners and CSOs[[3]](#footnote-4) in the decision making process. Please attach any HSCC meeting minutes as relevant.
 |
| The reprogramming is based on findings from field visits carried out by the project management team, meetings and discussions with Somali Health Authorities and held at the Health Sector Committee (HSC) and feedback from WHO zonal project officers. The earlier draft reprogramming document (September 15) had been shared with WHO zonal officers who discussed it with the MoH GAVI/HSS focal points. The final draft was presented to the HSC for endorsement. After discussion and official endorsement, the Health Sector Coordinator singed the document of behalf of the HSC. The Minister for Human Development and Public Services, Directorate for Health, signed it on behalf of the Government. Since funds are only disbursed to two UN agencies (UNICEF and WHO) and the Government is not directly receiving GAVI/HSS funds, the Ministry of Finance is not signing this document. The programme management team provides regular up-date to the Somali Health Sector Committee (HSC). The HSC meets on quarterly basis and is composed from the three Somali Health Authorities, representatives from UN agencies, NGOs and donors. The HSC entered into force in February 2011 with its first HSC and HAB meeting. In 1993 the Somali Aid Coordination Body (SACB) had been established, later renamed into the Coordination of International Support to Somalis (CISS), comprising representatives from donors (3), UN agencies (3) and international / local NGOs (3) as well as from the civil society (3) and the Ministries of Health (3). The CISS operated through a network of sectoral committees supported by the Somali Support Secretariat (SSS). The HSC coordinates international support to the health sector within the CISS framework and oversees the coordination of health activities but also facilitates a more in depth analysis of the health sector and fostering strategic actions towards health sector development. A Health Systems Analysis Team (HSAT) is being formed now to conduct assigned analysis to support the HSC in accomplishing its task. The HSC is the coordinating health mechanism, including oversight of GFTAM awards and development of new proposals. It provides a coordination platform for SHAs as well as development and implementing partners, develop comprehensive strategies and health policies in collaboration with zonal health coordination forums and referring draft policies and strategies to the HAB for review and endorsement. Recommendations on these actions are being discussed at the Health Advisory Board (HAB), a policy forum that brings together senior Heads of Agencies, donor and NGO representatives and the Health Ministries and that meets on a six-monthly basis to set overall health policy objectives, strategies and priorities whilst at the same time providing guidance and support to the HSC (6 members). The next HSC is planned for December 2013 but its functioning is currently on hold as contracts for HSC staff came to an end mid-September. Interim arrangements are being set in place. However, a national GAVI/HSS meeting is planned for early December where this latest document and latest development for GAVI grants will be shared and discussed.  |

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## Health System Bottlenecks to Achieving Immunisation Outcomes

***This section is only relevant and should be filled in if the reprogramming request includes new/revised objectives not in the originally approved GAVI HSS grant.***

This section will be used to understand the main bottlenecks affecting the health system performance. The analysis here underpins the reprogramming, ensuring the new objectives and revised activities are designed to address the bottlenecks.

→ Please describe key health and immunisation system bottlenecks at national, sub-national and community levels preventing your country from improving immunisation outcomes. Consider bottlenecks to providing services to specific population groups, such as the under reached, marginalized or otherwise disadvantaged populations. The country is also asked to consider gender related barriers to accessing quality services.

In order to keep this section concise, please summarise the key elements in the context of the HSS support being asked for, providing a reference to the relevant section in the National Health Plan for further detail.

→ Please refer to bottlenecks which impact on gender and equity-related access to immunisation.

→ Please reference the analytical work that led to identification of the bottlenecks.

→ Describe the bottlenecks identified in any new vaccine proposals submitted to GAVI, the National Health Plan, and any recent health sector assessments such as the Effective Vaccine Management (EVM) assessment or Post Introduction Evaluation (PIE).

→ Which of the above specified bottlenecks will be addressed by the reprogrammed HSS grant? Which bottlenecks are addressed by other national or externally supported programmes?

In order to keep this section concise, please summarise the key bottlenecks and provide references to the relevant sections in existing bottleneck analyses (such as in annual EPI reviews, annual health sector review reports, etc.). Please ensure the referenced analyses are provided as attachments.

|  |
| --- |
| N/A |

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| Lessons Learned and Past Experience***This section is only relevant and should be filled in if the reprogramming request includes new objectives not in the originally approved GAVI HSS grant.***  |
|  ONE PAGE MAXIMUM

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| --- |
| This description will highlight to GAVI how lesson-learning has been incorporated into the design of the reprogramming. It will provide the evidence base that demonstrates that the reprogrammed objectives will be effective, and that implementing them will achieve the desired intermediate results and immunisation outcomes. → Please use the table in the proposal form to summarise the evidence base and/or lessons learned related to each of the new objectives in the reprogramming submission. Applicants are asked to provide examples specific to their country of relevant interventions that were successful from GAVI grants and/or other programmes. → Please include/describe experiences and outcomes on civil society engagement through the GAVI HSS grant and their contribution to successful implementation and outcomes for immunisation. → In addition please provide examples illustrating the challenges to successful implementation. \*Where possible, please provide evidence of this learning by providing a reference or a web-link to a published document related to each example. |
| **New/revised Objective** | **Example(s) of lessons learned, highlighting both successes and challenges** |
| N/A |  |
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| Objectives of the Reprogramming Request  |
| ***This section is only relevant and should be filled in if the reprogramming request includes new objectives not in the originally approved GAVI HSS grant.*** This section will be used to assess whether the newly proposed objectives are relevant, appropriate and aligned with the National Health Plan and cMYP, and contribute to improving immunisation outcomes. It will also ensure alignment with the bottleneck analysis above. → Please succinctly describe the immunisation and HSS objectives to be addressed in this reprogramming request and explain how they relate to, and contribute to, reducing HSS and immunisation bottlenecks (identified above) and strengthening of the health system. Please describe how these new objectives are aligned with those in the National Health Plan and cMYP. The new objectives need to be aligned to and numbered in the same way in the revised HSS M&E Framework, Budget and Workplan submitted as attachments with this reprogramming request. For each new objective, please describe: 1. Which immunisation outcomes will be improved by implementing the activities, and how will the activities contribute to their improvement? Please focus on the key activities related to each objective rather than every single activity. Please demonstrate this link in the next section on the results chain.
2. Whether and how the proposed objectives relate to the equity and gender related barriers to access as identified in the bottleneck analysis, and how the new objectives will result in narrowing the equity gap in immunisation coverage and contribute to reaching the under reached, underserved and marginalised populations. Countries are requested to consider gender related and geographic barriers to access of immunisation and other health services.

→ Please list and describe all of the proposed activities for the remainder of the grant in the revised budget. If GAVI funding is requested to go into pooled funds, please attach the Annual Work Plan and Budget for the pooled fund and related Terms of Reference. |
| N/A |

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| Gap Analysis and Complementarity |
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| ***This section is only relevant and should be filled in if the reprogramming request includes new objectives not in the originally approved GAVI HSS grant.*** The information included in Table 2 below will ensure GAVI is aware of support provided by other donors, thereby avoiding overlap or duplication, and highlighting the value-added of the requested GAVI support. → Please complete a gap analysis that is related to each of the new GAVI HSS grant objectives. The gap analysis should use information as available in National Health Sector Strategy/Plan, cMYP, or other gap analysis conducted. GAVI encourages the use of data from existing gap analyses, rather than undertaking a new gap analysis.→ For each of the new objectives, applicants should list different resources for HSS financing already in place that contribute to the new objective, including government and external donor contributions, the project name if applicable (or indicate budget support), duration of support, funding amount provided (in US$), and geographic location covered by the support. Multiple rows may be used for each new objective depending on the number of different funding sources available. |
| **Table 2: Sources of HSS funds in your country** (insert as many rows as necessary & attach any supporting documents to justify reprogramming) |
| **New Objectives** | **Funding Source** | **Project Name** | **Duration of support** | **Amount in US$** | **Geographic Location**  |
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→ In the box below, please provide a narrative description of other efforts by the Government or development partners that focus on the bottlenecks that are addressed by the reprogramming submission objectives, including the timeframe and the geographic location of this support, thereby highlighting the value-added of GAVI support and how the reprogrammed grant complements those efforts.

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| N/A |

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| Results Chain  |
| This description will detail to GAVI how the proposed **new/revised activities** will result in improved immunisation outcomes. *In this reprogramming, objectives are unchanged. However, since the M&E framework has been revised in relation to the intermediate results, the result chain is herewith provided for the activities that have not yet been implemented. New activities are in green. It is anticipated that all activities directly and indirectly contribute to improved immunization outcome targets.* → Please present a Results Chain for all objectives, using the template provided below. This diagram should demonstrate how new/revised activities contribute to achieving outputs/intermediate results and how outputs/intermediate results contribute to achieving immunisation outcomes. The outputs/intermediate results should link directly to the HSS bottlenecks identified above, and should address or contribute to addressing the selected bottlenecks for the GAVI HSS reprogramming request. → Please only include the new/revised activities for each objective. The full list of activities should be completed in the workplan and budget submitted with the reprogramming request.→ The Results Chain should be consistent with the HSS M&E Framework. For every output / intermediate result and immunisation outcome listed in the Results Chain there should be corresponding indicator(s) in the HSS M&E Framework to measure achievement.→ Please note that the HSS M&E Framework must include the six immunisation outcome indicators listed in part 11. Monitoring & Evaluation Framework. Countries are encouraged to include other immunisation outcome indicators as well that relate specifically to the part of the health system where funds will be used. |
| ***Objective 1:*** To improve availability and utilization of immunization and other essential maternal and child health service through strengthening of selected MCH centres; |
|  | **Activities:**1.3: Procurement and supply of essential medicinesand equipment for MCH services (based on gaps)1.4: Provide comprehensive support for BEMONC in selected MCH centres (3);1.5. Development /adapt curriculum for training of MCH and EPI staff in supervision, outreach and HMIS 1.6 Conduct training of MCH and EPI staff (in 40 MCH centres)1.7 Develop curriculum for training of all MCH staff in EPI injection safety and vaccine management1.8 Training of all MCH centres staff (EPI, injection safety and vaccine management)1.10 Develop/Implement a system of regular EPI outreach from MCH centres to the catchment areas of health posts and FHWs1.11 Develop system of regular supervision for MCHC from R/Z MoH1.12 Provide transport support to MOH for supervision of Regional offices1.13 Provide transport support to RM for supervision of MCH centers1.14 Provide performance based incentives to MCH staff1.15. Provide incentives to MoH HSS focal points |  | **Outputs / Intermediate Results:** * *# of MCH centres providing EPI outreach services ;*
* *# of MCH centres correctly monitoring and meeting their monthly vaccination target*
* *# of MCH clinics offering immunisation services that have tracer items for delivery of immunisation including:*

*- At least one staff trained in EPI in last two years**- Cold box/vaccine carrier with ice packs**- Functioning refrigerator and thermometer**- Sharps container** *Availability of health workers newly trained in EPI in # of MCH clinics*
* *# of MCH clinics having functional cold chain equipment for static and outreach;*
 |  | **Immunisation Outcomes:*** DTP3 coverage - % of surviving infants receiving three doses of the diphtheria-tetanus-pertussis vaccine (DTP3);
* MCV1 coverage - % of surviving infants receiving first dose of measles containing vaccine;
* Geographic equity of DTP 3 coverage - % of districts that have at or above 80% DTP3 coverage
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| ***Objective 2:*** Improving access of rural communities to immunization and other basic preventive, promotive and curative health services through supporting CHWs and health posts; and creating on a pilot basis, a new cadre of Female Community-based Health Workers; |  |
|  | **Activities:**2.7 Develop & implement system of supportive supervision/outreach2.8 Develop and implement a community based HMISActivity 2.11: Procure and distribute/re-supply medicines for Health posts (50%)2.10 Procure and distribute/resupply FCHW kitsActivity 2.11: Procure and distribute/re-supply equipment for Health posts2.12 Refresher training for FCHWs and Supervisors2.13 Incentives for CHWs2.14 Incentives for FCHWs |  | **Outputs / Intermediate Results:** * *% of target population in FHW catchment receiving immunization;*
* *Community based information system in place and functional;*
* *# of FCHW trained, provided with essential kits and supervised;*
 |  | **Immunisation Outcomes:*** Drop- out rate;
* Socio-economic equity in immunisation coverage - DTP3 coverage in the lowest wealth quintile is +/- X % points of the coverage in the highest wealth quintile
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| ***Objective 3:*** To improve awareness and demand for immunization and other essential quality maternal and child health services by the year 2014, through implementation of a comprehensive and sustained campaign of behavioural change communication; |
| **New / Revised Activities:**Activity 3.1: Formative research to identify key maternal and child caring behaviors and barriersActivity 3.2: Develop five year strategic communication planActivity 3.3: Develop print, audio-visual and IPC package for health workersActivity 3.4: Develop and broadcast radio program on key child caring and health practicesActivity 3.5: Identify three strong communication NGOs to build capacity of existing NGOs and to scale up public awareness at community levelActivity 3.6: Strengthen and establishing structured/systematized partnership with religious leaders, religious organizations, clan leaders, community elders and networksActivity 3.7: Work with school structures to increase dialogue on key child survival and development messagesActivity 3.8: Develop community friendly materials (discussion guides etc.) with key iCCM messages for FCHWs, CHWs, TBAs for home based family promotionActivity 3.9: Partner for m-health videos to remind on key child survival messagesActivity3.10: Evaluation of C4D interventionsActivity3.11: Technical Assistance for BCC/C4D activities |  | **Outputs / Intermediate Results:** * *% of mothers having knowledge about immunization and danger signs of pregnancy and childhood illnesses*
 |  | **Immunisation Outcomes:*** DTP3 coverage - % of surviving infants receiving three doses of the diphtheria-tetanus-pertussis vaccine (DTP3);
* MCV1 coverage - % of surviving infants receiving first dose of measles containing vaccine;
* Proportion of children fully immunised - % of children aged 12-23 months who receive all basic vaccinations in a country’s routine immunisation program
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| ***Objective 4:*** To provide evidence (on utilization, impact and cost of services) in order to generate appropriate, equitable and affordable health care delivery models for maximisation of efficiency and equity of immunisation and other essential |
| **Activities:**4.1 Conduct baseline and end-line surveys;4.2 Establish & support operational research committee;4.3 Commission operational research studies;4.4 Conduct focus groups for operational research;4.5 Support data analyses and use;4.6 Training of MoH Managers in operational research;4.7 Organize study tours for health authorities;4.8 Technical Assistance for Operational Research; |  | **Outputs / Intermediate Results:** * *Regular production of information products based on a) facility assessments, b) supportive supervision; c) community based HIS system*
 |  | **Immunisation Outcomes:*** Proportion of children fully immunised - % of children aged 12-23 months who receive all basic vaccinations in a country’s routine immunisation program
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Summary of Activity Revisions Please complete Table 1 below to summarize only the activities that will be revised from the original approved HSS grant. Please explain the revision of each activity - for example, is the activity completely new, revised from an originally approved activity, or being removed from the grant. Please provide a justification for all new, revised or removed activities. For revisions to originally approved activities, the original approved activity budget does not have to match the new/revised activity budget. For new activities, the original approved activity budget will be $0. For activities that are removed from the grant, the new/revised activity budget will be $0. Please note, since this table only includes activities that have changed from the original approved grant, the total amount of the activities listed here is the total reprogrammed budget, and does not necessarily reflect the total budget available for the remainder of the grant. A detailed budget must be submitted as a separate attachment which will include all activities for the entire amount of the remaining grant budget.

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| **Table 1:** **Summary of key revisions to activities and budget in HSS grant** (insert as many rows as necessary)

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| **Original approved activity to be revised/removed***(Please list each activity by objective, using the original activity number from the approved proposal. If a new activity is being added without corresponding original activity, then write N/A in this column and fill in the new/revised activity column.)* | **New/revised activity** *(Please list and describe each new/revised activity using a new activity number from the revised budget. If the original activity is proposed to be removed from the grant, without a corresponding new activity, then write N/A in this column.)* | **Justification for new, revised or removed activities** *(attach supporting documents as needed)* | **Original approved activity budget** **($)** | **New/revised activity budget ($)** | **Budget to be re-programmed for Q4Y3 to Y5****($)**  |
| 1.1 Develop list of priority facilities & conduct survey |  | *Implemented*  | 45,000 | 25,188 | 0 |
| 1.2 Rehabilitation of selected MCH centres (based on assessment) |  | All facilities in Puntland and Somaliland were rehabilitated. Rehab. of SCZ facilities is in process and will be completed in 2013 | 200,000 | 200,000 | 25,000 |
| Activity 1.3: Procurement and supply of essential equipment for MCH services (based on gaps) | Activity 1.3: Procurement and supply of essential medicinesand equipment for MCH services (based on gaps) | In original budget, the essential medicines component was missing; the budget has been increased to USD 362,000 (with $68,000 providing these supplies for 2013) | 200,000 | 362,000 | 213,000 |
| Activity 1.4: Provide comprehensive support for BEMONC in selected MCH centres (6) | Activity 1.4: Provide comprehensive support for BEMONC in selected MCH centres (3) | The # of BEMONC facilities is reduced to 3 due to the limited budget. As respective HA has not decided on selection of BEMONC facilities, only required equipment has been procured in 2013 and operational support will be provided in 2014 and 2015 | 300,000 | 240,000 | 231,000 |
| 1.5 Development /adapt curriculum for training of MCH and EPI staff in supervision, outreach and HMIS  |  | Planned budget and activity unchanged; is being performed in Year 3 instead of Year 1. | 15,000 | 15,000 | 15,000 |
| 1.6 Conduct training of MCH and EPI staff (in 40 MCH centres) |  | Budget had to be adjusted accounting for expenses occurred during similar trainings conducted in Somalia. During field visits a low overall knowledge in key PHC areas including EPI was observed; therefore it has been decided to intensify this activity, in collaboration with other programmes, e.g. EPI, and increase budget allocation.  | 55,000 | 195,000 | 195,000 |
| 1.7 Develop curriculum for training of all MCH staff in EPI injection safety and vaccine management |  | No change in the amount required for the activity from the original budget, the activity is just being reprogrammed for Year 3 instead of Year 1.  | 15,000 | 15,000 | 15,000 |
| 1.8 Training of all MCH centres staff (EPI, injection safety and vaccine management) |  | See 1.6. | 120,000 | 195,000 | 195,000 |
| 1.9: Renovation of cold chain equipment in all MCH centres |  | Budget has been reduced to USD 86,000, as majority of the health facilities already have cold chain equipment. Activity is completed | 320,000 | 86,000 | 0 |
| 1.10 Develop/Implement a system of regular EPI outreach from MCH centres to the catchment areas of health posts and FHWs |  | Initially the costing only included funds for development of a system for EPI outreach; however, as the EPI policy still needs to be finalized as well as the strategy, partners agreed to include the implementation of an outreach system (estimated 250 $ / month) for the 40 MCH clinics;  | 15,000 | 310,000 | 310,000 |
| 1.11 Develop system of regular supervision for MCHC from R/Z MoH |  | Costing of this activity was initially done in 2009. Original costs for contracting a consultant to develop a framework for the system and required tools including of travel in & out of Somalia were insufficient and therefore revised*; this work was completed in 3/2013.*  | 15,000 | 35,000 | 0 |
| 1.12 Provide transport support to MOH for supervision of Regional offices |  | The annual amount allocated for this activity increased (from 22,500 to 26,400) due to overall increase of cost for transportation; however, remaining time for implementation results in decreased total amount.  | 112,500 | 79,200 | 79,200 |
| 1.13 Provide transport support to RM for supervision of MCH centers |  | As 1.12 | 385,500 | 243,000 | 243,000 |
| 1.14 Provide performance based incentives to MCH staff |  | No change in unit costs; reduced budget due to savings resulting from delays in implementation. Until today, only Somaliland has identified and placed MCH staff;  | 1,092,000 | 664,000 | 664,000 |
| 1.15. Provision of incentives to MoH HSS focal points |  | This activity was initially accommodated under management costs; it seems appropriate to place it here.  | Not detailed in initial budget  | New activity  | 440,000 |
| 2.1 Develop scope of work, incentive/criteria for selection of FCHWs |  | Savings are made in Year 1 as the activity was implemented for fewer funds than required; *work completed by end Q3/2013* | 36,000 | 56,255 | 30,000 |
| 2.2 Recruitment of FHWs and supervisors. |  | Recruitment of FHWs was initially planned in Y1 &2. It is anticipated that a number of FHWs pull out of the programme and have to be replaced; minimum funds have been allocated for throughout the period of the project.  | 28,800 | 56,255 | 30,000 |
| 2.3 Development/adapt curriculum for FHWs and supervisors |  | The original allocated amount did not foresee translation into Somali, printing and annual revision & adaptation of the curriculum; *activity implemented by Q3/2013.*  | 36,000 | 73,704 | 20,000 |
| 2.4 Training of trainers |  | The initial amount allocated for this activity was insufficient. The revised amount represents actual amount spent for 2 ToTs held in Somalia in 2012 & 2013 (*activity completed*). | 27,000 | 107,051 | 107,051 |
| 2.5 Training of FHWs |  | Recruitment of FHWs was delayed thus training of all FHWs is being reprogrammed for 2013 and early 2014. Therefore, on one hand, carry-over was moved into 2013; on the other hand costs have to account for increased cost for transportation, refreshment, training venue, contracts for trainers etc. ; training of new FHWs is included in 2014; | 200,000 | 289,000 | 100,000 |
| 2.6 Training of supervisors |  | Less costs, reflecting actual spending on training of supervisors in 2013; supervisor follow the three-months-block training plus one additional months; unit costs partially absorbed by funding for training of FHWs;  | 90,000 | 78,954 | 40,142 |
| 2.7 Develop & implement system of supportive supervision/outreach |  | Annual amount has increased ; however, implementation is delayed and total reprogrammed amount is smaller; includes Per Diem for supervisors and transportation costs.  | 768,000 | 520,000 | 520,000 |
| 2.8 Develop and implement a community based HMIS |  | Less funds required; activity reprogrammed for year 3 (2013); funds have been transferred from UNICEF to WHO; still needs to be formalized.  | 36,000 | 24,000 | 24,000 |
| 2.9 Printing and distribution of HMIS tools |  | Activity will be implemented by WHO and funds have been transferred; needs formalization. | 20,000 | 20,000 | 20,000 |
| 2.10 Procure and distribute/resupply FCHW kits |  | Unit cost of FCHW kits increased; activity and funds transferred to WHO for implementation; needs to be formalized.  | 63,000 | 260,000 | 160,000 |
| Activity 2.11: Procure and distribute/re-supply equipment for Health posts | Activity 2.11: Procure and distribute/re-supply medicines for Health posts (50%) | Unit cost was calculated in 2008. Kits cost as per EPHS criteria is high; therefore budget allocation has been increased but even revised budget will be able to cover only 50% of the health posts. Gap will be covered from UNICEF other bilateral donors;  | 24,000 | 160,000 | 100,000 |
| 2.12 Refresher training for FCHWs and Supervisors |  | No changes are made to the costing or to the activity but have been planned for Y 5 instead of year 3 as initially planned. | 100,000 | 100,000 | 100,000 |
| 2.13 Incentives for CHWs |  | The implementation was delayed due to delayed nomination of CHWs; (so far only taken place in Somaliland). This delay also results is a smaller amount than original. The payment started on March 1, 2013 (SL) and includes 8% increase on annual basis. Monthly incentives 80 $/ m; SC does not have health posts as yet. | 326,400 | 200,912 | 185,912 |
| 2.14 Incentives for FCHWs |  | Recruitment process was delayed as ladies often do not meet selection criteria; remaining time induces smaller amount for budget allocation; annual increase of 8% is included; monthly incentive in starting phase is 80 $ /m. | 777,600 | 529,309 | 457,309 |
| 3.1: Formative research to identify key behaviours and barriers | 3.1: Formative research to identify key maternal and child caring behaviours and barriers | Activity is rephrased. Cost has been increased as compared to 2008 plans. Consultant has been recruited, and work is in progress through research institutes | 30,000 | 120,000 | 60,000 |
| 3.2: Develop National BCC strategy | 3.2: Develop five year strategic communication plan | Activity is rephrased. This is an activity of 2012, but will be completed in 2013. Cost has been reduced as initial work will be done by BCC/C4D specialist instead of hiring a consultant | 36,000 | 26,000 | 16,000 |
| 3.3: Develop, print and distribute IEC material (MCH centres, health posts) | 3.3: Develop print, audio-visual and IPC package for health workers | Activity is rephrased. Units costs increased as compared to 2008 plans;  | 30,000 | 87,000 | 60,000 |
| 3.4: Develop video programs |  | Cancelled and merged with activity 3.3 | 30,000 | 0 | 0 |
| 3.5: Disseminate video messages through cable |  | Cancelled and merged with activity 3.3 | 25,000 | 0 | 0 |
| 3.6: Develop radio programs | 3.4: Develop and broadcast radio programme on key child caring and health practices | Activity is rephrased. Units costs increased as compared to 2008 plans and funds will be required for three zones every year; funds for 2013 is US$ 20,000 for production of radio spots;  | 40,000 | 140,000 | 125,000 |
| 3.7: Disseminate BCC messages through radio |  | Cancelled and merged with activity 3.4 | 520,000 | 0 | 0 |
| 3.8: Increase public awareness through print media | 3.5. Identify three strong communication NGOs to build capacity of existing NGOs and to scale up public awareness at community level | Activity was rephrased with new activity. | 130,000 | 165,000 | 120,000 |
| 3.9: Organise advocacy/BCC events for community elders and religious leaders  | 3.6: Strengthen and establishing structured/systematized partnership with religious leaders, religious organizations, clan leaders, community elders and networks | Activity was rephrased with new activity. Costs reduced; budget for 2013 is USD 20,000;  | 480,000 | 60,000 | 50,000 |
| 3.10: Organise school events on key messages | 3.7: Work with school structures to increase dialogue on key child survival and development messages | Activity was rephrased with new activity. Costs reduced; as activity has been narrowed to schools related to GAVI facilities catchment areas only | 240,000 | 60,000 | 50,000 |
| 3.11 Produce and distribute IEC material to private pharmacies |  | Cancelled and merged with activity 3.8 | 135,000 | 0 | 0 |
| 3.12: Produce and distribute IEC material (flipcharts) to FCHWs and CHWs | 3.8: Develop community friendly materials (discussion guides etc) with key iCCM messages for FCHWs, CHWs, TBAs for home based family promotion | Activity was rephrased with new activity. Unit cost has been increased but will be produced for GAVI-HSS facilities; Budget for 2013 is USD 10,000 | 50,000 | 60,000 | 60,000 |
| 3.13: SMS text messaging for BCC | 3.9: Partner for m-health videos to remind on key child survival messages | Activity was rephrased with new activity. Unit cost has been increased. Budget for 2013 is USD 10,000 | 45,000 | 70,000 | 70,000 |
|   | 3.10: Evaluation of C4D interventions | Budget has been reduced and any additional cost will be covered by UNICEF other funding sources. To be performed in 2015 | 60,000 | 50,000 | 50,000 |
| 4.1 Conduct baseline and end-line surveys |  | This is a 2012 activity which will be completed in 2013. Budget has been reduced as it will be supported by BCC/C4D specialist and National consultant. | 120,000 | 60,000 | 60,000 |
| 4.2 Establish & support operational research committee |  | Small difference in costing due to increased initial costs associated with establishment of OR committees and subsequent yearly support. | 60,000 | 61,815 | 36,000 |
| 4.3 Commission operational research studies |  | Still to be implemented;  | 75,000 | 75,000 | 75,000 |
| 4.4 Conduct focus groups for operational research |  | This work will be supported by BCC/C4D specialist and formative research consultant under activity 3.1; budget has been reduced. Includes balance from 2012; budget for 2014 is USD 36,000 | 144,000 | 72,000 | 72,000 |
| 4.5 Support data analyses and use |  | Activity yet to be implemented. Capacities for data analysis weak; many of GAVI intermediate results lack baseline; budget line therefore increased (uneven number accounts for accommodating overall grant amount). | 30,000 | 76,416 | 76,416 |
| 4.6 Training of MoH Managers in operational research |  | Budget adjusted; plans for enabling MoH staff (from research committee) to participate in workshops and trainings; overall low levels of PH managers needs to account for a comprehensive approach to building knowledge and skills of research functions.  | 30,000 | 135,000 | 135,000 |
| 4.8 Technical Assistance for Operational Research |  | Decreased in allocated amount; savings made due to delayed implementation; no activity in Y3. | 112,500 | 95,481 | 95,481 |
| Management Cost  |  | This is WHO costs; costs for paying incentives shifted to objective 1; amount also decreased as savings made due to delayed implementation. | 880,740 | 313,247 | 313,247 |
| M&E support costs  |  | This is UNICEF costs and cover the costs of security, administration and finance support functions (both at central Nairobi level and in the zonal offices), operations (including office rent, utilities, communications, fuel, stationery, IT, etc), transport, planning, monitoring, evaluation and reporting. Out of total, 3% is allocated to Planning, Monitoring and Evaluation which also includes Communications and Risk Management. The other 12% contributes to the Operations Budget, which for 2013 is approximately USD 16 million. The budget breakdown is approximately as follows: Office rent, utilities, etc. (4%); Logistics, transportation, etc. (4%); Security of premises, staff and convoys (2%); Financial management and financial transaction costs, etc. (1%); Governance and Human Resources management (1%). Every grant contributes to these costs, and expenditure against each category can be reported upon at the end of the project. As funds arrived in Dec 2011, costs has been readjusted to four years (2012-2015) | 339,000 | 512,062 | 512,062 |
| Technical support WHO  |  |  | 2,499,140 | 1,681,661 | 1,187,644 | 702,049 |
| Technical support UNICEF |  | UNICEF has acquired a full time Technical Assistance to support national BCC activities from 2013. Therefore technical support cost of has been increased by USD 502,662. Total technical support budget for UNICEF is now US$ 1,320,142 as compared to US$ 472,741 in original proposal. |  | 1,320,141 | 343,562 |
| 7% PSC  |  | Please note that 7% for PSC was not accounted for in the original budget as it has not been separated from activities costed (PSC should be calculate for total of activity budget and then added to form total budget) and thus was left to be deducted from the amount accounted for activities. This left WHO and UNICEF with 755,226 USD less in total. This has now been adjusted in this revised / reprogrammed budget. | 755,226  | 755,313 | 755,313 |
| **Total Reprogrammed Budget ($)** |  | **8,610,880** |

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## Sustainability

This description will enable GAVI to assess whether issues of sustainability have been adequately addressed.

→ Please describe how the Government is going to ensure sustainability of the results achieved by the GAVI grant after its completion. This should encompass sustainability of financing for immunisation services and health system strengthening, as well as programmatic sustainability of results.

→ If there are other recurrent costs, such as operational and maintenance costs, included in this reprogramming request please describe how the country will cover these costs after the funding finishes.

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| Somalia’s health sector is largely depending on external funds with insignificant revenue from other sources such as taxes. Mechanisms for health financing are still to be identified and set in place. Out-of pocket expenditure is estimated at 80% with a growing unregulated private sector where the majority of Somali see health care. Sustainability of health programs depends on socio-political sustainability. Recent developments in Somalia have created an environment that seems to be more stable and conducive for long term investments and development in the health sector. Local functioning Governments in the relative politically stable zones of Somaliland and Puntland have created more secure programming and sustainability spaces in which capacities of local health authorities can be built and increasing ownership of programmes achieved. The programme provides incentives for staff at MCH clinics and in Health Posts as well as incentives for MoH staff at zonal, regional and district level. The Somali Health Authorities (SHAs) are in the process of rolling out the EPHS; its implementation is largely being carried out by NGOs. In case of the facilities included in this grant, the Somali Health Authorities, in most of the cases, will roll out the implementation of the EPHS with GAVI/HSS funds being their only support. In early 2013, a review of compensation, salaries, incentives and benefits for health personnel in Somali had been carried out, recommending various scenarios for the SHA of which the middle scenario had been accepted. The recommended level of remuneration is gradually being applied to the roll out of services. Current level of incentives under this grant are in line with it but need to examine how these incentives can complement Ministry salaries. Discussions with the health authorities need to take place but given the specific context of Somalia with almost no functioning health system structures and processes in place, the full resumption of activities implemented under this grant will be a challenge after its ending in December 2015.  |

## Involvement of CSOs

This description will be used to assess the involvement of CSOs in implementation of the new/revised activities. CSOs can receive GAVI funding through GAVI HSS grants going to the MoH and then transferred to the CSO.

→ Please describe how CSOs will be involved in the implementation of any new/revised activities, indicating the approximate budget allocated to CSOs.

→ Please ensure that any CSO implementation details are reflected within the detailed budget and workplan.

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| CSOs were involved in the planning process and will be responsible for implementation of selected GAVI-HSS activities. The SRCS (Somalia Red Crescent Society) supports some of the selected MCH centres and participate in the coordination of GAVI HSS activities including selection of FHWs and FHW supervisors, recruitment of additional staff for the MCH sites they support, participation of GAVI HSS WG meetings, rehabilitation of MCH centres,etc.Community elders have been involved in the selection process of the FHWs and FHW supervisors.  Local FM Radio stations managed by local communities and Somali diaspora, Religious Networks and SDO Local NGO support the dissemination of BCC messages. In Puntland, the Haji Abdi Nursing School in Garowe and the Bosaso college of health sciences have provided their training centres for the training of FHWs. Two NGOs PSI and BBC Media Action have been identified to support and mentor at least 5 local NGOs in Behavior Change Communication. Five local NGOs will be selected in 2013. In Puntland the IHSAN Religious Leaders Network (IRLN) has signed a small scale agreement with UNICEF to work with the MOH to promote Child Health in 12 communities within the GAVI districts. In Somaliland an agreement has been signed with International Horn University to reach communities, especially in hard to reach areas, with key child health messages mainly on immunization, childhood illnesses, polio vaccination nutrition, sanitation and hygiene, and prevention of HIV/ AIDS.In collaboration with the Ministries of Health and Education, Kow Media Corp (KMC), an ‘edutainment’ media NGO with presence in all the three zones, has been identified to support implementation of Work with school structures to increase dialogue on key child survival and development messages.CSOs are part of the constituencies of the Health Sector Coordination (HSC) Committee both at national as well as zonal level and as such exposed to regular up-date of the programme and discussion on challenges to be addressed. CSOs, especially service providing national and international NGOs are actively involved in zonal and national working groups on EPI.  |

##  Implementation Arrangements

This section will be used to determine if the necessary arrangements and responsibilities for management, coordination, and technical assistance inputs of the implementing parties have been put in place to ensure that programme activities will be implemented for the remainder of the grant, as included in this reprogramming request.

Please describe:

→ How the grant implementation will be managed. Identify key implementing entities and their responsibilities with regard to specific grant activities.

→ Mechanisms which will ensure coordination among the implementing entities.

→ Financial resources from the grant proceeds that will be allocated to grant management and implementation.

→ The role of development partners in supporting the country in grant implementation.

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| WHO and UNICEF lead the implementation of GAVI-HSS Programme in close collaboration with health authorities and other partners. For the implementation of HSS interventions, clear roles and responsibilities have been developed between all partners. *Financial resources from the grant* - the programme is managed by a WHO / UNICEF team that is funded by the grant and composed from a full time international health systems strengthening (HSS) specialist, two programme assistants and (2, 3 are planned) national officers in the zonal offices (all WHO) and a Maternal, Child Health Manager and BCC/C4D specialist. This team provides hands on technical support to the respective zonal, regional and district MoH teams. Grant funds are also being utilized to support MoH focal points in each zone and in regions and districts that are included into the grant through the payment of incentives. The level of incentives have been discussed and agreed upon with Ministry authorities and reflect the level of incentives paid to similar positions by other programmes. Operational management costs such as regular monthly coordination meetings, led by the Ministry, at zonal level are also being covered by this grant. Such meetings involve WHO, UNICEF, relevant NGOs and respective EP managers.in these meetings, operational plans are being up-dated and progress reported against set targets. More funds had to be allocated to support costs to cover costs for transportation and travel of international staff and security arrangements. These costs have substantially increased and will have an impact on the grant budget in light of the planned move of UN implementing agencies to Mogadishu. For specific technical support short terms expertise is being contracted such as for developing tools for supervision or the formulation of a BCC (Behaviour Change Communication) strategy. ToRs are being shared with zonal teams and deliverables being shared and jointly reviewed. Closer communication has been established with on-going activities to strengthen the national EPI programme and systems have been established to transfer funds to the Somali Health Authorities for prompt use at district and community level. Some of this technical assistance is being budgeted under specific budget lines. To allow for a flexible deployment of consultants as areas might arise, a budget line has been included under “technical support WHO consultants”. 7% of all budget items are being retained by the agencies’ head quarter to account for related project support costs. These costs typically include service and administrative units, as well as their related system and operating costs. Usually referred to as Programme Support Costs, or PSC, these costs must be recovered and included in all donor proposals and negotiations” . Selected activities will be contracted 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.

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| Monitoring & Evaluation Framework  |

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| This description will enable GAVI to assess how programme performance will be monitored and to ensure alignment with national M&E arrangements. The revised M&E Framework for the HSS grant should link to the Results Chain. While the Results Chain provides the rationale for how the new/revised activities will result in improved immunisation outcomes, this section provides details of how the monitoring and evaluation will be undertaken.→ Please provide an updated M&E Framework as an attachment in the excel template provided. Please use this template to propose revised indicators at the Immunisation Outcome and Intermediate Results level of the M&E Framework for the remainder of your HSS grant.→ Please provide a description of how the monitoring and evaluation will be carried out for the grant, indicating how M&E is aligned with the National Health Plan results framework. → Which sources of data will be used?→ How much budget will be allocated to M&E for the remainder of the grant?→ Please describe the M&E system strengthening activities to be funded through this proposal.→ Please identify one or more immunisation outcomes for each objective. → Please identify a number of intermediate results indicators related to each objective of the grant that shall be used for tracking the overall progress of the grant implementation. These are the same intermediate results indicators that are included in the M&E Framework, and will be used to measure the outputs/intermediate results that are included in the results chain.Please note that GAVI strongly recommends that 5-10% of the budget be allocated for M&E, including an end of grant assessment if this has not already been budgeted for.  |
| As of today, there is no national M&E framework as yet. However, under a different programme in support to HSS, the Joint Health and Nutrition Programme (JHNP), the recruitment of M&E advisors and theproduction of a national M&E framework are planned to be implemented in 2013. Discussions have already been held among the three JHNP implementing UN agencies and the Somali Health Authorities to align any programme related M&E activities with the national M&E framework e.g. for GAVI HSS, Global Fund Grants, and to the Health Sector Strategic Plans (HSSP). Similarly, it is foreseen to conduct Joint Annual Health Sector Reviews as well as reviews of the implementation status of the plans that will integrate the assessment of this grant implementation (first foreseen in October / November 2013). Data Sources: * Impact and outcome indicators: MICS; Joint Reporting Form;
* Output indicators: reports from M&E and supervision visits; monthly coordination meetings; supervisory checklist of Lady Health Workers, filled by supervisors; training reports produced by Master trainers; monthly activity report produced by GAVI/HSS Focal points; quarterly WHO/UNICEF progress reports;

For the implementation of HSS interventions, no vertical M&E mechanism is suggested. The programme will strengthen the a) on-going HMIS reform intervention; b) establishment of a national M&E framework and c) the development of a national research agenda. Community based LHW MIS will be an additional and integrated component of the national HMIS. Use of established governance mechanism for coordination such as the Health Sector Working Group (HSWG), Health Sector Committee (HSC) and Health Advisory Board (HAB) will ensure that decisions follow a consultative and informed process. Gaps in M&E mechanisms will be covered through the operational research component of the HSS programme.  |

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## Detailed Budget and Work Plan Narrative

This description will be used to assess if the revised budget submitted with the reprogramming request shows sufficient justification for the activities and activity costs for the remainder of the HSS grant.

→ Please provide a detailed budget and work plan as an attachment to this reprogramming request. Countries may use the budget template submitted with the original proposal, or the GAVI HSS Budget, Gap Analysis and Workplan template. Countries can also provide this information in the format of an existing national Annual Operational Plan or equivalent document.

→ Please include additional information on the assumptions within the budget and justification of unit costs to demonstrate that they are reasonable and supported by in-country planning. These assumptions and unit cost justifications may be inserted here or attached as separate documentation.

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| The reprogrammed budget is attached.  |

# HSCC SIGNATURE PAGE

**For submission with GAVI HSS Reprogramming Request**

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| **National Coordinating Body - Health Sector Coordination Committee**Country: Somalia; Date of Reprogramming Request: August 16, 2013 |

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| We the members of the HSCC, or equivalent committee [Health Sector Committee] met on September 10, 2013 to review this reprogramming request. At that meeting we endorsed this reprogramming request on the basis of the supporting documentation which is attached. |

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| **[1]** Health Sector Coordination Committee or equivalent committee which has the authority to endorse this reprogramming in the country in question. This includes any committee/body responsible for the oversight of the country’s National Health Plan. Endorsement from the EPI coordinating committee (ICC) only is not sufficient.  |

Name of the Committee in country: **Health Sector Coordination Committee** The **endorsed and signed** minutes of this meeting that took place in Nairobi on September 10 and 11, 2013, are attached.  |
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| **Name/Title** | **Agency/Organisation** | **Signature** | **Date** |
|  Minutes of the Meeting |  Marina, Madeo, Health Sector Coordinator, Health Sector Coordination Committee  |   |  September 10 / 11, 2013 |
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| Please tick the relevant box to indicate whether the signatories above include representation from a broader CSO platform: **Yes** 🞎 No 🞎 |  |  |
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Individual members of the HSCC may wish to send informal comments to: gavihss@gavialliance.org

All comments will be treated confidentially.

# Minister of Health SIGNATURE PAGE

**For submission with GAVI HSS Reprogramming Request**

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| **Minister of Health signature** |
| Please note that this document will not be reviewed or approved by GAVI without the signature of the Minister of Health or their delegated authority.Minister of Health: **H.E. Dr Maryan Qasim**. **Minister for Human Development & Public Services**Federal Government of Somalia Signature: Date: September 14, 2013   |

# Annex 1: GAVI HSS Grant Categorisation

This table is not intended to be prescriptive. Countries are encouraged to identify activities to be included in their reprogramming request based on the bottleneck analysis. Activities should link with a measurable outcome. This table is intended purely as a means of classifying activities into GAVI’s grant categories.

The grant categories below are based on the WHO’s six health system building blocks and are to help classify the HSS support sought from GAVI. Improving equity in immunisation coverage (including geographic, socio-economic and gender equity) is a cross-cutting issue and may be classified by the most relevant grant category.

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|  **Grant Category** | **Grant Sub-Category** |
| 1. Scale-up and improve accessibility and quality of **service delivery** (including community level services and implementation support: outreach, access, mobilisation, operational research). | 1.1. Capital Investment in infrastructure including upgrading & renovations |
| 1.2. Improving service organisation & facility management |
| 1.3. Improving quality of care |
| 1.4. Demand generation activities (includes Information, Education and Communication) |
| 1.5. Cold chain facilities |
| 1.6. Cold chain equipment (investment/procurement) |
| 1.7. Transportation (includes vehicle procurement) |
| 1.8. Waste Management |
| 1.9. Other equipment |
| 1.10. Maintenance and operating costs (recurring costs) |
| 2. Produce, distribute and retain skilled health and community **workforce and human resources** | 2.1. Providing or improving pre/in-service training and supervision (health professionals) |
| 2.2. Scaling-up trained workforce (health professionals) |
| 2.3. Supporting workforce retention (health professionals) |
| 2.4. Scaling-up volunteer/community health workers |
| 2.5. Supporting volunteer/community health worker retention |
| 2.6. Volunteer/community health worker training and supervision |
| 3. Strengthen **procurement & supply chain management system** (including access to essential medicines and commodities management) | 3.1. Scaling-up or upgrading procurement and supply management (PSM) infrastructure |
| 3.2. Improving operationalisation of PSM system (and strengthen linkages with other health services such as maternal, neonatal and child health (MNCH) and integrated management of childhood illness (IMCI)) |
| 3.3. Commodities, other than drugs and vaccines (GAVI HSS funds cannot be used to procure drugs or vaccines) |
| 4. Strengthen facility reporting and health **information systems** | 4.1. Scaling-up or improving routine HMIS and M&E including electronic capture of data |
| 4.2. Scaling-up or improving analytical and research capacity, including the strategic use of data and information for programme management |
| 4.3. Scaling-up or improving vaccine preventable disease surveillance systems |
| 4.4. Strengthening logistics management information systems (LMIS) |
| 4.5. Strengthening and improving data quality through assessments, training, and use of tools. This can include conducting regular health facility assessments to assess and monitor service availability and readiness to provide services, including immunisation. |
|  | 4.6. Conducting and institutionalising a systematic approach to monitoring routine data quality, including regular and periodic assessments of data quality. |
|  | 4.7. Adverse events following immunisation (AEFI) monitoring |
|  | 4.8. Household surveys to assess immunisation coverage and factors associated with non-immunisation |
| 5. Empower **community and other local actors** | 5.1. Enhancing enabling environment and advocacy |
| 5.2. Strengthening and scaling-up resources and capacity of community groups and networks |
| 5.3. Facilitating community mobilisation and communication strategies |
| 6. Create enabling **legal, policy and regulatory environments,** including national strategic planning and management | 6.1. Developing, ratifying and executing non-discriminatory, evidence-based laws, policies, national planning, regulations, coordination and supervision mechanisms |
| 6.2. Building capacity to implement laws, policies and regulations, including strengthening capacity of any national regulatory authorities |
| 6.3. Developing and supporting independent mechanisms to supervise, monitor and report on implementation of laws and policies |
| 7. Ensure adequate **financing** of the health and community system | 7.1. Improving revenue collection, pooling and purchasing for ensuring financial sustainability of service delivery |
| 7.2. Improving equity of healthcare and community level financing |
| 7.3. Improving public financial management, including accurate tracking of government and donor investments |
| 8. **Other**  | 8.1 Any activity not captured in other categories |
| 9. **Programme management** (planning and administration) | 9.1. Management costs (includes financial audits) |
| 9.2. Technical support for grant implementation |
| 9.3. Monitoring & Evaluation (includes end of grant assessment) |
| 9.4. Operations Research related to health system strengthening and immunisation services |

# Annex 2: Illustrative Indicators

Below is an illustrative list of indicators. Please note that this list is neither exhaustive nor mandatory. Countries should adapt their indicator lists to the reprogramming request context.

Proposed Activities

Intermediate Results

Outcomes

Impact

**Service availability and readiness**

• % of facilities offering routine child immunisation services (including outreach)

• % of the population within a 5km of a health facility or health post offering routine immunisations

• % of facilities offering immunisation services that have tracer items for delivery of immunisation including:

- At least one staff trained in EPI in last two years

- Cold box/vaccine carrier with ice packs

- Functioning refrigerator and thermometer

- Sharps container

* Number of immunisation sessions planned and completed
* Vaccine wastage rates
* Vaccinator distribution, knowledge and skills
* % of registered private sector facilities providing and reporting on immunisation services
* % of vaccinations delivered by facility type and professional category

 **Data quality**

• Timeliness and completeness of district reporting

• Timeliness and completeness of facility reporting

• Adequacy of accuracy of reporting (from Data Quality Report Card (DQRC))

• DTP3 data verification factor (from SARA)

**Service availability & readiness**

• Capital investment in infrastructure

• Investment in cold chain equipment and facilities

• Training of health workers in EPI and IMCI

• Supervision of health workers

•Private sector engagement strategies

**Supply chain management**

* Upgrading PSM infrastructure
* Improving operationalisation of PSM system

**Health information systems**

* Investment in strengthening HMIS
* Conduct data quality and service readiness assessments
* Investment in surveys and disease surveillance systems
* Investment in analytical capacities
* Investment in reviews/evaluations and link to planning

**Community mobilisation and demand generation**

* Engagement with civil society organisations for community mobilisation
* Information and education campaigns
* Demand side financing

**Six mandatory indicators:**

* DTP3 coverage - % of surviving infants receiving 3 doses of DTP-containing vaccine
* Measles coverage - % of surviving infants receiving first dose of measles containing vaccine
* Geographic equity of DTP3 coverage - % of districts with ≥80% DTP3 coverage
* Equity in immunisation coverage - DTP3 coverage in the lowest wealth quintile is +/- X% points of the coverage in the highest wealth quintile
* Drop-out rate – percentage point drop out between DTP1 and DTP3 coverage
* Fully Immunised Child – % of children aged 12-23 months who receive all basic vaccinations in a country’s routine immunisation programme.

**Other illustrative indicators:**

* Change in scores in data quality report card
* % target (hard to reach) populations receiving immunisation services
* % total government expenditure on health

**Health Status**

• Improved survival

• Children (under five mortality rate, and distribution of causes of death)

• Adults (VPD mortality rates)

• Reduced morbidity

• VPD Incidence, prevalence and hospitalisations

# Annex 3: Monitoring & Evaluation (M&E) Activities

The categories below represent a guide to activities countries can consider funding as part of their effort to strengthen M&E and data systems. Countries should use this list as helpful and relevant, but they are not limited to the activities listed here. Nor are they expected to necessarily use the tools provided below as examples. GAVI encourages countries to pursue innovation in strengthening their M&E systems and data quality.

**Strengthening routine health reporting (including surveillance and facility assessments)**:

1. Integrating immunisation reporting within routine health facility reporting systems. This process should ensure the inclusion of minimum data required for immunisation programme monitoring and improved reporting from health posts. This may include instituting web-based reporting for the national health information system which will increase availability and timeliness of facility level data, including immunisation data.
2. Assessing and strengthening quality of facility data through an annual, independent verification process which includes a facility record review and data quality report cards. This can be done through a WHO Service Availability and Readiness Assessment (SARA) or similar approach.
3. Conducting in-depth assessments of the numerator of children immunised through an Immunisation Data Quality Assessment tool or similar approach.
4. Supporting the ongoing supervision and management of systems and processes related to collecting and reporting data on children immunised through a Data Quality Self-Assessment or similar approach.
5. Supporting the improvement of VPD surveillance systems, and establishing linkages between surveillance systems that may be fragmented (e.g. expanding acute flaccid paralysis surveillance systems to strengthen surveillance of measles, neonatal tetanus and yellow fever or other VPDs).

**Improving vital registration (and population estimates used for denominators):**

1. Improve reliability of national vital statistics, stratified by age and sex (in collaboration with other ministries and entities who are involved in vital registration).
2. Improve hospital reporting of cause of death (disaggregated by age and sex), including vaccine preventable diseases, using an electronic reporting system and training of physicians in International Classification of Diseases (ICD-10), quality control of certification and improved coding practices.

**Improving survey design, frequency, methods and content:**

1. Increasing the frequency of household surveys[[4]](#footnote-5) by reducing the gap between surveys. WHO recommends two surveys every three years, including one with a full birth history.
2. Increasing survey availability and utility at sub-national levels and exploring innovative analytical techniques to improve estimates at sub-national levels. Some example activities would include: 1) Improving quality of small sample household surveys and ensuring the inclusion of immunisation indicators; and 2) improving small area estimation techniques.

**Improving administrative and finance data sources:**

1. Improving tracking of general health expenditure, specifically immunisation expenditure.
2. Instituting a Logistic Management Information System (LMIS) where none exists or ensuring inclusion of immunisation commodities in an existing system. Care should be taken that systems are interoperable to ensure compatibility with other systems.
3. Institute or improve the national health workforce database (both in the public and private sector) and ensure that community health workers are included.

**Increasing analytical capacity:**

1. Building analytical capacity to conduct a stronger annual health sector review, with a focus on strengthening the immunisation component of the annual health sector review and linkages between EPI reviews and annual health sector reviews. Strengthening activities could include training in analytical capacity of health managers at national and sub-national levels through analytical workshops.
2. Improve the analytical content of EPI reviews as well as the immunisation component in health sector reviews by using data from multiple sources including facility and survey data, and equity analyses.
3. Align immunisation programme reviews with the national annual health sector review cycle, and define establish appropriate linkages.

**Dissemination and use of information:**

1. Increasing transparency of information by making reports, surveys and data, including immunisation data, publically available on the internet.
1. Signing of MoU was delayed in relation to submission of proposal [↑](#footnote-ref-2)
2. 1,316,929 WHO; 1,390,061 UNICEF [↑](#footnote-ref-3)
3. For further details on CSO involvement, please refer to <http://www.gavialliance.org/support/cso/> [↑](#footnote-ref-4)
4. Efforts should be made to mobilise DHS and MICS surveys. GAVIHSS funds can be used for interim coverage surveys when DHS or MICS are unable to reduce the gap between two surveys. [↑](#footnote-ref-5)