Joint Appraisal report 2019

Country	Somalia
Full JA or JA update[1]	☑ **full JA** ☐ JA update
Date and location of Joint Appraisal meeting	
Participants / affiliation[2]	MoH, UNICEF CO & RO, WHO CO & RO, Gavi
Reporting period	2018
Fiscal period[3]	
Comprehensive Multi Year Plan (cMYP) duration	2016-20
Gavi transition / co-financing group	*initial self-financing*

1. RENEWAL AND EXTENSION REQUESTS

Renewal requests were submitted on the country portal

Vaccine (NVS) renewal request (by 15 May)	Yes X No ☐
Does the vaccine renewal request include a switch request?	Yes ☐ No X N/A ☐
HSS renewal request	Yes X No ☐ N/A ☐
CCEOP renewal request	Yes ☐ No X N/A

2. GAVI GRANT PORTFOLIO

Existing vaccine support *(to be pre-filled by Gavi Secretariat)*

Introduced / Campaign***	Date***	2018 Coverage (WUENIC) by dose*	2018 Target			Approx. Value $ for 2019 doses**	Approx. Value $ for 2020 doses**
			%*	Children**	Birth Cohort**		
Penta Routine	**2013-04-01**	*42%*	*63%* *67%*	*387,299 (1st dose)* *367,934(last dose)*	*553,284*	*USD 478,500*	*USD 524,000*
IPV Routine	**2015-11-30**	*42%*	*61%*	*367,934*	553,284	*USD 893,500*	*USD 773,000*

**Source of data: GPF*
*** Source of data: PAR*
**** Source of data: dashboard*

[1] Information on the differentiation between full JA and JA update can be found in the Guidelines on reporting and renewal of Gavi support, https://www.gavi.org/support/process/apply/report-renew/
[2] If taking too much space, the list of participants may also be provided as an annex.
[3] If the country reporting period d
eviates from the fiscal period, please provide a short explanation.

Existing financial support *(to be pre-filled by Gavi Secretariat)*

Grant	Channel	Period	First disbursement		Cumulative financing status @ December 2019				Compliance	
				Commitments	Approv. total	Appr. For each IP	Disb.	%Util as of 31 Dec 19 / Self reported	Fin. 2018	Audit
HSS 2 Year 1 & 2	UNICEF	2017-2021	18-Dec-17	21,250,000	8,581,706	6,163,440	6,163,440	93%	yes	NA
	WHO		4-Apr-18			2,418,266	2,418,266	87%	yes	NA
HSS DQIP	UNICEF	2017-2021	29-Nov-19	4,050,000	4,050,000	1,645,482	1,645,482	NA disbursed in Nov 19	NA	NA
	WHO		6-Dec-19			2,353,202	2,353,202	NA disbursed in Dec 19	NA	NA
HSS addit.	UNICEF	2019-2020	19-Dec-19	12,497,378	12,497,378	9,527,008	9,527,008	NA disbursed in Dec 19	NA	NA
	WHO		19-Dec-19			2,970,370	2,970,370	NA disbursed in Dec 19	NA	NA
CCEOP Year 1 &2	UNICEF SD	2018-2022	11-Dec-18	2,669,830	2,625,972	2,625,972	2,621,473	100%	NA	NA
Measles SIA	UNICEF	2019	17-Jul-19	3,634,791	3,634,791	1,177,623	1,177,623	38%	Will be submitted in March 2020	
	WHO		17-Jul-19			2,422,468	2,422,468	50%		

Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future[4]

Indicative interest to introduce new vaccines or request HSS support from Gavi	Programme	Expected application year	Expected introduction year
	MCV2	2020	2021

Grant Performance Framework – latest reporting, for period 2018 *(to be pre-filled by Gavi Secretariat)*

Intermediate results indicator	Target	Actual
Puntland IR-C 1.1.2: Number of surviving infants who received the third recommended dose of pentavalent vaccine (Penta3)	69,410	44,656
Puntland IR-T 21: Drop out rates between Penta1 and Penta3 vaccine in HSS2 target districts	5%	6%
Puntland IR-T 22: Number of children reached for Penta 3 through outreach	9,539	4,163
Puntland IR-T 23: Proportion of health facilities in HSS2 target districts that had a major stock out of any Gavi supported vaccine	0%	0%
Puntland IR-T 24: Proportion of health facilities in HSS2 targeted districts that have reported a non-functional cold chain equipment in last quarter	10%	3%
Puntland IR-T 28: Puntland: Percent of health facilities submitting complete immunization reports located in HSS2 target districts	90%	91%
Somaliland IR-C 1.1.2: Number of surviving infants who received the third recommended dose of pentavalent vaccine (Penta3)	106,738	52,306
Somaliland IR-T 21: Drop out rates between Penta1 and Penta3 vaccine in HSS2 target districts	6%	7%
Somaliland IR-T 22: Number of children reached for Penta 3 through outreach	14,601	1,595
Somaliland IR-T 23: Proportion of health facilities in HSS2 target districts that had a major stock out of any Gavi supported vaccine	0%	0%
Somaliland IR-T 28: Puntland: Percent of health facilities submitting complete immunization reports located in HSS2 target districts	95%	90%
Federal States IR-C 1.1.2: Number of surviving infants who received the third recommended dose of pentavalent vaccine (Penta3)	159,035	91,589
Federal States IR-T 21: Drop out rates between Penta1 and Penta3 vaccine in HSS2 target districts	13%	18%
Federal States IR-T 22: Number of children reached for Penta 3 through outreach	8,758	2,644
Federal States IR-T 23: Proportion of health facilities in HSS2 target districts that had a major stock out of any Gavi supported vaccine	0%	ND
Comments		
All three zones did not achieve their targets for children vaccinated with penta3. Particularly, the zones did not meet their outreach related targets. All three zones had low reporting against required indicators in 2018 which has impacted our ability to assess performance of the grant. Reporting completeness has increased in 2019.		

[4] Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.
Countries are encouraged to highlight in subsequent sections, and particular in the Action Plan in Section 7, key activities and potentially required technical assistance for the preparation of investment cases, applications and vaccine introductions, as applicable.

PEF Targeted Country Assistance: Core and Expanded Partners at 11 November 2019 *(to be pre-filled by Gavi Secretariat)*

	Year	Funding (US$m)			Staff in-post	Milestones met	Comments
		Appr.	Disb.	Util.			
Core Partners	**2018**	1.81mill	1.56mill	1.55mill	3/5	27/33	
	2019	1.52mill	1.14mill	440K	4/6	9/10	
UNICEF	**2018**	800K	800K	799K	3/3	12/15	
	2019	869K	652K	250K	3/4	8/9	Position expected to be filled early 2020
WHO	**2018**	1.01mill	760K	759K	0/2	15/18	
	2019	655K	491K	190K	1/2	1/1	Position expected to be filled early 2020
Expanded Partners	**2018**	314K	77K	77K	--	20/21	
	2019	241K	204K	204K	--	7/8	

3. RECENT CHANGES IN COUNTRY CONTEXT AND POTENTIAL RISKS FOR NEXT YEAR

*Comment on changes which occurred since the previous Joint Appraisal, if any, to **key contextual factors** that directly affect the performance of the immunisation programme and Gavi grants (such as natural disaster, political instability, conflict, displaced populations, inaccessible regions, etc., or macroeconomic trends, health worker industrial actions, disease outbreaks or severe and unexpected Adverse Events Following Immunisation, etc.).*

*For **countries facing fragility, affected by emergencies or hosting refugees**[5]: Please indicate if any flexibilities in grant management are being requested, and also mention in case the vaccine or HSS renewal requests were adjusted.*

*For countries transitioning from the **Global Polio Eradication Initiative**: Please briefly describe the impact on immunisation and primary health care services and specify whether the country has a polio transition plan in place. If such a transition plan exists, please briefly describe it with particular focus on health workforce and surveillance. If no transition plan exists, please describe actions being taken to prepare for polio transition. Please also comment on whether Gavi investments are being used/expected to be used in the polio transition.*

1- Background

Somalia is a federal country, sub-divided into federal member states. Newly formed states in the central and southern areas are Galmudug, Hirshabelle, South-West and Jubbaland. Puntland earlier established, (located in north-east). There is a different level of autonomy in the political system of Somaliland (located in the north-west). Banadir is the capital region with Mogadishu as the capital city. Under each state, administrative areas are called regions and districts.

In 2018, total population of Somalia was estimated to be more than **15 million** in 2018 (as per PESS projection). The infant mortality rate is extremely high at **85/1000 (2015)** with under 5 child mortality rate of **137/1000**. In 2018, The estimated number of live births a year was **619,063** with **588,110** Surviving infants.

Somalia is committed to improve the coverage of universal health coverage (UHC) benefit packages to its population and addressing key health care issues, including equity and community engagement. The country faces multiple challenges in improving access, efficiency and quality across health – low expenditure on health, shortage of skilled and trained human resources for health, security challenges and weak institutional systems are the key bottlenecks.

Over the last two and half decades, internal and external conflict continued, which negatively affected already weak health systems in the country, negligible public sector allocation of resources for the social/ health sector, and more difficulties for the partner organizations to implement programmes that support the health sector. The Somali authorities have placed a emphasis on security, reconciliation and trust building.

The security gains over the past years are real but remain incomplete and fragile. Significant areas of the country especially Central South remains under the influence of terrorist groups and areas recovered from the insurgency are especially volatile. The authorities being aware of the risk, are in process of establishing several policy frameworks and legislations to help the stabilization process. However, the government structures lack capacity to pursue reconciliation, guarantee basic services, security and justice for the population. The risk of internal & clan conflict also persists.

Somalia's health indicators are improving but the ace of improvement is very slow. Reliable data is scarcely available, and the task is further challenging, particularly for those who are poor or vulnerable, persons with disabilities, older people, internally displaced persons and nomadic population.

With Gavi support there is improvement in immunization services and all antigen coverages as per the administrative data e.g. MCV1 for 2018 reflect 70% with Penta 3 69% coverage. However as WUNIEC estimate, Somalia immunization coverage is stagnating for the last 5 yrs at 46% for MCV1 and 42% for Penta 3. Under HSS2, targeted regional and district hospitals started to provide full immunization services with limited outreaches. Nationwide Measles vaccination campaign conducted in 2018 to reach 4.7 million children (6m to 10yrs) as a response to measles outbreak.

I. Humanitarian Context

The humanitarian crisis in Somalia is among the most complex and longstanding emergencies. While large-scale famine has been averted in 2017, the humanitarian impact of the drought has been devastating. More than 6.2 million people, half of the population, was in need of humanitarian assistance and protection. The ongoing conflict continues to reduce the resilience of communities, trigger displacement and impede civilian's access to basic services and humanitarian's access to those in need. Exclusion and discrimination of socially marginalized groups are contributing to high levels of acute humanitarian need and lack of protection among some of the most vulnerable. Disease outbreaks such as acute watery diarrhea (AWD)/cholera and measles continue to lead to preventable deaths across the country.

Due to the above issues, humanitarian staff in Somalia have been under an increasing level of pressure in 2018. Despite this, local and international humanitarian partners have managed to reach over 1.7 million people since the beginning of the year, and they will continue making efforts to reach most vulnerable people in the country. A robust response to assist flood affected population has been put in place, as outlined in the 2018 Somalia Flood Response Plan[6] – however, this plan remains severely underfunded. In urban and peri-urbans areas, especially IDP settlements, the lack of available resources is constraining the ability of partners to control disease outbreaks, to protect vulnerable persons from eviction and further displacement, and to provide food security, nutrition and health services to people in need.

WHO and UNICEF under the leadership of MOH joined the humanitarian response by implementing country wide measles campaign to all accessible and partially accessible districts to contain measles outbreak, almost 94% of all eligible children have received one dose measles vaccine during the outbreak responses.

II. Political Context

Parliamentary and Presidential elections took place in 2017 in Federal Somalia .Country is preparing for next election, which is due by 2021. Constitutional review processing and deepening of federalism is bringing a lot of concern and disagreements between federal government and member states as well as other political parties.

In 2019, Puntland and Jubaland has undergone Presidential and parliamentarian election. Puntland successfully concluded its election with new elected President and parliamentarian are on board. However election of Jubaland faced some challenges.

Since Somaliland considers itself as a separate entity, the MOH of Somaliland did not participate in JA 2019 meeting.

[6] https://reliefweb.int/sites/reliefweb.int/files/resources/Somalia%20Flood%20Response%20Plan_May%20-%20August%202018.pdf

III. Key contextual issues affecting programme performance

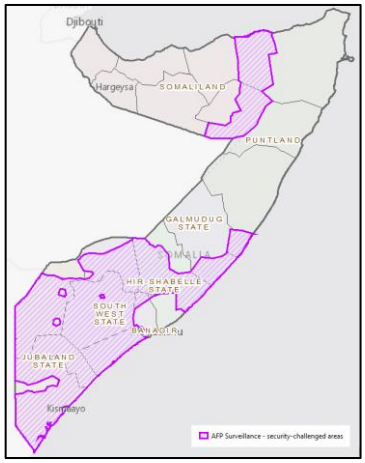
Recurrence of Natural emergencies like Drought and Flooding in major areas of Somalia due to seasonal heavy rains and spells of dry weather. Somalia is prone to natural disasters doubling with weak reactive system, It lead to massive displacement of communities and livestock. Almost every year there is a heavy loss of lives and properties due to these emergencies. The United Nation Systems use Health cluster system which rapidly respond to these disasters. But such emergencies take all the attention and create competitive prioritization for humanitarian efforts than developmental program.

Surge in security incidences targeting high level meetings and Political figures: In 2018 -2019 , High number of targeted attacks ,sprayed shooting, road blocks were reported which resulted in heavy loss of innocent lives and created panic especially in Federal member states. Fortunately no UN missions were harmed in any incidences but such attacks creates cancellation of planned missions and activities, premature closure of running activities but above all human life matters more than dangerous operation.

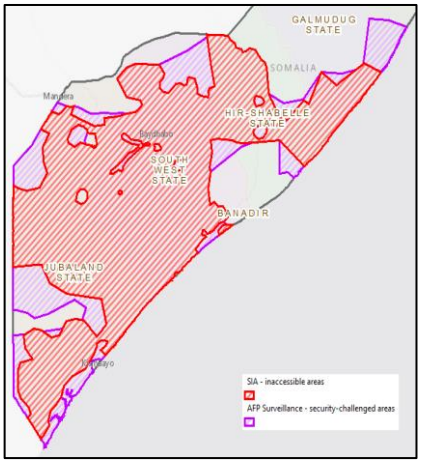
Disease outbreaks-Polio, Measles and AWD/Cholera:

Measles, Cholera/AWD and Polio (cVDPVs) have continued to be reported in Somalia during 2018 and 2019. Such outbreaks are common in Somalia due to multiple natural disasters, poor hygiene, access to safe water and competitive priorities for parents to complete immunization.
The World Health Organization (WHO) supports the Somali health system to monitor trends of disease epidemic in all districts using the electronic based Early Warning Alert and Response Network (e-EWARN) that has been activated in all States. The e-EWARN surveillance system is used to report 14 health events/priority diseases/syndromes on a weekly basis, including vaccine preventable diseases. Currently 455 health facilities are actively reporting on a weekly basis using the e-EWARN mobile application.

Figure 1: Map of accessibility status, 2019



Somalia EPI Security-challenged areas



SIA accessibility vs Surveillance security

IV. Health Sector Development and Coordination

FMoH has developed the first ever Somali National Health Policy (NHP I) endorsed by all Somali health authorities and the Federal Cabinet in 2014. The HSSP II has therefore been developed to operationalise the NHP I and the health sector component of the National Development Plan (NDP I) set for 2017 - 2019. Separate HSSP has been developed by Puntland and Somaliland that recognize their health priorities.
Along with HSSP II, FMoH has developed several strategic documents for specific programs or areas as per below list:

I. Reproductive, Maternal, Neonatal, Child And Adolescent Health Strategy 2019 2023
II. Cholera Preparedness and Response Plan 2017-2022
III. Somali Mental Health Strategy 2019-2022
IV. Somali National Malaria Epidemic Detection, Preparedness and Response Strategy 2015-2020
V. Somali National Strategic Plan for Tuberculosis Control 2015-2019.pdf
VI. Drafted Somali National Development plan (2020-2023)
VII. Drafted and revised Somalia EPI Policy

The Federal Government of Somalia launched the roadmap to UHC for Somali people in a formal ceremony in September 2019. The UHC roadmap portrays the strategic framework and medium-term goals for the Somali health sector and was developed jointly by the Somali Ministry of Health and Human Services along with WHO, UN and development partners, civil society organizations and the donor community

After Joint Health and Nutrition Program(JHNP) phase out in 2016, , alongside the existing Health Sector Coordination mechanism, the health sector signals the start of a more fragmented approach to development financing for the Health Sector, which is likely to continue into the lifecycle of the new country programme.
The United Nations Sustainable Development Cooperation Framework (UNSDCF) for Somalia is being currently developed and will succeed the current United Nations Strategic Framework (UNSF, 2017-20) for Somalia. The UNSF articulates the strategic programme planning framework for collaboration between the UN system and the Government of Somalia to support Somalia's humanitarian, development, political and security priorities as outlined in the Somalia National Development Plan and is aligned to the Sustainable Development Goals (SDGs

V. Status of polio transition and polio programmes

The Somalia transition plan fundamentals and goals is to sustain a polio-free Somalia and to ensure that the investments made to eradicate polio contribute to future health goals. Transition in Somalia has been seen as an opportunity to strengthen country capacities for immunization, surveillance, and emergency preparedness and response. A strong immunization system and increased coverage will also help reduce outbreaks of Vaccine derived polio viruses, Vaccine Preventable Diseases and health emergencies. Although Somali's transition plan needs to be finalized, considerable progress has been seen since the first draft. Several activities have been done and are ongoing since the Polio transition workshop which was held in April 2018. Mapping of the functions and assets of the polio programme and the development of the outline of the Communication Strategy for the Polio Transition has been completed. Development of the Business Case and costing for the Polio Transition and the Advocacy and Resource Mobilization Strategy is pending.
Since Somalia is currently experiencing an ongoing outbreak of vaccine derived polio viruses, the programme's top priority is to stop and contain the outbreak. In 2018, there were 12 confirmed cases of Vaccine derived polio viruses. In response to the outbreak, in 2018, the GPEI partners supported the government in the implementation of 5 bOPV campaigns; 4 NIDs and 1 SNID targeted High Risk Populations (IDPs and Nomads), and 9 monovalent Oral Polio Vaccine type 2 (mOPV2) response campaigns. In addition to the OPV campaigns, one Inactivated Polio vaccine (IPV) campaign targeted children between 4 and 23 months was implemented in May 2018. In 2019, there are 3 confirmed cases of vaccine derived polio viruses and the program has implemented 3 monovalent Oral Polio Vaccine type 2 (mOPV2) response campaigns, 2 bOPV SNIDs in targeted high risk populations and 2 bOPV NIDs of which one was integrated with measles, Vitamin A and Albendazole. Nearly 3.1 Million children under the age of 5 years were targeted and reached with polio vaccines multiple times.
The robust AFP surveillance system continues to detect polio viruses' circulation in both the environment and human cases. To ensure that the surveillance network does not miss any circulation, the programme's community surveillance network through the village polio volunteers continues to cover all inaccessible areas and those areas with no health infrastructure. All Somali's polio immunization operations and surveillance are guided by the programme's innovations including GIS mapping, use of open data kit and dashboards that enable microplanning, real time data dissemination and support. This advancement in the use of data supports the programme in decisions and risk modelling. In addition to all polio related activities and polio outbreak control, the programme human resources still managed to support the implementation of 2 Oral Cholera Vaccine campaigns, Measles case base surveillance, conducted an EPI site survey and supported implementation of Routine immunization improvement activities under CERF and GAVI-HSS funds.

Potential future issues (risks)

Also provide a forward-looking perspective on what else may happen over the next year (given current conditions, vulnerabilities, dependencies, trends and planned changes) and needs to be anticipated. E.g.

potential security challenges due to upcoming elections, risks of vaccine hesitancy, stock-outs or vaccine expiry, or risks to a sustainable transition out of Gavi support.

Drawing on existing country risk assessments, please list a maximum of five most important risks (i.e. with a high likelihood to happen and / or a high potential impact if it did happen). Consider the need for proactive actions to prevent them from happening or to timely detect and effectively respond once they will happen. Also clarify whether these risk mitigation actions are being prioritised in the action plan (section 7 below).

Political conflicts among member states and Federal government are affecting the implementation of humanitarian responses and development projects and service delivery as member states claimed independent working protocols with limited or no instruction or assistance from Federal authorities. In addition, role and responsibilities are not always well defined and lead to programmatic challenges.

Due to above mentioned issues, it become very difficult to endorse certain key national strategies and documents as well as conducting country coordination meetings.

Recurrent droughts and floods trigger outbreaks of communicable diseases (mainly waterborne diseases, skin infections and pneumonia), as well as malnutrition and injuries. They also seriously affect peoples' health and overall economic development. Disasters have a disproportionate impact on women and children, who comprise 70 percent of disaster-affected populations and put more demand and pressure on existing health facilities and limited service delivery.

Political campaigning for Election 2021 may result in some unforeseen conflicts and will have direct implication on health and other sectors programs.

Security concerns will remain high priority for all programs which can create new dynamic in operation or halt ongoing operations.

Somalia is prone to Humanitarian emergencies which divert attention toward emergency services and responses. Developmental program may get effected with such divided attentions.

4. PERFORMANCE OF THE IMMUNISATION PROGRAMME

*This section is expected to capture primarily the **changes since the last Joint Appraisal** took place. It should provide a succinct analysis of the performance of the immunisation programme with a focus on the evolution / trends observed over the past two to three years and including an analysis of immunisation coverage and equity, as well as a review of key drivers of poor coverage*

Information in this section will substantially draw from the recommended analysis, of coverage and equity and other relevant programme/service delivery aspects, which can be found in the Joint Appraisal Analysis Guidance (http://www.gavi.org/support/process/apply/report-renew/). In addition, the annual data quality desk review exercise is considered an important source of analytics that can be used for populating the Joint Appraisal report.

Countries are encouraged to present the information in tables, graphs and maps, and to reference the source of data.

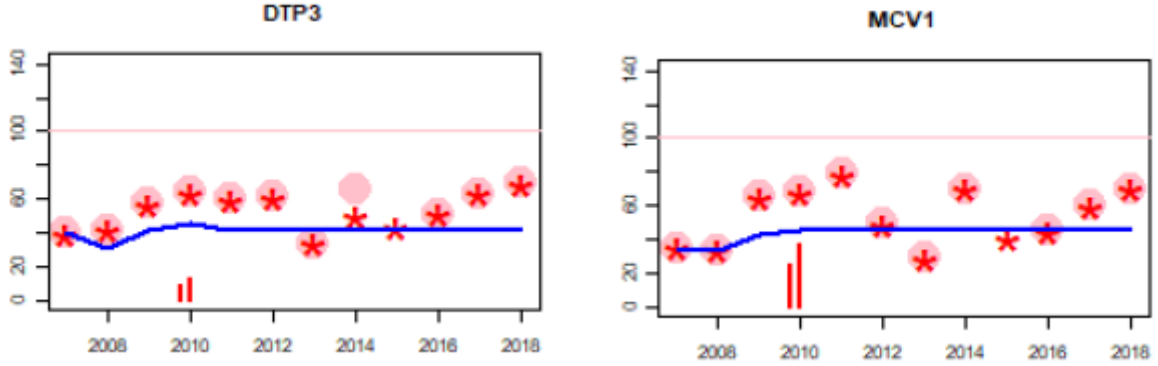
4.1. Coverage and equity of immunisation

*Please provide **national and sub-national analysis** of the situation related to coverage and equity of immunisation in the country, **focusing on newly available data & analysis, trends and changes, including outbreaks and details on outbreak responses observed since the last Joint Appraisal** was conducted.*

- *Provide a summary of the trends in **coverage and equity**, across geographical areas, socio-economic status including gender-related barriers, populations and communities, including **urban slums, remote rural settings and conflict settings** (consider population groups under-served by health systems, such as slum dwellers, nomads, ethnic or religious minorities, refugees, internally displaced populations or other mobile and migrant groups).*
- *Relevant information includes: overview of districts/communities which have the lowest coverage rates, the highest number of under-vaccinated children, highest dropout rate, disease burden: number and incidence of vaccine preventable diseases (VPD) cases as reported in surveillance systems in regions/ districts, etc.*
- ***Achievements against agreed targets**, within the country monitoring and evaluation (M&E) framework (and captured in the grant performance framework (GPF). If applicable, reasons why targets have not been achieved, identifying areas of underperformance, bottlenecks and risks.*

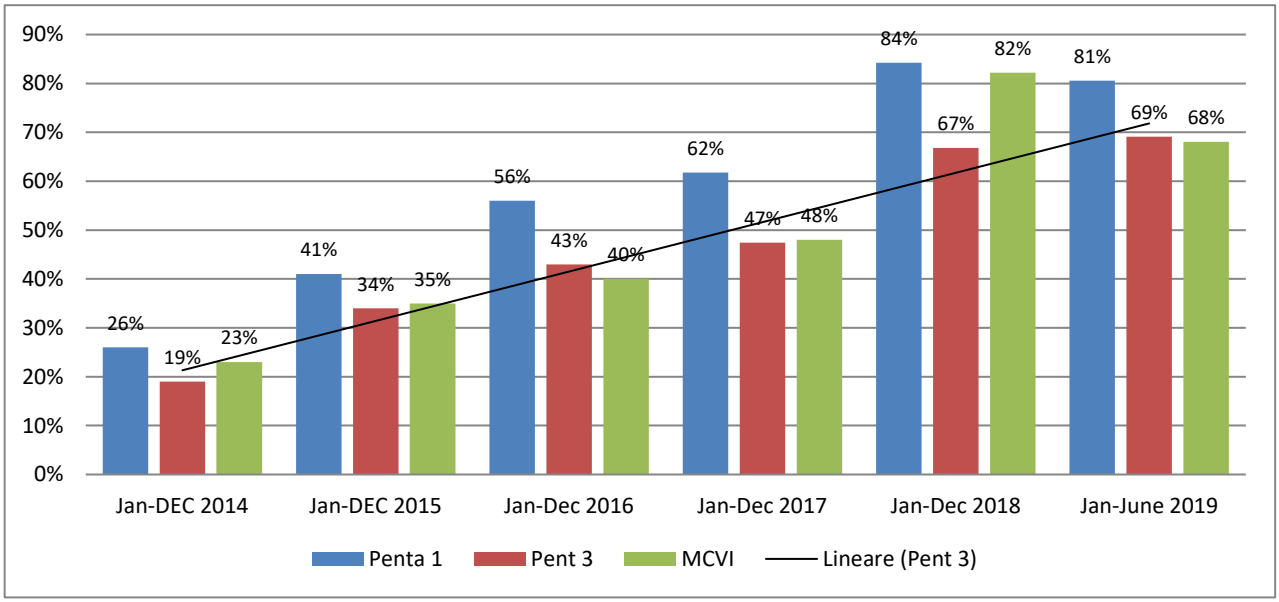
*Briefly indicate whether programme targets, according to the country's multiyear plan (such as the cMYP) have been met in the year under review. To elaborate on the data provided, countries are strongly encouraged to include **heat maps** or similar to show immunisation coverage trends over time. Examples of such analysis are available in the Joint Appraisal Analysis Guidance (available via http://www.gavi.org/support/process/apply/report-renew/)*

The WUENIC estimates that the pentavalent 3 coverage in Somalia has stagnated at 42% over the last seven year. Administrative and official coverage, on the other hand, indicates a steady increase in the coverage from 44% in 2015 to 69% in 2018. Similarly, the WUENIC estimates that the MCV1 coverage in the country has stagnated at 46% for the last nine years, as shown in the graphs below.



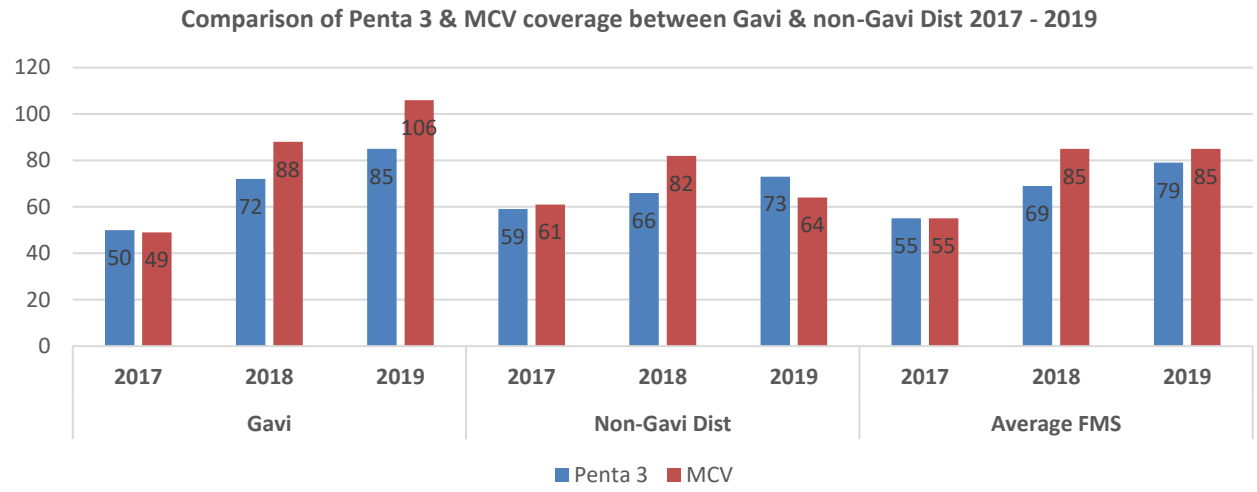
Federal Member States

The pentavalent 3 coverage has improved from 19% in 2014 to 69% in 2019, whereas the MCV1 coverage improved from 23% in 2014 to 68% in 2019.

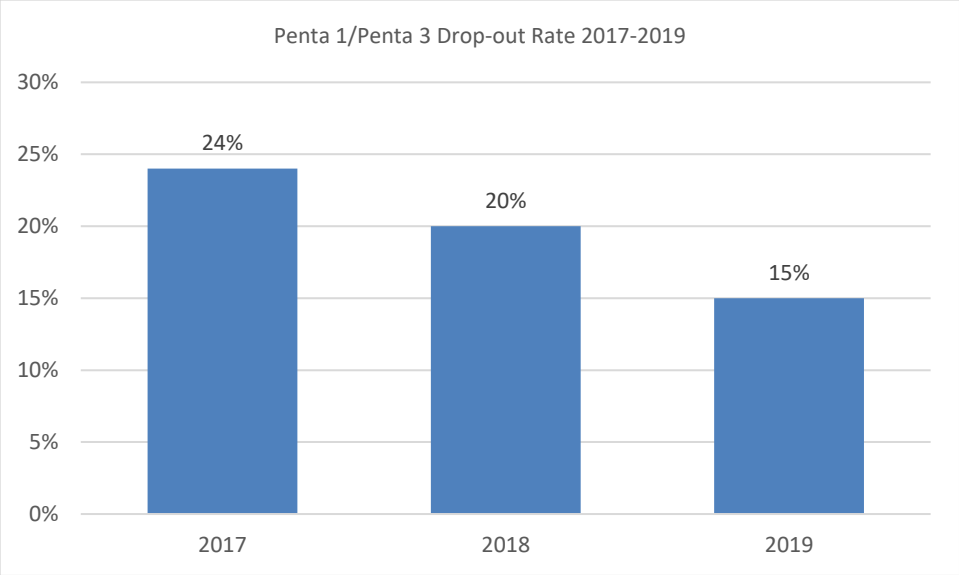


Graph 1 showing administrative coverage in the FMS (2014 – 2019). Data source: DHIS2

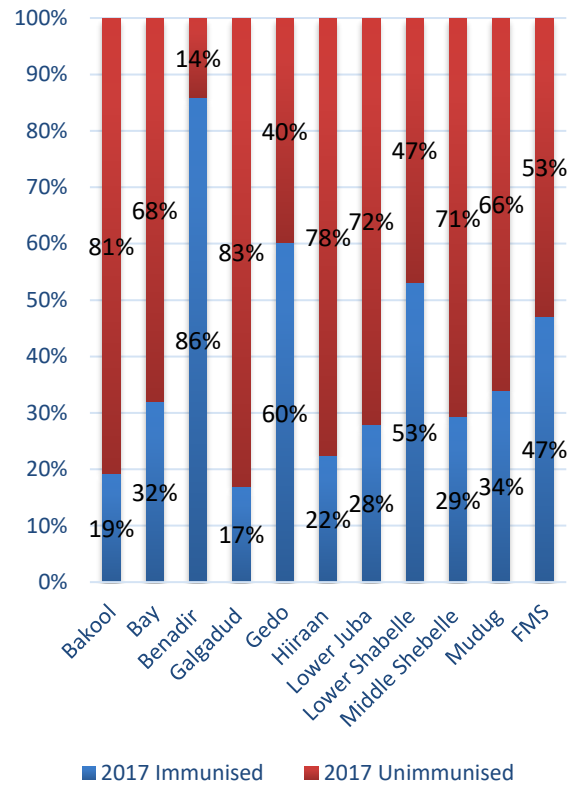
The increase in the vaccinated coverage was notable in 2018 and 2019, and this is attributable to the delivery of routine immunisation services through outreaches in the 10 Gavi-supported districts as shown in the graph below. In addition, the new vaccination centres that were established with the support of Gavi have also played a key role in reaching more children with vaccination services. Coverage in the non-Gavi supported districts experienced a marginal increase in coverage as compared to the Gavi-supported ones.

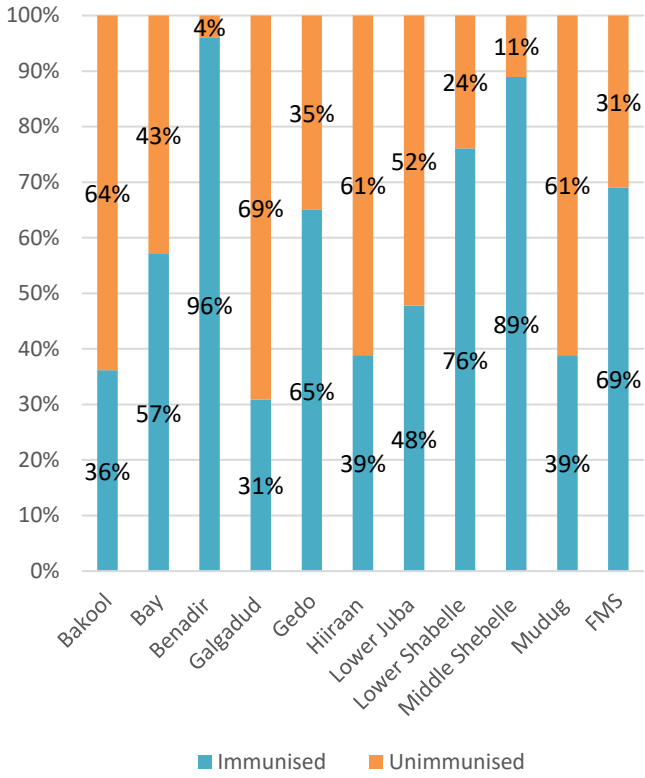


The increase in vaccination coverage has also contributed to a notable decrease in the penta1/penta3 drop-out in the FMS between 2017 and 2019. Sensitisation sessions in the health facilities and communities by health workers and community health workers has contributed to this decrease. Defaulter-tracing mechanisms are still weak in the country, and this remains a priority for the country to put in place strong mechanisms to ensure that more children are completing the vaccination schedule.



In terms of equity, Bakool (36%), Galgadud (31%), Hiraan (39%), Mudug (39%) and Lower Juba (48%) have the highest number of under-immunised children in the FMS. None of the districts in these regions are supported by Gavi. In addition, there are significant nomadic populations living in Bakool, Galgadud, Hiraan and Mudug regions.



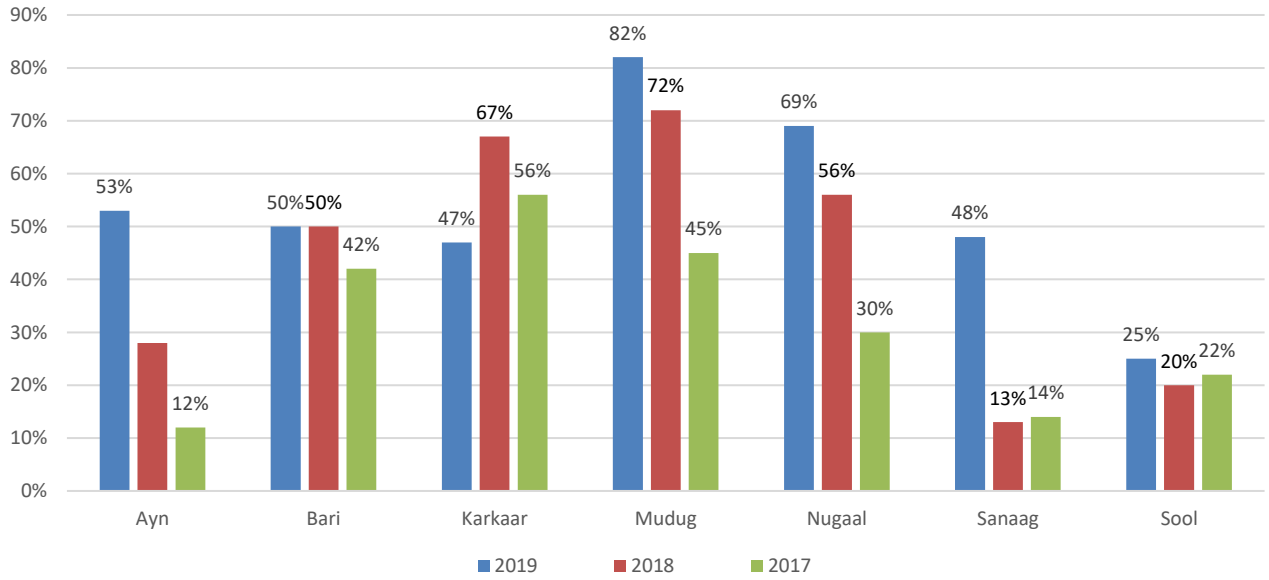


Comparison between penta 3 coverage between regions in 2017 (graph on the left) and 2019 (graph on the right). Data source: DHIS2.

In 2019, 76% of the districts reported a pentavalent 3 coverage less than 50% as compared to 64% of the districts in 2017. The decrease in performance is attributed to the lack of outreach services in non-Gavi supported districts, and therefore, most children are only vaccinated through the fixed strategy.

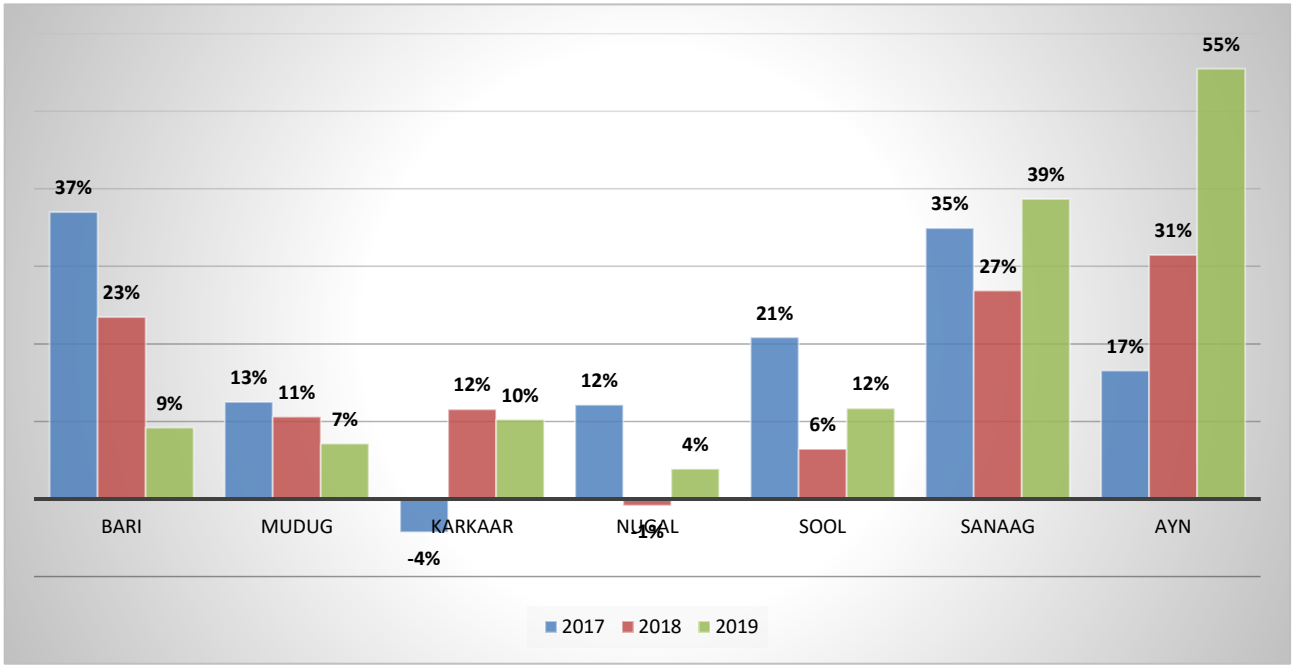
Puntland

Apart from Karkar, all the other regions in Puntland had an improvement in vaccination coverage from 2017 to 2019. Gavi supports 8 districts in Puntland which deliver routine immunisation services through fixed, outreach and mobile strategy that is implemented in 4 districts to track and vaccinate nomads.

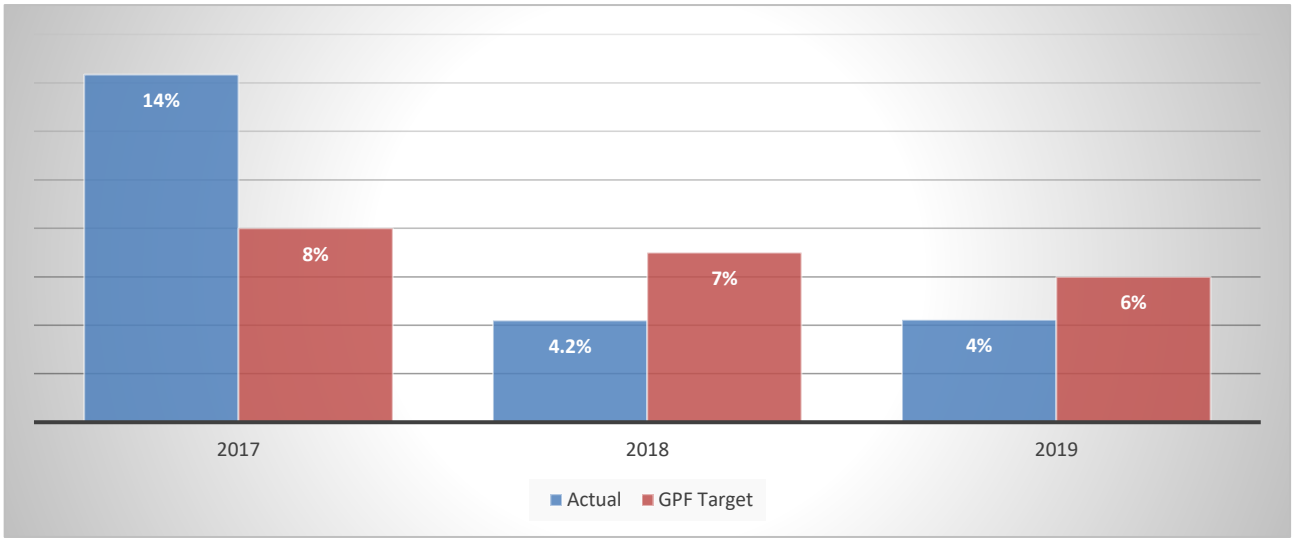


There was a reduction in the pentavalent 1/pentavalent 3 drop-out in all regions, apart from Ayn and Sanag which experienced an increase in the drop-out. It is noteworthy that these two regions are mainly inhabited

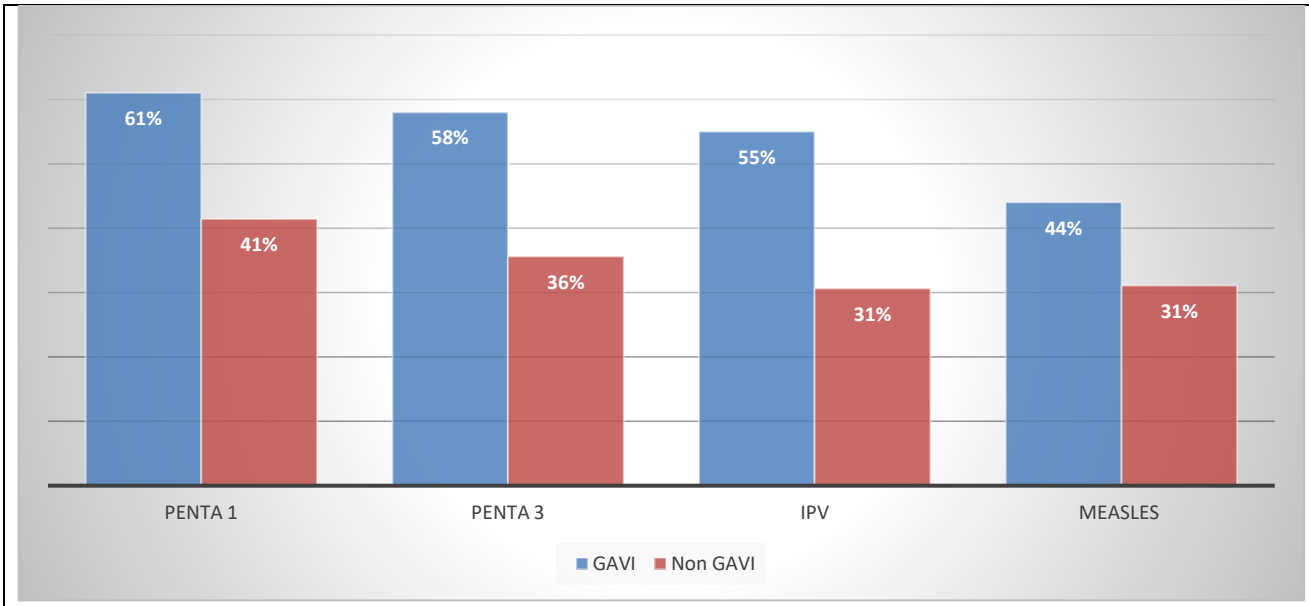
by nomadic communities and have experienced armed conflict due to territorial disputes, and thereby displacing families. There appears to be data quality issues in Karkar (2017) and Nugal (2018) where negative drop-out rates were reported.



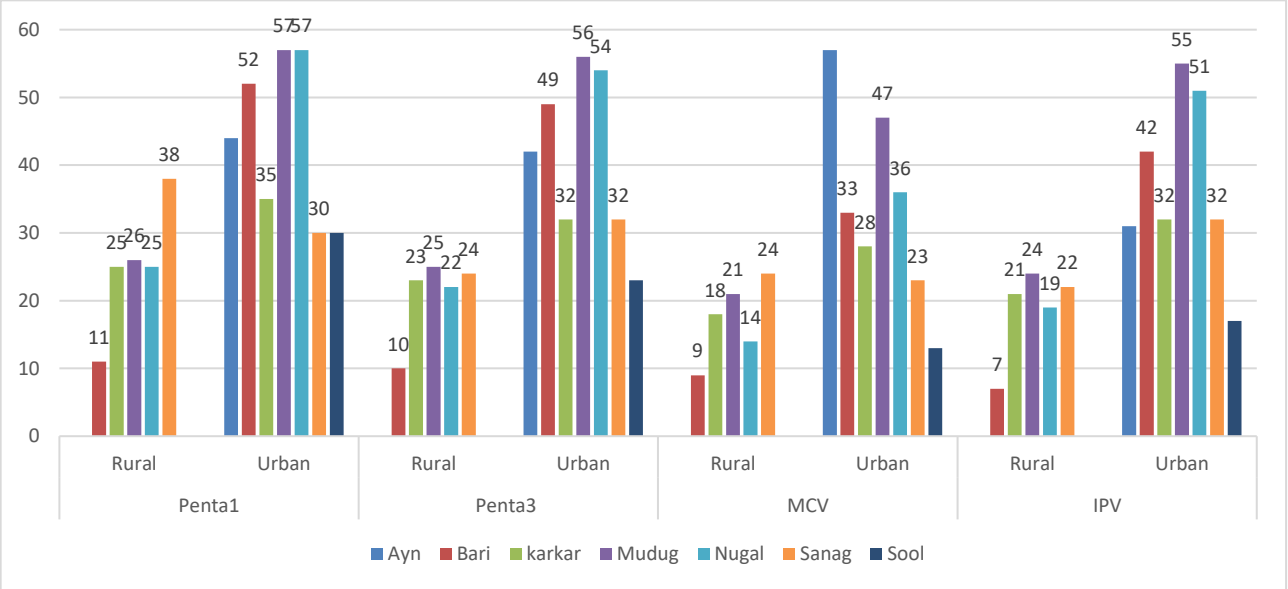
Puntland surpassed the drop-out rate as set in the GPF targets, as shown in the graph below. This is attributed to sensitisation conducted in the health facilities and communities, tracking and vaccination of nomadic populations and defaulter tracing through community health workers, community leaders and nomadic leaders.



As observed in the FMS, there was better performance in Gavi-supported districts for all antigens as compared to non-Gavi supported districts. This is due to the delivery of services through a multi-pronged strategy composed of fixed, outreach and mobile strategies in 8 districts of the State.

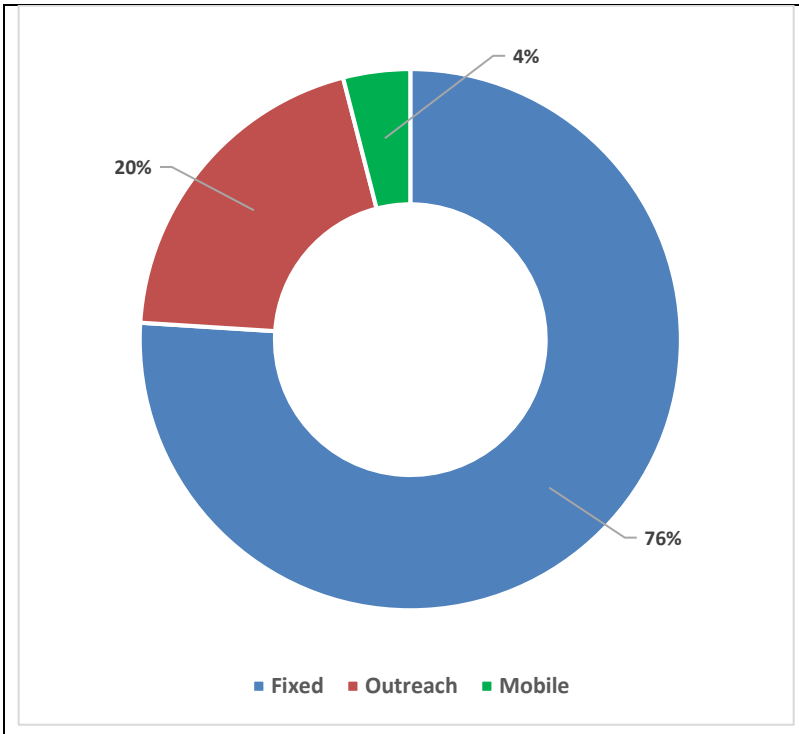


It was also observed that children living in urban areas were twice as likely to be vaccinated than children living in rural areas in the seven regions of Puntland. This is due to ease of access to health facilities and possibly better literacy rates in urban areas as compared to rural areas.



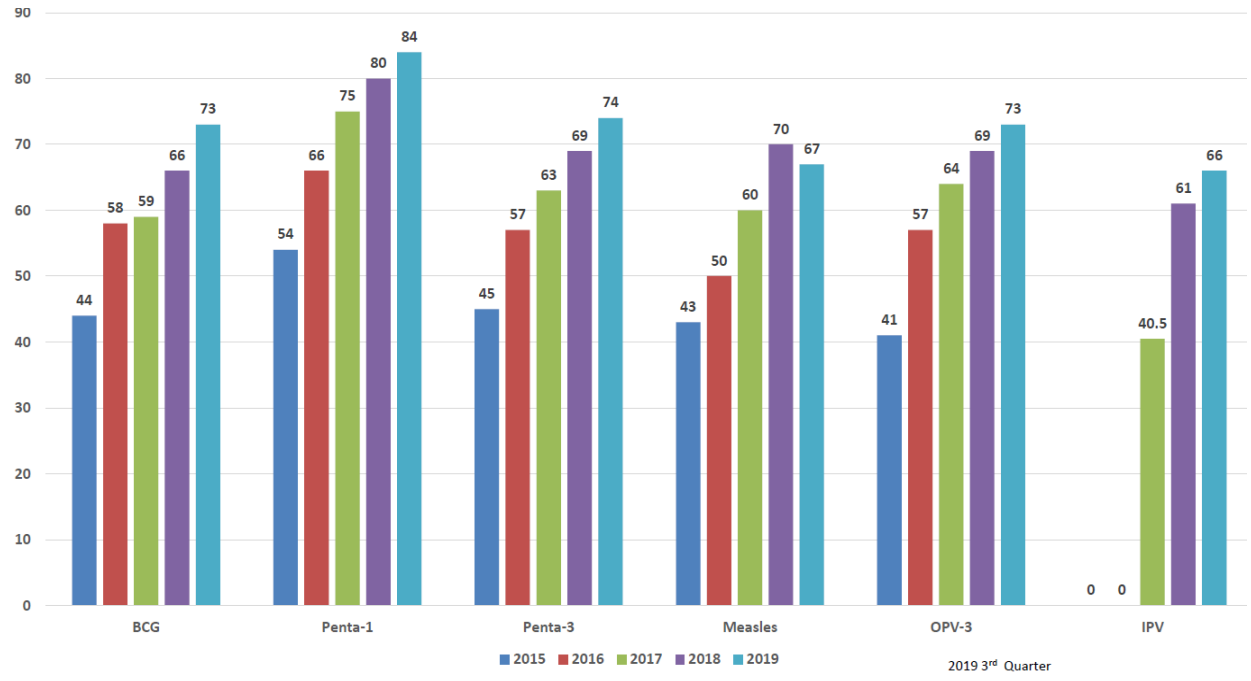
EPI Performance by Strategy in Puntland

76% of the children were vaccinated through fixed strategy, 20% through outreaches and 4% through mobile strategy. In terms of operational cost, the mobile strategy costed 32% of the overall allocated HSS2 funding disbursed to Puntland, 35% for outreaches, and 33% for fixed strategy, respectively. This shows that it is more expensive to reach nomadic populations who constituted only 4% of the vaccinated children in Puntland. However, due to the risk of vaccine preventable disease outbreak among nomadic populations, the investment in mobile strategy is worthwhile to vaccinate and confer immunity in this vulnerable group of children.



Graph showing EPI performance by strategy, Puntland State 2019. Data source: DHIS2 2019.

Routine Immunisation Performance in Somalia

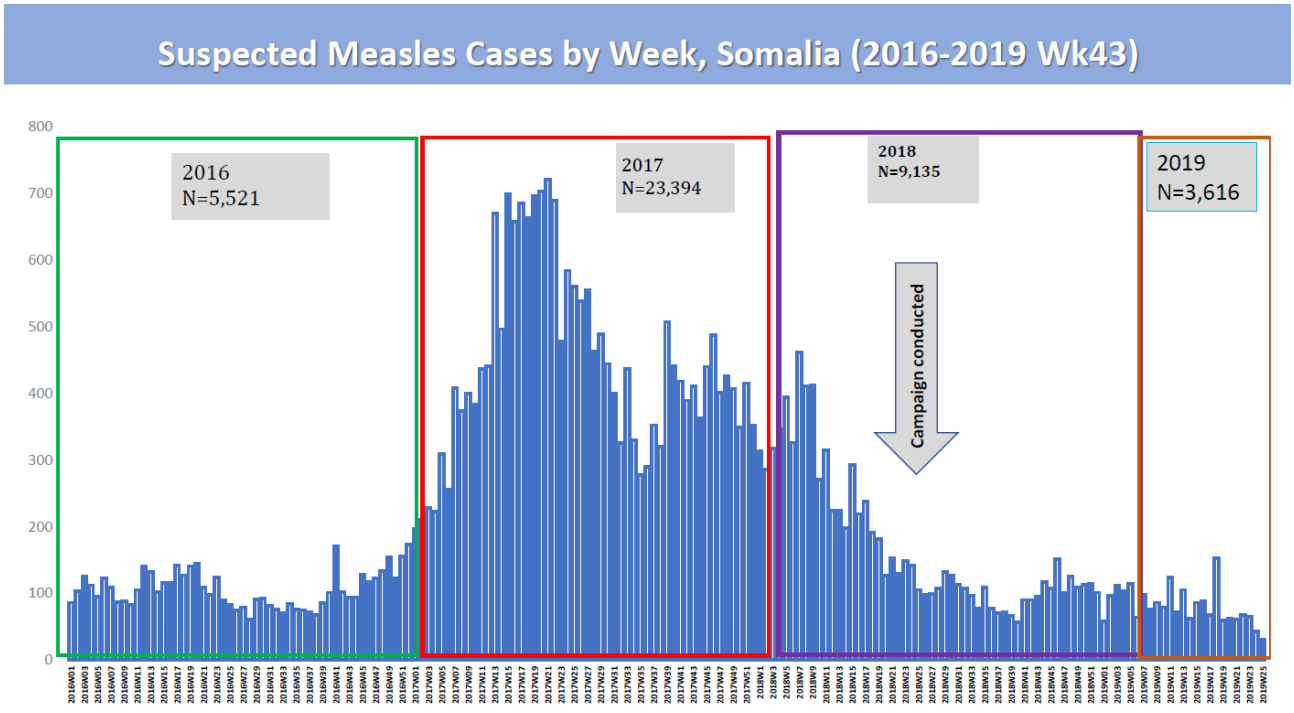


The trend of routine immunisation in the country has been on upward trend from 2015 to 2019. The pentavalent 3 coverage improved from 45% in 2015 to 74% in the third quarter of 2019. Likewise, the measles coverage improved from 43% in 2015 to 67% in the third quarter of 2019. Despite the initial hiccups experienced during the introduction of IPV, its uptake has improved from a low of 41% in 2017 to 66% in 2019. However, more sensitisation to mothers and health workers needs to be done in order to reduce the disparity between IPV and pentavalent 3 coverage that currently stands at 8%.

Disease Surveillance

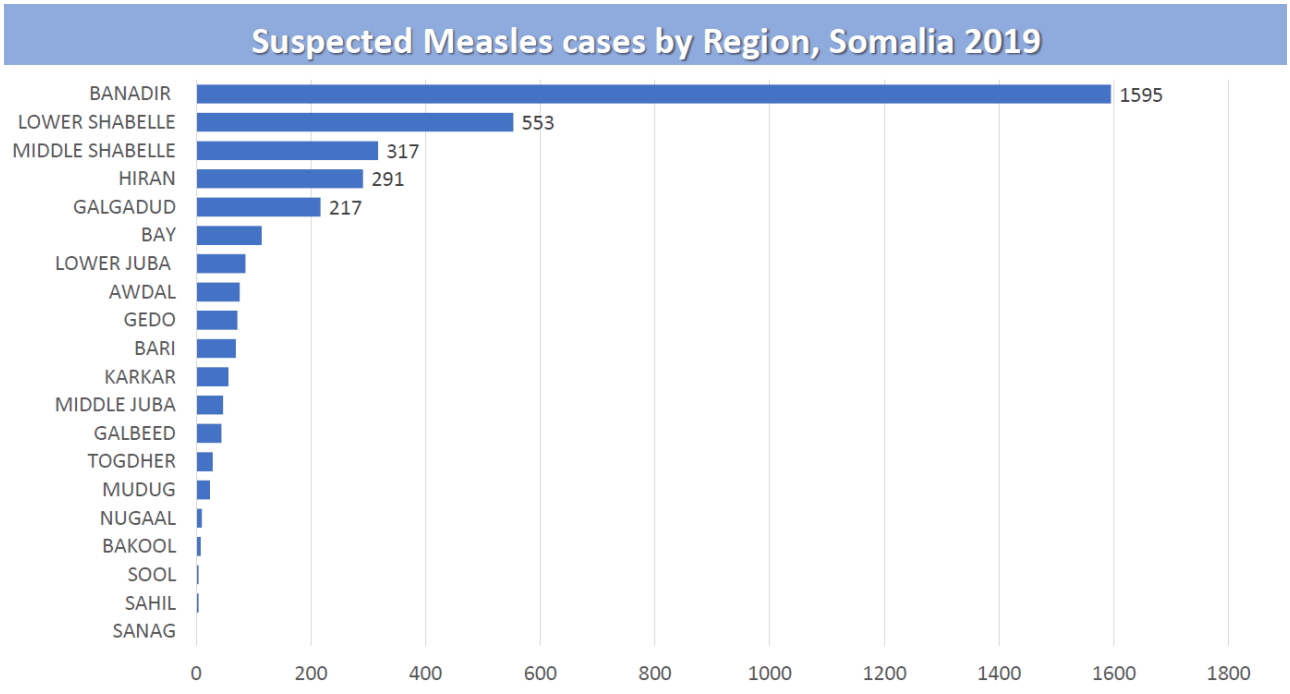
297 cases of AFP were reported in the first 43 weeks of 2019 and 4 cases of cVDPV2 were confirmed in Lascanod and Buhodle districts in Somaliland, and Bosaso and Efeyn districts in Puntland. Numerous rounds of polio campaigns were conducted in response to this outbreak targeting children 0 – 59 months.

3,616 suspected cases of measles have been reported in the country from January to week 43 of 2019. 78% of the suspected cases were in children below 5 years and the most affected regions are Banadir (1,595), Lower Shabelle (553), Middle Shabelle (317), Hiran (291) and Galgadud (217). These regions accounted for 81% of all suspected cases of measles in the country. 89% of blood samples had positive IgM when taken for laboratory confirmation (204/230).



Graph showing suspected cases of measles by week from 2016 to week 25 of 2019. Data source: weekly surveillance report, Somalia.

Note the reduction in suspected cases from Q2/2018 after a mass measles campaign was conducted in Q1/2018.



Graph showing the geographical distribution of suspected cases of measles in Somalia in 2019. Data source: weekly surveillance report Somalia.

The number of suspected cases reported in 2019 (3,616 cases) is lower than that reported during the measles outbreak in 2017 (23,394 cases) and 2018 (9,135 cases). The reduction in the number of cases is attributed to the effectiveness of the measles campaign that was conducted in Q1/2018 targeting children aged between 6 months and 10 years.

However, the presence of confirmed cases of measles in 2019 led to the decision of conducting an integrated measles campaign targeting 2.4million children aged 6 months to 59 months in all the districts of the country. This will be conducted in Q4/2019. The target children will also receive Vitamin A and for the first time, the country will integrate bOPV campaign into the measles campaign where 2.9million children aged 0 – 59 months will be targeted.

4.2. Key drivers of sustainable coverage and equity

*Briefly summarize the health system and programmatic drivers of the levels of coverage and equity based on the key areas listed below, **focusing on the evolution and changes since the last Joint Appraisal**. For those districts/communities identified as lower performing, explain the evolution of key barriers to improving coverage and improving programmatic sustainability.[7] If there are no updates, please indicate and provide rationale.*

- ***Health Work Force**: availability, skill set and distribution of health work force*
- ***Supply chain**: integration, procurement planning and forecasting, key insights from latest EVMs and implementation of the EVM improvement plan, and progress on the five supply chain strategy fundamentals.[8]This subsection might be informed by available dashboards and tools, for example the Immunisation Supply Chain Management Dashboard that links EVM, Maturity Scorecard and DISC (Dashboards for immunisation Supply Chain) indicators.*
- ***Service delivery and demand generation[9]**: key insights related to service quality improvement and community engagement strategies; access, availability and readiness of primary health care/immunisation services; integration and cost-effectiveness strategies; strategies on demand generation for immunisation services; immunisation schedules, etc.*
- ***Gender-related barriers faced by caregivers[10]**: Please comment on what barriers caregivers currently face in bringing children to get vaccinated and interventions planned or implemented (through Gavi or other funds) to facilitate access to immunisation services by women for their children. (For example: flexibility of immunisation services to accommodate women's working schedules, health education for women on the importance of vaccination and social mobilisation targeting fathers, increasing the number of female health workers etc.)*
- ***Data / Information system:** Strengths and challenges related to the immunisation data (routine data collection and reporting system, integration within the health information system, regular surveys, targeted surveys, quality of data, use of data. Links with the surveillance system). At national and at sub-national levels.*
- ***Leadership, management and coordination**: leveraging the outcomes of the Programme Capacity Assessment and/or other assessments, please describe the key bottlenecks associated with management of the immunisation programme. This includes the performance of the national/regional/district EPI teams/health teams managing immunisation (e.g. challenges related to structure, staffing and capabilities); use of data for analysis, management and supervision of immunisation services; coordination of planning, forecasting and budgeting, coordination related to regulatory aspects; and broader sectoral governance issues.*

[7] Relevant discussion questions on a number of the strategic areas here can be found in the programming guidance available on the Gavi website: http://www.gavi.org/support/process/apply/additional-guidance/

[8] More information can be found here: http://www.gavi.org/support/hss/immunisation-supply-chain/

[9] Programmatic guidance on demand generation https://www.gavi.org/library/gavi-documents/guidelines-and-forms/programming-guidance---demand-generation/

[10] For additional programmatic guidance refer to http://www.gavi.org/support/process/apply/additional-guidance/#gender. Gender-related barriers are obstacles (for access and use of health services) that are related to social and cultural norms about men's and women's roles. Women often have limited access to health services and are unable to take their children to get vaccinated. Barriers include lack of education, lack of decision-making power, low socio-economic status, women unable to move freely outside their homes, inaccessibility of health facilities, negative interaction with health workers, lack of father's involvement in healthcare etc.

- ***Other critical aspects****: any other aspect identified, for example based on the cMYP, EPI review, C&E assessment, PIE, EVM or other country plans, or key findings from available independent evaluations reports[11].*

To better understand and come up with solutions and recommendations, the participants of the Joint Appraisal were divided into groups so as to have in-depth discussions on the key drivers to sustainable coverage and equity in Somalia. The participants were divided into their areas of expertise in order to have maximum contributions. The participants were divided into 5 groups: health workforce; supply chain; health information system; leadership, management & coordination and service delivery, quality of service and demand generation.

i) Health Workforce

Key challenges	**Solutions/Recommendations**	**Required Technical Assistance**	**Timeline**
Service Delivery Level			
There is maldistribution of workers with more in urban compared to the rural areas. There is also no policy that stipulates the duration that one can serve in a particular area, thus demotivating staff posted in rural areas. There is no special incentive to retain workers in remote or rural areas.	-To support the Ministry in putting in place a posting/retention policy or review the existing policy -Institute special incentive package for staff working in rural and remote areas	No	Jan 2020
There are no SOPs on minimum standard of staff capacity.	The Ministry should implement the just ended SOPs on minimum standard staff capacity	No	As soon as possible
Very low or no remuneration (donor-driven)	-Advocate that health workers salaries are paid by the Government -A performance-based payment is introduced to motivate health workers and improve performance	No Yes	On-going Jan 2020
The capacity of the health workers in low	**-**The EPI programme should collaborate with the HR Division of the MoH to put in place a database of health workers The MoH should do a gap analysis of the health workers and develop a training plan through in-service training sessions, on-the-job training and the practical training manual (work book)		
Programme Management			
It was noted that there is low staff capacity for District, Regional, State and National	Training in MLM for this cadre of managers was recommended	Yes	

[11] If applicable, such as Full Country Evaluations (relevant for Bangladesh, Mozambique, Uganda and Zambia) and Technical Assistance evaluations (conducted for Gavi Partners' Engagement Framework tier 1 and tier 2 priority countries).

teams in terms of leadership, planning, supervision, coordination, evaluation skills and EPI supply chain management.			
-No payment for state staff -No supervision support to state official	• Advocate to government to support state officials • FMOH to delegate function to State Officials	Yes	Q1/2020

ii) Supply Chain

Key challenges	**Solutions/Recommendation**	**Required Technical Assistance**	**Timeline**
Some facilities offering EPI services have a shortage of equipment such as fridges.	These challenges will be addressed during the CCEOP implementation. However, in event that all facilities are not covered, we shall reassess and add these additional facilities to the new CCEOP application.		Q2 2020
There are no guidelines on the public disposal of assets such as cold chain equipment	The Ministry of Health should work with relevant Government departments/institution to establish a committee to develop the guidelines for disposal of public assets	Yes	Q2 2020
Transportation of RI vaccines from the district to the last mile remains a challenge as the Ministry did not honour its commitment to do so.	Partners should continue with advocacy on the need for the Ministry to fulfil their commitment, and also continue exploring alternative resources to address this activity.	No	
The country lacks a policy to guide the management of medical waste, inclusive of waste generated by the EPI programme.	To support the country, develop a waste management strategy for all medical waste and plan for its implementation	Yes. To develop the waste management plan	Q2 2020

Stock management – reporting on vaccine utilisation is weak	To avoid parallel reporting, the Country should seek advice on how to incorporate and harmonise the vaccine utilization into the DHIS 2	To be explored with Oslo University	Q1 2020
Vaccine stores at all levels lack space to store dry EPI supplies	The country should develop a proposal to mobilise resources to address the storage gaps	Yes, in-country TA	

iii) Health Information System

Key challenges	**Solutions/Recommendation**	**Required Technical Assistance**	**Timeline**
There are inadequate data collection tools such as registers, child vaccination cards, tally sheets, immunisation summary book, MCH supervision book, monitoring charts. This is a perennial challenge that the EPI programme faces.	Adequate resources to print and distribute adequate immunisation tools should be mobilised.	No	Continuous
Health workers lack capacity to complete, analyse and make decisions based on the monthly activity reports. There are also data quality issues across all levels	Capacity building of health workers on data collection, analysis and quality should be conducted during on-the-job training and supervision	No	Continuous
Apart from districts supported by the SHINE programme, there are no dedicated HMIS Officers at the district level. This will also enable the scaling-up of DHIS2 to the district level	Efforts should be made to put in place HMIS Officers at district level and capacity build them	No	
Denominator challenge at regional and District level (More political	There is need to bring together all stakeholders (administrative, community, political		

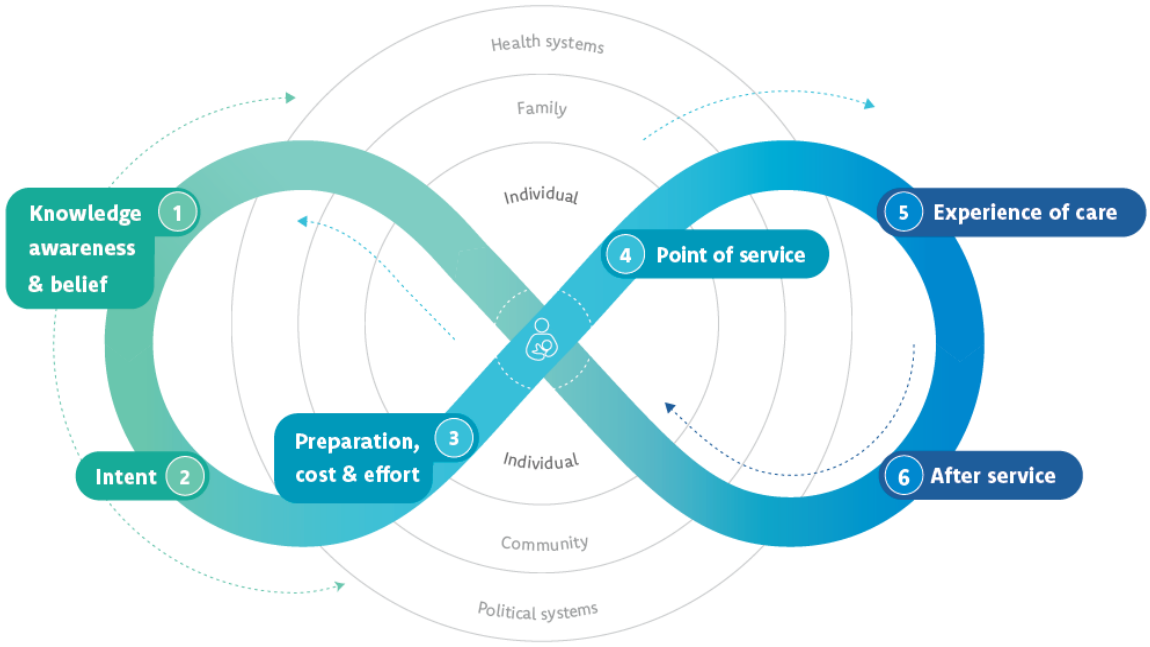
than community services) The question of denominator remains a long-standing challenge that is beyond technical/programme.	etc) to consultative workshops to discuss and agree on this question		
There is limited or no data quality assessment	Periodic data quality assessment should be conducted and the DQIP proposal should be finalised and submitted to Gavi.		October 2019
No EPI Coverage survey conducted	Coverage survey		
There is no logistical support for the collection and transportation of samples for laboratory confirmation of suspected VPDs	This should be integrated with the existing surveillance system, such as for polio and SOPs to guide this should be developed by the MoH		

iv) Leadership, Management and Coordination

Key challenges	**Solutions/Recommendation**	**Required Technical Assistance**	**Timeline**
The ICC have been established but are still weak. There are also areas that need more clarity such as the composition, ToR, mandate and role & responsibilities.	The ICC should be strengthened, whereas ToRs and mandates should be reviewed to better reflect the different needs/realities of the regions.	No	Q4/2019
There are weak coordination mechanisms at the State level between the MoH, NGOs, private sector and UN agencies.	Coordination mechanisms at the State level should be strengthened/established and their capacities built. ToR to guide these coordination mechanisms should also be developed/reviewed and harmonised.	No	Q4/2019
District management/EPI teams are only functional in 25% of the districts in the country.	District teams should be established in the other districts and should be composed of the DMO, DSMC, EPI Officer, HMIS and PHC Officers. To cultivate a culture of performance, a		Q1/2020

These districts are supported by Gavi under HSS 2 support	performance-based financing and reward system should be put in place.		
The absence of the MoH from Somaliland was noted as a gap in the JA	High-level management of the FMoH and partners to meet with the Somaliland Health team and define the way forward	Minister of Health and WHO, UNICEF and other development partners.	Q4/2019

v) Service Delivery, Quality of Services and Demand Generation



Key challenges	Solutions/Recommendation	Required Technical Assistance	Timeline
Data availability			
Lack of qualitative data to inform planning in urban settings	Formative research undertaken in selected areas to understand underlying causes of low vaccine uptake	Yes. Consultant	2020
Knowledge, awareness and beliefs			
Low health literacy	-Reinforce training and supportive supervision of front-line workers	Review of checklist	2020

	-Quarterly review of outreach plans, that include targeted communities -Include health education in vaccination sites	Funds for supportive supervision, trainings and review of outreach plans	
Low linkages between service and demand			
-No link between communities and facilities due to lack of CHW (some health facilities do not have CHW, other facilities CHW are doing non-integrated vertical job) -Low defaulter tracing -Competing priorities due to scarcity	- Enabling environment: • Strengthening of cross-ministerial platforms • Joint planning of EPHS package is implemented by all partners, aligned with the national strategy -Reinforcement of Community platforms: • Enhanced used of women community health workers (i.e.: DFID-funded pilot in 8 districts across the country) • Increased involvement of renowned and trusted Polio community workers in RI • Increased partnerships with religious leaders / red crescent volunteers • Increased involvement of community elders and other gatekeepers	-Funding for coordination mechanisms -Funding for engaging community focal persons and increase community workers task-force -Funding for high-level advocacy -Funding for polio transition -Funding for partnerships with religious leaders, CSOs,	2020-2021
Availability of Services			
-Catchment area – Health workers do not know how many children have been immunized (lack of integration with other services such as nutrition) -Same areas regularly missed because they are new – where to go for care? -Lack of trust in health services	-Increased outreach -Promote health facility-centered demand promotion activities to improve defaulter tracking -Reinforce training and supportive supervision of front-line workers, SOP / Check-lists that include clinical and SBCC competences of HW -Involvement of community in: 1. planning and monitoring of service delivery, 2. review meetings of data, 3. Implementation, regular review and update of micro-plans	-Funding for community outreach sessions -Funding for demand promotion activities at health facility -Funding for training, supportive supervision -Funding for participative review meetings, including micro-plans	2020-2021

-High turnover of qualified staff **Quality of care** -Distress at health facility, non-reliability of accessible services -Catch up – children no longer in the age group so no vaccinated -Social distance -Lack of convenience of services -Service delivery: health workers overwhelmed, they collect data but do not know how to use it, defaulters tracing systems are not there, no supportive supervision -High non-assisted home deliveries, therefore lack of birth dosing and TT vaccine amongst mothers	-Institutionalization of preventive health services, interpersonal communication and SBCC in mainstream curricula to ensure that new staff have sufficient/basic skills -Promote community feedback mechanisms	-Consultancy to review the curricula content (preventive health services, interpersonal communication and SBCC) and advise on integration with other health and nutrition packages	2020-2021

4.3. Immunisation financing[12]

Please provide a brief overview of the main issues affecting the planning, budgeting, allocation, disbursement and execution of funds for health and immunisation. Please take the following aspects into account:

- ***Availability of timely and accurate information for planning/budgeting (e.g. quantification of vaccine needs** and pricing data), availability of **medium-term** and **annual immunisation operational plans and budgets**, whether they are integrated into the wider national health plan/budget, their relationship and consistency with microplanning processes and how they are reflected into national health financing frameworks.*
- ***Allocation of sufficient resources in national health budgets for the immunisation programme/services**, including for Gavi and non-Gavi vaccines, as well as operational and service delivery costs. Discuss the extent to which the national health plan/budget incorporates these costs, which partners might be providing funding for traditional vaccines, and any steps being taken to increase domestic resources for immunisation. If any co-financing defaults occurred in the last three years, describe any mitigation measures that have been implemented to avoid future defaults.*
- ***Timely disbursement and execution of resources:** the extent to which funds for immunisation-related activities (including vaccines and non-vaccine costs) are made available and executed in a timely fashion at all levels (e.g., national, province, district).*

[12] Additional information and guidance on immunisation financing is available on the Gavi website https://www.gavi.org/support/process/apply/additional-guidance/#financing

- ***Adequate reporting*** *on health and immunisation financing and timely availability of reliable financing information to improve decision making.*

The immunisation programme in Somalia is highly-dependent on external funding for the procurement of traditional and new vaccines, operational costs and the payment of incentives/allowances for workers at all levels of the pyramid. The annual forecasting of vaccine needs is conducted in Q2/Q3 of each year and is led by the UNICEF Country Office. UNICEF Supply Division provides support to procure and ship vaccines to the Cold Chain Store in Nairobi, before onward distribution to the 3 cold chain stores in Mogadishu, Garowe and Hargeisa.

Gavi through its new vaccine support (NVS) supports the country to procure new vaccines, namely pentavalent and IPV. On the other hand, UNICEF procures traditional vaccines; TT, measles and BCG. In line with the global shift, UNICEF is supporting the country to switch from TT to Td vaccine.

Health facilities report on the number of children vaccinated, but there are challenges in reporting vaccine utilisation as this is not captured in DHIS2. Participants in the supply group of the 2019 Joint Appraisal recommended that vaccine utilisation reports are integrated into DHIS2 to remedy the situation.

Co-financing requirements have been met by UNICEF since the last three years. Gavi continues to advocate to the Government on increasing domestic funding for health.

5. PERFORMANCE OF GAVI SUPPORT

5.1. Performance of Gavi HSS support (if country is receiving Gavi HSS support)

Provide a succinct analysis of the performance of Gavi's HSS support for the reporting period.

- ***Progress of the HSS grant implementation*** *against objectives, budget and workplan, and significant deviations from plans (e.g. implementation delays, low expenditure rates, etc.),* ***using the below table****.*

Objective 1	
Objective of the HSS grant (as per the HSS proposal or PSR)	**Expand and strengthen availability of routine immunisation services**
Priority geographies / population groups or constraints to C&E addressed by the objective	There are 5.7million people inhabiting the 25 Gavi-priority districts in Somalia, constituting 45% of the total population in the country. The State-specific coverage is projected at Puntland 1.5 million (74% of total population), Somaliland 1.9 million (60% of total population) and Federal Member States 2.1 million (30% of total population). The beneficiary population includes: 0.22 million new-borns (0.20 million surviving infants) and 0.29 million women of child bearing age. Nomadic population constitutes approximately 25% of the total population and they are available in 24 out of the 25 priority districts. In 18 priority districts, IDPs are living in IDP camps near cities or big towns (Puntland-6, Somaliland-2 and Southern States-10). The districts being supported with a full package of immunisation services are: Bosaso, Qardho, Galdogob, Galkayo-PL, Jariban, Burtinle, Dangorayo, Garowe in Puntland; Gabiley, Hargeisa, Bali Gubadle, Laascaanod, Hudun, Badhan, Burao in Somaliland; and Balcad, Jowhar, Afgooye, Baraawe, Kurtunwaarey, Marka, Qoryooley, Wanla Weyn, Baidoa, Buur Hakaba in the Federal Member States.
% activities conducted / budget utilisation	100% of the planned activities in this objective have been conducted; • Establishing and providing immunisation services in new immunisation centres in Regional Hospitals; 3 FMS, 5 Puntland and 1 in Somaliland • Establishing and providing immunisation services in new immunisation centres in District Hospital; 6 FMS, 8 Puntland and 3 in Somaliland • Establishing and providing immunisation services in new immunisation centres in MCH; 21 FMS and 15 Puntland • Supporting the delivery of immunisation services through outreaches; 21 MCH in FMS, 19 MCH in Puntland and 36 MCH in Somaliland • Support the tracking and vaccination of nomads in 4 districts of Puntland

	87% of the allocated budget has been utilised (726,340 USD/834,182 USD for UNICEF supported activities. The remainder is for the payment of incentives for health workers, especially in the FMS where there was a delay in implementation in 2018.
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	Routine immunisation services are being provided in the fixed and outreach sites in the 25 priority districts. Qualified nurses are receiving monthly incentives to provide the services. In the outreaches, community health workers provide the link with the community to sensitise and mobilise mothers/caregivers to have their children vaccinated. On the day of the outreach activities, the community health workers are also incentivised through the support of Gavi. 15,303 children aged under 1 year received Penta 3 in the 3 zones through outreaches in 2018 (6,321 – SL, 1,596 – FMS and 7,386 PL, respectively) compared to 1,721 children reached through the same strategy in 2017 (1,035 – SL, 666 – FMS and 20 – PL, respectively). This shows that more children are receiving vaccination services through Gavi support in the 25 priority districts. Under targeted and non targeted HSS2 project, 69 District EPI micro-plans based on RED/REC strategy has been developed in the three zonal ministries of health in Somalia. (In Somaliland (17 district) and Puntland (30 districts) while in SCZ (22 districts micro plans) has been developed. Financial resources covered for the establishment of EPI micro plans is partially charges under HSS2 program while the remaining costs has been covered from the 2018 PEF grant.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**[13]	Vaccination services will continue to be offered through fixed and outreach strategies in the 25 districts, as well as mobile services targeting nomads in 4 districts in Puntland. 16 districts in south central zone still have no EPI micro plans, due to security concerns or inaccessibility and shortage of the required resources. Tthe implementation of the EPI micro plans especially the outreach services are planned for upcoming period.
Objective 2	
Objective of the HSS grant (as per the HSS proposal or PSR)	**Enhance the physical capacity and effective management of cold chain and logistic system**
Priority geographies / population groups or constraints to C&E addressed by the objective	Same as objective 1
% activities conducted / budget utilisation	100% of the planned activities have been conducted. 83.8% of the budget (2,025,787USD/2,416,942USD) has been utilised.
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	Incentives for cold chain staff were paid regularly through the MoH in Puntland & Somaliland, and through the implementing partners in the FMS. These cold chain staff are responsible for the day-to-day management of the cold chain stores, distribution of vaccines to the districts and facilities, reporting and repair & maintenance of cold chain equipment. The vaccine supply chain management is on-going where vaccines are distributed from Nairobi on a quarterly basis to the 3 cold chain stores in Mogadishu, Garowe and Hargeisa based on consumption. Distribution to the regional and district stores is on a monthly basis. Health facilities collect vaccines from the district vaccine stores on a monthly basis. The situation on the CCEOP is captured in the section on CCEOP.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**[13]	The main activity for the upcoming period is the arrival and installation of cold chain equipment under the CCEOP.

Objective 3:	
Objective of the HSS grant (as per the HSS proposal or PSR)	**Increase demand for immunisation services**
Priority geographies / population groups or constraints to C&E addressed by the objective	Same as objective 1
% activities conducted / budget utilisation	100% of the planned activities have been conducted and 258,290 USD has been utilised for the implementation of this objective.
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	Advocacy meetings have been going on a quarterly basis with influential religious and administrative leaders at the district level. DSMCs and social mobilisers have also been conducting monthly meetings with women groups, community and religious leaders in their catchment areas, in order to advocate for routine immunisation. Awareness raising was also carried out through TV, radio and social media in the FMS. IEC materials were also distributed to raise awareness on routine immunisation. However, due to gaps in funding, awareness raising on TV and radio halted in the FMS. Health workers were trained on IPC skills in order to improve their communication skills and relations with mothers/care-givers.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**[13]	Sensitisation meetings will continue in the priority districts through community dialogue meetings and in meetings with influential leaders at the district level.
Objective 4:	
Objective of the HSS grant (as per the HSS proposal or PSR)	**Strengthening immunisation programme leadership, management and coordination**
Priority geographies / population groups or constraints to C&E addressed by the objective	Same as objective 1
% activities conducted / budget utilisation	100% of the planned activities were implemented and 79% of the allocated budget was utilised (807,680 USD/ 1,027,200 USD).
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	25 district teams and 9 regional teams are functional in Puntland, FMS and Somaliland. These teams conduct quarterly supervision of MCH and coordinate EPI activities in their regions and districts. These teams receive monthly incentives through the support of Gavi. Inter-agency Coordination Committees have been established in all the three zones, each ICC composes fifteen to twenty members from MOH, MOE,MOF,MOR, MOW affairs, SMA, Private sector, NGOs, Unicef and WHO, the EPI Managers are selected to chair while HSS focal person as a secretory. The orientation for ICC has been facilitated by zonal EPI/HSS team, the ICC meetings has been conducted on quarterly basis, so far MCV2 introduction and Measles Control strategy has been endorsed by this forum, In the future, further orientation and translation of their roles/terms of References is required to improve the core role of ICC coordination, it was also advised to review the composition and to reduce the membership from 20 to 15 particularly south central zone. EPI working groups has been conducted as planned or on monthly basis, the working group is attended by all the EPI partners including NGOs and

[13] When specifying Technical Assistance (TA) needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning. The TCA planning will be informed by the needs indicated in the JA. TA needs should however describe - to the extend known to date - the type of TA required (staff, consultants, training, etc.), the provider of TA (core/expanded partner) the quantity/duration required, modality (embedded; sub-national; coaching; etc.), and any timeframes/deadlines. JA teams are reminded to both look back (TA which was not completed/successful in the past) and forward (planned vaccine introductions, campaigns, major upcoming HSS activities, etc.) when specifying TA priorities for the coming year. The TA menu of support is available as reference guide.

	UN agencies, the working group meeting has become very regular, informative and helpful due to embedded technical assistances to the ministry of Health. 14 professional members have been contracted and fixed to already existed MOH structures the three zonal ministries four for Somaliland five for Puntland and 5 for south central zone, these are intended to provide technical assistance and policy advice to the Ministry of Health. The Technical Assistance that embedded to MOH have made substantial contribution to the strengthening institutional capacity and EPI related policies particularly in the areas of capacity building and training facilitation, support supervision and report writing.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**[14]	Quarterly supervision of EPI services delivery in the MCH, district and regional hospitals will continue. In addition, a measles SIA will also be conducted, and these regional teams will play an important role in the planning, implementation, monitoring and supervision of the SIA.
Objective 5:	
Objective of the HSS grant (as per the HSS proposal or PSR)	**Improve data availability, quality, analysis and use**
Priority geographies / population groups or constraints to C&E addressed by the objective	Same as objective 1
% activities conducted / budget utilisation	50% of the planned activities have been implemented, namely the printing of various data collection tools. 100% of the allocated budget has been utilised.
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	Various data collection and monitoring tools were printed and distributed to the health facilities providing immunisation services. These tools include child passports, vaccine monitoring charts and EPI registers. Due to the high cost of printing child passports in Somalia, the available budget in the HSS2 grant is not able to cover the annual needs of this important tool. Cognisant of this fact, the Ministry of Health in Puntland began revising the child passport so that they would come up with a cost-effective document that can be sustained. An operational research on on-going HSS2-suported activities to generate evidence, best practices, critical feedback and lessons learnt so as to improve the programme was not carried out. During the 2019 JAR, it was decided that the amount allocated for this activity should be used for social mobilisation and defaulter tracing. Joint supportive supervision visits was conducted in all zones on quarterly basis and the main purpose of the supervision was to monitor program performance of the health facilities, technical support through on the job training and EPI data verification using the three data source of EPI register, EPI monthly summary reporting register and DHIS2. Initially, EPI supervision check list has been developed as discussed and approved during the EPI working group meeting, the checklists captured all components including C4D, Cold chain, Human resource, EPI Monitoring and data recorded vs reported. The supervision visits targets MCHs which are identified in the working group meeting and special consideration is given to the facilities based on

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	their low/higher coverage these supervision visits covered both priority and non HSS2-target districts. The supervision teams observed that there are discrepancies between different data sources and necessary guidance and feedback has been shared to all concerned and presented during the review meeting occasions when all EPI managers are on board. WHO has facilitated a periodic EPI reviews to assess and understand if the planned EPI services are taking place and producing the intended results, the EPI reviews has been conducted in three levels, the district , regional and zonal in which all the review meetings discussed on the performance/ coverages and strategies and development of plans and identifying major barriers hampering the accomplishment of services planed and as well focusing more on the low performing districts and facilities to improve services and lessons learnt approaches. For successful review a standard template has been shared to district/regional management teams for presentation of EPI review and to simplify/unify the discussion points, summarize the outcome and action points of the EPI review. The EPI reviews at district, regional and zonal levels has not been limited to HSS2 priority districts but covered the most of districts to have wider experience sharing, lessons learnt from all the EPI services from different situations and avoid only focusing only on certain areas with support. The EPI reviews has been participated by the regional and district Management teams established including EPI, Cold chain, HMIS officers, District EPI officers and heath facility teams leaders to update at facility and service delivery points, the ICC established have been invited to participate to get update and orientation of the services to be coordinated. These review meetings gave opportunities to regional and district teams to take the lead of immunization program at their level and provide quick response and support to the health facility staff and have great understanding their immunization service performance
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated **changes in technical assistance**[15]	

In the text box below, briefly describe:

- ***Achievements against agreed targets*** *as specified in the grant performance framework (GPF), and key outcomes. E.g. how does the number of additional children vaccinated and under-immunised children in districts supported by the HSS grant compare to other non-supported districts/national targets. Which indicators in the GPF were achieved / impacted by the activities conducted?*
- *How Gavi support is* ***contributing to address the key drivers of low immunisation*** *outcomes?*
- *Whether the* ***selection of activities is still relevant****, realistic and well prioritised in light of the situation analysis conducted, as well as financial absorption and implementation rates.*
- *Planned* ***budget reallocations*** *(please attach the revised budget, using the Gavi budget template).*
- *If applicable, briefly describe the usage and results achieved with the* ***performance based funding*** *(PBF) the country received. What grant performance framework (GPF) metrics will be used to track progress?*

[15] When specifying Technical Assistance (TA) needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning. The TCA planning will be informed by the needs indicated in the JA. TA needs should however describe - to the extend known to date - the type of TA required (staff, consultants, training, etc.), the provider of TA (core/expanded partner) the quantity/duration required, modality (embedded; sub-national; coaching; etc.), and any timeframes/deadlines. JA teams are reminded to both look back (TA which was not completed/successful in the past) and forward (planned vaccine introductions, campaigns, major upcoming HSS activities, etc.) when specifying TA priorities for the coming year. The TA menu of support is available as reference guide.

- ***Complementarity and synergies with other donor support*** *(e.g. the Global Fund, Global Financing Facility)*
- ***Private Sector and INFUSE[16] partnerships*** *and key outcomes (e.g. increasing capacity building and demand, improving service delivery and data management). Please outline the sources (e.g. Private sector contributions, Gavi matching Fund and Gavi core funding – HSS/PEF) and amount of funding.*
- ***Civil Society Organisation (CSO) participation*** *in service delivery and the funding modality (i.e. whether support provided through Gavi's HSS or other donor funding).*

(i)Private Sector Partnerships

- Federal Member States (FMS)

The FMoH is already engaging the private sector in providing routine immunisation services in Mogadishu City/Banadir Administration. 15 private hospitals are currently engaged and are providing the services. The FMoH provided cold chain equipment, regular EPI supplies to conduct immunisation sessions and training of health workers on immunisation practices. On their part, the private facilities are providing monthly activity reports through DHIS. The EPI services are provided free of charge. The private facilities are in Mogadishu City and Lower Shabelle Region.

An MoU was signed between the FMoH and the private facilities that are currently engaged. As part of this MoU, the FMoH and Regional MoH conducts supervision to monitor on the quality of services provided and also to conduct on-the-job training to health workers, where necessary. The FMoH plans to engage additional private facilities in other States so as to increase the coverage of private facilities providing EPI services in urban areas. The list of private facilities that are currently providing EPI services in Banadir/Mogadishu and have MoU with the FMoH are Atlantic Hospital, Yardimeli Hospital, Somecare Hospital, Baybook Hospital, Erdogan National Hospital, Figi Private Hospital, Kalkal Hospital, Somali Sudanese Hospital, Abu Bashir Hospital, Duco Hospital, Hawa Abadi Hospital, Jazeera Hospital, Bidey Hospital and Uma Hospital.

- *Puntland*

The MoH in Puntland plans to collaborate with 2 private facilities to provide routine immunisation services in Bossaso town under the urban immunisation strategy, namely Hayat and Daryeel Clinics. The MoH will put in place an MoU with the facilities, train the health workers on vaccination, provide cold chain equipment, vaccines and non-vaccine supplies and monitor the quality of services. The facilities will offer vaccination services on a daily basis and provide monthly reports to the Bossaso District EPI Team, for integration into DHIS2. In addition, the private sector will not charge fees for the provision of routine immunisation services.

The MoH also plans to designate the two private clinics as surveillance sites that will help monitor and report VPD diseases. To do this, the MoH will train staff on case detection, reporting and will provide the required resources with the support of WHO.

- *Somaliland*

UNICEF, Ministry of Health Development (MoHD) and Somaliland Medical Association (SMA) commenced an initiative to provide immunisation services in private hospitals. A total of 12 private hospitals were selected in 2017. The current distribution of the 12 private hospitals is; Hargeisa district (8 facilities), Burao district (2 facilities) and Boroma district (1 facility). The names of the private facilities are *(Hargeisa)*-Edna Hospital, International Hospital, Gargaar Hospital, Kaah Hospital, Daloodho Hospital, Hormood Clinic, Arab Union Hospitals, Daloodho Hospital, MAS Hospitals; Mahdi Paediatric Hospital *(Burao)*- Manhal Hospital, DaruHanan Hospital and *(Boroma)*- Hayaat Hospital. The MoHD will develop MoU with these 12 private facilities and add eight others which have the potential to provide RI service. The MoHD will provide vaccines, cold chain facilities and other EPI supplies, conduct monitoring visits, invite the private facilities to attend periodic programmatic reviews and provide data tools for EPI. On their part, the private facilities will provide the vaccination services at no fee. However, they may charge a minimal fee for administrative purposes. They will also send the monthly reports for integration into DHIS2. The SMA will continue to be the link between the private hospitals and the UNICEF/MoHD. The Coordinator of the Private Hospitals Consortium is a member of the ICC and will also facilitate the RI implementation in the private facilities.

[16] INFUSE was launched by the Gavi Alliance to help bridge the gap between the supply and demand side for new technologies and innovations and to create a market place for these innovations.

(ii) NGO Involvement

UNICEF is supporting cold chain activities in the Federal Member States through NGOs partners that operate the cold chain stores at the national, regional and district levels. Currently, implementation of Gavi HSS2-supported activities such as the provision of vaccination services in the new immunisation centres located in the MCH, district and regional hospitals is done through local NGOs in the Federal Member States.

These NGOs also provide outreach services in the catchment areas of the MCH. The NGOs were selected and contracted by UNICEF as they are also delivering other primary health care services as well as other basic services such as WASH and child protection in the same areas/districts where there are Gavi-supported activities. This means that GAVI support is integrated with the other health and WASH interventions that are provided by these NGOs. They are currently providing services across the FMS, including Gavi-supported districts in Bay, Middle and Lower Shabelle Regions.

UNICEF is also engaging local and international NGOs in the implementation of other programmes such as the essential package of health services (EPHS), nutrition and emergency programmes across the country. Therefore, there is a strong engagement of NGOs in Somalia in the delivery of health programmes, including routine immunisation.

In Puntland, the MoH manages the overall public health facilities including the cold chain centres in health facilities, districts, regions and at the zonal level. The MoH has a Letter of Agreement (LoA) with each local and international NGO in Puntland stipulating the terms of engagement and working modalities between the parties. NGO partners also deliver other integrated primary healthcare services as well as other basic services such as WASH, nutrition and child protection in the same areas/districts where there are Gavi-supported activities.

In Somaliland, immunisation services are provided by Government-supported health facilities (which is currently supported by GAVI HSS2 grant in the selected districts) and both local and international NGOs. All the NGOs are approved by the Government (MoHD) through a Letter of Agreement (LOA) to operate in Somaliland. UNICEF contracts these NGOs to implement programmes through short term projects lasting a maximum of 2 years. The UNICEF-supported programmes offer integrated health and nutrition service where immunisation services are provided through fixed, outreach and mobile sessions.

On the other hand, UNICEF and the World Bank have identified an opportunity to support the Somali health system through developing guidance on PPPs, the strategic guidance and tools will be important for establishing PPP models, with a specific focus on contracting between the public and private sectors for the delivery of health services such as immunization services.

5.2. Performance of vaccine support

*Provide a succinct analysis of the performance of Gavi vaccine grants, focusing on **recently (i.e. in the last two years) introduced vaccines,** or planned to be introduced vaccines, **and campaigns**, supplementary immunisation activities (SIAs), demonstration programmes, MACs etc., as well as switches in vaccine presentations. This section should capture the following:*

- ***Vaccine-related issues which may have been highlighted for the vaccine renewals**, such as challenges on stock management (overstock, stock-outs, significant consumption variations etc.), wastage rates, target assumptions, annual consumption trend, quantification data triangulation, etc., and **plans to address them**.*
- ***NVS introductions and switches:** If country has recently introduced or switched the product or presentation of an existing vaccine, then the country is requested to highlight the performance (coverage) and lessons learned from the introduction/switch, key implementation challenges and the next steps to address them.*
- ***Campaigns/SIA:** Provide information on recent campaigns (since last JA) and key results of the post-campaign survey, including the coverage achieved. If achieved coverage was low, provide reasons. Provide other key lessons learned and the next steps to address them. If post-campaign survey has not been conducted, highlight reasons for the delay and the expected timelines. Are there any key observations concerning how the operational cost support was spent? Explain how the campaign contributed to strengthening routine immunisation e.g. by identifying zero-dose children and lessons learned.*
- *Update of the **situation analysis for measles and rubella** (using the latest immunisation coverage and surveillance data for measles, rubella and congenital rubella syndrome from national and sub-national*

levels[17]) and update of the country's ***measles and rubella 5 year plan*** *(e.g. future dates of MR intro, MCV2 intro, follow-up campaigns, etc.).*

- ***Describe key actions related to Gavi vaccine support in the coming year*** *(e.g. decision-making on vaccine introduction, future application, planning and implementation of introduction/ campaigns or decisions to switch vaccine product, presentation or schedule)* ***and associated changes in technical assistance[13].***

Vaccine related issues

Due to improved stock management, the country did not experience any stock-out of new or traditional vaccines at the National, regional and District level. However they were some sporadic stock-outs reported in some health facilities. In terms of vaccine utilization, the country still faces challenges due to numerous factors i.e. data quality, parallel reporting tools and plans are under way to establish if the vaccine utilization tool can be incorporated in the DHIS 2.

NVS and switches

The country applied for NVS to introduce MVC2 in 2020. The application was recommended for re-submission again. Gavi, with country and partners will work during 2020 to develop a new application for submission in Q3 2020. The target age for MCV2 is 15 months. In line with the global switch, the country has also received technical support from UNICEF and WHO to switch from TT to Td starting in January 2020. UNICEF has already received 320,000 doses of Td vaccines (10 dose vials same as the original TT) that are adequate for first quarter and has placed orders for extra 874,840 doses to arrive in March 2020. Information has already been shared with the Health Authorities on the switch, advised them to change all new data tools and a one-pager document will be developed and shared to health workers.

Supplementary Immunisation Activities

- Polio

Supplementary immunisation activities were conducted in 2019 using bOPV in March (100% NID), April (50% sNID in high risk groups) and Sept (50% sNID) targeting 6,306,172 children under 5 years of age. Post-campaign independent monitoring showed that 93.7% of the target children we vaccinated, equivalent to 5,908,884 children.

In addition, to contain the transmission of cVDPV2 an immediate response (round zero) and 3 larger scale rounds of outbreak responses using mOPV2 vaccine were conducted in Somaliland and Puntland targeting 2,430,541 children below 5 years. Post-campaign independent monitoring showed a coverage of 96%, equivalent to 2,333,320 children. One round was synchronised with Ethiopia in response to the Horn of Africa cross-border circulation of vaccine derived poliovirus.

- Campaigns

A bOPV campaign funded by the Rotary was conducted in mid-December 2019, and integrated with measles SIA, Vitamin A supplementation, deworming and birth registration. A fractional IPV/ bOPV combined campaign in IDP populations (target of 350,079 children under 5 years) was to take place in 2019 but has been postponed to early 2020 due to the busy SIAs calendar.

A measles SIA targeting 2.4 million children aged 6 – 59 months was conducted in FMS in Q4/201. For PT and SL the campaign is planned in Q1 of 2020. Technical preparations are on-going with technical support from WHO and UNICEF. In addition to measles, the target children will receive Vitamin A, deworming with Albendazole and children aged 0 – 59 months will receive bOPV.

Challenges

Some of the challenges are;

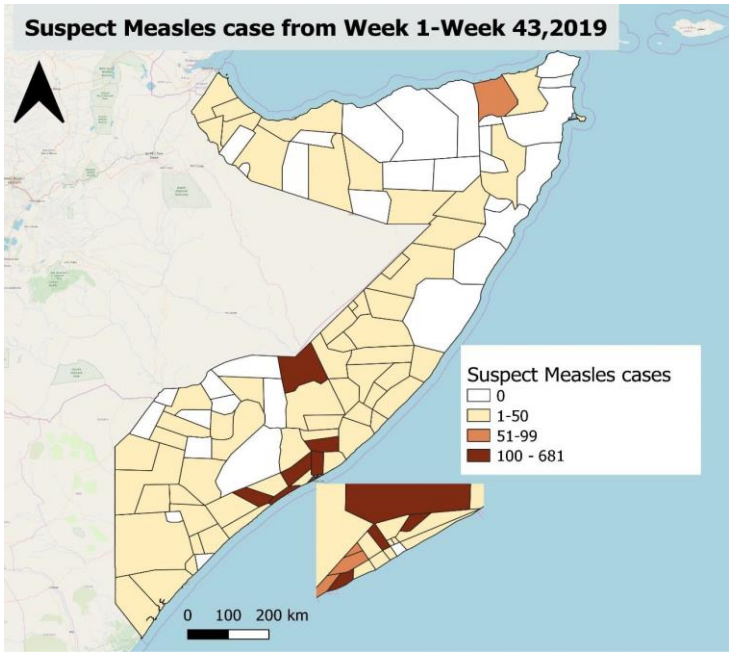
- The Somalia polio eradication programme is challenged by concurrent disease outbreaks and natural disasters such as the October 2019 flooding in Galgadud which affected 548,000 people, displacing approximately 370,000 people. Outbreaks of measles and acute watery diarrhoea have also been reported.

[17] Please refer to the JA analysis guidance document for additional information on the expected analyses for measles and rubella.

- Insecurity due to political instability continues to prevail in Somalia, causing inaccessibility to high risk populations trapped in conflict zones. It also impacts the programme's ability to monitor the implementation of outbreak responses and planned SIAs in the districts affected by insecurity.
- In a post switch (tOPV to bOPV) era, with consistent risk of transmission of cVDPV2, premature polio transition is leading to funding uncertainty for outbreak response (HR and programs) in an unstable epidemic context.

Situation analysis for measles

3,616 suspected cases of measles have been reported in the country from January to the 43rd week of 2019. 78% of the suspected cases were in children below 5 years and the most affected regions are Banadir (1,595), Lower Shabelle (553), Middle Shabelle (317), Hiran (291) and Galgadud (217). These regions accounted for 81% of all suspected cases of measles in the country. 89% of blood samples had positive IgM when taken for laboratory confirmation (204/230 samples).



5.3. Performance of Gavi CCEOP support (if country is receiving Gavi CCEOP support)

If your country is receiving CCEOP support from Gavi, provide a brief update on the following:

- ***Performance** on five mandatory CCEOP indicators and other related intermediate results – achievement against agreed targets as specified in the grant performance framework (GPF) with discussion on successes, challenges and solutions for reaching targets;*
- ***Implementation status** (number of equipment installed / waiting installation, user feedback on preventive maintenance training, refrigerator performance, etc.), including any challenges / lessons learned;*
- ***Contribution** of CCEOP to immunisation performance (i.e. how CCEOP is contributing to improving coverage and equity);*
- ***Changes in technical assistance** in implementing CCEOP support.[13]*

Note: an updated CCE inventory must be submitted together with the CCEOP renewal request.

Performance

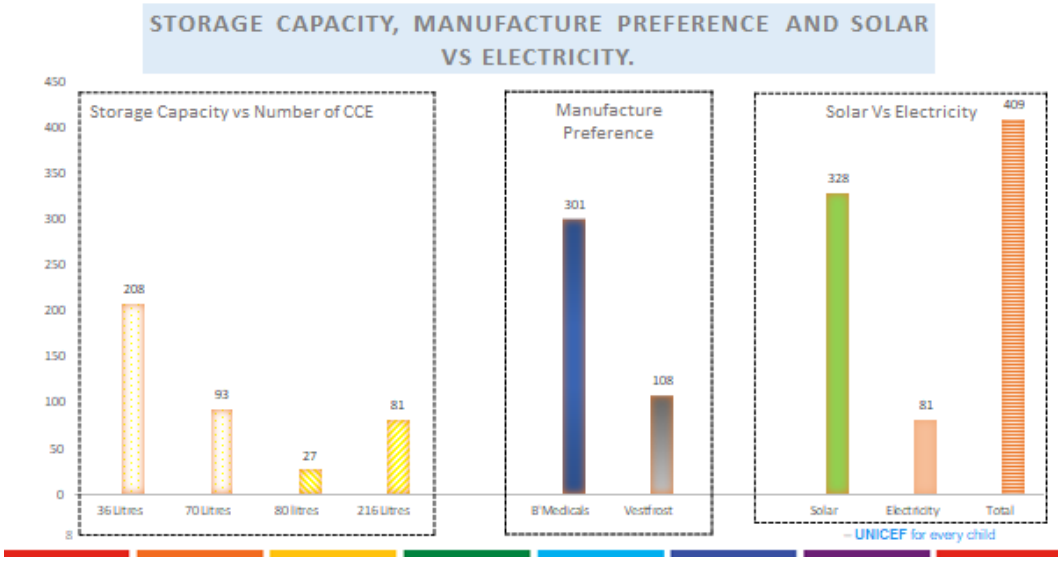
The performance framework will be based on the proposed indicators that were specified in the CCEOP proposal which include; 1- CCE replacement/ rehabilitation in existing equipped sites, 2- CCE expansion in existing equipped sites, 3- CCE extension in unequipped existing and/or new sites and 4- CCE maintenance. Below is table 1 which shows the indicators that will be monitored in initial phase, table 2 with indicators to be monitored during the scale up phase and table 3 additional intermediate indicators to be monitored once the implementation has started

Table 1	*Table 2*	*Table 3*
Number of Regional Hospitals equipped. Number of District Hospitals equipped. Number of District Stores equipped. Number of outreach points equipped. Number of Mobiles equipped.	Number of absorptions CCE replaced. Number of old CCE replaced. Percentage of facilities with functioning cold chain.	Number of facilities converted from kerosene/gas to solar energy source. Number of facilities converted from electricity to solar energy source. Ratio of districts with at least 90% functional equipment. Number of health workers trained in cold chain management. Number of cold chain officers trained in maintenance of CCE.

Implementation Status

There have been delays in implementation of the CCEOP and this was mainly caused by two factors which included the Country's equipment choice of preference cost ($ 4,178,897) which was higher than the approved budget ($ 3,282,465) by 24% and reversing of 20% government's contribution from UNICEF Country Office to UNICEF Supply Division. Due to the country's equipment choice of preference, it was agreed that procurement process will be phased and divided upon the CCEOP budget (phase one 2019) and Gavi HSS2 additional funds (phase two 2020) grants respectively. The tables below show the number and type of equipment that will be procured for each specified phase per location.

Due to major challenges in electricity supply and recurring cost implications, the Country plans to shift from electricity-operated to solar-operated refrigerators with time. Improvements in the availability of cold chain equipment will go hand-in-hand with the training of cold chain staff in repair and maintenance. The expansion of the cold chain network will support the expansion of EPI service delivery. Below are graphs showing storage capacity for different CCE to be procured, manufacture's preference and solar verses electricity for the CCE to be procured under CCEOP.



Challenges

- The country equipment choice of preference cost ($ 4,178,897) was higher than the approved budget ($ 3,282,465) by 24%.
- Reversing of 20% government's contribution from UNICEF Country Office to UNICEF Supply Division.
- The PQS has suspended some equipment types from the catalogue, and yet some of them were earmarked for the Country in 2020.
- The Country has not yet engaged with the local supplier to establish if they are fully aware of the country's distribution process
- In terms of site readiness, funds for uninstalling facilities that need replacement are yet to be in-country as they were not factored into the initial CCEOP proposal however, they were included in the Gavi HSS2 additional funds budget.

Contribution

The current cMYP describes the objectives of reaching those sections of the population who have not been immunized before by prioritizing new immunization points and adding outreach activities and mobile teams to reach nomadic, IDP and rural communities.

The cold chain logistics service for Somalia will aim to ensure that all immunization points have high quality, well-functioning and reliable cold chain equipment to protect the vaccines wherever the services are needed. During the next 5 years, special emphasis will be placed on those newly established immunization services to ensure that they have access to such cold chain equipment and to enable them to reach these new target populations such as nomads, IDP and marginalized communities.

5.4. Financial management performance

Provide a succinct review of the performance in terms of financial management of Gavi's cash grants (for all cash grants, such as HSS, PBF funding, vaccine introduction grants, campaign operational cost grants, switch grants, transition grants, etc.). This should take the following aspects into account:

- *Financial **absorption** and utilisation rates on all Gavi cash support listed separately[18];*
- ***Compliance** with financial reporting and audit requirements noting each grant (listing the compliance with each cash support grant separately, as above);*

[18] If in your country Gavi funds are managed by partners (i.e. UNICEF and WHO), fund utilisation by these agencies should also be reviewed.

- *Status of high-priority "show stopper" actions from the Grant Management Requirements (GMRs) and other issues (such as misuse of funds and reimbursement status) arising from review engagements (e.g. Gavi cash programme audits, annual external audits, internal audits, etc.);*
- *Financial management **systems**[19].*

Please refer to financial management summary in section 2.

5.5. Transition plan monitoring (applicable if country is in accelerated transition phase)

If your country is transitioning out of Gavi support, specify whether the country has a transition plan in place. If no transition plan exists, please describe plans to develop one and other actions to prepare for transition.

- *If a transition plan is in place, please provide a brief overview on the following:*
  - *Implementation progress of planned activities;*
  - *Implementation bottlenecks and corrective actions;*
  - *Adherence to deadlines: are activities on time or delayed and, if delayed, the revised expected timeline for completion;*
  - *Transition grant: specify and explain any significant changes proposed to activities funded by Gavi through the transition grant (e.g., dropping an activity, adding a new activity or changing the content/budget of an activity);*
  - *If any changes are requested, please submit a consolidated revised version of the transition plan.*

Not applicable

5.6. Technical Assistance (TA) (progress on ongoing TCA plan)

- *Describe the strategic approach to Technical Assistance (TA) delivery to improving coverage and equity in reaching the under-immunised and unimmunised children. (i.e. embedded support, subnational support, support from expanded partners etc.)*
- *On the basis of the reporting against PEF functions and milestones, summarise the progress of partners in delivering technical assistance.*
- *Highlight progress and challenges in implementing the TCA plan.*
- *Specify any amendments/ changes to the TA currently planned for the remainder of the year.*

The technical assistance to the country in 2018/2019 was focused on the implementation of the 5-year HSS2 programme to strengthen the immunisation programme, increase coverage and ensure equity in immunisation. The support was also to support the implementation of the CCEOP and the measles SIA that is planned in Q4/2019.

Significant staffing support is available in the PEF TCA, HSS2 and the measles SIA grant, as summarised in the tables below.

Table 1: Gavi-supported positions for UNICEF Somalia

Funding Source	Staff Position	Status
PEF/TCA 2018/2019	Cold Chain Specialist (P3)	Staff in place
PEF/TCA 2018/2019	Immunisation Officer (NOB)	Staff in place
PEF/TCA 2018/2019	HSS/EPI Officer (P2)	Staff in place
HSS-2	Health Specialist (Immunisation) – P4	Staff in place
HSS-2	Immunisation Officers NOB – (3)	Staff in place
HSS-2	Programme Assistant (GS)	Staff in place
PEF/TCA 2018/19	C4D Specialist (P3)	Recruitment in progress

[19] In case any modifications have been made or are planned to the financial management arrangements please indicate them in this section.

Table 2: Gavi-supported positions for WHO Somalia

Funding Source	Staff Position	Status
PEF/TCA 2018/19	Medical Officer/EPI (P4)	Recruitment ongoing
PEF/TCA 2018/19	Immunisation Officer (NOB)	Staff in place
HSS-2	Medical Officer (P4)	Staff in place
HSS2	03 EPI/ HSS officers (NOB)	Staff in place
HSS2	Program support assistant	Staff in place
PEF 2019/2020	3 new NOB Staff recruited under PEF 2020 will provide support in strengthening integrated surveillance system	Recruitment will be started once PEF TCA 2020-21 is approved

Status of Implementing PEF/TCA Activities

a) WHO Supported Activities

Programmatic Area	Activity	Milestones	Status
Leadership Management and Coordination (LMC)	Development of EPI Micro plans for all the remaining districts – those don't have micro plans (for both GAVI-HSS2 target and non-target districts)	50% of accessible districts completed micro plans	Completed
Leadership Management and Coordination (LMC)	Consultative meeting with decentralized health authorities (state-regional-district levels) on defining the PESS projection and denominators for EPI per district.	Consultative meeting held for the state, regional level authorities	This activity has been reviewed in consultation with Ministry of Health Authorities, UNICEF, WHO country and regional office meeting in Nairobi on 19-21st November 2018 and agreed to be reprogrammed due to political sensitivity and border disputes between zones, states and within the regional states. It was proposed the funds for this activity to be partially relocated to complete development of microplans in remaining districts.
Vaccine-Specific Support	Expand sentinel surveillance sites to all accessible districts	MoH focal persons, polio staff are trained on measles case-based surveillance at least of one sentinel site in each district	Completed

Programme Management - LMC	Development of new cMYP for next cycle.	Comprehensive plan developed by engaging all stakeholders.	Development of cMYP will be started in Q2, 2020

Plan for PEF/TCA

1. The development of the cMYP for new cycle 2021-25.
2. Recruitment of 3 new additional NoB National positions to support the immunization programme.
3. One P4 and one NOB will continue to support MoH
4. Support implementation of data quality improvement plan
5. Support MoH in implementation of urban immunization strategy
6. Support in strengthening surveillance system
7. Support in polio transition plans

b) UNICEF Supported Activities

Program Area	Planned activities	Status of implementation	Outcomes
Coverage & Equity/ Program Implement.	Support in the development of immunisation annual work plan, implementation of RI activities including strategies to reach the marginalized pop.; Ensure integration of immunization with other saving live programs; Support coordination of immunization activities including Support introduction of new EPI vaccines and switch of TT to Td, MCV2.	Achieved	Outreach activities and mobile strategy conducted as per the micro plan EPI has been integrated with 150 OTP situated in the hard to reach areas of FMoH, managed by Nutrition section. Technical support to ICC, EPI working group, guidance on switch of TT to Td including logistic aspect, monitoring of the integration for regular supply of vaccine and logistics.
Coverage & Equity/ Program Implementation	Support GAVI HSS project activities for planning, implementation, monitoring, evaluation of UNICEF component.	Achieved	RI services are provided in 62 fixed and 76 outreach sites in the 25 supported districts in the FMS, Somaliland and Puntland, RI improved in Gavi supported districts. Demand creation activities are also on-going through SM activities in the communities, engagement with

	Review of feasibility and key potential challenges for integration and suggest realistic recommendations.		women groups, influential leaders, the media and through IEC materials. Monitoring visits are conducted quarterly by field and country-office based staff, which contribute to the transfer of competences.	
Supply chain and vaccine wastage	EPI logistics were estimated and delivered as per forecast which lead to no short shipment or stock out at the national and zonal stores.	Achieved	Quarterly vaccine distribution plan and 2020 vaccine forecast submitted.	
Periodically updated of the cold chain equip. inventory	The cold chain inventory has been updated on a quarterly basis and information used for decision making.		Annual updated cold chain inventory report available;	
Capacity building and skills transfer in cold chain and vaccine management	This is an ongoing and continuous process		Cold Chain training report with clear number of staff trained	
Demand generation	Data for the generation of additional social evidence to inform the development of priority demand creation interventions	Partially achieved	C4D plan developed and implemented with strong community ownership and accountability framework.	
	Support the implementation of the social mobilization activities	Achieved	Increased demand for immunisation activities; reduced refusal and defaulter rates.	
	Support training of health care providers in focused districts in FMS, Somaliland & Puntland on C4D methods to reinforce the capacity of collecting and using social data to design and implement effective C4D interventions including social mobilization and IPC.	Partially achieved	Training conducted with some outcomes such as the drop-out rate of Penta 1 & Penta 3, and Penta 1 & measles decreased by 3 percentage points	

Plan for PEF/TCA

To continue with technical assistance to strengthen the immunisation programme at the national and state level using the existing 4 staff supported through PEF/TCA;

- 2 staffs to support programme implementation; coverage and equity focusing on reducing the number of under immunized and zero dose children.
- 1 staff focusing on improving cold chain, vaccine management and logistics, as well as the implementation of the CCEOP.
- 1 staff to support demand creation activities; increase awareness on routine immunisation with focus on urban populations, slum dwellers, IDPs and also nomadic populations. In addition, the staff will also focus on demand creation activities at the community level, such as conducting community dialogue sessions.

6. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Provide the status of the prioritised strategic actions identified in the previous Joint Appraisal[20] and any additional significant Independent Review Committee (IRC) or High Level Review Panel (HLRP) recommendations (if applicable).

Prioritised actions from previous Joint Appraisal	Current status
Significant progress in the commencement of HSS- has been realised, however, due to delays in fund disbursement there is a need to accelerate HSS-2 implementation for 2018 funds to be utilised and activities to be implemented.	Implementation is On-going ***(Achieved)*** **UNICEF** – funds were disbursed to Puntland in Q2/2018 & Q3/2018 to Somaliland and the FMS. **WHO** – Activities implemented from Q2/2018
The private sector represents an opportunity to expand service delivery; it is recommended that (1) the MoH develops a framework for PPP in immunisation (2) explore contracting models.	***Partially achieved***; Terms of Reference were developed and a consultancy firm has been engaged jointly by Global Fund, Gavi, UNICEF to develop the framework for private sector engagement in the health sector.
Not enough is known regarding the barriers to seeking immunisation services. Generation and synthesis of social data to inform the development of priority demand generation interventions to be included in additional HSS support.	***Not achieved***; A formative research/study to better understand the socio norms influencing immunisation seeking behaviours was factored in the proposal for additional funds. This will be carried out once the additional funds are secured by the country
There are opportunities to further integrate immunisation in other ongoing health activities, particularly nutrition.	***(Ongoing)*** • An integrated package of services is provided in all the programmes supported by UNICEF through implementing partners (package includes EPI, MNCH, nutrition and WASH).

[20] Refer to the section "Prioritised Country Needs" in last year's Joint Appraisal report

	• An integrated package of EPI and nutrition services will be offered in the selected districts that will be supported by the additional funds
Increasing the availability of outreach activities for RI and ensure it is recognized as a key priority	***(Ongoing)*** The country is conducting outreach services in MCH that supported by Gavi . However; a) outreach services are few or non-existent in non-Gavi supported districts b) Increase the frequency of outreach sessions in Gavi districts

If findings have not been addressed and/or related actions have not taken place, provide a brief explanation and clarify whether this is being prioritised in the new action plan (section 7 below).

7. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND RESOURCE/SUPPORT NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

*Briefly summarise the **key activities to be implemented next year** with Gavi grant support, including if relevant any **introductions** for vaccine applications already approved; preparation of **new applications**, preparation of **investment cases** for additional vaccines, and/ or plans related to HSS / CCEOP grants, etc.*

*In the context of these planned activities and based on the analyses provided in the above sections, describe the five **highest priority findings and actions to be undertaken to enhance the impact of Gavi support or to mitigate potential future risks to programme and grant performance**.*

*Please indicate if any **modifications** to Gavi support are being requested (indicating the rationale and main changes), such as:*

- *Changes to country targets as established earlier, either from the agreed Grant Performance Framework (GPF) or as part of the NVS renewal request submitted by 15 May;*
- *Plans to change any vaccine presentation or type;*
- *Plans to use available flexibilities to reallocate budgeted funds to focus on identified priority areas.*

Overview of key activities planned for the next year and requested modifications to Gavi support:

1. It was noted that there is low staff capacity for District, Regional, State and National teams in terms of leadership, planning, supervision, coordination, evaluation skills and EPI supply chain management.
   TA: TA is required; Training in MLM for this cadre of managers was recommended
2. There are inadequate data collection tools such as registers, child vaccination cards, tally sheets, immunisation summary book, MCH supervision book, monitoring charts. This is a perennial challenge that the EPI programme faces.
   TA: No TA, Adequate resources to print and distribute adequate immunisation tools should be mobilised.
3. Apart from districts supported by the SHINE programme, there are no dedicated HMIS Officers at the district level. This will also enable the scaling-up of DHIS2 to the district level
   TA: No TA, Efforts should be made to put in place HMIS Officers at district level and capacity build them
4. Lack of qualitative data to inform planning in urban settings
   TA: Consultant is required: Formative research undertaken in selected areas to understand underlying causes of low vaccine uptake
5. No payment for state staff/ No supervision support to state official

TA: TA is required to advocate to government to support state officials and FMOH to delegate function to State Officials

Recommendations of the 2019 Joint Appraisal

1.Microplanning

Microplanning at the health facility level should be strengthened to ensure the engagement of community in the process

2.Demand creation activities

- In view of the currently low funding for demand creation activities in the HSS2 grant, advocate for increased funding in the HSS2 in view of the importance in improving coverage and addressing equity.
- The country should engage polio mobilisers to conduct routine immunisation in between polio rounds. However, there is need to mobilise resources to fund the activities of the community mobilisers.

3.Reproduction of vaccination tools like child passports

The country should agree on viable strategies for sustainably financing the production of child passports, including involving other programmes like nutrition, maternal and child health, whose data is also included in the child health cards. Use the experience of Puntland

4.Coordination

There is need to have coordination bodies at the State level, especially in the newly created ones.

5.Cold chain

Train health workers on the use of fridge tags and to also take advantage of the installation of the CCEOP to develop their technical skills to repair and maintain solar-powered fridges (SDD)

6.Leveraging on polio

- Involve the Health Authorities in the use of polio assets for routine immunisation given the very huge resources, expertise and new technologies available to the polio programme
- The routine immunisation programme should access and use data available through polio programme to improve routine planning and evaluation
- Polio mapping for communities and data collection from health facilities can be resourceful to strengthen routine

7.Implementation of the integrated measles SIA

- Ensure quality planning and implementation of a quality SIA that will result in low measles incidence in all district, thereafter.
- Need to strengthen the demand creation aspects of the SIA, using the appropriate and targeted strategies, given the many interventions and the need for awareness among the communities
- Consider the appropriate type of post campaign coverage survey such as LQA, convenience survey etc.
- Consider how the data from post-coverage survey will be used to revaccinate in areas with poor coverage, while considering the additional cost implications
- There is need to have a consensus on the methodologies and sample size of the post campaign survey

TA Needs: Gavi has already provided TA to the country through 3 Consultants and on-going technical expertise from UNICEF and WHO staff supported through PEF/TCA and HSS-2.

8. IRC comments on the country's proposal for additional funds

- Use targeted and innovate approaches to remind mothers about the date of their children's vaccination, which could include SMS reminders, phone calls, reminders through health workers, local leaders, religious leaders, women association, female health workers etc.
- SMS reminders – participants recommended that there should be more focus on calling mothers for defaulter tracking rather than sending SMS as most of the mothers are illiterate. And if the country adopts SMS, then they should be personalised rather than sent in bulk to the mothers.
- The existing polio social mobilization network is also a good opportunity for the reminder
- Review the current urban immunisation strategy to address the peculiar context and needs of the urban areas in the country, especially in Mogadishu and other cities with large urban populations. Currently, there are global guidelines and tools for urban immunisation planning, implementation and evaluation
- Link the urban immunisation work with demand creation
- Integrate AFP, EWARN and DHIS2 and explore opportunities to migrate polio data to DHIS2 systems and gradually merge the various surveillance and data management systems.
- Use polio surveillance to strengthen other VPD surveillance

9.Review of the 2019 annual workplan

- Need to include narratives to the status of implementation of activities to facilitate better understanding of the plan
- Gavi will support capacity building for all levels using a third party mostly for leadership, management & coordination. There is however, the need to have detailed TNAs ahead of the capacity building and explore the possibility of including fund raising skills in the capacity building
- Contents of the capacity building should be defined in collaboration with the country team

10.Urban Immunisation

- Map urban population and available services working collaboratively with other sectors including food distribution
- Consider the mobile nature of the sub-urban population who are in constant move, and to tailor services to meet their needs.
- Consider outreach services to target mothers wherever they may be during the day and include flexible vaccination hours.
- Consider integrated service delivery during outreaches to make the sessions more attractive to clients
- Service delivery to urban population should address the social distance that could hamper access to service
- The country to develop a robust monitoring and evaluation mechanism for the urban immunisation strategy

11.Coverage survey

-After discussions in the JAR, it was decided that the country will not conduct a coverage survey as was initially planned. It was deemed that the survey would not provide further information on the vaccination coverage in the country, and that the country should focus more on reaching more children with vaccination services and to also improve data quality.

12. Issue of denominator

A consultative meeting is required with the Government, local authorities and other stakeholders to find a mechanism to fix the issue related to the denominator for the EPI programme.

The country has submitted the TA request for 2020-2021 prioritizing the areas that required TA and in consultation with partners and government.

- **JOINT APPRAISAL PROCESS, ENDORSEMENT BY THE NATIONAL COORDINATION FORUM (ICC, HSCC OR EQUIVALENT) AND ADDITIONAL COMMENTS**

- *Does the national Coordination Forum (ICC, HSCC or equivalent) meet the Gavi requirements (please refer to http://www.gavi.org/support/coordination/ for the requirements)?*

- *Briefly describe how the Joint Appraisal was reviewed, discussed and endorsed by the relevant national Coordination Forum (ICC, HSCC or equivalent), including key discussion points, attendees, key recommendations and decisions, and whether the quorum was met. Alternatively, share the meeting minutes outlining these points.*
- *If applicable, provide any additional comments from the Ministry of Health, Gavi Alliance partners, or other stakeholders.*

- **ANNEX: Compliance with Gavi reporting requirements**

Please confirm the status of reporting to Gavi, indicating whether the following reports have been uploaded onto the Country Portal. ***It is important to note that in the case that key reporting requirements (marked with *) are not complied with, Gavi support will not be reviewed for renewal.***

	Yes	No	Not applicable	Comments
End of year stock level report (due 31 March) *****	X			
Grant Performance Framework (GPF) * reporting against all due indicators	X			
Financial Reports *				
Periodic financial reports	X			
Annual financial statement	X			
Annual financial audit report			X	
Campaign reports *				
Supplementary Immunisation Activity technical report			X	
Campaign coverage survey report			X	
Immunisation financing and expenditure information	X			
Data quality and survey reporting	x			
Annual data quality desk review		x		We have not received any reports of annual desk review of data, although they do conduct an annual review of HMIS data
Data improvement plan (DIP)	x			We received the data improvement plan after the JA; yet to be implemented (planned 2020)
Progress report on data improvement plan implementation		x		See comment above.
In-depth data assessment (conducted in the last five years)	x			Somalia conducted a DQA in 2016 next DQA should be planned for 2021 to stay compliant
Nationally representative coverage survey (conducted in the last five years)		x		Challenges in past to conduct a robust, nationally representative survey aligned to global guidelines." Though, the country conducted an EPI Coverage Survey in 2018; there were major concerns about the methods and implementation of the survey and WHO ended up rejecting the results.
Annual progress update on the Effective Vaccine Management (EVM) improvement plan	X			
CCEOP: updated CCE inventory			X	
Post Introduction Evaluation (PIE) (specify vaccines):			X	
Measles & rubella situation analysis and 5 year plan	X			
Operational plan for the immunisation programme		X		Under development for 2019 – CT to follow up
HSS end of grant evaluation report			X	

HPV demonstration programme evaluations			X	
Coverage Survey			X	
Costing analysis			X	
Adolescent Health Assessment report			X	
Reporting by partners on TCA and PEF functions	X			

In case any of the required reporting documents is not available at the time of the Joint Appraisal, provide information when the missing document/information will be provided.
