APPLICATION FORM FOR GAVI NVS SUPPORT

Submitted by
The Government of Somalia
for
Measles 1st and 2nd dose routine

Gavi
The Vaccine Alliance

Reach Every Child
www.gavi.org

1 Gavi Grant terms and conditions

1.2 Gavi terms and conditions

1.2.1 Gavi terms and conditions

The terms and conditions of the Partnership Framework Agreement (PFA) between Gavi and the Country, including those provisions regarding anti-corruption and anti-terrorism and money laundering, remain in full effect and shall apply to any and all Gavi support made pursuant to this application. The terms and conditions below do not create additional obligations or supersede those of the PFA. In the event the Country has not yet executed a PFA, the terms and conditions of this application shall apply to any and all Gavi support made pursuant to this application.

GAVI GRANT APPLICATION TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES
The applicant country ("Country") confirms that all funding provided by Gavi will be used and applied for the sole purpose of fulfilling the programme(s) described in the Country's application. Any significant change from the approved programme(s) must be reviewed and approved in advance by Gavi. All funding decisions for the application are made at the discretion of Gavi and are subject to IRC processes and the availability of funds.

AMENDMENT TO THE APPLICATION
The Country will notify Gavi in its Joint Appraisal, or in any other agreed annual reporting mechanism, if it wishes to propose any change to the programme(s) description in its application. Gavi will document any change approved by Gavi according with its guidelines, and the Country's application will be amended.

RETURN OF FUNDS
The Country agrees to reimburse to Gavi all funding amounts that Gavi determines not to have been used for the programme(s) described in its application. The Country's reimbursement must be in US dollars and be provided, unless otherwise decided by Gavi, within sixty (60) days after the Country receives Gavi's request for a reimbursement and be paid to the account or accounts as directed by Gavi.

SUSPENSION/ TERMINATION
Gavi may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programme(s) described in the Country’s application, or any Gavi-approved amendment to the application. Gavi retains the right to terminate its support to the Country for the programme(s) described in its application if a misuse of Gavi funds is confirmed.

NO LIABILITY
The Country shall be solely responsible for any liability that may arise in connection with: (i) the implementation of any programme(s) in the Country; and (ii) the use or distribution of vaccines

and related supplies after title to such supplies has passed to the Country.
Neither party shall be responsible for any defect in vaccines and related supplies, which remain the responsibility of the relevant manufacturer. Gavi shall not be responsible for providing any additional funding to replace any vaccines and related supplies that are, or became, defective or disqualified for whatever reason.

INSURANCE
Unless otherwise agreed with Gavi, the Country shall maintain, where available at a reasonable cost, all risk property insurance on the Programme assets (including vaccines and vaccine related supplies) and comprehensive general liability insurance with financially sound and reputable insurance companies. The insurance coverage will be consistent with that held by similar entities engaged in comparable activities.

ANTI-CORRUPTION
The Country confirms that funds provided by Gavi shall not be offered by the Country to any third person, nor will the Country seek in connection with its application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

ANTI-TERRORISM AND MONEY LAUNDERING
The Country confirms that funds provided by Gavi shall not be used to support or promote violence, war or the suppression of the general populace of any country, aid terrorists or their activities, conduct money laundering or fund organisations or individuals associated with terrorism or that are involved in money-laundering activities; or to pay or import goods, if such payment or import, to the Country’s knowledge or belief, is prohibited by the United Nations Security Council.

AUDITS AND RECORDS
The Country will conduct annual financial audits, and share these with Gavi, as requested. Gavi reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.
The Country will maintain accurate accounting records documenting how Gavi funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of Gavi funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against Gavi in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY
The Country and the signatories for the Country confirm that its application, or any other agreed annual reporting mechanism, is accurate and correct and forms legally binding obligations on the Country, under the Country's law, to perform the programme(s) described in its application, as amended, if applicable.

COMPLIANCE WITH GAVI POLICIES
The Country confirms that it is familiar with all Gavi policies, guidelines and processes relevant

to the programme(s), including without limitation the Transparency and Accountability Policy (TAP) and complies with the requirements therein. All programme related policies, guidelines and processes are available on Gavi's official website and/or sent to the Country.

USE OF COMMERCIAL BANK ACCOUNTS

The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage Gavi cash-based support. The Country confirms that it will take all responsibility for replenishing Gavi cash support lost due to bank insolvency, fraud or any other unforeseen event.

ARBITRATION

Any dispute between the Country and Gavi arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either Gavi or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland. The languages of the arbitration will be English or French.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by Gavi. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: Gavi and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

Gavi will not be liable to the country for any claim or loss relating to the programme(s) described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. The Country is solely responsible for all aspects of managing and implementing the programme(s) described in its application.

1.3 Gavi Guidelines and other helpful downloads

Guidelines and documents for download

Please refer to the relevant guidelines concerning your request for support.

Please ensure to consult and download all documents. It is important to note that some documents must be completed offline, and will need to be uploaded in the final steps of your application.

This application form is designed to collect information needed by Gavi to process requests for support, plan procurement of vaccines, plan technical assistance, track data for future reporting, and more.

A key component of the application is a solid operational plan (New Vaccine Introduction Plan for routine support, or Plan of Action for campaign support), explaining how the country will

introduce the vaccine or conduct the envisaged campaign, with a corresponding budget. The New Vaccine Introduction Plan or Plan of Action must be submitted together with this application form and will be considered as the foundation of the support request.

For more information on the documents to submit with your application and what they should contain, please refer to the appropriate guidelines: http://www.gavi.org/support/process/apply/

2 Review and update country information

2.1 Country profile

2.1.1 Country profile

Eligibility for Gavi support

Eligible

Co-financing group

Initial self-financing

Date of Partnership Framework Agreement with Gavi

No Response

Country tier in Gavi's Partnership Engagement Framework

2

Date of Programme Capacity Assessment

June 2017

2.1.2 Country health and immunisation data

Please ensure your Country health and immunisation data is up to date. If not, please go to the Overall expenditures and financing for immunisation section of the portal to submit this information.

	2019	2020
Total government expenditure	316,000,000	

Total government health expenditure	15,921,125	
Immunisation budget	13,239,724	24,879,129

2.1.3 National health planning and budgeting cycle, and national planning cycle for immunisation:

The government planning cycle starts on the

No Response

The current National Health Sector Plan (NHSP) is

From	2017
To	2021

Your current Comprehensive Multi-Year Plan (cMYP) period is

2016-2020

Is the cMYP we have in our record still current?

Yes☒ No☐

If you selected “No”, please specify the new cMYP period, and upload the new cMYP in country documents section.

Note 1

If any of the above information is not correct, please provide additional/corrected information or other comments here:

Somalia is requesting for waiver for the cMYP under the current circumstances, country is planning to develop new cMYP starting in last quarter of 2020

2.1.4 National customs regulations

Please describe local customs regulations, requirements for pre-delivery inspection, and special documentation requirements that are instrumental for the delivery of the vaccine.

UNICEF supports MoH in clearance and handling of vaccines and all EPI supplies. All supplies procured under UNICEF are tax excepted and the following documents are required for

clearance (bill of lading, invoices, packing lists and COOs for customs clearance. Measles vaccine is already in use and no additional requirements are required by customs

2.1.5 National Regulatory Agency

Please provide information on the National Regulatory Agency in the country, including status (e.g. whether it is WHO-certified). Please mention a point of contact with phone number and e-mail address. UNICEF will support the process and may need to communicate licensing requirements to the vaccine manufacturers where relevant.

Currently Somalia doesn't have regulatory Agency and , WHO prequalified vaccines are allowed to be used with in the Country.

2.2 National Immunisation Programmes

2.2.2 Financial Overview of Active Vaccine Programmes

IPV Routine

Note 2

	2020	2021	2022
Country Co-financing (US$)			
Gavi support (US$)	944,355	977,580	1,011,316

Pentavalent Routine

	2020	2021	2022	2023	2024
Country Co-financing (US$)	215,247	226,397	235,535	244,863	254,375
Gavi support (US$)	594,115	624,892	650,114	675,860	702,115

Summary of active Vaccine Programmes

	2020	2021	2022	2023	2024
Total country co-financing (US$)	215,247	226,397	235,535	244,863	254,375
Total Gavi support (US$)	1,538,470	1,602,472	1,661,430	675,860	702,115
Total value (US$) (Gavi +	1,753,717	1,828,869	1,896,965	920,723	956,490

Country co-financing)	

2.3 Coverage and Equity

2.3.1 Coverage and equity situation analysis

Note: If a recent analysis of the coverage and equity analysis is already available, for example as part of a Joint Appraisal report, you may simply reference the report and section where this information can be found.

Describe national and sub-national evidence on the coverage and equity of immunisation in the country and constraints to improvement. In particular, identify the areas and groups of low coverage or high inequity linked to geographic, socioeconomic, cultural or female literacy considerations, as well as systematically marginalized communities. Specify both the areas and/or populations with low coverage (%) and those with the largest absolute numbers of un-/under-vaccinated children. Among data sources, consider administrative data, coverage surveys, DHS/MCS, equity analyses, Knowledge-Attitude-Practice surveys, and patterns of diseases like measles.

Describe the challenges underlying the performance of the immunisation system, such as:

- Health work force: availability and distribution;
- Supply chain readiness;
- Gender-related barriers: any specific issues related to access by women to the health system;
- Data quality and availability;
- Demand generation / demand for immunisation services, immunisation schedules, etc;
- Leadership, management and coordination: such as key bottlenecks associated with the management of the immunisation programme, the performance of the national/ regional EPI teams, management and supervision of immunisation services, or broader sectoral governance issues;
- Financing issues related to the immunisation programme that impact the ability to increase coverage, including bottlenecks related to planning, budgeting, disbursement and execution of resources;
- Other critical aspects: any other aspect identified, for example based on the cMYP, EPI review, PIE, EVM or other country plans, or key findings from available independent evaluations reports.

Describe lessons learned and best practices on the effectiveness of implemented activities to improve coverage and equity; recommendations on changes or new interventions that might be required to accelerate progress (include data to support any findings or recommendations).

Currently there are 7 states Banadir, Galmudug, South west state, Jubbalanad, Hirshabele, Puntland and Somaliland, each governed by their elected governments. Health ministries are led be respective Minister of health , with Director Generals being the technical head. The states are further divided into regions and districts. Regions are managed by Regional health officers and districts are managed by district health officers – each having their own team.

Most of the public health facilities are run by NGOs in the country indeed NGOs run 67% of health facilities in the country. It is slightly higher in Puntland (72%) and slightly lower in Somaliland (64%).EPI services are delivered by health facilities through fixed, outreach and mobile services depending on availability of funds and required human resources.
As per the recent routine immunization coverage, it has been observed that children in some districts were not accessing and utilizing RI services due to lack of awareness and distance to the health facilities. Also the children who were receiving the first doses of vaccines were not coming back to complete the schedule before they reach one year of age. For instance, Penta1 coverage was 78% while Penta3 was 67% in 2018 and Penta1 was 89% and Penta3 was 77% in 2019. This shows the lack of continuity of immunization services. Based on the monitoring, we found out that the caregivers from some villages only access RI antigens during the first contact of delivery and never come back to complete their immunization series. Probing further, the reason for these gaps were attributed to inadequate sensitization, poor record-keeping, as defaulters could not be traced due to non-functional defaulter mechanism. Although we acknowledged the contribution and the support of the community (Female health workers, SOMNET etc.) on the improvement in the uptake of RI services in Somalia, we are using the opportunity of Gavi support to improve data quality. Health workers are currently strengthening immunization defaulter mechanism through supply and use of SMSs, tickler files and CHWs. This mechanism is focusing on increasing the number of children receiving RI services and especially increasing awareness for the caregivers and mothers to bring back children to complete the RI schedule.
According to DHIS2, it is estimated that in 2019 approximately 29% of children under one year (i.e 170,000 children) were under-immunized in Somalia, with most of them living in the central-southern regions of the country.
PENTAVALENT 3: Nationally, the administrative coverage of pentavalent 3 in 2018 was 69% and in 2019 it was 77%, but the 2019 WUENIC estimates stagnated at 42% over the last eight years. The Somali Health and Demographic Survey (SHDS) published in April 2020 reveals a national coverage of Penta valent 3 of 12%. In 2018, the administrative data related to routine immunization shows that more than half of the children living in Bakool, Galgadud, Hiran, Sanag-PL, Sool-PL, Lower Juba and Lower Shabelle regions are faced with the highest inequity in terms of access to routine immunization, as these regions have the lowest coverage of pentavalent 3 in the country. During 2019 based on Penta 3 admin data around 140,000 (23% of target children) under 1year children missed Penta 3 dose. 63% of unimmunized children are in 3 states i.e Jubaland, southwest state and Galmudug state and 18% of unimmunized children are residing in Somaliland.
The above graphs highlight an improvement in the number of districts with high coverage of Penta 3 and an improved number of districts reported coverage. 45% (55) districts reported coverage of 80 and above of Penta 3 vaccine in 2019 compared to 29% districts in 2018 and 27 districts in 2017.
MEASLES: Improvement in measles 1 coverage based on administrative data Nationally coverage was at 41% in 2015 and it increased to 71% in 2019 as reflected in graph (Figures 3). According to WUENIC, it has stagnant at 46% for last seven years. There are areas at sub-national level where children are missed in all states of Somalia and Somaliland. Somalia is also facing data quality issues, which is evident from the graph showing higher coverage of measles compared to Penta 3 coverage. Possible reasons for this are issues in data entries. Measles is endemic in Somalia and sometime data of response to measles cases is also

entered as routine immunization data which leads to a higher vaccination coverage for measles than other antigens. Children above the target age are also vaccinated especially when there are reports of measles cases in the community.

SDHIS, 2020:

The Somalia Health and Demographic Survey 2020 was carried out in 2020 by the Federal Government of Somalia, with support from the United Population Fund, Somalia and some donors. Regarding the Child Health Status, the morbidity and mortality trends have remained similar for years, with the children under five affected by the same diseases, including diarrhea, acute respiratory infections (ARI), malaria, malnutrition, and other vaccine-preventable diseases. Regarding the immunization program, the objective was to assess coverage of vaccine antigens provided through the health system among children aged 12-23 months.

The finding of the survey showed that the National Crude Fully Immunisation Coverage (FIC) was 11 percent, meaning that they children received BCG vaccine, three doses of pentavalent and Polio vaccines, and one dose of measles vaccine. Thirty- seven percent of children had received CG, 21 percent received the first dose of pentavalent while 30 percent received the fist dose Polio vaccine. Twelve percent of children completed the required three doses of the pentavalent vaccine and 26 percent received the three doses of the polio vaccine. Twenty-three percent of children had been vaccinated against measles.

There is a variation based on the level of education of mothers; 24 percent of the children of mothers with secondary education have received all basic vaccinations, while among children of mothers with no schooling only 8 percent have received all basic vaccinations.

It is important to bring to the attention of all partners that since 2018 Gavi Health System Strengthening (HSS) 2, additional funds, CCEOP and Data quality improvement plans are supporting the delivery of routine immunisation activities in Somaliland, Puntland and the Federal Member States (FMS) of Somalia. Through HSS2 and additional funds support is provided to 78 districts in the country and CCEOP and DQIP are supporting all districts of the country.

COVID 19 impact on RI:

Routine immunization like all other health programme in Somalia impacted by COVID 19, Many activities are postponed after detecting first case of COVID 19 in March 2020. The movement of people was restricted including flight operations, there was fear in communities and also amongst health care providers. It resulted in decreasing coverage of all antigens compared to same period of 2019. Below graph (Figure 4) is showing decreasing monthly trend of vaccination coverage from Jan -May 2020. Social mobilization activities started to encourage parents to complete vaccination schedule of their children and PPEs are provided to vaccinators and health care providers to protect themselves and parents from contacting COVID 19. Trainings will be conducted before introduction of MCV2 and section will be included on use of PPEs, social mobilization activities to concentrate on importance of immunization and encourage parents to complete vaccination schedule for all required antigens.

Even in regions with a relatively high administrative coverage of health and nutrition services, disparities still exist within districts of the same region. The Multiple Indicator Cluster Survey (MICS) Somalia 2016 measures highlighted that children of mothers with secondary education are two times more likely to be fully vaccinated than children of mothers with no education. Children born in rich families are six times more likely to be fully vaccinated than children of poor parents, and children in urban areas are three times more likely to receive the Pentavalent 3 vaccine than children in rural areas. 3 cities will implement urban immunization strategy i.e Mogadishu, Hargeisa and Bossaso, house to house enumeration exercise is completed in Mogadishu and also started in Bossaso and Hargeisa. All the children in urban slums including IDPs in these cities will be reached with services and encourage parents to complete vaccination schedule of their children. Mobile vaccination sessions are being implemented

especially for nomadic population.
Similarly, to the results of the MICS 2016, an Immunization Equity Assessment conducted by UNICEF in 2017 showed that inequities existed due to socio-economic status, education level of mothers and geographical location of the children. Despite better coverage in urban areas, children living in urban slums had lower Immunization coverage rates than those in some rural areas. The assessment revealed that DPT-3 coverage for children with mother's education level of secondary (or higher) was 13 percentage points higher than from those children with mother's education level of none and it was while it was 21 percentage points higher in the case of measles. The performance was lower in rural areas compared to urban areas with a difference of 19% for DPT-3 and 16% for measles. The greatest disparity was noted for children born to women in the wealthiest quintile compared with those born to women in the poorest quintile – with an absolute difference of 22 and 23 percentage points for DPT-3 and Measles coverage respectively.
Additionally, geographic accessibility especially in the rural areas has been a key factor preventing access to immunization services. The geographic accessibility barrier is most predominant in southern states, in part due to security challenges.
There are 2.6 million Internally Displaced Persons (IDPs) in the country, with 56.5% of them living in the central-south regions of Somalia, 22.4% in Somaliland, and 21% in Puntland. Most of the IDPs living in the central-south regions of Somalia are found in Banadir, Bay, Lower Shabelle, Hiran and Mudug Regions. This population constitutes a high-risk group that is extremely vulnerable to communicable disease outbreaks, including vaccine preventable diseases. Additionally, other high-risk groups include nomadic populations that are constantly mobile and account for approximately 25.9% of the population in Somalia, as well as populations living in hard-to-reach areas and in urban slums.
The private sector is one of the dominant providers of essential health services in Somalia. However, the private health sector is largely unregulated. A DFID assessment of the private health sector found that the private sector to be fragmented, lacking professional networks, or forum to cohesively engage with the public sector or donors on issues of reform, policymaking, regulation enforcement and quality control. In 2019, the Global Fund, UNICEF and Gavi started working to develop a formal public private partnerships (PPP) for the provision of comprehensive integrated health services, in order to sustainably improve health outcomes including immunization.
Currently there are 29 private hospitals in the country providing routine immunization services. Most of these hospitals are located in big cities like Mogadishu, Hargeisa, Kismayu, Burao and Baidoa.
Routine immunization services are also available from private providers in Somalia. There is a large network of private sector providers that is rapidly expanding immunization services in Somalia; this has been observed especially in the urban cities such as Mogadishu. Information on their services is poorly captured in the national RI database. Due to lack of regulation, some private sector providers are not geographically well distributed across the districts which affect the opportunity of using this platform to deliver immunization service to the most marginalized community. This contributes to the inequitable distribution of services.
New EPI policy is also highlighting importance of involvement of private sector in immunization activities to provide quality immunization services. EPI policy is also encouraging for private public partnership with private sector for routine immunization.

Given the important contribution of private providers in improving RI, the MCV2 introduction will be an opportunity to engage with the private sector in the planning and implementation before the effective introduction of MCV2 into the public sector. This approach will help to bridge this gap for the provision of immunization and contribute to strengthening routine immunization services in the country. MCV2 introduction will help in the capacity building of private sector service providers in immunization services, cold chain and recording data for vaccine utilization

and children immunized at the private centres. Vaccines will be replenished as per the utilization and provision of data. It will improve the accountability of the private sector whenever requesting for vaccine stocks versus immunization data.Routine immunization services are also available from private providers in Somalia. There is a large network of private sector providers that is rapidly expanding immunization services in Somalia; this has been observed especially in the urban cities such as Mogadishu. Information on their services is poorly captured in the national RI database. Due to lack of regulation, some private sector providers are not geographically well distributed across the districts which affect the opportunity of using this platform to deliver immunization service to the most marginalized community. This contributes to the inequitable distribution of services.

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Challenges to immunization in Somalia are well known and range from coordination to implementation of activities, in particular given within the changing political. The country has also experienced challenges in access due to insecurity in some locations. As a result, many communities have faced difficulties in accessing routine immunization services. Experience with the recent IPV introduction has shown that there will be no major challenge in the community accepting the vaccine. Some challenges anticipated with MCV2 introduction are the following:

• Coordination & Programme Management: Somalia's health system is still fragile and there is a weak district health system. The EPI programme staffing at the MOH level is weak.

• Denominators: High movement of population due to conflict/insecurity, lifestyle and drought/flood has made it difficult to have proper denominators at region/district levels. MCH catchment areas have no defined target population.

• Access: About 40% of the population is estimated to be rural, including 26% of the population are nomadic. About 15% of the territory is under Al Shabab control and still inaccessible for immunization.

• Defaulter tracing: There is high drop-out rate in some of the districts and regions. Weak or near to no defaulter tracing at lower level due to lack of financial resources or incentives for health workers.

• Human Resource Quantity & Quality: Appropriate staffing and job descriptions are not available in most MCHs. Staff are overwhelmed with multiple responsibilities. There is a scarcity of trained manpower, delayed salaries and low incentives for service providers in public facilities.

• Supervision and monitoring: There is a weak supervision and support from health authorities to MCH/OPDs; poor monitoring of NGOs performance, and weak monitoring and evaluation system.

• Surveillance: AFP surveillance is well established, and measles case-based surveillance has been started in all zones and expanded to all accessible districts. Apart from AFP surveillance, there is limited monitoring of surveillance activities, little use of surveillance data at local level.

EWARN system is expended to 761 health facilities, notifying 14 priority diseases.
• High logistics cost: Distribution of vaccines and supplies along with other logistics cost for Somalia is high. Main vaccine cold store and warehouse is located in Nairobi and supplies are then distributed by air freights to all main parts of Somalia.
• Cold chain availability & functionality: The absence of District Stores necessitates the distribution of vaccines on a monthly basis to the health facilities from the Regional Stores.
• Community Demand & Utilization: Demand and uptake of vaccination services is low because the parents/caregivers are not motivated and do not have adequate knowledge on the value of immunization; poor IPC skills amongst HW; weak linkage between communities and the health facilities; HW do not have client oriented approach; communities have limited involvement in planning of routine vaccination services. Advocacy for higher level participation and ownership of the program is weak due to gaps in skills, funds and priorities.
• Data management: Vaccination data is reported through DHIS2 to central level from districts. Health facilities share monthly reports with the district on paper based monthly reporting forms. There are issue like discrepancy between the reported coverage and the coverage surveys, under and over reporting has been observed. Limited use of data at peripheral level for decision making.
• Financial resources: Gap in dedicated government budget contribution or regular allocation for EPI. Program is heavily donor-dependent, unpredictable and dwindling budget for immunization activities. Emergencies are gaining more attention of donors and shifting the priority away from regular programs including EPI. Currently GAVI is the only traditional donor for EPI services aimed at strengthening the health system.
Mitigations/Way forward:
Recent Overall Immunization services have improved in Somalia with more obvious improved coverage been observed in 43 GAVI-supported districts due to comprehensive support including
leadership and management, capacity building and service delivery of service providers in immunization practices. In 2018 and 2019 many health workers from all accessible districts were trained on immunization practices, defaulter tracing and vaccine safety. MLM training conducted for managers including state and regional and some district level. MCV2 introduction will be an opportunity to address most of the issues listed above. The expansion of GAVI support to other districts will improve the quality of immunization services and motivate health workers with appropriate knowledge of immunization.
The establishment of ICC and capacity-building of immunization management through mid-level management training have provided an opportunity to conduct regular EPI reviews at regional and district levels and have been a platform to develop improved skills and capacities of health workers in microplanning, data management, IPC skills. This is helping to calculate accurate and realistic denominators, estimates for the targets of catchment area by triangulating all available resources including Polio data, small household surveys per catchment areas.
Immunization programme is integral part of PHC package and most of the NGOs are now providing immunization services in their health facilities. It will be further improved by taking them onboard in planning process, reviews etc. Immunization services are also integrated with nutrition services and they are providing routine immunization at their OTPs. Efforts are made in engaging private sector hospitals in provision of immunization services under MoU with the MoH.
The current COVID-19 pandemic response activities laid the ground for raising awareness in the community about the importance of vaccination. Indeed, more than 3000 rapid response team members were deployed in the country and they have been disseminating information about routine immunization. MCV2 introduction will refresh training on personal communication skills including social mobilization activities for good and clear communications with the mother, care takers and clear messages about next visits for vaccination including for missed vaccines. Every opportunity will be used for disseminating messages on importance of vaccination to

create demand for vaccination in the community.
Dissemination and adaption of recently approved and endorsed revised EPI policy at all level will emphasize the establishment of the 2nd year life platform and the catchment schedule to ensure completion of all missed doses during first and 2nd year of child life according to the national schedule.
Since DHIS2 rolled out, Somalia's health system has been addressing gaps in data including training, compilation, analysis, record keeping and data use through implementation of the DQIP (Data Quality Improvement Plan). Under this plan data management tools will be revised and updated to accommodate new changes, including data related to new vaccines (MCV2 and other vaccines which will be introduced in near future including IPV2, PCV, Rota etc). It will also address the 2YL vaccination and catch-up schedule, hoping that this will improve data availability and ease the validation and data use.
Implementation of urban immunization with the help of additional resources from GAVI will assist in addressing the issues of engagement of the private sector to mitigate the gap of trained manpower and improve immunization coverage.
Accelerated immunization activities will be used for reaching unreached children especially in hard to reach population like nomads and in rural areas. 4 rounds in year of accelerated immunization activities will improve coverage in nomadic and poor performing areas.
Experience of accelerated immunization activities in Baidoa district will be replicated for other areas. 10-15 USD per child operational cost will be enough for 4 rounds. Different donors other than GAVI are approached to support accelerated immunization activities.

2.4 Country documents

Upload country documents

Please provide **country documents** that are relevant for the national immunisation programme and for multiple vaccines, to be taken into account in the review of your application. If you have already provided one or more of these country documents, you do not need to upload it/them again unless the document version changed. If documents cannot be provided, please use the comment functionality to explain why, or by when they will be available.

Note that only general country documents are uploaded here; at the end of section 3 (sub-section "Upload new application documents") you will be required to provide those documents that are specific to the support requested (for example the new vaccine introduction plan and/or campaign plan of action, new budget, application endorsements etc.)

Country and planning documents

✓	**Country strategic multi-year plan** Comprehensive Multi-Year Plan for Immunisation (cMYP) or equivalent country strategic plan	National_CMYP Somalia Final_10-09-18_10.48.57.pdf
✓	**Country strategic multi-year plan / cMYP costing tool**	10. cMYP Costing Tool_Somalia_15-01-19_04.06.03.xlsx

✓	**Effective Vaccine Management (EVM) assessment**	SomaliaEVMAFinal_Report20170406_06-10-20_07.56.16.pdf
✓	**Effective Vaccine Management (EVM): most recent improvement plan progress report**	7 Somalia EVMimprovement plan Aug2020_06-10-20_07.57.14.xls
✓	**Data quality and survey documents: Final report from most recent survey containing immunisation coverage indicators**	MICS4 Puntland Final report Draft4_for review October2013_11-09-18_11.27.35.docx
✓	**Data quality and survey documents: Immunisation data quality improvement plan**	Data Improvement PlanSomalia_11-09-18_11.28.20.docx
✓	**Data quality and survey documents: Report from most recent desk review of immunisation data quality**	Somalia DQS final report 2016_11-09-18_11.29.43.pdf
✓	**Data quality and survey documents: Report from most recent in-depth data quality evaluation including immunisation**	Comprehensive EPI reviewSomalia2017_11-09-18_11.30.40.pdf

✓ **Human Resources pay scale**

If support to the payment of salaries, salary top ups, incentives and other allowances is requested

003 Somalia Health Staff Remuneration Study REVISED_11-10-18_20.03.06.pdf

Coordination and advisory groups documents

✓ **National Coordination Forum Terms of Reference**

ICC, HSCC or equivalent

ICCs Terms of Reference Somalia_12-09-18_10.47.12.pdf

✓ **National Coordination Forum meeting minutes of the past 12 months**

ICC Meeting Minutes Somalia 09_September 2018_01-09-19_10.42.34.pdf

Other documents

✓ **Other documents (optional)**

Please also provide other country documents to support the review of the applications, for example Health Facility Assessment Reports, Knowledge-Attitude-Practice surveys or other demand-related surveys, if available.

Somalia EPI policy July 2020_06-10-20_08.00.02.pdf

Measles Outbreak Response Plan Somalia Sep2018_12-09-18_15.23.30.pdf

3 Measles 1st and 2nd dose routine

3.1 Vaccine and programmatic data

Choice of presentation and dates

For each type of support please specify start and end date, and preferred presentations.

Note 3

Measles 1st and 2nd dose routine

Preferred presentation	M, 10 doses/vial, Lyophilised
Is the presentation licensed or registered?	Yes ☒ No ☐
2nd preferred presentation	M, 5 doses/vial, Lyophilised
Is the presentation licensed or registered?	Yes ☒ No ☐
Required date for vaccine and supplies to arrive	6 June 2021
Planned launch date	5 September 2021
Support requested until	2021

3.1.2 Vaccine presentation registration or licensing

If any of the selected presentations are not yet licensed or registered, please describe the duration of the registration or licensing procedure, whether the country's regulations allow the expedited procedure for national registration of WHO-pre-qualified vaccines, and confirm whether the licensing procedure will be completed ahead of the introduction or campaign.

No Response

3.1.3 Vaccine procurement

Gavi expects that most countries will procure vaccine and injection supplies through UNICEF or PAHO's Revolving Fund.Does the country request an alternative mechanism for procurement and delivery of vaccine supply (financed by the country or Gavi)?

Yes☐	No☒

If you have answered yes, please attach the following in the document upload section:* A description of the mechanism, and the vaccines or commodities to be procured by the country through this mechanism.* A confirmation that vaccines will be procured from the WHO list of pre-qualified vaccines, indicating the specific vaccine from the list of pre-qualification. OR, for the procurement of locally-produced vaccines directly from a manufacturer which may not have been prequalified by WHO, a confirmation should be provided that the vaccines purchased comply with WHO's definition of quality vaccines, for which there are no unresolved quality

problems reported to WHO, and for which compliance is assured by a fully functional National Regulatory Authority (NRA), as assessed by WHO in the countries where they are manufactured and where they are purchased.

3.2 Target Information

3.2.1 Targets for routine vaccination

Please describe the target age cohort for the Measles 1st dose routine immunisation:

Note 4

9	weeks ☐	months ☒	years ☐

Please describe the target age cohort for the Measles 2nd dose routine immunisation:

15	weeks ☐	months ☒	years ☐

	2021
Population in the target age cohort (#)	595,480
Target population to be vaccinated (first dose) (#)	535,932
Population in the target age cohort for last dose(#)	595,480
Target population to be vaccinated for last dose (#)	208,418
Estimated wastage rates for preferred presentation (%)	35

3.3 Co-financing information

3.3.1 Vaccine and commodities prices

Price per dose (US$) - Measles routine, 1st and 2nd dose

	2021
10 doses/vial,lyo	0.29

Commodities Price (US$) - Measles routine, 1st and 2nd dose (applies only to preferred presentation)

	2021
AD syringes	0.036
Reconstitution syringes	0.004
Safety boxes	0.005
Freight cost as a % of device value	4.18

3.3.2 Country choice of co-financing amount per vaccine dose

The table below shows the estimated financial commitment for the procurement of vaccines and supplies for the country, and the portion of Gavi support.
Please note that the values represented in this table do not account for any switches in co-financing group. The calculations for the entire five year period are based on the countries co-financing group in the first year.

Note 5

	2021
Country co-financing share per dose (%)	69.69
Minimum Country co-financing per dose (US$)	0.2
Country co-financing per dose (enter an amount equal or above minimum)(US$)	0.2

3.3.3 Estimated values to be financed by the country and Gavi for the procurement of supply

Measles routine, 1st and 2nd dose

	2021
Vaccine doses financed by Gavi (#)	507,600
Vaccine doses co-financed by Country (#)	925,300
AD syringes financed by Gavi (#)	1,134,100

AD syringes co-financed by Country (#)	
Reconstitution syringes financed by Gavi (#)	
Reconstitution syringes co-financed by Country (#)	
Safety boxes financed by Gavi (#)	12,475
Safety boxes co-financed by Country (#)	
Freight charges financed by Gavi ($)	13,356
Freight charges co-financed by Country ($)	24,345

	2021
Total value to be co-financed (US$) Country	287,000
Total value to be financed (US$) Gavi	214,000
Total value to be financed (US$)	501,000

3.3.4 Estimated projection of the required domestic financing for the measles monovalent component of MCV1

Countries are required to domestically finance the first dose in their measles containing vaccine routine (MCV1) in order to be able to receive Gavi support for any measles/ measles-rubella programmes. Below is the estimated projection of the required domestic financing for MCV1, based on the information provided in the previous sections.

Note 6

	2021
Minimum number of doses financed	1,031,688

from domestic resources	
Country domestic funding (minimum)	296,094.46

3.3.5 Co-financing payment

Please indicate the process for ensuring that the co-financing payments are made in a timely manner.

Most of the time, UNICEF is using the internal resource to ensure the co-financing of Penta vaccine, in fact, UNICEF is procuring traditional vaccines (BCG, measles, Td, OPV). Due to low national revenue generation and the budget priority is given to other core sectors i.e. security, justice, and reconciliation, the country requested a waiver from co-financing of GAVI supported vaccines for Somalia for a period of 3 years. in 2020, Gavi, UNICEF, and other partners have conducted the advocacy to WB for the co-financing so as the country will avoid the stock out of Penta, fortunately this request was approved and 198, 000 was released for the co-financing.

If your country is in the accelerated transition phase for Gavi support, please answer the following question:

Please provide evidence that the co-financing obligations for the new introduction have been budgeted for, and elaborate on how the country plans to pay for the fully self-financing amounts. Please discuss the extent to which medium-term immunisation/health plans and medium-term expenditure frameworks incorporate the additional costs associated with this introduction. Discuss any co-financing defaults that may have happened in the last five years.

No Response

Following the regulations of the internal budgeting and financing cycles the Government will annually release its portion of the co-financing funds in the month of:	August

The payment for the first year of co-financed support will be made in the month of:

Month	July
Year	2021

3.4 Financial support from Gavi

3.4.1 Routine Vaccine Introduction Grant(s)

Measles-rubella 1st and 2nd dose routine

Live births (year of introduction)

626,821

Gavi contribution per live birth (US$)

0.8

Total in (US$)

501,456.8

Funding needed in country by	28 February 2021

3.4.2 Operational budget

Please complete the Gavi budgeting and planning template to document how the Gavi Vaccine Introduction Grant will be used to facilitate the timely and effective implementation of critical activities in advance of and during the introduction of the new vaccine. Please ensure to upload the completed budgeting and planning template as part of this application.

If Gavi's support is not enough to cover the full needs please indicate how much and who will be complementing the funds needed in the Operational Budget template. In the following fields please provide an overview of your request.

Total amount - Gov. Funding / Country Co-financing (US$)

501456

Total amount - Other donors (US$)

0

Total amount - Gavi support (US$)

501456

Amount per target person - Gov. Funding / Country Co-financing (US$)

0

Amount per target person - Other donors (US$)

0

Amount per target person - Gavi support (US$)

0.8

3.4.3 Key Budget Activities

List the key budgeted activities to be undertaken in implementing the requested support. Please provide details on the key cost drivers, inputs and assumptions required for these activities.

Coordination and communication
Microplaning
Capacity building
Advocacy, communication and social mobilization
revision and printing of tools
Supervision and Monitoring

3.4.4 Financial management procedures

Please describe the financial management procedures that will be applied for the management of the NVS direct financial support, including any procurement to be incurred.

WHO and UNICEF will receive funds and will implement activities according to the MoU

3.4.5 Compliance with guidelines for use of Gavi financial support for human resources (HR) costs

Does the submitted application and budget comply with existing guidelines, criteria and requirements for use of Gavi financial support for human resources (HR) costs?

Yes☒ No☐

Please provide further information and justification concerning human resources costs, particularly when issues and challenges have been raised regarding the compliance with Gavi guidelines.

Most of the budget is used for advocacy, communication and social mobilization, training, microplanning, revision of tools and printing, supervision and monitoring. The VIG is not used for HR cost. No salary will be paid to HR from VIG

3.4.6 Fiduciary management

Please indicate whether funds for operational costs should be transferred to the government or WHO and/or UNICEF and when funding is expected to be needed in country. Attach banking form if funding should be transferred to the government. Please note that UNICEF and WHO will require administrative fees as follows.

- **UNICEF Tripartite Agreement: 5%**
- **UNICEF Bilateral Agreement: 8%**
- **WHO Bilateral Agreement: 7%.**

Funds will be transferred to WHO and UNICEF

3.4.7 Use of financial support to fund additional Technical Assistance needs

Gavi funds through its Partner Engagement Framework / TCA, tailored and differentiated technical assistance in response to specific country needs. Please review the currently approved technical assistance plan (also referred to as the "One TA plan") with a view to assess that required support for the implementation of the new vaccine support is contained in the approved technical assistance plan. If gaps in technical assistance are identified for the new vaccine support, the additionally required technical assistance may be funded through the vaccine introduction grant or campaign operational costs support. In this case, the relevant costs must be reflected in the budgeting and planning template. In addition, please indicate the programmatic areas for additional technical assistance needs and the respective agencies providing the technical assistance (if already identified) below.

Note 8

Available TA will be used for NVI

3.5 Strategic considerations

3.5.1 Rationale for this request

Describe the rationale for requesting these new programme(s), including the burden of disease. If already included in detail in the Vaccine Introduction Plan or Campaign Plan of Action, please cite the sections only.

Burden of Disease
Rationale for MCV2 introduction
Imapct of MCV2 introduction

3.5.2 Alignment with country strategic multi-year plan / comprehensive multi-year plan (cMYP)

Please describe how the plans and key assumptions in this request align with the most recent country strategic multi-year plan (cMYP) and other national health and immunisation plans.

It is align with cMYP and 5 years measles and Rubella in Somalia. Current cMYP is coming to an end by end of December 2020, new cMYP will be developed for next cycle.

3.5.3 Coordination Forum (ICC, HSCC or equivalent) and technical advisory committee (NITAG)

Provide a description of the roles of the national Coordination Forum (ICC, HSCC or equivalent body) and national immunization technical advisory group (NITAG) in developing this request.
If any of Gavi's requirements to ensure basic functionality of the relevant national Coordination Forum (ICC, HSCC or equivalent) were not met, please describe the reasons and the approach to address this. Requirements can be found in the general application guidelines.
In the absence of a NITAG, countries should clarify the role and functioning of the advisory group and describe plans to establish a NITAG.

Currently NITAG is not functional in Somalia and ICC is established and function. Member of ICC were involved in discussion and agreement on MCV2 introduction. All the federal member states and Somaliland held a series of meetings and discussions with partners to agree on the schedule of routine immunization, especially during 2nd year of life including MCV2. They agreed on the age for the MCV2 and the type of vaccine. After agreement, the matter was referred to the ICC.
Following the advice of the ICC, the country decided to introduce a second dose of measles into the immunization schedule so that it would boost the collective immunity of children and therefore the program will be able to eliminate measles in the coming years. On 9th January 2019, the National ICC members approved the planned introduction of MCV 2 vaccines as per the 5-year strategic plan.

3.5.4 Financial sustainability

Please discuss the financing-related implications of the new vaccine programs requested, particularly how the government intends to fund the additional co-financing obligations. Please mention if any defaults occurred in the last three years and, if so, describe any mitigation measures that have been implemented to avoid future defaults. Additionally has the country taken into account future transition from Gavi support?

Currently world Bank is supporting country with to cover cost of co financing of vaccine. It is expected that world bank will continue their support till government is able to pay their share.

3.5.5 Programmatic challenges

Summarise programmatic challenges that need to be addressed to successfully implement the requested vaccine support, and describe plans for addressing those. These may include plans to address the barriers identified in the coverage and equity situation analysis section, and include vaccine supply chain, demand generation/ community mobilisation, data quality/ availability/ use and leadership, management and coordination, etc.

Challenges to immunization in Somalia are well known and range from coordination to implementation of activities, in particular given within the changing political environment and lack of coordination between different administrative levels of authority. The country has also experienced challenges in access due to insecurity in some locations. As a result, many communities have faced difficulties in accessing routine immunization services. Experience with the recent IPV introduction has shown that there will be no major challenge in the community accepting the vaccine. Some challenges anticipated with MCV2 introduction are the following:

• Coordination & Programme Management: Somalia's health system is still fragile and there is a weak district health system. The EPI programme staffing at the MOH level is weak. The EPI managers are not 100% for EPI; in addition, they are fulfilling functions of other units of the health department.

• Denominators: High movement of population due to conflict/insecurity, lifestyle and drought/flood has made it difficult to have proper denominators at region/district levels. MCH catchment areas have no defined target population.

• Access: About 40% of the population is estimated to be rural, more than 20 – 30% of the population are nomadic; and most are excluded from the benefits of immunization that are mainly located around urban areas. About 15% of the territory is under Al Shabab control and still inaccessible for immunization.

• Defaulter tracing: There is high drop-out rate in some of the districts and regions. Weak or near to no defaulter tracing at lower level due to lack of supervision as well as minimal financial resources or incentives for health workers.

• Human Resource Quantity & Quality: Appropriate staffing and job descriptions are not available in most MCHs. Staff are overwhelmed with multiple responsibilities. There is a scarcity of trained manpower, delayed salaries and low incentives for service providers in public facilities.

• Supervision and monitoring: There is a weak supervision and support from health authorities to MCH/OPDs; poor monitoring of NGOs performance, and weak monitoring and evaluation system.

• Surveillance: AFP surveillance is well established and measles case-based surveillance has been started in all zones and expanded to all accessible districts. Apart from AFP surveillance, there is limited monitoring of surveillance activities, little use of surveillance data at local level, as well as weak capacity at local level in detecting and responding to outbreaks.

• High logistics cost: Distribution of vaccines and supplies along with other logistics cost for Somalia is high. Main vaccine cold store and warehouse is located in Nairobi and supplies are then distributed by air freights to all main parts of Somalia.

• Cold chain availability & functionality: The absence of District Stores necessitates the distribution of vaccines on a monthly basis to the health facilities from the Regional Stores.

• Community Demand & Utilization: Demand and uptake of vaccination services is low because the parents/caregivers are not motivated and do not have adequate knowledge on the value of immunization; poor IPC skills amongst HW; weak linkage between communities and the health facilities; HW do not have client oriented approach; communities have limited involvement in planning of routine/SIA vaccination services. Advocacy for higher level participation and ownership of the program is weak due to gaps in skills, funds and priorities.
• Data management: Data are collected by multiple partners, coverage calculated by UNICEF and WHO, and endorsed by local health authorities. Big discrepancy between the reported coverage and the coverage surveys, under and over reporting has been observed. Limited use of data at peripheral level for decision making. All EPI activities are performed based upon round estimates given by central level. Coverage data and vaccine management are not monitored on regular basis.
• Financial resources: Gap in dedicated government budget contribution or regular allocation for EPI. Program is heavily donor-dependent, unpredictable and dwindling budget for immunization activities. Emergencies are gaining more attention of donors and shifting the priority away from regular programs including EPI. Currently GAVI is the only traditional donor for EPI services aimed at strengthening the health system.

3.3b Mitigations/Way forward: Immunization services have recently improved in GAVI-supported districts due to capacity building of service providers in immunization practices. In 2018 and 2019 many health workers were trained on immunization practices, defaulter tracing and vaccine safety. MCV2 introduction will be an opportunity to address most of the issues listed above. The expansion of GAVI support to other districts will improve the quality of immunization services and motivate health workers with appropriate knowledge of immunization.

The establishment of ICC and capacity-building of immunization management through mid-level management training have provided an opportunity to conduct regular EPI reviews at regional and district levels and have been a platform to develop improved skills and capacities of health workers in microplanning, data management, IPC skills. This will lead to accurate and realistic denominators, estimates for the targets of catchment area by triangulating all available resources including Polio data, small household surveys per catchment areas.

The current COVID-19 pandemic response activities laid the ground for raising awareness in the community about the importance of vaccination. Indeed, more than 3000 rapid response team members were deployed in the country and they have been disseminating information about routine immunization. MCV2 introduction will refresh training on personal communication skills including social mobilization activities for good and clear communications with the mother, care takers and clear messages about next visits for vaccination including for missed vaccines. Every opportunity will be used for disseminating messages on importance of vaccination to create demand for vaccination in the community.

Dissemination and adaption of recently approved and endorsed revised EPI policy at all level will emphasize the establishment of the 2nd year life platform and the catchment schedule to ensure completion of all missed doses during first and 2nd year of child life according to the national schedule.

Since DHIS2 rolled out, Somalia’s health system has been addressing gaps in data including training, compilation, analysis, record keeping and data use through implementation of the DQIP (Data Quality Improvement Plan). Under this plan data management tools will be revised and updated to accommodate new changes, including data related to new vaccines (MCV2 and other vaccines which will be introduced in near future including IPV2, PCV, Rota etc). It will also address the 2YL vaccination and catch-up schedule, hoping that this will improve data availability and ease the validation and data use.

Implementation of urban immunization with the help of additional resources from GAVI will assist in addressing the issues of engagement of the private sector to mitigate the gap of trained manpower and improve immunization coverage.

Immunization for the 2nd year of life

The 2nd year life platform is one of the ways forward from most of the challenges mentioned above. The updated EPI policy highlights that the 2nd year of life is an opportunity to further integrate immunizations with other health interventions such as Vitamin A supplementation, nutrition, growth monitoring and deworming. Second Measles Containing Vaccine dose (MCV2), IPV2 is recommended; and some new vaccines are strongly recommended beyond infancy.
2nd year life is also an opportunity for the children who were unable to get vaccines during their first year of Life to finally get immunized. Health workers and vaccinators will be trained to use this opportunity for a catch-up of missed children to complete their vaccination schedule and boost their immunity against vaccine preventable diseases.
2nd year life platform will also be used for a booster dose of vaccines like DPT4.
Data tools are being revised and updated and will capture vaccination records and reports during 2nd year of life. The country will adapt the WHO guidelines for the establishing of the 2YL platform in all steps (planning, implementation and monitoring) of the MCV2 introduction and during any future new vaccine introduction.

3.5.6 Improving coverage and equity of routine immunisation

Explain how the proposed NVS support will be used to improve the coverage and equity of routine immunisation, by detailing how the proposed activities and budget will contribute to overcoming key barriers.

Immunization coverage has improved in recent years although there are disparities at sub national level. Some districts and regions are performing better than others. The improvement is more evident in GAVI-supported districts due to many factors including capacity building of service providers in immunization practices. In 2018 and 2019 many health workers were trained on immunization practices, defaulter tracing and vaccine safety. MCV2 introduction will be an opportunity to address most of the issues listed above. The expansion of GAVI support to other districts will improve the quality of immunization services and motivate health workers with appropriate knowledge of immunization.
The establishment of ICC and capacity-building of immunization management through mid-level management training have provided an opportunity to conduct regular EPI reviews at regional and district levels and have been a platform to develop improved skills and capacities of health workers in microplanning, data management, IPC skills. This will lead to accurate and realistic denominators, estimates for the targets of catchment area by triangulating all available resources including Polio data, small household surveys per catchment areas.
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2nd year life platform will also be used for a booster dose of vaccines like DPT4.
Data tools are being revised and updated and will capture vaccination records and reports during 2nd year of life. The country will adapt the WHO guidelines for the establishing of the 2YL platform in all steps (planning, implementation and monitoring) of the MCV2 introduction and during any future new vaccine introduction.
During MCV2 introduction refresher trainings will be conducted for vaccinators and EPI manager, microplans will also be revised and updated. It will lead to vaccinate more children with improved skills and knowledge and improve vaccine management, reporting and recording.
Advocacy, communication and social mobilization activities will also create demand for vaccine in community and influential including IDPs, urban slums and rural areas. Supervision and monitoring will identify any gaps in service delivery and in programme performance and can action will be taken for corrective measures.

3.5.7 Synergies

Describe potential synergies across planned and existing Gavi support, including planned introductions, campaigns and HSS support. If relevant, comment on capacity and appropriate systems to introduce multiple vaccines. Also describe how the country will mitigate any programmatic and financial risks associated with multiple introductions. Furthermore, how is the requested support complementary and creating synergies with the support of other Global Health Initiatives, such as the Global Fund and GFF?

Note 9

Every opportunity is used for synergy with other programmes, like recently conducted integrated measles, polio, vitamin A and deworming campaign. Opportunity of MCV2 introduction will also used for synergy with other programmes including GF and GFF especially at the district and regional level.

3.5.8 Indicative major measles and rubella activities planned for the next 5 years

Summarise in one paragraph the indicative major measles and rubella activities planned for the next five years that are reflected in the annual EPI plan (e.g. measles second dose introduction, measles or measles follow up campaign, etc.).

Introduction of MCV2
MR introduction in 2023

3.6 Report on Grant Performance Framework

Grant Performance Framework – Application Instructions

The Grant Performance Framework (GPF) contains all indicators that will be used to monitor programmatic performance for your requested type of support. Targets that were entered for number to be vaccinated in section 3 on the Target Information tab, have been carried over into their respective indicators in the GPF. Based on these numbers, coverage and dropout rate targets were calculated (where applicable). These appear as “calculated targets”. If you wish to revise these target values, please revise in the application form – they are not editable in the performance framework. In addition, as a part of your application, there are several items to be filled directly into the GPF. These are broken into required and optional items, below:

Required
1. In addition to the calculated targets, country targets are required to be submitted for outcome indicators. These targets should align to those in your cMYP or NHSP. If these targets are not in your cMYP or NHSP, or are the same as the calculated targets, please enter “NA” for each target value.
2. Additional indicators that appear in the Performance Framework that are not included in the application form. Please enter targets for these indicators.
3. For many indicators, reporting dates have been pre-populated. For those that have not yet been pre-populated, please add reporting dates.

Optional
1. Adding data sources to existing indicators: If there are data sources for indicators that you would like to include, you may add an additional source by clicking on the pencil icon next to the indicator name.
2. Adding new indicators: Gavi requires all countries to report on core indicators, which are already included in the GPF. If you wish to add supplemental indicators to monitor performance, you may do so by clicking the “Add indicator” button at the respective performance level (Outcome, Intermediate Result, or Process).

Please note that the GPF is filtered by default to only show indicators that are relevant to the specific types of support contained in the application. You may view the entire GPF by using the “Grant Status” filter. Please ensure your pop-up blocker is disabled when launching the GPF.

If you have any questions, please send an email to countryportal@gavi.org.

3.7 Upload new application documents

3.7.1 Upload new application documents

Below is the list of **application specific documents** that must be provided with your application.

In the case a document cannot be provided, please use the comment box to explain why, or by when it will be available.

Application documents

✓	**New vaccine introduction plan (NVIP) and/or campaign plan of action (PoA), including checklist & activity list and timeline** If support for a campaign and routine introduction is requested at the same time, the new vaccine introduction plan and campaign plan of action can be combined into one document to minimise duplication.	Somalia New vaccine introduction plan091020_09-10-20_13.43.25.doc
✓	**Gavi budgeting and planning template**	Budgeting and Planning TemplateSomalia 28092020 v3_06-10-20_08.23.30.xlsm
	Most recent assessment of burden of relevant disease If not already included in detail in the Introduction Plan or Plan of Action.	**No file uploaded**

Endorsement by coordination and advisory groups

✓	**National coordination forum meeting minutes, with endorsement of application, and including signatures**	Somalia ICC Meeting Minutes_MCV2 introduction Proposal on 3rd October 2020_06-10-20_18.56.29.pdf

The minutes of the national coordination forum meeting should mention the domestic funding of MCV1

✓ **NITAG meeting minutes**

with specific recommendations on the NVS introduction or campaign

Somalia ICC Meeting Minutes_MCV2 introduction Proposal on 3rd October 2020_06-10-20_18.58.26.pdf

Vaccine specific

✓ **cMYP addendum**

Situation analysis and 5 year plan captured in the cMYP or as an addendum to the cMYP

9. CMYP Somalia Final_06-09-20_19.57.24.pdf

✓ **Annual EPI plan**

Annual EPI plan detailing planning of all measles and rubella-related activities for the current year, including realistic timelines, designated responsible individual(s) and a budget

Copy of Annual EPI WP2021_06-09-20_19.48.21.xlsx

✓ **MCV1 self-financing commitment letter**

If the country is not yet financing the measles monovalent component of MCV1, a letter signed by the Minister of Health and Minister of Finance committing for the country to self-finance MCV1 from 2018 onwards.

commitment letter_06-09-20_19.59.31.pdf

✓ **Measles (and rubella) strategic plan for elimination**

If available

27. National Mealsles Strategy 5 yr plan_06-09-20_19.58.10.pdf

Other documents (optional) **No file uploaded**

4 Review and submit application

4.1 Submission Details

Country vaccine funding summary

Please review the estimated projections for new vaccine programmes included in this application.

Active Vaccine Programmes

Note 10

IPV Routine

	2020	2021	2022
Country Co-financing (US$)			
Gavi support (US$)	944,355	977,580	1,011,316

Pentavalent Routine

	2020	2021	2022	2023	2024
Country Co-financing (US$)	215,247	226,397	235,535	244,863	254,375
Gavi support (US$)	594,115	624,892	650,114	675,860	702,115

Total Active Vaccine Programmes

	2020	2021	2022	2023	2024
Total country co-financing (US$)	215,247	226,397	235,535	244,863	254,375
Total Gavi support (US$)	1,538,470	1,602,472	1,661,430	675,860	702,115
Total value (US$) (Gavi + Country co-financing)	1,753,717	1,828,869	1,896,965	920,723	956,490

New Vaccine Programme Support Requested

Measles 1st and 2nd dose routine

	2021
Country Co-financing (US$)	287,000
Gavi support (US$)	214,000

Total country co-financing (US$)	
Total Gavi support (US$)	
Total value (US$) (Gavi + Country co-financing)	

Total Portfolio Overview – Existing Programs + New Vaccine Support Requested (US$)

	2020	2021	2022	2023	2024
Total country co-financing (US$)	215,247	513,397	235,535	244,863	254,375
Total Gavi support (US$)	1,538,470	1,816,472	1,661,430	675,860	702,115
Total value (US$) (Gavi + Country co-financing)	1,753,717	2,329,869	1,896,965	920,723	956,490

Contacts

Person(s) who should be contacted in case Gavi needs to ask for more information in regard to the application.

Name	Position	Phone Number	Email	Organisation
Mukhtar Abdi	EPI Manager	+252615541871	epi@moh.gov.so	Fedral Ministry of Health

Comments

Please let us know if you have any comments about this application

No Response

Government signature form

The Government of Somalia would like to expand the existing partnership with Gavi for the improvement of the immunisation programme of the country, and specifically hereby requests Gavi support for:

Measles 1st and 2nd dose routine

The Government of Somalia commits itself to developing national immunisation services on a sustainable basis in accordance with the national health and immunisation strategic plans. The Government requests that Gavi and its partners contribute financial and technical assistance to support immunisation of children as outlined in this application.

The co-financing commitments in this application include the amount of support in either supplies or cash that is requested from Gavi, and the financial commitment of the Government for the procurement of this new vaccine.

Please note that Gavi will not review this application without the signatures of both the Minister of Health and Minister of Finance (and Minister of Education, if applicable) or their delegated authority.

We, the undersigned, affirm that the objectives and activities in this request are fully aligned with the national health and immunisation strategic plans (or equivalent), and that funds for implementing all activities, including domestic funds and any needed vaccine co-financing will be included in the annual budget of the Ministry of Health.

We, the undersigned, further affirm that the requested funding for salaries, salary top-ups/allowances, per diems and incentives does not duplicate funding from other sources (e.g. from other donors).

We, the undersigned, further affirm that the terms and conditions of the Partnership Framework Agreement between Gavi and the Country remain in full effect and shall apply to any and all Gavi support made pursuant to this application.[1]

Minister of Health (or delegated authority)	**Minister of Finance (or delegated authority)**
Name	Name
Date	Date
Signature	Signature

For countries requesting HPV support, with a school linked strategy, the signature of the Minister of Education (or delegated authority) is also required.

Minister of Education (or delegated authority)

Name

Date

Signature

[1] *In the event the Country has not yet executed a Partnership Framework Agreement, the terms and conditions of this application shall apply to any and all Gavi support made pursuant to this application.*

Appendix

NOTE 1
The new cMYP must be uploaded in the country document section.

NOTE 2
The purpose of these estimates is to provide visibility into the current and future vaccine funding requirements. The values reflected here are a combination of actuals and estimates. Specifically, current year values reflect values approved by the secretariat, while future values are based on data provided by the country – when data isn't available we rely on extrapolations to estimate funding needs. Please note that any future values might be subject to change, and for the official obligations a country should refer to its active Decision Letter.

NOTE 3
* For more information on the vaccine presentations available, please refer to the detailed product profiles available here: http://www.gavi.org/about/market-shaping/detailed-product-profiles/

* Please note Gavi may not be in a position to accommodate all countries first product preferences. In such cases, Gavi will contact the country and partners to explore options.

* Due to a variety of factors, the launch date may vary compared to the date stipulated in the application. Gavi will work closely with countries and their partners to address these issues.

* For routine vaccine introduction, support is usually requested until the end of the country's valid cMYP, as per the guidelines and may be extended in the future. If you wish to request Gavi support for a shorter time period than the end of your cMYP you may do so.

* For campaigns the "support requested until" field will normally be one calendar year from the launch date, but can be extended for a phased campaign.

NOTE 4
* The population in the target age cohort represents 100% of people in the specified age range in your country.

* The target population to be vaccinated is the number of people in the cohort that are expected to be vaccinated.

* For indicative wastage rates, please refer to the detailed product profiles available here: http://www.gavi.org/about/market-shaping/detailed-product-profiles/

* The wastage rate applies to first and last dose.

NOTE 5
Co-financing requirements are specified in the guidelines.

NOTE 6
*The price used to calculate costs is based on UNICEF-single dose per vaccine procurement cost for measles monovalent vaccine.** This value will differ from the total cost if the vaccine selection is MR, as a country is only required to finance the cost of the measles monovalent vaccine.

NOTE 7
https://www.gavi.org/support/process/apply/additional-guidance/#leadership

NOTE 8
A list of potential technical assistance activities in each programmatic area is available here: http://www.gavi.org/support/pef/targeted-country-assistance/

NOTE 9
E.g. if two introductions are planned in the same year, there should be synergies at least in training and social mobilisation events.

NOTE 10
The purpose of these estimates is to provide visibility into the current and future vaccine funding requirements. The values reflected here are a combination of actuals and estimates. Specifically, current year values reflect values approved by the secretariat, while future values are based on data provided by the country – when data isn't available we rely on extrapolations to estimate funding needs. Please note that any future values might be subject to change, and for the official obligations a country should refer to its active Decision Letter.