EVALUATION OF THE GAVI, THE VACCINE ALLIANCE SUPPORT TO HEALTH SYSTEM STRENGTHENING IN SOMALIA

Evaluation conducted by:

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KEY ACRONYMS

APR	**Annual Progress Report**
BCC	**Behaviour Change and Communication**
CBHIS	**Community Based Health Information System**
CHWs	**Community Health Workers**
cMYP	**comprehensive Multi – Year Plan**
DFID	**Department 3for International Development (United Kingdom)**
DHT	**District Health Team**
DPT3	**Third dose of the Diphtheria-Tetanus-Pertussis vaccine**
EPHS	**Essential Package of Health Services**
EPI	**Expanded Programme on Immunization**
FCHWs	**Female Community-based Health Workers**
FGD	**Focus Group Discussion**
GDP	**Gross Domestic Product**
GNU	**Government of National Unity**
JAR	**Joint Appraisal report**
JHNP	**Joint Health and Nutrition Programme**
HA	**Health Authorities**
HMIS	**Health Management Information System**
HP	**Health Post**
HSC	**Health Sector Committee**
HSS	**Health System Strengthening**
KII	**Key informant Interview**
IDPs	**Internally Displaced Persons**
IEC	**Information, education and communication**
IMR	**Infant Mortality Rate**
LHWs	**Lady Health Workers**
MCH	**Maternal and Child Health**
M&E	**Monitoring and Evaluation**
MOH	**Ministry of Health**
Penta	**Pentavalent vaccine**
PHC	**Primary Health Care**
PHUs	**Primary Healthcare Units**
SCM	**Senior Country Manager**
Sida	**Swedish International Development Agency**
TBAs	**Tradtional Birth Attendants**
TWG	**Technical Working Group**
U5MR	**Under-5 Mortality Rate**
UN	**United Nations**
UNICEF	**United Nations Children's Fund**
UNFPA	**United Nationals Fund for Population Activities**
WB	**World Bank**
WHO	**World Health Organization**

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EVALUATION TEAM

This evaluation was conducted by the following members of staff from the University of Zambia:

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EXECUTIVE SUMMARY

Background to Gavi HSS support to Somalia

The Somalia Gavi HSS proposal was reviewed and recommended for approval by the Gavi Independent Review Committee in October 2009. In the same year, Gavi, the Vaccine Alliance, approved the proposal. However, the grant was only signed and became effective in September 2011, with the implementation of the grant scheduled to start in September 2011 and run through 31st December 2015. The first tranche of Gavi HSS funding was disbursed in October 2011. Because of the delay in the start date, the Government and partners got approval for a reprogramming in September 2013. The country also asked to shift the end date for implementation to the year 2016 instead of 2015 (as contained in the reprogramming decision letter).This no-cost extension to October 2016 was provided in 2015. Given that no evaluation of any sort has been done for the Gavi HSS grant, the Gavi Alliance sponsored an evaluation of the implementation of the Gavi HSS programme in Somalia. The aim was to assess programme performance in various aspects including design, relevance, implementation, efficiency, sustainability, and results. The results of the evaluation will among other things, inform proposal development for the next Gavi HSS grant to Somalia.

Objectives of Gavi HSS grant

The key objectives of the Somalia Gavi HSS grant as outlined in the original proposal, as well as in the reprogrammed proposal, were stated as follows:

Objective 1: To improve availability and utilization of immunisation and other essential maternal and child health services within 40 MCH facilities and 80 Health posts.

Objective 2: Introduce, on pilot basis, a new cadre of 200 Female Community- based Health Workers (FCHWs) providing mainly preventive services to a defined catchment population to help improve immunization coverage.

Objective 3: Implementation of a comprehensive and sustained behavioural change communication strategy.

Objective 4: Undertake operational research of the Gavi HSS components**.**

The targets of these objectives were: to increase national DPT 3 coverage from 36% in 2006 to 55%, increase number of regions achieving at least 80% DPT 3 coverage by 30%, reduce under five mortality rate from 145 per 1000 in 2007 to 125, increase measles immunization coverage from 19% in 2006 to 60%, increase the percentage age of pregnant women aged 15-49 years attending at least one antenatal visit from 26% in 2006 to 50% in 2014, and increase coverage of Vitamin A supplementation from 24% in 2006 to 60%.

During the reprogramming process, a number of key activities were changed, particularly under objective 3. According to the reprogramming proposal, the rationale for the reprogramming was to a) intensify implementation of activities; b) account for increased unit costs and c) accommodate the substantial amount of carry-over from previous years.

Methodology

The evaluation is retrospective in nature and uses various qualitative and quantitative methods to evaluate the performance of the Gavi HSS grant in Somalia. Four main data collection methods have been used and these include in-depth interviews with key informants, document reviews, focus group discussions and facility visits for direct observation. Field visits were also undertaken to six health facilities in two districts in Somaliland and Puntland.

Key results

Planning and design

1. Unforeseen security challenges in some parts of the country have invalidated initial assumptions regarding the country's political and health system context leading to overstated feasibility of some of the proposed activities. To a large extent the assumptions made at design stage regarding the security situation have turned out to be correct especially in Somaliland and parts of Puntland; Somaliland enjoyed relatively a calmer and more peaceful environment, while pockets of violence were evidenced in Puntland. The situation in the South/Central zone remained with a more unpredictable and violent environment. This is evidenced by the different rates of implementation in the three zones with the Central/South region lagging behind.
2. The link between the Gavi Health System Strengthening (HSS) and the expanded programme on immunisation (EPI) outcomes was weak. For example, the Female Health Workers (FHWs) are trained to promote utilization of primary health care (PHC) in general but their work is not directly linked to EPI provision except remotely through community sensitization. It is noted that the Gavi guidelines for that Gavi HSS grant did not have a mandatory requirement for a link between Gavi HSS and EPI outcomes.
3. The scope of Gavi HSS proposal in terms of geographic coverage was narrow. One of the outcome indicators for instance was to increase National DPT3 coverage from 36% to 55%. This seems too ambitious and not feasible given that the programme was implemented in few districts and in less than 20 % of the MCHs. Further the programme was not EPI-focused, and the level of funding was too limited to yield the stated impact.
4. There was broad consensus that the proposed disbursement modalities were appropriate given the country's context and capacity constraints within the government.
5. Though relevant, the feasibility of implementing the strategy of recruiting and deploying 200 FHWs has been constrained by local context. The 200 FHWs have an estimated total coverage of 40,000 households out of a total of about 2,000,000 households in the country. The strategy of FHW needed to be adapted to suit the context in which the FHWs operate. Some of the challenges which have hindered the effectiveness of the FHWs are as follows: (a) sparse density of the population was not adequately considered, (b) the work of FHWs is made harder by the highly mobile population, and (c) most FHWs are not trained to administer vaccines although this is enshrined in the Somali Gavi HSS compendium, and (d) although there is an EPI component to their work, they mainly perform non–EPI functions which limits their contribution to increasing immunization coverage.

Implementation

1. Implementation of the Gavi HSS grant activities has achieved many of the milestones stipulated in the implementation plan. Key activities such as facility refurbishment, cold chain equipment procurement, vaccine supplies and staff incentives and training, and community sensitization have been successfully conducted. A community Health Information Systems has been set up and is functional. However, there has been delay in conducting operations research under the fourth and last objective of the grant. Most of the activities under operations research might not inform implementation as they will come too late in the lifespan of the grant. Further, there have been delays in implementation of the Behaviour Change and Communication (BCC) programme. As of September 2015, BCC has only been implemented in four of 13 targeted regions in Puntland. Initially, BCC was handed to the government to implement. However, due to delays, the activity was taken back from the government and handed to NGOs under coordination of UNICEF.
2. There has been no institutionalised outreach yet despite outreach being stated as a key activity to increase access to EPI services.
3. Implementation of some activities is being hampered by weak health system management capacity in the government, weak public financial management systems, limited human resource capacity and security concerns (especially in central-south and Puntland).
4. Implementation of Gavi HSS M&E function is still fragmented. Under the Gavi HSS grant, two activities were scheduled; one was addressing the production and distribution of M&E tools while the other was the development of a community based information system. The national M&E framework has been developed (through other programs) for all three zones, but its implementation is still developing. The only HMIS data available is from 2013 and this data gap creates problems when evaluating performance of the Gavi HSS grant.
5. Many stakeholders have expressed dissatisfaction about the quality of coordination of the Gavi HSS grant. Information sharing is generally considered to be poor, while government leadership is evidently weak, and several points of differences of opinion between the UN and other stakeholders point to weaknesses in coordination which need to be resolved. Decision-making authority is sometimes unclear between the UN and the Health Authorities.

6. During our field visits, it was established that none of the six facilities visited reported having had ran out of Penta, Measles, BCG, Measles vaccines or syringes for more than one week in the one month prior to the survey.

Efficiency

7. By and large this evaluation established that the programme actual expenditure has been implemented according to the plans.

8. Overall, the efficiency of the grant has been undermined by the delays in implementing activities. The grant now ends in October 2016 instead of the initial December 2015 end date. There were also indications that administrative delays in procurement and decision making were sources of inefficiency in executing the grant. Some of the delays in decision-making and implementation have been caused by the location of the partners in

Nairobi while the programme is being implemented in Somalia. These points were not heavily substantiated though, and have been somewhat disputed by the UN partners managing the grant.

9. About 62 % of the funds have been utilized, meaning more than a third of the funds will have to be spent in the remaining one year. Largely, the programme management has had limited ability to find innovative ways to deal with the problem of delayed disbursement by Gavi other than to delay implementation of activities.

10. Despite delays in disbursement of funds, all expenditures incurred so far have been on planned activities.

Sustainability

There is limited evidence that the activities supported by the Gavi HSS grant would be sustainable beyond the lifespan of the grant. There are a number of factors, both internal and external to the program, which would undermine sustainability:

11. Although there are other health systems programmes being implemented in Somalia, notably the (Joint Health and Nutrition Programme) JHNP and the information systems capacity development efforts under a GFATM grant, there is little connection or synergy between these efforts and the Gavi HSS grant. Health authorities have expressed a concern at the limited connection between Gavi HSS and other systems strengthening support. Risks of duplication and failure to leverage existing support have been pointed out as a missed opportunity to make Gavi HSS support more sustainable.

12. The Health Authorities, at least in Somaliland and Puntland, do not express overall control over implementation of the Gavi HSS grant. Further, marginalisation of some EPI staff within the country has caused tension which might undermine programme implementation in future. In addition, limited capacity strengthening within the government has occurred under Gavi HSS. "The seeming continuation of managing Gavi HSS as a vertical programme cannot contribute to long term sustainability". It is the view of the evaluation team that the perception that the government is not fully in control of Gavi HSS limits the sustainability of Gavi support.

13. On a positive note, there is broad consensus among partners that HSS is a top priority for the future of Somalia's health system. It has been pointed out by the government and partners that Gavi HSS has played a role to increase the level of interest in HSS in Somalia.

Results

Results of the Gavi HSS grant have been difficult to assess in the absence of data, especially post Gavi HSS introduction. The core impact indicators in the Gavi HSS M&E framework cannot be determined because of a lack of underlying data.

14. Paucity of data hampered a comprehensive assessment of the contribution of Gavi HSS in terms of the key outcome indicators. Many of the endline or midline indicators in the HSS M&E framework could not be derived due to a lack of data.

15. Available data from the HMIS as well as estimates by UNICEF/WHO show that coverage of DPT3, measles and Vitamin A are still below the targets, although there has been some improvement in coverage particularly in Somaliland. Further, there is consensus among country-level partners that the Gavi HSS programme has not achieved its targeted impact on coverage.

Key recommendations

Recommendations for the country

1. The proposed new Gavi HSS proposal should set more realistic achievement targets, and be based on realistic assumptions about what can be implemented given the country's security and political context. The implementation plan should be more tailored to the specific context of each of the zones of the country.

2. Gavi HSS proposal should articulate a clear operational link between HSS and EPI objectives and direct resources accordingly. In the new Gavi HSS application guidelines, it is a requirement that country HSS applications should demonstrate a direct connection between their HSS application and the goal of strengthening health systems to deliver immunization services.

3. Greater investment in M&E particularly through strengthening the HMIS will be required to support implementation of the next phase of Gavi HSS.

4. The country should strategically plan to leverage other donor support in designing Gavi HSS proposals with a clear intention to being catalytic or synergistic with other support.

5. Coordination of Gavi HSS grant needs to be strengthened, with the leadership role of the government being emphasised and strengthened.

6. Government should consider investing in broad based human resource development programme for EPI implementation.

7. There should be a functional district health system to support design and implementation of HSS programs.

Recommendations for Gavi Secretariat

1. Gavi Secretariat should allow countries to apply Gavi HSS resources more flexibly to catalyse system development in partnership with other donors. More targeted interventions are more likely to achieve results than spreading resources too thin.

2. Greater responsibility for implementation and results should be placed on the government and greater accountability should be demanded of the government.

3. A household survey should be conducted to establish the coverage and equity of access to EPI and MCH services at baseline as well as the end of the implementation.

4. Sufficient funding towards institutional capacity building in public health management, financial management, and technical support to regions is required.

5. The UN must find more cost-effective ways of implementing Gavi HSS. "It is not efficient when you have so many implementing partners on the ground on such a small project."

6. Partners should work to reduce the bureaucracy in disbursement of funds and procurement of implementing agencies and goods and services.

7. Gavi Secretariat should consider providing support to assist accelerate human resource development for EPI implementation.

8. Gavi Secretariat could consider key areas in logistics and supply chain systems, planning and information systems for support in future HSS programs at district level.

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Chapter 1: Overall Country Context

1.1 Country Context

Political and economic context

Somalia is located in the Horn of Africa in East Africa with an estimated population of 12,300,000 (UNFPA 2014). Since the early 1990s, the country has faced security challenges which have left the country with an unstable and fragile political and governance situation. In fact, following an initial merge of previously British controlled and Italian controlled territories, there emerged a secession of the unitary state of Somalia in the late 80s, which has more or less persisted to current times effectively impacting on the political, social and economic existence of the Somali people. Politically, the country has been separated into three relatively autonomous self-governing zones, namely Central-South, Puntland (also referred to as North-East Zone) and Somaliland (also referred to as North-West Zone). Local administrative units and partnerships have emerged over time, which have provided governance structures at community and local government level. The security situation in the south and central parts including the capital city continue to remain unstable. Hostilities have remained a characteristic feature of these regions. The effect of political tension is the somewhat unstable situation in the three zones, which is more pronounced in the Central-South region and to a lesser extent in Puntland. Somaliland is on the whole relatively calmer than the other two regions (Joint Appraisal Report, 2015). Internationally, there has been recognition of the Government of National Unity (GNU), which has its national offices in Mogadishu which is located in the South–Central Zone. At the sub-national level, there are 18 sub-regions and 98 districts according to documentation. Local government administration exists and is functional in Somaliland and Puntland (Coordination of International Support to Somalia, Somalia: Comprehensive Multi- Year Plan 2011 – 2015).

Partly as a result of the unstable political situation, the country's economy has suffered, living millions of Somalians living in poverty. The country's Gross Domestic Product (GDP) is about US$ 2.5 billion with an estimated GDP per capita of US $320. The GDP growth rate is estimated as 2.6% (World Bank World Development Indicators 2013). The Somali economy is dependent on livestock for export earnings, which are currently estimated at about US$350 million per annum (WHO, 2010) as well as remittances from the diaspora which are in the region of US$ 1 Billion per annum. The economy is fragile particularly in view of the fact that almost 65% of the total food requirements are said to be imported (WHO, 2010). The majority of the people live in poverty.

Demographic and health status of Somali population

A large proportion of the population of Somalis is relatively young. Persons under the age of 15 comprise almost 50% of the Somali population, while children under five years of age constitute about 13% of the population. About two thirds of the population lives in rural areas. It is also noteworthy that 25% of the population is nomadic and nearly one in ten is classified as internally displaced persons (Table 1). In the northern parts of the country, the proportion of the population that is nomadic can be as high as 50%. Childhood mortality rates among Somali children, though still very high, have been consistently declining since 2014. It

is estimated, for example, that over the past ten year period, the country's under-five mortality rate has fallen by 33 deaths per 1000 live births; i.e. from 174 in 2006 to 141 deaths in 2014.

Table 1: Selected demographic and health indicators, Somalia 2010-2014

Indicator	**2010**	**2011**	**2012**	**2013**	**2014**
Total population	9,581,714	9,806,670	10,033,630	10268157	10,517,569
Population under 5 years	1,255,205	1,284,674	1,314,406	1,345,129	1,377,802
Population under 15 years (%)	47.7	47.5	47.3	47.1	46.9
Population living in urban areas	3,570,051	3,697,311	3,828,131	3,964,741	4,110,056
Population living in rural areas	6,011,663	6,109,359	6,205,499	6,303,416	6,407,513
Infant mortality rate(per 1000 live births)	97.8	95.1	92.6	90.1	87.4
Under 5 Mortality rate(per 1000 live births)	160	155	151	146	137
Maternal mortality rate(per 100,000 live births)	930	_	_	850	_
Neo natal mortality rate (Per 1000 live births)	43.0	42.4	41.9	41.2	40.5

Sources: WHO statistical information system, UNFPA, UNDESA statistics division and World Bank estimates

Health System Context

Two important elements characterise the health system in Somalia. First, the Federal Government of Somalia has a Federal Ministry of Health based in the South/Central Zone. The Federal Ministry of Health assumes oversight functions of governance and stewardship of the health sector. Although the three zones have joint health policies and programmes, they tend to also have zone-specific health plans. This approach has been responsible for the creation of a decentralized system of sector governance not only in the health sector but also in the government at large. Each zone has a Ministry of Finance responsible for the necessary revenue and expenditure oversight functions and budgetary administration. This is important in the context of health care financing and resource allocation to and within the health sector in each zone.

Second, the health system does not have a functional district health system. From the zonal level, we have the regional health offices which are responsible for the network of health facilities and hospitals. In line with the EPHS framework and the Health Policy of 2014, the structure of the health system is organised around a five-tier level of service delivery and management organs:

- Community level
- Primary health unit
- Health centre
- Referral health centre
- Hospital

The composition of health facilities in the country is indicated in the table below. Like in many African health care systems, primary health care units, in this case Health Posts and MCH centers constitute more than three quarters of the total number of health facilities in the whole country. The structure is the same across the three zones. Notable also is that the South Central zone has proportionately more facilities at all levels while Somaliland has the least.

Table 2: Distribution of Health Facilities

Regions	Zones Health Post	MCHs	District Hospital	Referral Hospital
Somaliland	160	70	8	1
Puntland	192	84	14	5
South Central	264	134	15	5
TOTAL	616	288	37	11

Source: UNICEF Somalia, 2008; personal communication from Health Authorities

Generally, health infrastructure is old, dilapidated and is served by a very limited human resource establishment. The country faces challenges of effectively providing EPI services with such limited infrastructure and human resources. Table 3 shows the numbers and composition of human resource cadres in Somalia. Given the national population, it is evident that the country has a serious shortage of human resources. The situation is particularly acute

for the frontline workers on whom so much of immunisation work is dependent on i.e. nurses and midwives.

Table 3: Distribution of Human Resources for Health, by zone

	Central-South	**Somaliland**			**Puntland***	**Grand total**
	Total	**Public**	**Private**	**Total**	**Total**	
Doctors	94	43	42	85	110	**374**
Pharmacists	4	-	-	-	17	**21**
Qualified Nurses	189	240	96	336	664	**1525**
Qualified Midwives	10	44	15	59	321	**449**
Auxiliaries and technicians	333	462	242	704	375	**2116**
TOTAL	**630**	**1241**	**243**	**1184**	**1,487**	**4485**

Source: GAVI HSS Country Proposal 2009

*Figures provided as at September 2015.

Developments in policies and strategies for improving EPI in Somalia

To provide some policy context, we briefly describe the developments which have taken place in Somalia recently which have implications for immunization and HSS. A significant policy development in Somalia was the development of an essential health care package for the population, the Essential Package of Health Services (EPHS), which is increasingly being implemented since 2012. The definition of the essential health care package of services provides a significant step towards establishing a policy framework for health systems development for a country which has witnessed devastating humanitarian effects of war. Subsequently, the Somali Health Authorities have reached consensus on having common health policies and national strategic plans. Improvement of child health service delivery, including EPI, and health system strengthening are vital components of the EPHS.

A major health programme called the Joint Health and Nutrition Programme (JHNP) provides technical, material and financial resources towards meeting the goals of the EPHS (Joint Appraisal Report, 2015). The JHNP is sponsored by a consortium of donors which includes the Swedish Government through the Swedish International Development Agency (Sida), the Finnish government, the United Kingdom's Department for International Development (DFID), Switzerland and the United States. In addition, the Australian government provided funding for the initial six months of 'humanitarian support' phase of JHNP (JAR 2015, Interviews with Somali government officials). The JHNP which started in 2012 and ends in 2016 intends to provide, among other things, extensive capacity building for improved delivery of health services as defined in the EPHS. Implementation of the JHNP is being

done by three UN agencies, namely WHO, UNICEF and UNFPA. The essential features of the JHNP revolve around the six health systems building blocks (Joint Appraisal Report, 2015).

The general features of improving essential health services include (EPHS Report 2, 2009):

i. An integrated, functional health system: The strategic planning, policy formulation and coordination activities are determined by the extent to which the different regions or zones are able to integrate and provide a coherent and unified set of related factors.
ii. A sustainable and predictable financing strategy – includes revenue generation, risk pooling, purchasing and service provision: This is necessary to ensure that the resources that are generated are provided in the most efficient and effective manner. It also is necessary to ensure that the resources are put towards achieving the best value for performance.
iii. Systematic medicines and medical supplies supply chain stocks: Having a national formulary and an essential drugs list as part of a rationalised resource allocation and priority setting framework are necessary. This appears to have been addressed by the work on immunisation and the essential health care package.
iv. Pooling of resources: Currently the health care financing is fragmented and aligned to vertical programmes. Standalone programmes provide a complex and challenging environment for ensuring access to essential services
v. Adequate human resources for health: It is fundamental to ensure that the current limitations of clinical, preventive and promotive health workforce shortages are addressed to ensure a minimum and fundamental prerequisite for access to health care services of an essential nature.
vi. A priority setting and predictable resource allocation mechanism (Essential health services package), strategy and policy framework.
vii. Equity, access and utilisation given the population density and security factors.

The Gavi Health System Strengthening in Somalia

Proposal objectives

In 2009, the Government of Somalia through the Health Authorities in Somaliland, Central-South and Puntland applied to the Gavi Alliance for support towards health systems strengthening under the Gavi HSS stream of support. Gavi approved the grant in September 2011 in the sum of US$11,545,500. Actual implementation of activities started in 2012. The grant is managed by two UN agencies WHO and UNICEF. The health authorities in the three zones (working with the UN partners) lead programme implementation. The Somalia GAVI HSS grant was intended to achieve four core objectives in Somalia:

Objective 1: To improve availability and utilization of immunisation and other essential maternal and child health services by 2014- through strengthening and supporting 40 MCH/Health centres based on the Essential Package of Health Services (EPHS).

Objective 2: To improve the access of rural communities to immunisation and other basic but essential preventive, promotive and curative health services by the year 2014, through support to: 80 Health posts and CHWs; and introducing on a pilot basis a new cadre of 200 Female Community- based Health Workers (FCHWs) providing mainly preventive services to a defined catchment population

Objective 3: To improve awareness and demand for immunization and other essential quality maternal and child health services by the year 2014, through implementation of a comprehensive and sustained campaign of behavioural change communication.

Objective 4: To provide evidence (on utilization, impact and cost of services) in order to generate appropriate, equitable and affordable health care delivery models for maximisation of efficiency and equity of immunisation and other essential services, through managing a programme of operational/health system research.

The Somalia Gavi HSS grant was designed to achieve six core outcome and impact indicators by 2015 as stated below (Gavi Somalia HSS proposal 2009):

1. Increase national DPT 3 coverage from 36% in 2006 to 55%
2. Increase number of regions achieving at least 80% DPT 3 coverage by 30%
3. Reduce under five mortality rate from 145 per 1000 in 2007 to 125
4. Increase measles immunization coverage from 19% in 2006 to 60%
5. Increase the %age of pregnant women aged 15-49 years attending at least one antenatal visit from 26% in 2006 to 50% in 2014
6. Increase coverage of Vitamin A supplementation from 24% in 2006 to 60%

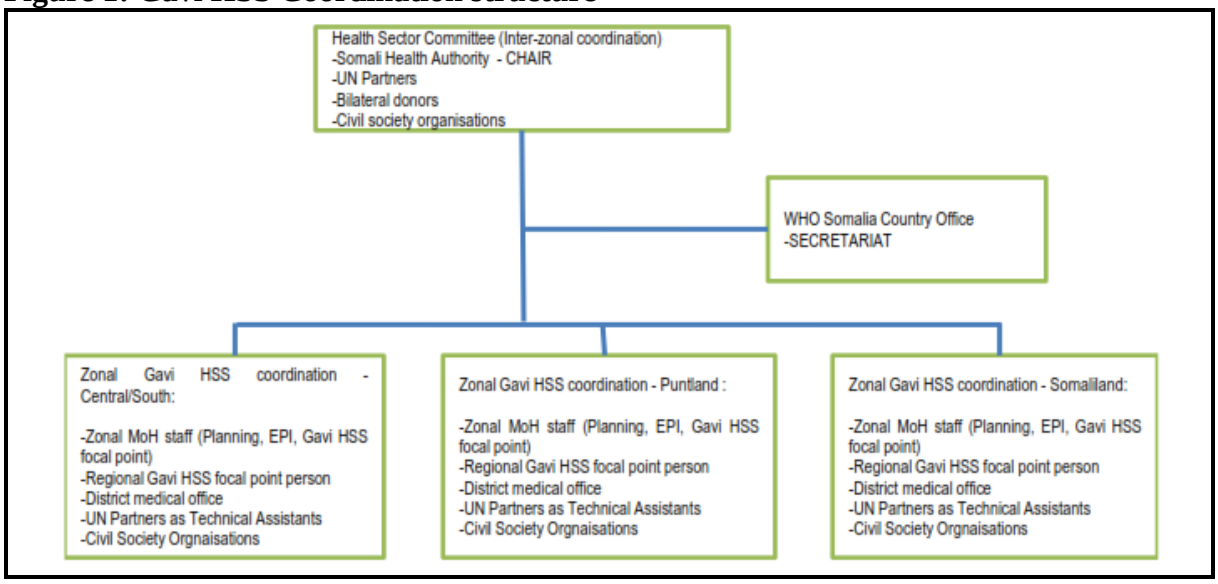
Overview of Gavi HSS grant coordination mechanisms

There is a hierarchy for coordination of Gavi HSS implementation (Figure 1). The structure for managing the Gavi HSS grant is stipulated in both the original and the reprogramming proposals. Management of the grant is under WHO and UNICEF, both organisations playing the role of fund holders. The mechanism for coordination of Gavi HSS grant is that the HSC is responsible for providing oversight over implementation and management of Gavi HSS in the respective zones. The HSC also reviews and approves progress reports for submission to Gavi Secretariat. In terms of implementation, although it is stated that WHO and UNICEF lead the implementation of the Gavi-HSS programme in close collaboration with the Health Authorities and other partners, it was clarified that in practice the health authorities are actually implementing the programmes with technical support from UN staff who are based in Somalia. The Somali Health Authorities are also responsible for calling and chairing Gavi HSS coordination meetings.

Civil society also provides support in implementing the programme. A number of NGOs have been subcontracted to implement activities (mainly activities relating to BCC) on behalf of the UN. Within the Ministry of Health, each zone has a Gavi HSS Focal Point who reports to the Director Planning. His/her role, among other things, is to lead in planning and implementation of activities under the Gavi HSS program. There are also focal point persons at regional and district level EPI Units.

There is a zonal structure in place for managing the Gavi HSS programme at country level. This zonal level structure is responsible for zonal-level planning, implementation, supervision and coordination of all immunization activities in the respective zones. Although the Health Authorities are responsible for providing oversight over implementation, the UN agencies have taken on a greater role in coordinating Gavi HSS activities at zonal level in response to capacity challenges. However, there are variations in terms of the specific mechanisms of coordination and the frequency of meetings. The relatively stable zones of Somaliland and Puntland have each an EPI unit organized under their respective MOH, and capacity has been strengthened with the appointment of M&E Advisor and HMIS staff. The Directorate of Health within the Minister of Human Development & Public Services (MHDPS) in Mogadishu is now in the process of re-organizing itself and has assigned an EPI manager who coordinates immunization activities implemented by partners (Joint Appraisal report 2015). From each zone, progress reports, plans, etc., are prepared and submitted to WHO and UNICEF in Nairobi at the inter-zonal level. Although the overall coordination should have been under a HSS Working Group, this structure has not been functional due to capacity constraints. Reports from the zones are submitted to WHO in Nairobi as a secretariat, which consolidates inter-zonal reports and submits to the Health Sector Committee (HSC). The HSC which is chaired by health authorities meets to consider HSS submissions and make decisions.

Figure 1: Gavi HSS Coordination structure



1.2 The Scope of the Gavi HSS evaluation

The scope of this evaluation was determined by the Terms of Reference provided by Gavi, the Vaccine Alliance, the Contractor. It was envisaged that this evaluation would provide an input into the next phase of Gavi HSS application process (submission expected in Q2 2016). In specific terms, this evaluation was required to answer the following key questions:

Design

i. To what extent did Somalia's Gavi HSS application take in consideration the country's political and security contexts?
ii. To what extent were the various planned activities relevant and feasible?
iii. To what extent were the disbursement modalities relevant and accepted by all parties?
iv. To what extent, and in what ways, did Somalia's Gavi HSS application demonstrate clear linkages to immunisation outcomes?

Implementation

i. To what extent were the activities set out in the Gavi HSS application implemented as planned (quality, quantity, ways and means)? A particular focus should be given to the following questions:
    a. To what extent did programme management appropriately adapt to challenges, changes in context and long delays observed spending funds? Were the responses adequately addressing the issues?
    b. To what extent were the role of Gavi secretariat, HSC and partners at country level effective in the implementation and monitoring process?
    c. To what extent were the management of Gavi HSS and EPI well-coordinated?
    d. To what extent was the M&E component properly implemented?
    e. What contextual factors could explain the actual implementation rate?
    f. What are the lessons learnt during the implementation process? What worked well and why? What did not work well and why?
ii. To what extend were activities, resources appropriately coordinated, and assessed (given the pilot aspect of the programme) and reported by the MOH to the Gavi Secretariat and Gavi Alliance partners?

Efficiency

i. To what extent were the funds used efficiently and as planned?
ii. What contextual factors explain the utilization rate of the funds received?
iii. What could have been done to improve the efficiency?

Results

i. To what extent did the programme achieve the outcomes and impact objectives as described (and possibly re-programmed) in Somalia's Gavi HSS proposal?
    a. What was the effect of the observed delays in spending funds?
ii. To what extent did the Gavi HSS programme contribute to observed trends in the following indicators:

a. DTP3 coverage (at national level and in supported districts).
b. Other indicators selected by the country as part of its Gavi HSS grant?

iii. What were the positive and negative unintended consequences of the Gavi HSS programme?

Sustainability

i. How sustainable, in financial and programmatic terms, are the achievement of the Gavi HSS programme at national, regional and operational levels? For example:
   a. To what extent have the various types of investments (capital versus recurrent) contributed to sustainability at the country level?

Lessons for the future

i. What are the major lessons that can inform improvements to future design, implementation and monitoring of HSS programmes in Somalia and elsewhere?

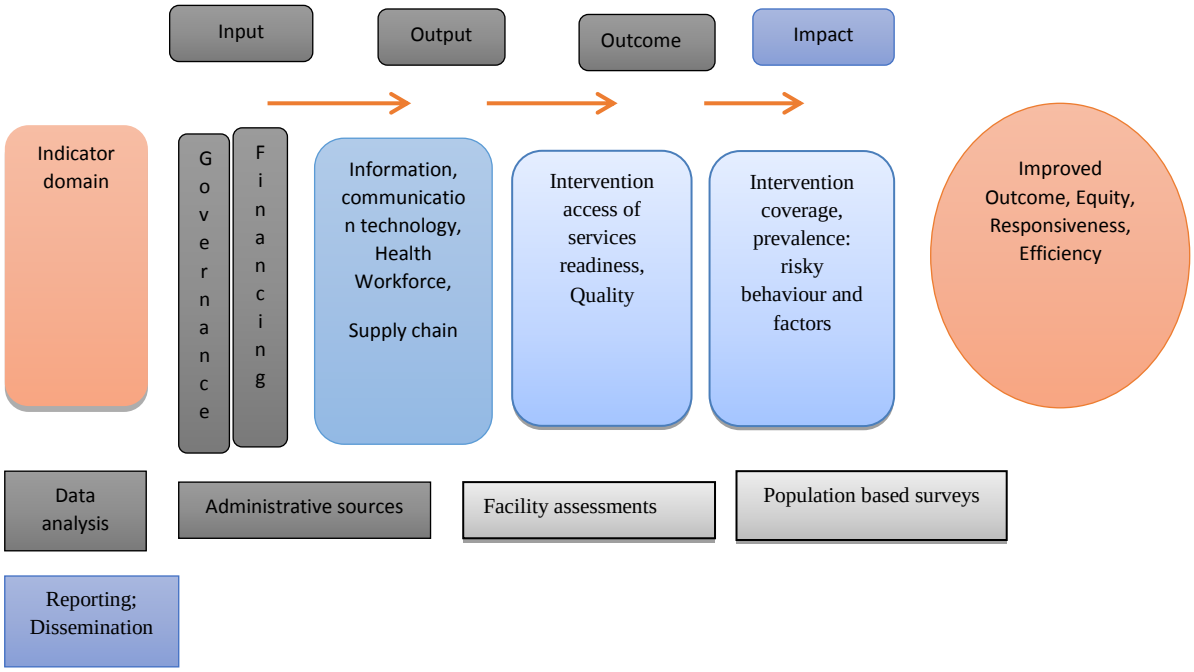
ii. What were the major strengths and weaknesses of this Gavi HSS grant?

1.3 The Evaluation Framework

The evaluation framework was based on the World Health Organisation framework of the Health Systems Building Blocks. In this framework, the following elements are identified:
Inputs: Human resources comprising the administrative structures, the service delivery levels inclusive of preventive and curative functions (community, health centres and referral hospitals); infrastructure, (buildings, health facilities, equipment, transport), energy sources, medicines, supplies and vaccines, financial resources; information – data for monitoring and evaluation, survey data and routine data, qualitative information such as consumer/patient response and perceptions of the health system; existing Strategic Plans and Policies.

Processes: Programming design and implementation; prioritisation, target setting; partnerships – roles and functions of partners; community organisation; health sector organisation and service provision; alignment, reporting, coordination, harmonisation, information, monitoring and evaluation

Figure 2: Health Systems Building Block Evaluation Framework



Source: Adapted from WHO HSS building blocks framework

Outputs: Catchment population served, immunisation coverage; numbers of pregnant women delivering under skilled or supervised conditions; availability and distribution of health workers, health worker – population density; stock-out periods for essential medicines and vaccines; planned activities successfully implemented; health workers trained; health workers produced; health workers provided with timely salaries and incentives;

Outcome: Immunization coverage, number of doses given, facilities providing EPI services,

Impact: Childhood or maternal mortality, mortality; lack of financial barriers in access to health care services; satisfaction and acceptability of health care services

1.4 Evaluation Methodology

1.4.1Evaluation Design

This evaluation used a combination of quantitative and qualitative data before and after implementation of Gavi HSS in selected sites in order to show the contribution of Gavi HSS to the achievement of the six core objectives. Where we are relying on qualitative data only, particularly perceptional information, efforts were made to ensure triangulation of information through careful selection of a wide spectrum of stakeholders at all levels (policy, planning, implementation, etc.) all of whom worked closely with the Gavi HSS design, implementation and monitoring. For example, the evaluation findings are backed by a few quotes from informed sources from interviews and reviewed documents or were verified by direct observations of health facilities and services during the field visits. A dissemination meeting was held at which the veracity of information and preliminary findings were subjected to a review. The meeting was held in Nairobi on 13th November, 2015. In addition, sources of documented data from relevant reports are used to support findings. In our mixed methods, we also gathered information from informed and verifiable analysis and assessment on how well Gavi HSS contributed to the achievement of its stated objectives.

Through the process of gathering data the evaluation team exercised due care and caution to minimise bias. Although the grant was intended to achieve the stated objectives, this evaluation has been limited in its ability to show evidence of the outcome and impact results. However, as in all such retrospective non-experimental evaluations, this evaluation cannot draw causal linkages or exclusive attribution. Nonetheless, the strength of our methodology lies in its rich documentation of insights based on accounts and experiences by a wide group of stakeholders who have been involved in planning and implementation of the Gavi HSS in Somalia. It would have been interesting to analytically explore the differences between those health facilities that have benefited from Gavi HSS grant and those that have not. However, such analysis, although important, was not feasible due to the lack of baseline data on several indicators in some parts of the country and potential spillovers between beneficiary and non-beneficiary health facilities.

1.4.2 Data collection methods

Document review

A major part of the methods used in this evaluation was review of available reports and other documents. We used our desk review to not only learn about Somalia's Gavi HSS application process and implementation experience but also to inform our evaluation framework and methodology. These reports provided useful information relevant to evaluating the performance of the Gavi HSS grant to the Somali government. Available reports were used to track Gavi HSS activities and sub-activities in the 2014-15 period to establish the level of progress against the programmatic benchmarks and timelines stated in the implementation plan. We document the reasons for any deviation from planned timelines. Further, the desk review exercise also guided the development of focused questions for follow up during our

key informant interviews and field visits. Documents were assembled via a shared electronic filing system using Dropbox. Most of the documents were obtained from Gavi Secretariat and WHO Somalia Country Office. Key documents that were reviewed include Government official documents (e.g. Health Policy, Strategic Plans, cMYP, etc), evaluation reports (e.g. APRs, Joint Appraisal report, etc), and other documents as shown in the reference section.

Key Informants interviews

The evaluation team conducted an extensive set of in-depth interviews with a broad network of health partners in Somalia's health system strengthening initiatives. A semi-structured interview guide, comprising questions along the six evaluation themes was used. The full list of key informants is attached in Annex A2. Briefly, our key informants constitutes officials of the Government of Somalia, UN partners based in Somalia, UN partners based in Nairobi, Civil Society Organisations based in Somalia, Civil Society Organisations based in Nairobi, bilateral partners in Nairobi, current and past Senior Country Manager (SCMs) as well as other Gavi Secretariat staff. These interviewees included individuals who were involved in the Gavi HSS application process or had good knowledge of the implementation of Gavi HSS in Somalia. The list of interviewees shows that about a third of these informants were based in Nairobi while the rest were from Geneva or within Somalia.

Global level KIIs

At the global level, we interviewed staff from Gavi Secretariat, particularly the current and immediate past SCM for Somalia and other relevant Gavi secretariat staff based in Geneva.

National level KIIs

We conducted key informant interviews with individuals representing the Ministry of Health in Somaliland and Puntland. These key informants included staff at the level of Director-General, Director of Planning, Director of Human Resource, EPI managers, Gavi HSS focal point persons, and others. Further, we interviewed a number of national EPI partners involved in the Somalia Gavi HSS programme. These partners are represented in various organisations such as the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nations Fund for Population (UNFPA), the European Union (EU), bilateral partners (principally, DFID and Sida) and non-governmental organizations. These partners have been working with the government in planning and implementing Gavi HSS or are supporting programmes or projects related to health system strengthening in Somalia. Given that some of these partners are based in Somalia while others are based in Nairobi, our team had to visit both Nairobi and Somalia to conduct the interviews. The full list of people we interviewed is provided in annex A2.

Sub-national KII with health staff

During the mission to Somalia, in-depth interviews were held with Regional Health officers, health workers (particularly facility managers) and Gavi HSS Focal Point persons (appointed within the Ministry of Health). The sub-national interviews focused on Gavi HSS grant

implementation experience, successes, challenges, and mitigation measures. These interviews used semi-structured interview guide as well as a structured health facility tool. In addition, Focus Group Discussions (FGDs) were conducted with selected FHW supervisors in Somaliland and Puntland, as part of the field work. The idea was to maximise our ability to solicit shared perspectives on each subject within a group session. The Ministry of Health at the zonal level and WHO facilitated all the meetings and interviews in the country.

Field visits

The request for proposal (RFP) document for this evaluation required us to conduct field visits in two districts. The criteria for selecting the two districts included a number of elements notably the security situation (some parts of the country, mostly around South and Central parts, are not accessible due to ongoing security issues), the scope of Gavi HSS activity going on in the district (our visit took place in areas which have received Gavi HSS support and have been actively implementing Gavi HSS activities), and to be drawn from Somaliland and Puntland. We interviewed staff from the Ministries of Health and Gavi HSS local partners to facilitate selection of districts. Based on their input, we identified a list of several 'candidate districts' in Somaliland and in Puntland from which we will eventually pick the two districts. Our evaluation visited a total of six health facilities in *four* districts, two each in Somaliland and Puntland. The following are the districts and facilities which were visited:

Somaliland

1. Arabsiyo MCH in Gabilex district
2. Dararweyne MCH in Hargeisa district

Puntland

1. Qarxis MCH in Qaurxis district
2. Sunajiif MCH in Garowe district
3. Gargaar MCH in Garowe district
4. Arw-culus MCH in Garowe district

Quantitative data collection

EPI vaccine coverage data

We obtained and analyzed available EPI vaccine doses data from the HMIS data. The data is available at regional or district level from January 2013. Unfortunately there is no data on vaccine coverage before January 2013. For this evaluation, we analysed DPT3, measles vaccine first dose, in each of the three zones in Somalia. In addition, we report secondary coverage estimates compiled by UNICEF to show national-level coverage trends since 2006. These coverage estimates are not available at district level. Because the HMIS data is not available at baseline (2010) at regional level or district level, we compare coverage and the number of doses given between regions. Any comparison of data between Gavi HSS and non-Gavi HSS regions or districts would still not be definitive evidence of the contribution of

Gavi HSS because we are unable to control for any other interventions in the non-Gavi HSS areas.

Expenditure analysis

The Annual Progress Reports (APRs) and other documents provided by partners were used to assess expenditure on Gavi HSS against budget and implementation plan as well as the composition of expenditure by line item in order to measure the program's efficiency. This analysis is limited by the data that were made available to the evaluation team.

Direct observation of immunisation and MCH service areas

During visits to health facilities, we conducted direct observation of immunization facilities and MCH departments using a checklist for observing EPI service provision specifically in so far as the objectives of the Gavi HSS grant are concerned.

1.4.3 Limitations of the evaluation methodology

This evaluation is faced with a number of limitations. First, this evaluation is based on observational data and perceptions from key Gavi HSS stakeholders. A drawback of such data is that we cannot with absolute certainty claim that the achievements we document are wholly attributable to the Gavi HSS grant that we have evaluated. Other confounding factors may have played a role in influencing all the outcomes of interest. For example, the data used does not permit us to isolate the role of factors such as security, sanitation, nutrition, and other health system programmes that may have contributed to changes in immunisation coverage. Also it is not possible to determine how much of health worker knowledge can be attributed to the training received from Gavi HSS in the absence of a counterfactual. In particular, it is possible that some interviewees might confuse attribution of change between the Gavi HSS and JHNP given that they were being implemented almost concurrently and in the same regions. Although we made attempts in our interviews to distinguish Gavi HSS activities from other programmes related to health system strengthening in Somalia. Often it can be difficult for local stakeholders to make appreciate distinctions between programmes in their assessments. Unfair comparisons across these programmes may also conflate stakeholder views. There is potential for confusion here.

Second, the quality of some of our data may be limited by insufficient triangulation. Perspectives can differ across the few players which poses challenges of interpretation. Furthermore, for some of the questions such as design process, many of the informants who were involved have moved on to other jobs and were unavailable to be interviewed. Third, the quantity and quality of available administrative data, particularly immunisation-related outputs, could not be verified. Incompleteness and reliability posed major challenges. With a mobile population due to security problems, coverage data can be unreliable.

Fourth, the four districts which were selected for field visits are not representative of the whole country or even their zones. Somalia, like many countries, has a health system that is complex in its structure and organisation. The three regions each pose unique challenges which make generalisation of findings impossible and unadvisable. It is important that we point out that the selection of the four districts was largely influenced by security considerations. This is a potential source of bias. Furthermore, our sample size and the limited time we dedicated to field visits present a snapshot with limitations in terms of identifying the key implementation and contextual factors. Our findings may be skewed on account of this limitation.

Finally, the section on results of the Gavi HSS could not be adequately addressed because of the lack of data. There is no relevant recent (post 2011) national household survey in Somalia to enable this evaluation determine achievements of the Gavi HSS programme against each of the objectives on the grant with a high degree of robustness. Therefore, coverage was estimated using administrative data and UN population estimates. Our evaluation relies significantly on using the HMIS. As is well known, administrative data are often of questionable quality. The national HMIS as well as the community level information system are both still under-development. Having said that, there is an increasing amount of HMIS data that is being collected through the routine system in Somalia. The data is collected at hospital and MCH levels from Gavi-HSS supported facilities. Clearly, this data will be useful to facilitate future HSS evaluations. However, the HMIS data provided to the evaluation team was of limited use in fulfilling the data requirements of this evaluation. For example, the HMIS data included only the number of children receiving the vaccines (i.e. the enumerator in the relevant coverage indicator) without giving the total number of children (denominator). The data also has a number of months of missing data even in Gavi HSS supported facilities. A further challenge is that there is no HMIS data on vaccine coverage before January 2013. Hence, no before-and-after comparisons could be made using the HMIS data.

1.5 Reprogramming of the Somali Gavi HSS grant

The implementation of the Gavi HSS grant in Somalia has undergone a round of rescheduling of activities and a subsequent reprogramming. In July 2012, the programme management (WHO, UNICEF, and Government) reviewed the original activities and plan and went through a process of rescheduling activities on account of the delay in signing of the grant. According to the implementation plan in the original proposal, implementation was to start in January 2010. However, given that the grant was only signed in September 2011 and the first disbursement of funds was made in November 2011, the grant management team and the government had to reprogram activities given the lost time. This involved a rescheduling of activities and M&E targets. There was no significant reorientation of programme activities. In addition, unit costs of some inputs and services such as security, administration and finance support functions, operations (office rent, communication, fuel, and utilities), transportation, planning both at Nairobi and Zonal offices, had increased significantly between the planning period around 2009 and November 2011 when the first disbursement was made (APR, 2014: Key informant interview with UN based in Nairobi).

From the outset, implementation of activities continued to be characterized by significant delays largely attributed to security issues and a challenging health system context. In addition, the distance between programme management in Nairobi and implementation teams

in Somalia continued to pose challenges which contributed to delayed implementation (Somalia Gavi HSS reprogramming Decision Letter, 2014). These delays culminated into a reprogramming of the grant in July 2013. It was hoped that reprogramming the grant for the remaining two years would increases grant effectiveness (Somalia Gavi HSS reprogramming proposal). This reprogramming was more substantial and included reprogramming of all activities under objective 3 (To improve awareness and demand for immunization and other essential quality maternal and child health services by the year 2014, through implementation of a comprehensive and sustained campaign of behavioral change communication). The following activities were cancelled or merged with other activities:

- Develop video programs
- Disseminate video messages through cable
- Disseminate BCC messages through radio
- Produce and distribute IEC material to private pharmacies

Further, budgetary re-allocations were made to reflect new priorities as reflected in the table below.

Table: 4 Allocation of funds to programme objectives - original and reprogrammed budget

	Original	Reprogrammed	Difference
Objective 1	2,890,000	3,104,388	214,388
Objective 2	2,532,800	2,434,185	-98,615
Objective 3	1,791,000	773,500	1,017,500
Objective 4	611,500	651,003	39,503
Program management	3,718,880	4,582,424	863,544
Total	11,544,180	11,545,500	1,320

1.6 New HSS application guidelines

In 2016, Gavi issued a new set of application guidelines which have implications for Somalia as the country plans to submit its application for another HSS grant in 2016. Among the new key elements in the Gavi HSS application guidelines for 2016, the nature of HSS support will be provided to "countries to improve immunisation outcomes by strengthening health system components that are bottlenecks to immunisation." This implies that the HSS grant should be more focused on improving immunization outcomes rather than address MCH bottlenecks more generally. Hence, countries are now required to demonstrate a strong link between HSS funding and EPI outcomes, particularly to fulfill the strategic goal to "contribute to strengthening the capacity of integrated health systems to deliver immunisation (Guidelines for Applications for Health System Strengthening (HSS) support in 2016).

Further, the new HSS guidelines place significant emphasis on the importance of a strong M&E function, especially to facilitate the results measurement and the PBF component of the Gavi HSS grant. However, the principles of Gavi HSS which include, a country-driven process, Gavi HSS being catalytic to other HSS efforts, harmonization with other efforts, sustainability, and so on, remain important aspects of the HSS grant. Thus, it is important that the planning, implementation, and monitoring of HSS grant involves active participation

from a broader group of stakeholders including the EPI Unit, other related Departments within the government (e.g. MCH or public health, Department of Planning, the ministry of Finance, etc.), civil society organisations, UN partners, other health sector donors, and other partners. The lessons learned from this grant will be key to exploring the other HSS-related programmes and to identifying the role and participation of CSOs in Somalia.

Chapter 2. EVALUATION FINDINGS

The findings are presented according to the topics outlined in the RFP that is in terms of, design, implementation, efficiency, sustainability and results of the Gavi support to health system strengthening in Somalia.

2.1 DESIGN

The Gavi HSS proposal for Somalia was premised on the principle of strengthening provision, and increasing availability of essential MCH services as reflected in the choice of areas of support namely: vaccines and immunization logistics; human resource (Female Health Workers); health facility renovations; cold chain; and health information system support. In this section, we address four key questions related to the design of the Gavi HSS proposal. These are: (a) To what extent did Somalia's Gavi HSS application take in consideration the country political and security contexts? (b) To what extent were the various planned activities relevant and feasible? (c) To what extent were the disbursement's modalities relevant and accepted by all parties? (d) To what extent, and in what ways, did Somalia's Gavi HSS application demonstrate clear linkages to immunization outcomes?

Finding 1: Unforeseen security challenges in some parts of the country have invalidated initial assumptions regarding the country's political and health system context leading to overstated feasibility of some of the proposed activities

Both the original and reprogramming Somalia Gavi HSS proposals include an assessment of the varying degrees of poor security in parts of the country. The general impression given in both proposals is that the security situation in Somaliland was more stable and amenable to achievement of the plans. As mentioned above, the reprogramming proposal contains largely the same objectives and activities as the original proposal. The security situation was considered as fair in Puntland while the South-Central was assessed as a zone which experienced some instances of hostilities and acts of violence periodically (Gavi HSS Reprogramming proposal 2013). Overall, this evaluation is of the opinion that to a large extent the assessment of the security situation with regards to the feasibility of the Gavi HSS programme was prudent, especially in Somaliland and most parts of Puntland. The review of Gavi HSS programme activities in the implementation section goes to confirm the feasibility of conducting the programme in most parts. However, pockets of Puntland have faced sporadic events of violence which were probably unforeseen. In Central-South, there has been relatively more violence and insecurity than was probably envisaged. It is in this part of the country that the proposal design provided insufficient attention about the ability of different zones to implement the proposal at same pace in all parts of the country. Due to political and security problems, feasibility of implementing Gavi HSS was varied across the regions of the country. The inability to adequately take these security and political considerations into account resulted in the Gavi HSS proposal/implementation plan being implemented at a different pace.

In some parts of the country, especially in the south and central zone, it has been difficult to do anything other than provide humanitarian or emergency mode of assistance rather than health system strengthening. As a result, "the Gavi HSS was implemented more or less as a stand-alone activity not very connected to EPI," (interview with a UN partner). Key activities such as monitoring, supportive supervision, outreach activities and demand generation in terms of the extent (quantity) of planned activities as well as the timeliness of the planned activities were affected. Even the recruitment of the Female Health Workers was hampered by the poor security situation in South Central (Somalia Gavi HSS reprogramming proposal 2013). It is noteworthy that in the reprogramming application security challenges were identified as having stalled implementation of the grant. This would suggest that the assumptions regarding the level of security in the original design and the feasibility of implementing Gavi HSS activities in all parts of the country were relatively optimistic. This is exemplified by the different levels of implementation in different parts of the country on account of security.

Finding 2: The Gavi HSS proposal design was too limited in terms of geographic coverage and programmatic scope given the level of funding to yield the stated impact

One of the weaknesses of the Gavi Somalia HSS proposal design lies in its broad scope. For example, although the program was targeted at only a few sites (i.e. MCH centres at a few selected health facilities) within the selected regions, the core coverage and health impact indicators were defined for the entire country (Gavi HSS proposal 2009). The proposal does define targets at the national and district level, when interventions are in relatively few MCH centres in the regions. Improvement in health facility coverage for a few facilities cannot yield meaningful gains in impact at the zones or country level. Efforts directed through this small number of facilities cannot guarantee to improve the overall performance of the EPI programme in the entire country. Further, designing a programmme that targeted only a few geographically-sparsed MCH facilities was not consistent with the target to increase the number of regions with coverage of at least 80%. Furthermore, many of the targeted MCH facilities were in very remote, very poor geographic areas and needed far more resources than was allocated to achieve the EPI objectives. The targeted facilities (representing 16 % of the number of facilities in the country) as can be seen in Table 5 represents a small proportion of the total number of facilities.

Further, the formulation of the Gavi HSS objectives, targets and performance indicators proved rather optimistic in relation to the baseline or starting indicators. The state of the health system in its nascent state e.g. the situation of the human resource, the financing levels of the health system all suggest that with a grant of US$ 11.5 million, the targets could not be achieved. The 2015 Joint Appraisal report of the Somalia health sector notes that "The Gavi HSS grant covers a relatively small fraction of the country with few complementary health interventions to improve health facilities performance" (*Joint Appraisal report 2015*). It was the perception of several key informants that, the plan was too ambitious. For example, one key partner acknowledged the limitation of the grant design: "We needed a more focused grant that can address a fewer set of objectives and achieve tangible results. And we are referring to the development of a health system. What can you really do with eleven million dollars?" (*Interview with UN partner based in Nairobi*). Another partner said the apart from the security issue; "I would say that the proposal was a little overzealous but not overly

ambitious; I think the overzealousness was mainly in stating the indicators, not the security situation." Ultimately, resources were spread too thinly to have had a meaningful impact on the outcome and impact indicators.

Finally, it is our view that the decision not to provide any support to strengthening crucial aspects of the district health office was a major weakness of the Gavi HSS proposal. Stakeholders mentioned that the approach of identifying a few facilities for Gavi HSS does not lend itself to building an integrated health system approach. From a system strengthening perspective, it is difficult to support HSS through a few selected health facilities within a district. "A feature of the prevailing conditions would be for example that you find that different facilities within the same district are offering different quality of health services and requiring different technical support" (*Key information with Somalia Health Authority official*). The argument presents a challenge for health systems development based on selective interventions within the same community.

Table 5: Distribution of Gavi HSS supported facilities

Regions	MCHs	Number of Gavi HSS supported MCHs	Proportion of HSS supported MCHs
Somaliland	70	13	(19%)
Puntland	84	13	(10%)
South /Central	134	14	(30%)
TOTAL	288	40	(16%)

Source: UNICEF Somalia, 2008

Finding 3: Feasibility of LHW strategy has been constrained by local context

The recruitment and deployment of FHWs was one of the major strategies under objective two for extending access to the public health system (referral and promotion) and improve uptake of low cost high impact promotive, preventive and basic curative health services, including EPI, through direct service provision to the population (Somalia Gavi HSS proposal 2009). While the strategy of FHWs as was described in the Gavi HSS application was considered relevant to improving the health system response to increasing utilization of EPI services, the feasibility of this strategy has been limited because the strategy has not been sufficiently adapted to the local conditions and overall health policy context. For example, the disperse nature of the Somali population coupled with limited availability of public transportation has made this strategy less effective in some cases. The point was made that the FHWs in some cases needed to be mobile in order to function more effectively. "The number of FHWs is too few to cover long distances, face the challenges of mobile population and leave unmet health need where males are concerned," (*Key informant in Somaliland).*

A number of specific points have been raised which need to be considered in adjusting the strategy of the FHWs:

- "As soon as we started to implement this strategy we realized that our country is much more sparsely populated and this poses a challenge to FHW because they do not have transport. It is easy in Pakistan because the population they are serving there has high density and is concentrated in town where transport is not a problem. The concept can't work here because the population density if very low and a lot of people are nomads.

Here, our FHWs are unable to function effectively because they cannot get women and children to health facilities because of distance. And they cannot reach many households," (*Key informant, Somaliland).*

- "The cultural context is also different. Here, we have to spend much time to convince a mother to come for services. In addition to the challenge of convincing mothers, the distances that these mothers have to cover is long. Even the LHW herself will have challenges making sure that the message reaches every mother; it may take her up to three days to move around and ensure that every one is informed. In Pakistan on the other hand, it takes just some hours and everyone will know about the planned activity and they will come in numbers," (*Key informant, Puntland).*

- "I can give an example of Central-South Zone of Somalia, the vegetation is different from the other two Zones so people are more settled there and this concept could work for them. In rural areas, the best they could have done instead of introducing FHWs was to use already existing structures and people like the TBAs Village midwives and PHUs," (*UN partner based in Somalia*). In addition, the work of FHWs does not provide a direct linkage to immunization as they do not conduct vaccinations. Thus, the contribution of FHWs to achieving the stated immunization targets through FHWs is constrained by these limitations.

Finally, it was also mentioned that the design of the FHWs strategy was adversely affected by local cultural and social factors (illiteracy and low levels of education were mentioned) which in fact delayed the recruitment of FHWs. "The recruitment of FHW was delayed as the initial requirement was that they have a minimum level of education….but when recruitment started it was found that the majority could not meet the minimum education standard that had been set." (*LHW supervisor Somaliland*). Cultural factors also tended to limit the ability of a mix of CHWs reaching male and female alike and being therefore able to have a more effective strategic influence on household behavior change with respect to EPI, child health in general and even maternal health. Generally, the foregoing points raise challenges in the design of the strategy that might require adaptation in order to make this strategy more effective. As we acknowledge later on, given the benefits of the work of FHWs to improving utilization of EPI services and other PHC services, their contribution to EPI activities and outcomes has been constrained and could be improved upon.

Finding 4: The link between Gavi HSS and EPI outcomes was weak

Overall, the link between the Gavi HSS grant and EPI strengthening was defined by the investments into strengthening selected MCH centres to be able to deliver a package of core EPI services. These investments included, among other things, rehabilitation of MCH centres, providing performance based incentives to EPI and MCH staff, renovation of cold chain equipment, building the capacity for outreach immunization sessions and supporting FHWs and CHWs at the community level (Gavi HSS proposal 2009). It was envisaged that the strengthened MCH centres would lead to increased availability and utilization of immunization and MCH services. In terms of detail, the link to core EPI outcomes suffers a few weaknesses. It is noted that the Gavi guidelines for that Gavi HSS grant didn't have a mandatory requirement for a link between Gavi HSS and EPI outcomes. A number of specific factors point to this lack of a direct connection between Gavi HSS proposal design and core EPI outcomes. First, the EPI units do not function effectively in most parts of

Somalia, thereby limiting the contribution of the Gavi HSS grant to EPI service delivery. Reasons for this are staff shortages, underfunding, lack of supervision of EPI, and very weak capacity in developing EPI micro-plans (*Gavi HSS Reprogramming proposal, 2013*).

The second point is that although the FHWs are trained to conduct community sensitization, their work is not designed to directly link to improving EPI coverage. For example, most FHWs are not trained to administer vaccines although this is enshrined in the Somali Gavi HSS compendium (Compendium to implement community based female health workers intervention 2011). Given that their work is not EPI-focused, this potentially limits their contribution to increasing immunization coverage. Third, apart from investments in cold chain and refurbishment of infrastructure, some of the EPI units were not the recipients of core Gavi HSS support. During a key informant interview with one of the partners, it was mentioned that "resources were not targeted at EPI core services to be able to meet the objectives". Specifically, other components of EPI remained under-funded and under-resourced. For example, many facilities and regional offices lack transportation services to conduct immunization outreach services. These challenges were not foreseen under the current Gavi HSS grant. General access to health care remained very low across the country (views expressed in several key informant interviews during field visits). The challenges of funding FHWs whose work does not directly lead to increased EPI outcomes was also highlighted in the Joint Appraisal Report of 2015.

Finding 5: Broad consensus was established that the proposed disbursement modalities were appropriate given the country's context

One of the questions under Design which this evaluation needed to address was the level of consensus on the disbursement modalities for the Somalia Gavi HSS grant. It has been established that at the design stage, all partners had reached consensus on the disbursement modalities that were deemed appropriate for the country. Partners and the government had agreed that there was no financial management and procurement capacity in the government at that stage to manage the funds. It was anticipated at that particular time that the design offered an acceptable working arrangement for disbursements and funds flow from source to implementation.

2.2 IMPLEMENTATION

As mentioned in the scope of work, this evaluation was required to address two main questions related to implementation of the Gavi HSS grant: (a) To what extent were the activities set out in the HSS application implemented as planned? (b) To what extent were activities and resources appropriately coordinated, and assessed (given the pilot aspect of the programme)? This assessment should answer specific questions on; (i) whether the programme management appropriately adapted to implementation challenges, (ii) whether coordination and management of Gavi HSS and EPI were well-coordinated, (iii) the extent to which the M&E component was implemented properly, and (iv) contextual factors which could explain the actual implementation rate.

Finding 6: Considerable progress achieved in implementing core HSS activities and attaining programme outputs

In this section, we demonstrate the achievement of Gavi HSS programme which was intended to strengthen the EPI system in Somalia. In outlining these achievements we followed the Gavi HSS activity implementation framework. There have been a number of documented positive achievements that can be associated with the implementation of the Gavi HSS programme in Somalia, as documented in Table 6.

Successful recruitment and deployment of FHWs leading to increased demand generation

Increasing coverage through routine service provision in an environment in which 35% of the population is mobile and the per capita health service utilization rate is as low as 0.13 visits per annum (*Health systems review, 2015*), presents a significant challenge. As shown under Objective 2 in Table 6, the concept of FHWs in the Gavi HSS Programme for Somalia was one of the four core objectives of the application. In Somaliland and Puntland, about 125 FHWs have been employed since the commencement of the programme. Among the existing notable functions performed by the FHWs are the following:

i. Treatment of basic conditions such as diarrheal diseases and fevers. The FHW receive community health worker kits and are able to attend to and distribute limited essential medicines and medical supplies within their communities. The FHW have theoretically a minimum catchment population of 150 households per month. However, due to logistical constraints such as transport they do not manage to reach all households.
ii. Maintaining Community Based Information System (CBIS). The CBIS provides the first part of the Health Information Management System (HMIS). Although the two are not integrated, the CBIS captures basic indicators on child health such as recording number of children that have been born, immunised, treated for fever and/or referred. It similarly captures basic data on maternal health.
iii. Community mobilisation, promotion and prevention of health through education and communication activities

The Gavi HSS support has been partially successful in implementing many key activities towards attainment of the programme objectives. As was shown in Table 6, the Gavi HSS has achieved many of the targets for recruitment and training of FHWs. Interviews with facility staff and supervisors of FHWs indicate that the recruitment, training and deployment of FHWs has been effective in improving capacity in service delivery. FHWs have engaged with communities to increase sensitization and create demand for immunization.

Informants' perceptions indicate that the role of the FHWs has helped bring PHC services closer to the families. The FHWs visit community members in their homes for provision of basic health care as well as community sensitization about PHC including immunisation. Gavi HSS is also partly associated with improvement of availability of PHC services at community level. The FHWs are able to reach communities and provide some curative health care service for minor ailments and provide information on referrals. In addition, they are also able to provide information as part of their social mobilization mandate.

There is clear evidence from among both national and sub-national stakeholders that the strategy of FHWs is making a real contribution to the EPI programme in Somalia.

> "EPI receives support from the FHWs because they communicate to the mothers about outreach programs. The programs are running okay and the communities are benefiting from them. They are very interested and would like to have the program expanded because so many mothers have been treated and saved." *Health Authority official based in Puntland*

> "LHW is a new approach which is contributing positively in improving uptake of services through information sharing with the community. The interaction of the FHWs with the community has helped to increase awareness and also remove some of the myths that people had." *UN partner based in Puntland*

> "FHWs have contributed positively in the communities they are working in, they treat minor diseases like diarrhea, they do health education, mobilization, keep record of the village population." *Key informant, Somaliland*.

Further, the Joint Appraisal which was conducted in January 2015, although not providing figures, asserts that the FHWs have provided a real contribution to service uptake: "The FHWs despite working in sometimes dispersed catchment areas and challenging circumstances, generally proved their acceptance in their communities and contributed to a modest increase in awareness and uptake of MCH services, including immunisation." (Joint Appraisal Report, 2015). In addition, Gavi HSS has also supported implementation of a system for supportive supervision of MCH facilities and recruitment of trained supervisors to supervise the cadre of FHWs. Our focus group discussions with FHW supervisors revealed that despite the challenges of funding, this system is helping to improve service delivery.

Table 6: Progress in implementing Gavi HSS grant in Somalia

Objectives	Activities	Progress
1. Improve availability and utilization of immunisation and other essential maternal & child health services - by strengthening and supporting selected MCH/Health centers based on Essential Package of Health Services (EPHS).	Develop and implement a system of regular EPI outreach from MCH centres to the catchment areas of health posts and FCHWs	There has been no institutionalised outreach yet. The mode of EPI outreach was also adjusted to cater for nomadic populations and low utilisation rates of public health services. There is limited funding for EPI outreach.
	Provide transport support to MOH for supervision of regional offices.	Gavi HSS funds are used to hire transportation services to facilitate supervision activities. Delays in procurement and release of funds cause inconsistencies in conducting supervision visits.
	Provide transport support to regional managers for supervision of MCH centers.	This is a continuous activity, WHO provides transport to MOH, regional offices to facilitate supervisory visits to the FHW.
	Provide incentives to EPI outreach and reproductive health staff at MCH centers.	Implementation of this activity started in 2013. An allocation of US$600 per month to each MCH centre which is shared among all the facility staff.
2. Improve access of rural communities to immunisation and other basic but essential preventive, promotive and curative health services through support to: Health posts and CHWs; and introduction on a pilot basis a new cadre of Female Community- based Health Workers (FCHWs) providing mainly preventive services to a defined catchment population.	Develop and implement a system of supportive supervision for health posts and FCHWs and outreach activities	The support supervision system was developed in 2013. However, implementation has been erratic due to poor funding.
	Develop and implement a community based HMIS	Community based HMIS was developed in 2012. However, there is inadequate supervision of and support to community HMIS. The LHWs are not adequately skilled to generate the reports. Furthermore, timely reporting and data quality issues of concern.
	Printing and distribution of HMIS tools	HMIS tools were printed and distributed in 2013. Utilization of these tools is still an issue due to non-availability of HMIS personnel at facility or district level.

	Procure and distribute/resupply FCHW kits	Kits were first procured and distributed in 2013. The activity has continued.
	Procure and distribute/re-supply equipment for Health posts	Procured and distributed to MCH centers which are the ones that are equipped with solar or kerosene powered cold chain equipment and not Health Posts. Field visit attempts were made to try and have a feel of what happens at Health Posts to no avail, Health Posts were found to be always closed.
	Provide incentives to CHWs	Provided incentives since 2013.
	Provide incentives to FCHWs	Incentives have been provided since 2013 and included three months of classroom training on providing basic disease treatment. A field visit to some of the community health workers proved that the ladies are equipped with all the necessary registers but not the IEC materials needed to conduct weekly FGDs in the communities.
3. To improve awareness and demand for immunization and other essential quality maternal and child health services through a comprehensive and sustained campaign of behavioral change communication.	Develop, print and distribute IEC material (MCH centers, health posts)	Achieved, IEC materials posted at all facilities. Our field pictures confirm that at the sites visited, IEC materials have been posted at the facility.
	Disseminate video messages through cable	Not yet done. BCC strategy is still under development.
	Disseminate BCC messages through radio	Not yet done. BCC strategy is still under development.
	Increase public awareness through print media	Posters at health centers only.
	Organise advocacy/BCC events for community elders and religious leaders	Started but needs scaling up to reach the required targets.
	Organise school events on key messages	Started and is working well according to local

		partners.
	Produce and distribute IEC material to private pharmacies	Has been done but not to all pharmacies
	SMS text messaging for BCC	This activity is not yet done.
	Formative research to identify key maternal and child caring behaviors and barriers	Completed. The study was conducted in 2014 because it was difficult to get a consultant.
	Develop five year strategic communication plan	Completed. Waiting for signature of the government authorities
	Develop print, audio-visual and IPC package for health workers both public and private	Completed. Samples available
	Develop and broadcast radio programme on key child caring and health practices	Completed Samples available
	Strengthen and establishing structured/systematized partnership with Faith-based Organizations and networks	Working with religious leaders on-going in all zones. Reports available.
	Work with school structures to increase dialogue on key iccm messages	On-going
	Develop community friendly materials (discussion guides etc) with key iccm messages for FCHWs, CHWs, TBAs for home based family promotion	Done and samples available
	SMS text messaging for BCC	Discussions and planning on-going
	Evaluation of C4D interventions	To be conducted in 2016 but funding inadequate
	Technical Assistance for BCC/C4D activities	

4. To provide evidence (on utilization, impact and cost of services) in order to generate appropriate and affordable health care delivery models for maximization of efficiency health essential services through managing a programme of operational research.	Conduct baseline and end-line surveys	Desk review conducted in 2014 and end line 2015
	Establish and support Operational research committee	Research committee was established 2013
	Commission operational research studies	Activity expected to be done this year (2015).
	Conduct focus groups for operational research	Activity expected to be done this year (2015).
	Support data analysis and use	Activity expected to be done this year (2015).
	Technical assistance for Operational research	Activity expected to be done this year (2015).

Investments in upgrading MCH facilities leading to improved routine EPI service delivery

Out of 40 MCH facilities which were targeted for infrastructure upgrading and provision of cold chain equipment, 31 facilities had been attended to adequately. Further, in the six facilities which we visited during this evaluation, it was confirmed by facility staff that the cold chain equipment at the site was bought from Gavi HSS funds. These investments have gone a long way to improve access and quality of immunization services.

In Somaliland, 13 health centers were identified and rehabilitated according to the original proposal, the same has been done to 12 health centers in Puntland. Cold chain equipment has been supplied to all the facilities and health facility personnel from each of the health centers have received EPI and injection safety training. Our field visits to six health facilities from four districts namely, Hargeisa, Gabilex, Garowe and Qaxis confirmed that facility refurbishment, cold chain installation, and so on, were done as planned. It is not established as to whether some of these facilities received support from other donors such as WVI and GFATM under the Basic emergency maternal, obstetric and neonatal care (BeMONC) programme. For example, Arabsiyo RHC a facility offering BeMONC services in Gabilex, Maroodijeex region of Somaliland is supported by both world vision and Gavi. The cold chain equipment at this facility and vaccines are supplied by UNICEF and one nurse is paid through the Gavi HSS project.

Further, training of staff has facilitated improvements in EPI knowledge base for health workers. A knowledge assessment conducted during our field visits indicated that the level of knowledge of basic EPI processes among EPI personnel in health facilities is quite high. Personnel in all the six MCHs visited during the field work have sufficient knowledge of the protocols in provision of immunization services. All the health workers interviewed in the facilities indicate that they had received some training on EPI as part of the implementation of Gavi HSS activities. One key informant indicated the following, "there has been some capacity built in MoH staff through the various trainings that have been conducted". However, in the absence of the counterfactual, it is not possible to determine how much of their knowledge is attributable to the training received from Gavi.

In addition, the facilities visited were all stocked with EPI supplies, particularly vaccines. Table 7 shows the vaccines which are typically stocked at the six facilities visited. All facilities reported to stock Measles, Penta (DPT-Hib-HepB), OPV and Tetanus Toxoid (TT) vaccines. Vaccine supply appears reliable as all the six facilities reported to have stocked these vaccines. However, only one facility had Vitamin A in stock. Hib (individually), Hepatitis B (individually) and DPT (individually) are never stocked at any of the facilities visited. Care must be taken to note that these tables present a snapshot situation on the day of the visit, and may not necessarily represent the situation over a long term.

Table 7: Vaccines stocked at the six facilities visited

Vaccine type	Number of facilities with vaccine
Measles	6
Penta (DPT Hib HepB)	6

OPV	6
BCG	6
Tetanus Toxoid (TT)	6
Hib (individually)	0
Hepatitis B (individually)	0
DPT (individually)	0
Vitamin A	1
Other	0

The findings from the field visits suggest that vaccine stock-outs are not a problem in Somaliland and Puntland; none of the six facilities visited reported having had ran out of Penta, Measles, BCG, Measles vaccines or syringes for more than one week during the one month preceding the survey. Extending the recall period to three months shows only one facility reported to have had measles vaccine stock out for more than one week. There were no vaccine stock-outs lasting more than a week for the rest of the vaccine types at all facilities surveyed.

Table 8 classifies the general state of the cold chain equipment based on the researcher's observation and judgment. All facilities visited had functional cold chain equipment. In the survey of facilities we also specifically asked if the cold chain was bought under Gavi HSS support. For the facilities we are reporting about, the cold was bought from Gavi HSS funds according to the staff interviewed. At five of the facilities the cold chain equipment was in very good condition and one facility had fairly good equipment. At no facility did we see either non-functional or dilapidated cold chain equipment.

Table 8: Field assessment of general condition of cold chain equipment

Condition	Number of facilities
Non-functional	0
Very dilapidated	0
Fair	1
Very good	5
No cold chain equipment	0

Table 9 gives an indication of time and staff dedicated to immunisation. The facility with highest number of days allocated for immunisation reported 6 days per week and the facility with the lowest number only conducted immunisations for one day. On average a facility dedicates about four days per week to immunisation activities. The number of hours allocated for immunisation varied between one and 12 hours per day. On days when immunisation is conducted each facility has either one or two health personnel to carry out the activity.

Table 9: Average number of days and hours of immunization and staff available for immunization

Facility name		**PENTA/DPT vaccination**	**Vitamin A supplementation**	**Measles vaccination**

Arabsiyo MCH	days per week	6	6	6
	hours per day	3	3	3
	staff per day	1	1	1
Darawayne MCH	days per week	1	6	6
	hours per day	12	12	12
	staff per day	1	1	1
Gargaar MCH	days per week	6	6	6
	hours per day	7.5	4	4
	staff per day	2	2	2
Sunajiif MCH	days per week	2	2	2
	hours per day	3	3	3
	staff per day	2	2	2
Qarxis MCH	days per week	6	6	6
	hours per day	4	4	4
	staff per day	1	1	1
Awr-Culus MCH	days per week	6	6	1
	hours per day	5	5	5
	staff per day	2	2	2

Community sensitization improving through BCC strategies

Despite the late start in implementation, the BCC is now running relatively well in schools. In addition, the religious leaders (Imams) are being used to sensitize the community on immunization through BCC. These leaders are the agents for community sensitization especially among men imparting knowledge and appropriate behavior change regarding immunization. The religious leaders have been trained to integrate health related messaging into their scheduled Friday prayer meetings. This is a significant achievement given that men generally make most of the decisions in the households. Additionally, conveying messages through the religious leaders gives the messages some form of legitimacy against the backdrop of strong myths pertaining to immunization that exist among Somalis. One key informant has this to say,

> "There is a religious aspect to health care and people are more willing to listen if things are coming from a religious leader than from anyone else. There are so many myths here and people are more willing to listen if a religious leader speaks." *Key Informant, Puntland.*

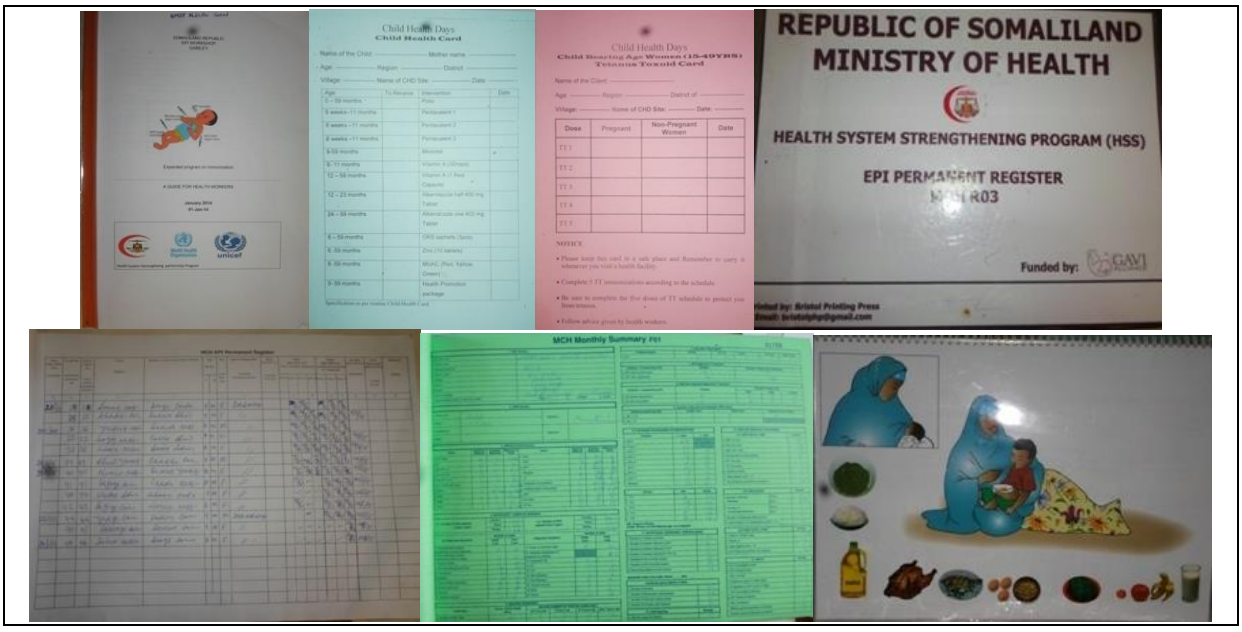
The FHWs are also playing a key role in taking the behavior change message throughout their communities. We note that behavior change takes time to bear results. Although we asked about the results from BCC it appears that it is still early to establish results yet.

Gavi HSS contribution to strengthening of HMIS

Although the Gavi HSS grant was not intended to create a parallel M&E system, the grant provided resources for printing standard registers for capturing HMIS data and supporting

FHWs to capture monitoring data. Registers have also been provided for community level HMIS and these are being used by the FHWs. This is a requisite development as it feeds into data/evidence driven planning and policies. These efforts are bearing fruit as the FHWs are now able to capture data not just on EPI but community-level PHC services more generally. This is a significant contribution of Gavi HSS to strengthening the monitoring function of EPI at community level. We provide some evidence of the data that is being captured below.

Figure 3: Evidence of the data that is being captured

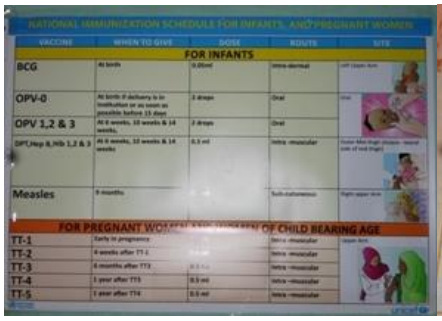


EPI registers, vaccination guidelines, monthly summery sheets flip charts and standardized under five cards used by health centers

Figure 4: Evidence of equipment in facilities surveyed

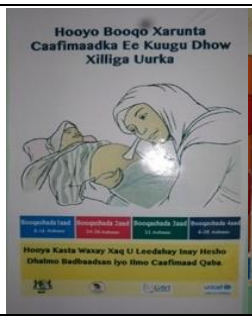
Solar panels, delivery beds and cold chain equipment supplied to facilities IEC materials distributed and posted at various health facilities

Figure 5: Selected IEC Materials in the facilities surveyed


NATIONAL IMMUNIZATION SCHEDULE FOR INFANTS AND PREGNANT WOMEN
VACCINE
WHEN TO GIVE
DOSE
ROUTE
SITE
FOR INFANTS
BCG
OPV-0
OPV 1,2 & 3
Measles
FOR PREGNANT WOMEN AND WOMEN OF CHILD BEARING AGE
TT-1
TT-2
TT-3
TT-4
TT-5


QARXIS MCH
Hooyo Booqo
Xarunta Caafimaadka
si aad u heshid.
◊ Dhalmo Badbaadsan
◊ Ilmo Caafimaad qaba
◊ Tallaalka Hooyada oo dhamaystiran
◊ Tallaalka Caruurta oo dhamaystiran
◊ Dawooyin
◊ Tallooyin Caafimaad
GAVI
unicef


Cudurka dabeysha ka badbaadi
carruurta dhawaan dhalatay,
kuwa hurda iyo kuwa xanuunsan
Ilmo hurda
Ilmo xanuunsan
Ilmo dhowaan dhashey
Cudurka dabeysha aynu ka ciribtirno dalkeena


Hooyo Booqo Xarunta
Caafimaadka Ee Kuugu Dhow
Xilliga Uurka
Hooyo Kasta Waxay Xaq U Leedahay Inay Hesho
Dhalmo Badbaadsan Iyo Ilmo Caafimaad Qaba


DACUUN CALOOLUHU WAA KHATAR
SII BUKAANKA
CABITAAN BADAN.
CUNTADA SI
WANAAGSAN
U KARI.
CAB BIYO KOLORIIN LAGAU
DAAREEYEY AMA LA
KARKARIYEY.

Finding 7: Programme has faced difficulties adapting to implementation challenges

In general, adaptation of implementation to accommodate or navigate around the challenges on the ground has been difficult for a number of reasons, leading to the programme not being implemented efficiently or effectively. Communication and decision-making are characterized by administrative delays. Some changes to implementation have proved unsustainable. For instance, the outreach strategy was adjusted from standard outreach to 'mobile outreach whereby facilities go out for days in communities, in order to maximize the capture of nomadic populations. A facility goes out five days of each month to conduct outreach or mobile vaccination in different parts of their respective regions. "The other challenge is that people are very mobile and service utilisation fluctuates as a result. You have situations where in one quarter, the number of people receiving a service is high and in the subsequent quarter, the number drops because some people have moved. Utilisation of preventive service like EPI and ANC is very low. We are trying to address this using outreach. Access to service is generally hard in areas where there is no public transport. To enhance service utilisation, social mobilisation ought to be intensified because people do not understand the importance/benefits of preventive service like EPI."(*Regional EPI officer Puntland*). However, it has been argued by many local and international partners that mobile outreach is not financially sustainable within the Gavi HSS grant. A final resolution is yet to be reached.

Given the very low level of access to health care in Somalia, with an average of 0.2-0.3 visits per capita utilization of public services per year, the country clearly still faces challenges of attaining the goal of increasing coverage through routine immunization. The proposal for EPI programme has to rely on outreach and mobile immunization delivery models which are considered to be quite costly for the programme. As such, outreach immunization activities are not conducted on a systematic basis due to shortage of funds. Hence, decisions about institutionalising EPI outreach activities are still pending, largely because of the financial implications of the child health days which are being proposed. Another example is the adjustment which was made to the eligibility for incentives. This change was made to not necessarily follow performance-based system, as was originally planned, in order to diffuse tension among staff cadres. Also, the facility in-charge of facility has authority to share the allocation to the health centre across all staff in the facility (*Key informant interview with UN partner in Somalia*)

On a number of occasions, the programme has been delayed because of administrative procedures for procurement and release of funds to implementing entities on the ground. Examples which were cited include key activities such as recruitment of FHWs, release of staff bonuses for FHWs, implementation of BCC activities. Keeping staff motivated under these circumstances is a real challenge. By and large, we point out that programme management especially at the country level has been unable to deal with these implementation challenges. "The procedures and processes for getting supplies and subcontracting NGOs are tedious and lengthy. The parts of the funds that are transmitted to the government are also subject to heavy bureaucracy and red tape. Further, delays in responding to implementation bottlenecks which are reported to UN partners by

implementing agencies on the ground were commonplace, causing frustration and loss of morale among staff," (*sentiment echoed in Government officials in Somaliland and Puntland*).

Finally, this evaluation found little evidence of the programme management responding to ongoing delays in release of funds. Although there is a Gavi HSS focal point in each zone, they do not have decision-making power. There is a perception among some partners that the location of the WHO and UNICEF main offices in Nairobi adds to the delays in providing feedback and making adjustments to meet implementation challenges which require prompt management action. Some partners were of the view that the programme coordination meetings are more focused on monitoring results and not solving problems of implementation that have been identified. Review meetings are held but no follow-up actions are documented. To illustrate this point further, concerns have been raised by implementing partners that the reporting requirements for FHWs put too much demand on their capacity. "Each LHW has 5 books to complete as part of the reporting. I feel that the HMIS tool is too detailed for the LHW. The reporting books are too much for them to handle and sometimes get spoiled if she has children at home". *Key Informant, Somaliland.* There has been no notable response to these concerns.

Finding 8: Gavi HSS programme coordination mechanism has faced challenges

This evaluation has identified several challenges related to the coordination of the Gavi HSS grant in Somalia. At the outset it should be noted that the Gavi HSS preceded other health systems initiatives which are being referred to in Somalia. However, once implementation of Gavi HSS and other systems strengthening programmes commenced there seems to be considerable desire among Gavi HSS stakeholders to find ways to harmonize coordination across these related programmes. The Health Sector Committee which is the main mechanism for coordination with regards to Gavi HSS has been perceived to be weak in a number of aspects. For example, information sharing among partners about Gavi HSS implementation is considered to be inadequate to inform partners about what is going on, let alone receive their feedback. As such, some key partners know very little about Gavi HSS implementation in Somalia. Typically, under the existing coordination mechanism, partners get a presentation in form of a high-level summary of issues surrounding HSS implementation in Somalia. However, there is little management feedback of information or recommendations from the HSC to authorities in the country. During these meetings, there is little time for partners to get a deep understanding of the implementation issues and understand the challenges. It is clear that several key partners are considerably less informed about HSS implementation. "A separate coordination mechanism specifically for HSS has not worked out. The current coordination framework does not provide partners with an opportunity to know what is really going. It is also important to get the government fully on board on how we are implementing this programme. It is hard to run Gavi HSS as a vertical programme as is the case at the moment." (*Somalia health sector donor representative based in Nairobi*).

Further, there are several partners implementing health system-related activities without coordination, leaving the available government capacity overstretched. "It is quite remarkable that two programmes that both have huge HSS components cannot be coordinated."(*KI,*

Nairobi) "There are too many parallel systems for implementation. No one knows what is happening. It is not possible to intervene and provide suggestions." (UN partner in Somalia; Government official). A UN partner involved with providing support to implementation of Gavi HSS gave an impression of better coordination: "You cannot use two eyes to look into a bottle." To the extent that coordination is also about improving programme implementation towards outcomes and impact, it is difficult to establish the real contribution of Gavi HSS vis-à-vis other programmes such as the JHNP.

Another symptom of the coordination challenges is reflected in the differences in perspectives about the quality of the coordination between the health authorities (who are responsible overseeing programme implementation) and the UN partners (responsible for managing the grant). On one hand, the UN partners provided an account of the Gavi HSS agreed workplan, budget, management structures and coordination mechanisms. On the other hand, the impression we obtained is a high level of dissatisfaction by health authorities, and other non-UN partners, regarding these implementation aspects of Gavi HSS. For example, the Somali Health Authorities do not appear to take the leadership role in implementation of Gavi HSS grant despite the fact that in the proposal this is their main responsibility. In some cases, some level of dissatisfaction between the government and partners is evident. It was mentioned that often, MOH authorities are not at the centre of coordination of key activities (called to meetings at short notice without being part of organisation of key meetings).

"On many occasions one partner would ask what the other is doing. Lines of responsibilities are sometimes unclear. Poor communication is also common, leading to occasions of finger-pointing in many instances." (Government official in Somaliland).

"Meetings are called on an ad hoc basis. We often go there (to meetings) without much preparation. Sometimes, we just see people implementing activities without knowing when decisions were made, and by whom." (Government official, Puntland). An example was given, by Somali government officials in Somaliland and Puntland, as well as three other partners interviewed in Nairobi, that the BCC activity, which was designed to be the cornerstone of the strategy for improving awareness and demand for immunization and other essential quality maternal and child health services at community level, has been implemented by partners without the government knowing much about what is going on.

The reasons for this situation are not entirely clear. It is stated in official documents and was confirmed in interviews that WHO and UNICEF lead the implementation of GAVI-HSS Programme in close collaboration with health authorities and other partners, and that clear roles and responsibilities have been developed between all partners. However, clearly, there are still coordination challenges or issues of misunderstanding and shared responsibility and accountability that need to be resolved. The Joint Appraisal report of 2015 also alluded to the geographical distance between the UNICEF and WHO program management team being based in Nairobi and the programme implementing teams based in Somalia as a factor that has posed challenges in terms of regular vis-à-vis communication and technical guidance needed on the ground;

Several factors have undermined coordination of Gavi HSS:

- Although we were given the Gavi HSS budget and informed that the budgets are shared with the health authorities, there was a perceived of lack of transparency about the execution of the Gavi HSS budget for each region and partner in the programme;

and suspicions about what proportion of funds are retained in terms of overheads in Nairobi;

- Some of crucial meetings are not called properly, often very late and not enough preparation is accorded to partners and the government, leaving many partners not clear about what Gavi HSS is about.

Finding 9: Limited technical and management capacity within Government slowing down implementation

Implementation of activities has been adversely affected by capacity limitations within MOH in all three zones, particularly the limited availability of skills in operational and financial reporting. Staff from WHO and the regional offices of the Ministry of Health in each of the three zones capture data on the financial retirements, activity profiles, and so on. They rely on health workers at the facility as well as the FHWs to provide background data in their respective areas. The lack of adequate capacity tends to delay reporting. Delayed submission of returns (financial and activity) to the region and to WHO and UNICEF has been cited as one of the major causes of the delay in disbursement of funds to providers (*KI in Nairobi; KI, Somaliland*). The consequence is delayed implementation of activities. The government is fully aware of this challenge. "Our weakest point in terms of capacity is financial management. This needs to be strengthened with the help of partners. But this should not prevent us from actively participating in implementation. What the UN needs is to do is to find a cost effective way of disbursing these funds. We are not saying that the money should be given to the government, no; we have capacity constraints. But they can for instance be fund managers and leave the implementation to us. There are other cost effective ways of doing it." (*Government official in Somaliland*).

Weaknesses in capacity have also affected the quality of programme supervision of Gavi HSS implementing entities (particularly PHUs, FHWs and MCHs) by the government. Further, structures for technical supervision and support to programme implementation are still ad hoc (apart from inconsistency in frequency, the tools for supervision are not comprehensive) and not tailored to solving implementation challenges. "We need to move away from conducting disparate activities of planning, monitoring, cursory supervision (each supervision focuses on a narrow set of issues), and so on, and move to comprehensive programme supervision and monitoring. We need to be solving problems than simply collecting information." Interventions to improve implementation are equally hampered by information gaps and a lack of problem-solving management culture. "For example, we still don't know why coverage remains low in Somalia" (*Interviews with UN and government officials in Somalia*). This perspective was also shared by MOH staff at the regional and facility levels who are involved in implementing the Gavi HSS grant.

Additionally, Gavi HSS management meetings are not held on a regular basis. (in Somaliland and Puntland, no Gavi HSS coordination meetings had been held in 2015). This issue was also pointed in the *Joint Appraisal Report 2015*: "Due to the absence of a national health and immunization structure, functional links between management at zonal MOH level, the regions and the MCHs on the ground are non-existent. This negatively affects planning,

implementation and monitoring of immunization services, including Gavi supported activities (*Joint Appraisal report, 2015*)". Finally, at the level of coordination, meetings are dominated more by presentations of review findings and less analytical and problem-solving sessions. Capacity to analyse and use data is not demonstrated. The fact that many of the partners are based in Nairobi has adversely affected the timely response to management issues.

Finding 10: Implementation of Gavi HSS M&E function is fragmented

In our assessment of the extent to which the M&E component has been properly implemented, we note the following challenges. This evaluation identified a number of challenges in terms of monitoring and assessment of implementation of activities. First, implementation of the M&E exercise is severely hampered by the lack of a reliable HMIS system. There is no functional routine data capture system with reasonable quality and completeness to facilitate regular and timely program performance and results. The only available data from the HMIS system is from 2014 onwards. This means that it is not possible to assess implementation and results to any baseline. The existing HMIS system is not robust set up to produce data that would be used to assess implementation and programme results. In assessing the extent to which the Gavi HSS M&E function was executed, it was confirmed that although a national M&E framework had been developed for all three zones, its implementation was virtually absent. Second, the data that are reported in the HMIS include only absolute numbers (numerators) and of varied quality by time and region. With a very high proportion of nomadic populations and disputed district boundaries it is even harder to estimate administrative coverage.

Third, efforts at collecting M&E data and assembling a framework are fragmented. For example, some of the data are captured at facility level for routine immunization and through CHDs and outreach. The data are submitted in raw form by hand to the regional office of the MOH in each region. The regions compile the data and transmit the data to the zonal MOH. A community based HIS is used to collect EPI-related data but is not integrated in the national HMIS and valuable data are not analyzed to trigger further action (Joint Appraisal report, 2015). Data collection system is fragmented. UNICEF compiles its own data and produces its own HMIS-based indicators and data. It is important to note that the data held by the government and UNICEF are not reconciled, often show significant discrepancies, and are disputed. Although some capacity has been built, the programme has lacked funding to provide the much needed consistent technical and supervisory support to MCH centres that collect data. "Completeness of reporting is a big issue that affects the quality of the data." (*KI in Nairobi*).

Finally, the impression of the evaluation team is that the existing HMIS and community based information system are not adequate to facilitate the M&E function of the Gavi HSS grant in Somalia. The completeness and reliability of the data systems are still in question. This view was confirmed by both the health authorities and the UN partners.

Finding 11: Several factors have determined the pace and nature of Gavi HSS implementation

A number of factors have influenced the implementation challenges of the Gavi HSS grant in Somalia.

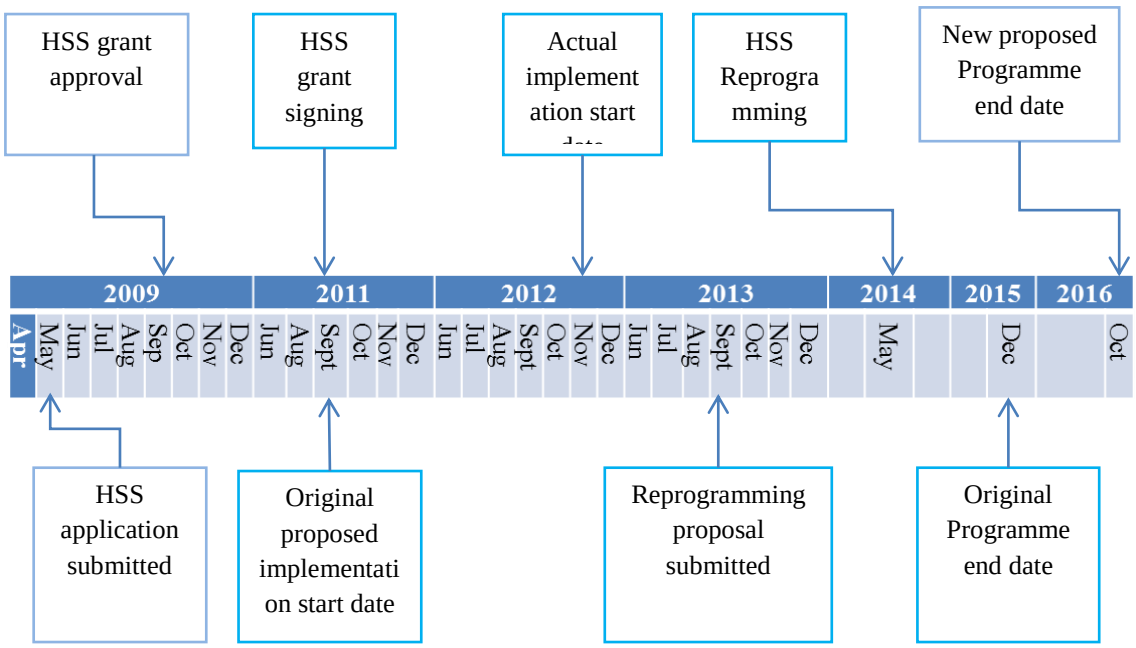
- *Weak public financial management systems capacity*
  Delays in implementing activities have been caused by weak capacity within the MOH. It takes long to get financial disbursement and reporting procedures completed due to weak systems in government. Weak public financial management systems are exacerbated by inefficient bureaucracy in the government (Joint Appraisal report, 2015).

- *Limited HR capacity: technical and support*
  All zones in Somalia the health sector is faced with critical shortage of human resources particularly in M & E, financial management, and procurement, logistics, supply chain management. Implementing the activities in the Gavi HSS proposal require a significant human resource base. It is only in the latter years of the implementation of Gavi HSS that staff have been recruited and trained to support programme management. The shortage of health staff has been associated with delays in implementing activities. Most clinics are only open 7.30 to 11 Hours a day.

- *Location of programme management and coordination based in Nairobi*
  That parts of management and coordination of Gavi HSS is based in Nairobi has on occasions caused delays in decision-making for implementation.

- *Security problems*
  Many parts of the country continue to face significant security problems which have restricted movement of programme staff and EPI logistics to facilities. The cost of running the programme has increased due to security considerations. The country geo-political context has changed with the emergency of states within Somalia. Now we have areas which are falling under different authorities, making implementation and monitoring of Gavi HSS very difficult. Some areas need humanitarian support than routine services. The political context is changing and the country is at a crossroads.

Figure 4: Key Gavi HSS milestones



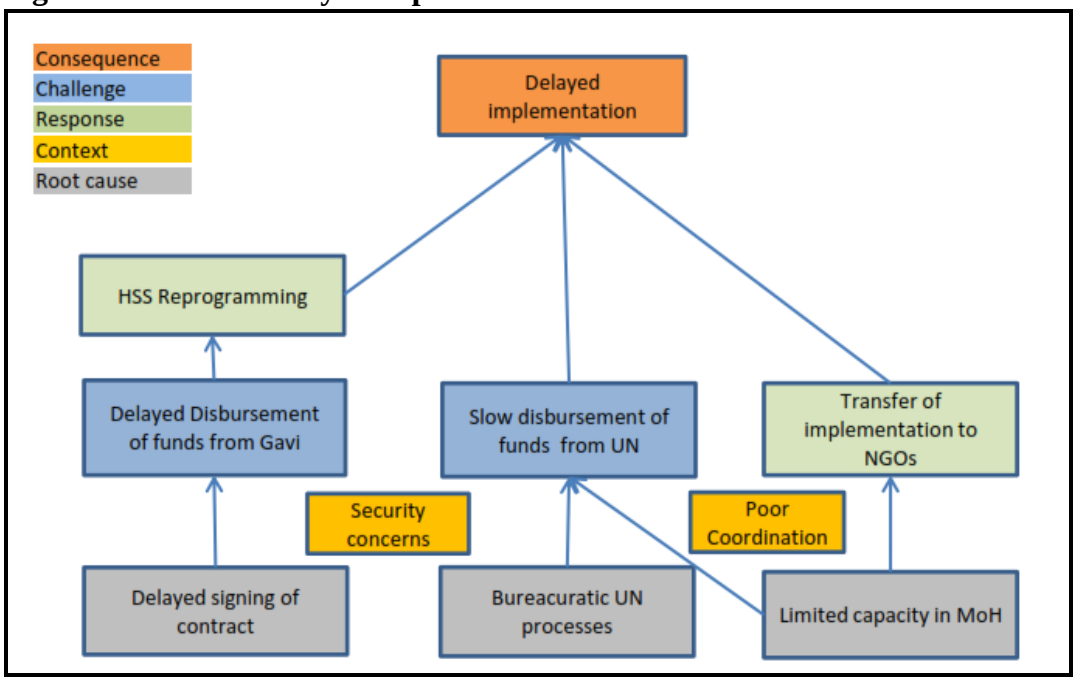
A Root Cause Analysis of delayed implementation of Gavi HSS activities

We present a schematic summary of the factors that affected the delayed implementation of the Gavi HSS activities. We identify three root causes. First, the programme suffered administrative challenges from the start. It is documented that about two years passed between the time the proposal was approved in 2009 and the time the first disbursement was made in 2011. This was attributed to the time lag between approval of proposal and signing of the contract. Activities could therefore not happen according to schedule and subsequently, a reprogramming had to be initiated in 2013. A number of activities were carried out in 2013, including the recruitment of programme manager and two professional officers (one for Puntland and one for Somaliland). Funding for the reprogrammed proposal however only started in 2014.

Second, slow disbursement of funds by Gavi has slowed down the pace of implementation of activities. Additionally, the bureaucratic procedures of the UN system have added to the slow execution of activities on the ground. Finally, the limited capacity in MoH also adversely impacted on the timing of implementation. It was indicated from the field work that some components of the Gavi HSS programme were initially meant to be implemented directly by MoH. But this did not happen largely because of capacity constraints. One such activity is the rollout of the BCC programme. Funds were initially given to MoH to conduct the activity by these funds were withdrawn from MoH when UNICEF noticed that time was passing and MoH was failing to implement. The implication is that the activity ended up being conducted much later than initially planned. The lack of capacity in government necessitated the UN to subcontract a number of NGOs to implement some of the activities, thereby adding to the bureaucracy and slowed down the pace of implementation.

The context within which the Gavi HSS grant was implemented also imposed some challenges and affected the pace of implementation. As was highlighted earlier, implementation was hampered by coordination challenges and the infrequency of coordination meeting did not help the situation. The poor security situation is another contextual factor which impacted the pace of implementation especially in the South/Central Zone of the country. It is documented for instance that recruitment of staff was delayed due to security concerns.

Figure 5: RCA for delayed implementation of Gavi HSS



2.3 EFFICIENCY

In this section, we address three related issues: (i) To what extent were the funds used efficiently and as planned? (ii) What contextual factors explain the utilization rate of the funds received? and (iii) What could have been done to improve the efficiency?

Finding 12: Low absorption capacity of funds

Of the total Gavi HSS grant of $11 million, WHO manages slightly above $6 million while UNICEF is responsible for managing about $4.5 million. In table 10 we show the utilization of funds from 2011 to 2014. The first disbursement was made in October/November 2011, after which the programme management had to review the activity plan for the year. Hence, very little of the funds were spent in 2011, as can be seen from the table. Spending improved in subsequent years and peaked in 2013. Budget execution has generally been quite slow, averaging 32 % over the years in question. This relatively low rate of utilisation of funds is a

reflection of the delays associated with the programme implementation, the reprogramming which took place in 2013, and capacity constraints in the Somalia MoH.

Table 10: Funds utilisation rate

		2011	2012	2013	2014
Original annual budgets (as per originally approved Gavi HSS proposal)		2,786,791	2,476,727	2,222,902	2,017,222
Revised annual budgets (If revised by previous annual progress reviews)		48150	1,019,474	2,839,438	3,899,631
Total funds received from GAVI during the calendar year (A)	A	2,786,791	2,470,387	0	2,549,515
Remaining funds (carry over) from previous year (B)	B		3,257,258	2,382,731	2,364,627
Total Funds available during the calendar year (C=A+B)	C	2,786,791	5,727,645	2,382,731	4,914,142
Total expenditure during the calendar year (D)	D	7,758	1,412,524	1,461,831	2,227,187
Balance carried forward to the next calendar year (E=C-D)	E	2,779,033	4,315,121	920,900	2,686,955
Proportion of available funds spent [F=(D/C)*100]	F	0.3%	24.7%	61.4%	45.3%

We first note that Gavi HSS funds were largely spent according to the budget. Given the long delay between the date of approval of the grant and the first disbursement, the programme management prudently initiated a reprogramming process for the funds. Apart from taking account of lost time, costs of some of the inputs has increased (*interview with UN partner Nairobi*). The reprogramming was approved in 2013 and the grant spending remains within the original plan in terms of the objectives.

We also learned that at least in Puntland and Somaliland, some adjustments were made to include all staff to be eligible for incentives. In Somaliland, an MCH had an average of five employees and all of them were getting paid. This means that for the 13 MCH implementing Gavi HSS activities, the number of people benefiting from the incentives was around 65. Furthermore, of the 13 facilities being supported by Gavi, six of them used to be PHUs before Gavi support was introduced and were therefore not even providing immunization services due to lack of cold chain and, in some cases, appropriate staff. Gavi funding helped in the upgrading of these facilities to MCH status and they are now able to provide immunization services (*Key informant based in Somaliland*). This meant that some of the MCH facilities which were supposed to benefit from the rehabilitation funds could not benefit because upgrading a facility needs more money since it involves adding new structures to existing ones.

Another concern for the efficiency of implementing the Gavi HSS grant in Somalia has to do with the cost associated with coordination among partners based in two different countries as well as coordination among the three health authorities. In the original budget the grant allocated 32.2% for programme management costs, and this increased to 39.7% in the reprogrammed proposal. Although the expenditure data we have did not show detailed costs items by function, the programme management staff informed us that the administrative costs are within the allocation.

The most notable cause of relatively low level of efficiency in the execution of the grant was lengthy administrative procedures for disbursement and retirement of funds. The 2014 APR also cited delays in disbursement of funds from Gavi as source of inefficiency in the management of the grant. Administrative procedures for requesting for and retiring funds in the UN system are lengthy. The paperwork has to be approved by a chain of offices starting from in country, to the Nairobi office and the WHO–EMRO office. If one of the offices along the chain did not approve, the process would have to start afresh and that resulted in loss of time. One example of an activity which has not been completed in Puntland because of procurement bureaucracies is the BCC; the exercise has just been conducted in two of the four regions where Gavi HSS is being implemented. The bureaucracy is also responsible for the delay in getting the incentives. In Puntland it was reported that delayed payment of incentives to health workers was common. For six months (March to September) in 2015, staff had not been paid their monthly incentives. There were also instances where one partner's implementation of activities was held back by the delay on another partner to conduct counterpart activities required to trigger spending/action from the other partner. For example, field staff in Somaliland mentioned that utilization rate of funds by one UN agency was slowed down because the staff were waiting for another UN agency to implement its activities.

2.4 SUSTAINABILITY

Basically, the main RFP question requires this evaluation to assess how sustainable, in financial and programmatic terms, the achievements of the Gavi HSS programme in Somalia.

Finding 13: There is limited evidence of Gavi HSS supported activities being sustainable

The contribution of Gavi HSS to sustainability has faced a number of challenges, many of which are related to the way in which the programme has been implemented as well as capacity limitations in-country. We cite a number of factors that challenge the sustainability of the programme. First, given that all the activities and equipment and running costs are funded by the Gavi grant without any government contribution, and considering the economic situation of the country, it is difficult to make a strong case that these achievements can be achieved without continued Gavi financial support. Second, the Gavi HSS programme has had limited ownership by the health authorities during implementation. A lot of the work has been done by partners through subcontracted NGOs with minimal capacity building. The impression we got from the field visits is that the government structure that is responsible for implementing and providing oversight over programme implementation of Gavi HSS are still weak. The mechanisms which were developed through country Gavi Focal Persons and Gavi HSS Working Groups are not fully operational. The Gavi HSS Focal Point persons have less influence and their relationship is weakened by their limited powers to make decisions or resolve problems. Sometimes activities are implemented in the field without him knowing." (*Gavi HSS focal point person*). There is still heavy reliance on the UN at the country level.

Third, despite the activities which have been undertaken, there is little evidence of Gavi HSS having contributed to strengthening EPI programme even in Gavi HSS-supported districts. Gavi HSS has been more focused on getting services to the population than strengthening the routine system for EPI. "In my view, the most important thing at the moment is to deliver

service to the people. If we focus on systems strengthening, then services will not be provided. There is a tradeoff between system strengthening and getting services provided. Capacity in MoH is too limited." (*UN partner based in Somalia, also mentioned in the Joint Appraisal report 2015*). This sentiment was echoed by another partner in Puntland: "I should mention that the routine system broke down a long time and we use campaigns to reach out to people. These are done for up to nine months in a year." Indeed, the bulk of activities and spending is not on routine EPI strengthening, but rather on campaign-mode immunization activities and delivery of supplies by UNICEF using parallel systems. As such, as we state elsewhere, most components (staffing, funding, logistics planning, supervisory system, M&E system, etc.) of a strong and effective EPI programme are still weak.

Fourth, the sustainability of Gavi's HSS support has been undermined by the inability by the government and partners to maximize synergies with other health system support, particularly the JHNP. "There is a lot of health system components in the JHNP which is supported by various donors based on the WHO six health systems building blocks, but we do not see the synergy between JHNP and Gavi HSS. We need to design synergies between all these different efforts" (Government official). Another respondent argued for more operational synergies between Gavi HSS and other health systems development efforts: "Gavi HSS is too small to stand alone" (UN partner in Somalia). Consideration is given to the existence and duplication of efforts of other programmes such as the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, Essential Package of Health Services and the Joint Health and Nutrition Programme. An official of the government mentioned the lack of coordination among donor projects. "There are too many organizations pushing different programmes with a lot of overlap and duplication of programmes among partners e.g. the payment of incentives by different organizations; the HRH program where DFID is supporting community health workers and Gavi, the FHWs. The limited coordination between Gavi HSS and other health systems initiatives such as the JHNP represents a missed opportunity to integrate programmes and improve sustainability.

At the operational level, sustainability is threatened by the lack of cohesion between the various Units of the MOH involved in executing the grant. Although the situation may vary from zone to zone, this evaluation can report that the involvement of heads of EPI Units in the regional offices are very remotely involved and were not even part of the staff receive a Gavi HSS incentives. This situation has created some tension within the system between staff. Some key informants actually feel that implementation of Gavi HSS should be spearheaded by EPI people, but unfortunately, the process has been hijacked by planners who know nothing about EPI:

> "To begin with, there is an inconsistency because the name Gavi HSS is not the correct name for the programme. The programme's ultimate goal is to improve uptake of EPI services. But when you look at the people who are implementing the programme, they are not EPI people. Most of them are from planning and they have hijacked the programme. We need to review the role of Gavi, if Gavi is interested in EPI, then they need to involve EPI people." *Key informant in Puntland*

This challenge is mostly attributed to decision-making within the Government and how the various departments (e.g. EPI Unit and Planning Departments) in government coordinate. This situation can create operational challenges would limit the prospects that the Gavi-HSS-supported activities can be routinized and sustained.

But it needs to be mentioned that the investment in recruitment and training of the FHWs provides a great opportunity for Gavi HSS support to contribute sustainably to EPI service delivery in Somalia. If more support can be secured for more training and incentives of FHWs as was being planned in Somaliland to recruit another 110 FHWs under DFID funding, this cadre is available to support attainment of national EPI goals. In summary, based on the foregoing assessment, it is our considered view that the achievements of the Gavi HSS grant in Somalia cannot yet be considered to be sustainable without support from Gavi or other partners. Additionally, the challenges facing the national health system overall render the goal of sustainability somewhat unrealistic. In fact, there has a sense among stakeholders that to a large extent, this programme appears to have served more of a pilot. The country will be in need of more Gavi HSS support to solidify the gains achieved so far.

2.5 RESULTS

In this section, we address the extent to which the Gavi HSS programme achieved its stated objectives of increasing DPT3 coverage and other indicators in the Gavi HSS proposal. We present the data that is available on key results indicators in Table 10 based on the Gavi HSS M&E framework.

Finding 14: Results of Gavi HSS show mixed results

There is a paucity of data to facilitate a cogent evaluation of many of the set targets in the Somalia Gavi HSS grant. Table 11 presents the data on some of the key result elements of the Gavi HSS M&E framework which the evaluation team was able to get access to. The available data shows that the Gavi HSS grant has achieved a few of the key programme targets while the majority of the set targets in key result areas have not been achieved. In particular, DPT3 coverage targets have not been achieved. However, available DPT3 coverage based on estimates by *WHO/UNICEF (*http://www.gavi.org/country/somalia*), Country administrative data and Multiple Indicator Cluster Survey (MICS) data*, the indication is that there has been some improvement in DPT3 coverage from the time baseline figures were estimated. Somaliland and Puntland have recorded some progress in terms of increasing DPT3 coverage, while there is less progress in Central-South zone. It is important to note, however, that the Gavi HSS grant is only one of the programmes that could have contributed to the observed increase in DPT3 in Somaliland and Puntland, as there are other health system strengthening efforts as mentioned earlier.

One of the targets of the programme was to increase the total number of DPT3 doses administered from 200,180 at baseline in 2012 to 251,831 in 2015. The data available shows that as at end of 2014 the total number of DPT3 administered was 170,871 which represent 65 percent of the target. Similarly, the measles doses given rose from a baseline figure of 161, 811 in 2012 to 240,337 doses at the end of 2014. This figure is however slightly below the targeted figure of 251, 831 for 2015. Efforts to increase MCV1 coverage have yielded mixed results across the three regions. The set target of 70% coverage has been achieved and exceeded by 8% in Somaliland. Coverage rates are still far behind the target in Central South and Puntland regions. Compared to the baseline values, the coverage rates in Somaliland and Puntland have improved while coverage in Central South region is below the baseline national coverage rate. The proportion of health facilities that provide routine immunization services is still below the targeted proportion of 40% by 2015. Only 25.6 % of health facilities are providing the service. It is not possible to evaluate whether there has been a positive change over time as no baseline figures were collected on this indicator.

Despite the low proportion of facilities offering immunisation, field visits undertaken to selected health facilities during this evaluation revealed that all MCH clinics offering immunisation services had tracer items for delivery of immunisation including, at least one vaccinator with good knowledge and skills, cold box/vaccine carrier with ice packs, functioning refrigerator and thermometers. Another indicator of interest is the timeliness of reports. Timeliness is calculated based on whether the reports have been completed within a

set number of days after the end of the reporting period. In Puntland, 79% of the reports were completed timely. This figure falls below the set target of 100% timeliness. There are no reported timeliness of facility reporting figures for Somaliland and Central South regions.

Table 11: Assessment of results in the Gavi HSS M&E framework

Immunisation Outcome Indicator	Baseline			Target	Actual(2014)		
	Value	Year	Source	2015	Value		Source
DTP3 coverage - % of surviving infants receiving three doses of the diphtheria-tetanus-pertussis vaccine (DTP3)	61%	2012	*Country administrative data*	70%	Somaliland	63.2%	*Country administrative data*
	42%	2012	*WHO/UNICEF estimate*		Central South	23.5%	
	7.2% / 10.8%	2011	*MICS*		Puntland	40%	
					National	42%	*WHO/UNICEF*
DTP3 coverage numerator (number of doses administered through routine services)	200,180	2012	*Country administrative data*	251,831	Somaliland	77,335	*Country administrative data*
					Central South	63,535	
					Puntland	30,001	
DTP3 coverage denominator (number in target group)	329,231	2012	*Country administrative data*	359,759	Somali land	122,302	*Country administrative data*
					Central South	270,295	
					Puntland	75,445	
MCV1 coverage - % of surviving infants receiving first dose of measles containing vaccine	49%	2012	*Country administrative data*	70%	Somali land	78.7%	*Country administrative data*
	46%	2012	*WHO/UNICEF estimate*		Central South	36.7%	
	16.6% / 25.8%	2011	*Latest coverage survey (Example: DHS or MICS)*		Puntland	59.3%	
MCV1 coverage numerator (number of doses administered through routine services)	161,811	2012	*Country administrative data*	251,831	Somali land	96,297	*Country administrative data*
					Central South	99,299	
					Puntland	44,741	
MCV1 coverage denominator	329,321	2012	*Country administrative*	359,759	Somali land	122,30	*Country*

(number in target group)			*data*		2 Central South 270,295 Puntland 75,445	*administrative data*
Geographic equity of DTP 3 coverage - % of districts that have at or above 80% DTP3 coverage	1 district / 20		*Country administrative data*	70	_	*No data*
Drop-out rate - percentage point difference between DTP1 and DTP3 coverage	11.6% (20%)		*Latest coverage survey (Example: DHS or MICS)*	7%	_	*No data*
Proportion of children fully immunised - % of children aged 12-23 months who receive all basic vaccinations in a country's routine immunisation program	16% 1.5% (5%)		*Country administrative data.* *Latest coverage survey (Example: DHS or MICS)*		_	*No data*
Vitamin A supplementation coverage among 6 months to under five children	24%	2006	*MICS*	60%	_	*No data*
ANC coverage (% of women 15-49, one or more during pregnancy) from health facility	26%	2006	*MICS*	50%	_	*No data*
Output / Intermediate results indicators						
% of MCH centres providing routine immunization services including outreach;	None		*SARA; monitoring and supervision visits;*	40%	25.6%	*Country administrative data*
# of MCH clinics offering immunisation services that have tracer items for delivery of immunisation.	Tbd		*SARA; monitoring and supervision visits*	100%	100%	*Field visits to six health facilities*
Availability of vaccinators in the selected MCH clinics with good knowledge and skills;	Tbd		*Monitoring and supervision visits; training reports.*	100%	100%	*Field visits to six health facilities*
Vaccine wastage rates;	Tbd		*Monitoring and supervision visits; EPI*	Tbd	_	*No data*

		HMIS records;			
% of target population (pregnant women, children < 1) in LHW catchment area fully immunized;	Tbd	*Household Survey; family register (community based HIS);*	>95%	_	*No data*
# of persons referred to the next MCH, disaggragated by gender and age;	Tbd	*Community based HMIS reports; referral slips*	Tbd	573	*Country administrative data*
% of mothers and fathers having knowledge about immunization and danger signs of pregnancy and childhood illnesses;	N/A	*Formative research;*	>30% of mothers/fathers	_	*No data*
Annual production of operational research reports on programme relevant topics;	Nil	*HSAT activity reports;*	4 / year	Not yet done	*Key informant interviews*
Timeliness of facility reporting	Nil	*Monitoring and supervision visits; compiled HIS reports zonal level;*	100%	Puntland: 79%	*Country administrative data*

Finding 15: there is a paucity of data to determine progress in achieving Gavi HSS results and impact

Owing to the challenges of implementing the M&E framework which was alluded to earlier, there is no data system in Somalia that can permit or facilitate a systematic assessment of the results or outcomes of the Gavi HSS against the stated programme objectives. The baseline for most of the indicators was based on multiple indicator cluster survey (MICS) which was conducted around 2006 and 2010. Furthermore, a number of indicators in the Gavi HSS M&E framework do not have baseline data. Programme implementers expressed the challenge of evaluating results without good baseline data. "The challenge is that the programme was implemented without a baseline. It is difficult to assess impact without a baseline. UNICEF was supposed to do the baseline and they even advertised but there was no expert to do it. Instead, a desk review was done, but the review cannot be equated to a baseline." (*Key informant in Somaliland*). In addition, there has been no repeat population-based survey to provide comparative data for later years. In later years of implementing the Gavi HSS, partners notably the Global Find for Aids, TB and Malaria (GFATM) have provided the much needed technical and financial support to the government of Somalia towards data improvement. Overall, there is no credible data to assess programme outcomes or impact. The HMIS is still in development. Partners are also planning household-based surveys within the coming years.

Finding 16: Successful introduction of Pentavalent vaccine to replace DPT

The Somalia Comprehensive Multi - Year Plan (cMYP 2011 – 2015) states, in its second Strategic Objective, that introducing new vaccines shall be a priority of the Government. It specifically mentions the introduction of Pentavalent (DTP – HepB-Hib) as one of those new vaccines to be added to the EPI in the country by 2013. This Strategic Objective of the cMYP was to a large extent achieved as pentavalent vaccine as well as IPV has been included in the EPI programme.

By April 2013, pentavalent vaccine was successfully launched in the country. In order to mobilise resources for implementation of the cMYP objective, the Government applied for funding for introducing new vaccines in addition to the Gavi HSS component as well as the IPV application (APR 2012, 2013, 2014)

The approved funding for pentavalent vaccine was as shown below:

Year 1:	US$2,891,000
Year 2:	US$2,550,000
Year 3:	US$2,476,500
Total Approved:	US$7,918,500

Facilitation for initiating commencement of the programme was undertaken through an initial disbursement of US$291,500. This was made through WHO. The funds were later disbursed to

UNICEF, a process which the country stated had taken too long. The main activities to be covered in this grant are:

a. Training of health workers in pentavalent vaccine administration and management
b. Storage and distribution of the vaccine, and
c. Communication and social mobilization of communities

Since the initial disbursement, pentavalent funding has been committed and disbursed to the country to support the expansion of the cold chain facilities and annual procurement of vaccine doses.

CHAPTER 3: LESSONS LEARNED

Design

The Gavi HSS programme in Somalia was perceived largely as a pilot project. However, going forward, a more realistic, focused and careful approach to design will be crucial. A major weakness of the Gavi HSS design lies in failing to provide a more direct link to strengthening immunization activities and systems in the country. The programmatic scope and level of funding were disproportionately less compared with the overly ambitious output and impact targets which were set in the proposal. Country security, political and health system capacity challenges have also provided lessons in terms of what is feasible.

Implementation

Overall, despite the early setbacks to begin implementation, the government working with UN partners and other partners has been able to implement most of the activities that were designed according to plan. Under this grant, country capacity has been strengthened in managing implementation at zonal and regional level, even though overall capacity remains weak. Coordination of Gavi HSS and other EPI related functions and the JHNP could have been improved upon. In a sense, implementation of Gavi HSS has been conducted more or less as a vertical programme. Further, this Gavi HSS grant has provided important lessons to stakeholders and the Gavi Secretariat about what is feasible in terms of programme implementation in Somalia. Finally, experience of implementation has shown that in the absence adequate human resource capacity especially in EPI programme planning and management as well as a strengthened district health system, successful implementation of health system strengthening for immunization programme will always be a challenge.

Results

Assessment of programme objectives and results as stipulated in the proposal M&E framework has been hampered by a lack of data. Results on some of the outcome indicators on which some data are available show mixed results. Although progress has been slow generally, there are some indicators on which some regions have met their targets. Efforts to build and strengthen health information systems which have been supported by other programmes have progressed fairly well. However, the available data systems are still largely insufficient to facilitate an assessment of the Gavi HSS programme results in line with the Gavi HSS M&E framework.

Efficiency and sustainability

Generally, the grant has managed to implement its expenditure according to allocations in the grant. The reprogramming ensured that the programme activities were implemented as planned in the original proposal. However, further delays in implementation have caused some level of inefficiency. The country is still experiencing significant challenges in terms of poor security, Gavi HSS coordination challenges, and a critical shortage of health human resources which

undermine sustainability of Gavi HSS gains. Greater and more substantive role and leadership of the Health Authorities would be key to ensuring sustainability of Gavi HSS support.

Contribution to EPI and strengthening the health system

In the pilot phase, the Gavi HSS has shown potential but has yet to deliver any real contribution to strengthening the health system particularly. As stated elsewhere in this report, the connection between EPI service and Gavi HSS was weak. As such, the bulk of Gavi HSS resources did not really target strengthening the components of EPI health system. For example, there has been minimal investment in information system which should inform planning and decision making. The Gavi HSS also was not designed to provide technical and supportive supervision to health facilities so as to address existing weaknesses and build a stronger health system. Furthermore, the function of planning and coordination of EPI has been under-emphasised in this programme. The interaction between service providers and Gavi HSS programme managers has been weak. Finally, most units remain without skilled staff in critical areas such as logistics planning, M&E, budgeting and so on and so forth. There was no focus in the Gavi HSS towards improving these aspects of the EPI programme. Overall, in this phase of Gavi HSS, there has been little capacity building achieved. As such it is fair to state that the Gavi HSS has had little contribution to strengthening the EPI service system, as it was conceived/intended in this pilot phase.

CHAPTER 4: RECOMMENDATIONS TO THE COUNTRY AND PARTNERS

Design

8. The process of developing a new Gavi HSS proposal should include all stakeholders at the country and zone level, with realistic achievement targets and a consensus established about the baseline. This should happen from the outset to secure buy-in from all stakeholders.

9. For grants as modest in amount as Gavi HSS, it is more prudent to strategically identify specific programme components which could leverage other donor supported health systems-related programmes within the health system strengthening programme. Gavi resources could be applied flexibly to catalyse system development in partnership with other donors. More targeted interventions are more likely to achieve results than spreading resources too thin.

10. Gavi HSS proposal should articulate a clear operational link between Gavi HSS and EPI objectives as contained in the health sector strategic plan. According to the new Gavi HSS application guidelines issued in 2016, it will be a requirement that the next Gavi HSS application should be focused on addressing immunization service delivery bottlenecks, and strengthening health systems to deliver immunization services.

11. The next Gavi HSS proposal should be more tailored to the specific context of all the parts of the country. While the programme tried in many ways to design activities in accordance with the context, some of the contextual issues were ignored. There is, for instance, no specific intervention for reaching out to the nomadic population. The outreach services had potential to cater for nomads, but outreach activities were only implemented towards the tail end of the programme. In addition, most outreach posts are static, and can therefore not adequately cater for nomads.

12. Below, we discuss the options for disbursement modalities, based on the views of many stakeholders, and the perspectives of the evaluation team:

Option 1: Continue status quo (through multilateral partners)

Pros

- More accountability
- Greater capacity to manage grant
- Institutional stability
- Predictability for implementation

Cons

- Weak country ownership and leadership
- Poor coordination less likely to strengthen health system development
- The UN agencies are characterized by heavy bureaucracy which has been associated with the observed long delays in implementation as funds are delayed at Gavi and UN levels.
- Weak accountability for results ('verticalisation' of donor support)
- Poor communication among partners leading to duplication of efforts and loss of confidence among partners

Option 2: Through Government (Health Authorities)

Pros

- Secure strong government ownership and leadership of implementation process. This is critical to health system strengthening in Somalia.
- Potential for better coordination of programmes and foster pursuit of common Gavi HSS priorities leading to efficiency gains.
- Potential for capacity building in the health system
- Donors could be allowed to play more oversight role
- Create better opportunities for harmony among partners (better coordination)

Cons

- Currently, the country does not have the PFM systems and personnel in place to manage cash-based support
- Government systems particularly public procurement are highly bureaucratic and inefficient; this would result in delays in implementation
- Capacity in preparing technical and financial reports is developing but is still inadequate
- Currently, there is limited scope to guarantee accountability of expenditures
- Parts of the country are still politically fragile and still experiencing challenges including bank closures and other financial sector challenges which would pose a threat to managing cash-based support.

Our opinion

What is clear from speaking with several partners and the government is that the majority of partners agree that some reforms in future disbursement modalities will be needed if the Gavi HSS is to be implemented as planned and to achieve its objectives. It is our belief that the capacity of the health authorities to manage funds is improving but not sufficient at this stage to assume the role of full fund manager. However, we are inclined to suggest that funds go through partners with some reforms in terms of budget process. In addition, we recommend that the grant provides for TA to build capacity in the government in financial management and procurement.

Based on further observations in country, we are of the view that while assuming responsibilities of fund manager may not occur at this juncture, we believe that there should be a capacity development plan that targets disbursement and management of funds. This function should be anchored with the provision of technical support by a management and/or accounting firm that would assist the Ministry to undertake partial responsibility on a pilot basis for a proportion of the budget.

Implementation and M&E

13. The next grant should strengthen programme implementation capacity by providing sufficient funding towards institutional capacity building in public health management, financial management and technical support to regions. This would ensure that the government will be able to take on greater responsibility for implementation and results.

14. Future Gavi HSS applications should incorporate a component for training of key EPI and planning personnel in MOH in financial management, procurement and technical reporting. This will improve future efforts in health system strengthening and also enhance sustainability.

15. Greater investment in M&E particularly through strengthening the HMIS will be required to support implementation of the next phase of Gavi HSS. Focus should be on improving data quality and completeness for EPI. All partners should work with one M&E framework, but different regions could develop their own implementation plan that adapts to their conditions.

16. A household survey should be conducted to establish the coverage and equity of access to EPI and MCH services at baseline as well as the end of the implementation.

17. Activities and programme components to sub-contract out should be critically evaluated. SOPs on how CSO and private agencies sub-contracted to implement programmes should work with Health Authorities should be defined. Ideally, some of the programmes could be given to Health Authorities to assume a proportion of the activities which are implemented by the health care providers, in line with the functions and responsibilities of health promotion and prevention.

18. Government should consider investing in broad based human resource development programme for EPI implementation.

19. There should be a functional district health system to support design and implementation of HSS programs.

Programme coordination

20. Greater emphasis should be placed on government leadership of the implementation of the grant (i.e. put government in the centre).

21. Specific mechanisms for improving coordination:
    a. The government authorities and partners should discuss and agree on a framework for improving capacity of in-country health authorities to manage funds in future. This framework could be included as part of the next grant application. Responsibilities for implementation and management of funds could include only the simplest components of the grant to start with, and stipulate long term programme of getting the country to where they need to be to be eligible for direct contracting (set targets).
    b. Build trust among partners and between partners and the government. The UN should be obligated to share full access of the budget and budget execution data with the government.
    c. Revitalise and strengthen HSS Working Group within each zone, and provide funding for more effective coordination and operations at country level.

Recommendations targeted to the Gavi Secretariat

Although the recommendations we have outlined above pertain to the government as well as the Gavi Alliance partners, below we add a few more recommendations which we believe are targeted specifically at the Gavi Secretariat.

- At design stage Gavi Secretariat should guide and support the country to identify synergistic opportunities with other HSS activities and programmes being supported by other partners.

- Develop a more effective mechanism for Gavi to provide sustained support to implementation. This mechanism should entail greater involvement of the Senior Country Manager in monitoring implementation and more communication with partners

- Given the challenges that exist in Somalia, the Gavi Secretariat should consider funding greater capacity building within the government.

- The Senior Country Manager should have more presence at country level through more effective mechanisms beyond APRs and JA, to reassure the country and the partners about Gavi's procedures and processes.

- Gavi Secretariat could consider mechanisms for minimising delays in disbursement of funds and improve flow of information with partners and the government regarding the process of disbursement of funds.

9. Gavi Secretariat should consider providing support to assist accelerate human resource development for EPI implementation.

10. Gavi Secretariat could consider key areas in logistics and supply chain systems, planning and information systems for support in future HSS programs at district level.

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Somalia MoH: Somalia health sector plan 2014

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UNICEF, WHO, and UNFPA: Joint Health and Nutrition Program, Annual report 2014

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UNDESA. United Nations Department of Economic and Social Affairs, Statistics division

WHO. World Health Statistical Information System. WHO

ANNEXES

A1: List of individuals interviewed

Names	Designation	Organisation	Location
Katja Schemionek	Gavi HSS Country Program advisor	WHO	Nairobi Kenya
Colette Selman	Somali SCM/Regional Head EMRO-EURO-PAHO Country Support	Gavi	Switzerland
Joyce Nyaboga	Health Information Liaison Officer	WHO	Nairobi Kenya
Rizwan Hamayun	WHO	WHO	Nairobi Kenya
Mohamed Abdi Jama	National Professional Officer	WHO Puntland	Puntland Somalia
Abdilahi Bare Fara	National Professional Officer	WHO	Hargeisa Somaliland
Feisa Ibrahim	Director of Health and Planning	MoH Somaliland	Somaliland Somalia
Abdirizak Hassan Isse	Director planning and policy	Somali MoH	Puntland Somalia
Abdirisaq Absuir Hirsi	PHC Director	MOH	Puntland
Ali Dirie	Acting Director – Policy and Planning	MOH	Puntland
Abdihamid Ibrahim	Director of policy and planning	MoH Federal Government of Somalia	Mogadishu SC zone Somalia
Yusuf Ahmed Ali	Director General, Ministry of Health	MoH Somaliland	Somaliland Somalia
Anirban Chatterjee	Head of UNICEF office Somalia	UNICEF	Nairobi Kenya
Charles Oscan	HMIS Consultant	Consultant	Nairobi Kenya
Anne Cronin	Former Gavi Somalia SCM	GAVI	Switzerland
Binay Kumar	Gavi focal point for Somalia for the Gavi Grant Performance Monitoring team	GAVI	Switzerland
Cosmus Wahinya	Gavi Program Financial Officer for Somalia	GAVI	Switzerland
Anthony Ray Brown	Gavi lawyer responsible for Somalia issues	GAVI	Switzerland
Marina Madeo	MD, Public Health, Health Systems		Brussels, Belgium
Achu Lordford Nde	Reproductive Health/Maternal Health Advisor	UNFPA	Nairobi Kenya

Katie Bigmore	DFID	DFID	Nairobi Kenya
Jihan Salad	Head - Reproductive and Maternal Health	UNFPA	Puntland Somalia
Sahid Mohamoud Abdi	National HMIS officer	MOH	Puntland Somalia
Abdi Jama	Director	ANPPCAN	Puntland Somalia
Mohamed Jama	Regional Health Officer	MOH	Puntland Somalia
Edil Hassan	Director Human Resource	MOH	Puntland Somalia
Awil Haji Ali Gure		UNICEF	Puntland Somalia
Salma Osman	Gavi Focal Point	MOH	Puntland Somalia
Abdiquani Sheikh Omar	Director General – Ministry of Health	MOH	Puntland Somalia
Michael Abaasiku	Health and Nutrition Coordinator	World Vision	Puntland Somalia
Bahan Hassan	Health Projects Officer	World Vision	Puntland Somalia
Hussein Ahmed Hashi	Director Human Resource	MOH	Hargeisa Somaliland
Saeed Mohamood Soleman	Strategic Planner	MOH	Somaliland
Muhsin Sheriff	Head of Immunization program UNICEF	UNICEF	Hargeisa Somaliland
Mohamed Barre	National Professional Officer	GAVI	Hargeisa Somaliland
Ahmed Abdi Muse	District Medical Officer	MOH	Hargeisa Somaliland
Mohamed Hashi Hussein	Regional HMIS Officer	MOH	Hargeisa Somaliland
Abdillahi Abdi Yusuf	National HMIS officer	MOH	Somaliland
Khaldoun Al Assad	National health Officer CRCS	CRCS	Hargeisa Somaliland
Abdi Hussein	Regional Health Officer	MOH	Hargeisa Somaliland
Muhamed Nasser	Gavi Focal Point	MOH	Somaliland
Mr. Mustafe	CEO SOLNADO	SOLNADO	Hargeisa Somaliland
Barni Nor	Program Manager	Embassy of Sweden	Nairobi Kenya
Saba Khan	Director	Director, Consortium of the Health of the Somali People	Nairobi Kenya
Edda Costarelli	Former Portfolio Manager-Quality Improvement and Health Sector Reform	EU	Nairobi Kenya

A2: Records from FHWs

Indicator	Value per annum	
Child Health indicators	**2014**	**2015(up to June)**
# of Live births	-	544
# New-borns initiated breast feeding within 1 hr. of birth.	1782	513
# New-born whose vaccination started	-	442
12-23 month children	-	8969
12-23 months old whose immunization completed	-	2088
Maternal Health indicators		
Total Registered pregnant women-	5936	2374
#pregnant women registered for ANC at MCH/CMW.	994	1735
# pregnant given Iron /Folic Acid tablets-	1818	428
# delivered with completed TT(02 shots) vaccination	368	279
# pregnant with 4 or more ANC by SBA-	468	125
# delivered by SBAs	398	153
# delivered whose post-natal checkups done within 24 hrs	281	96
Treatment indicators		
# of diarrheal cases	3500	1392
# ARI cases	6842	4082
# Fever cases	15285	8430
# of Anemia cases	7188	3348
# of Eye problem cases	6032	2825
#with intestinal worms	2778	1129
#suspected cases of malaria	57	26
# of confirmed cases of malaria.	18	3
# cases referred	132	71
#suspected cases of TB.	42	25
#diagnosed cases of TB	38	13
# of suspected cases of measles	33	10
# of cases referred	902	85
# of Anemia cases	_	3348

A3: Topic Guide for key informant interviews

STAKEHOLDER INTERVIEW GUIDE

Introduction

We are conducting an external evaluation of the Gavi HSS grant to Somalia. In this evaluation, we seek information around the following areas:

1. Design of Gavi HSS proposal
2. Implementation
3. Efficiency
4. Results
5. Sustainability
6. Lessons learned

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1. Design

1. Describe the process of developing the Gavi HSS proposal, who was involved, where they are resident, involvement of sub-national stakeholders,(similar question for strategic plan).

2. What assumptions were made about the feasibility of implementing Gavi HSS in all parts of the country given the security situation of the country, how realistic were these assumptions?

3. Given the political environment, how feasible were the Gavi HSS plans in the broader health system/strategic plan? (Infrastructure, HR, community mobilisation, etc.)

    (i). What was the rationale behind the Gavi HSS plans and assumptions embedded in there?

4. How well was the proposal objectives linked to EPI outcomes are defined in the proposal?

5. Could you describe the disbursement modalities for the Gavi HSS grant? What were the considerations/motivations for these disbursement modalities?

    (i). In which ways were these disbursement modalities/conditions appropriate/inappropriate for Somalia?
    (ii). Was there consensus about the disbursement modalities among stakeholders?

    (iii). What challenges did these disbursement modalities create in executing the implementation plan?

2. Efficiency

i. What factors influenced the pace of execution of the of Gavi HSS grant? Has this affected the cost of implementing the grant?

ii. Were there funds that were used on unintended activities? What were those activities? Why were the funds used on those activities?

iii. Describe how the following factors could have affected the efficient utilization of Gavi HSS funds: Coordination of key partners (federal system and partners being based in Nairobi), govt. bureaucracy, procurement procedures, security issues (economic context), availability of commodities for the Gavi HSS programme, etc.

iv. Could you explain if and how the presence of other partners e.g. GFATM, DFID, WVI etc. contributed to implementation of Gavi HSS?

v. What measures could have been taken to streamline disbursement and expenditure of GAVI HSS funds?

3. Programme implementation

1. How are the LHW recruited, trained and supervised? How effective are the LHWs in reaching target population. Are they as effective as expected-mobility, cultural factors, etc.? Has the Gavi HSS programme (e.g. LHWs) helped increase coverage of DPT3, Measles, Vitamin A and ANC? How do you describe the relationship between LHWs and other HR (e.g. nurses)? Illustrate.
2. Is there evidence that Gavi HSS grant has contributed to implementation of health strategies such as increasing coverage?
3. To what extent is the zonal MOH able to effectively facilitate and monitor implementation in all areas of the regional given that the District Health Office is not functional? (e.g. ability to identify gaps in implementation or service delivery challenges, work with the stakeholders in the district to solve any problems, nurture relationship with local stakeholders, etc.).
4. Describe how the various partners work together in implementing Gavi HSS activities?
5. To what extent is the zonal MOH able to provide oversight and adherence to minimum standards, and supervisory support to district and health facilities, on Gavi HSS programme implementation? Describe the relevance and adequacy of technical support?
6. How is the security situation between Somalia and Kenya affecting Gavi HSS programme implementation? How is the programme management adapting to this new challenge?

7. In there a system to capture data that is used to develop indicators for monitoring the Gavi HSS grant? Has there been training of HR to manage the M&E framework? Is there evidence of regular use of M&E data to promote decision making? How reliable is the M&E data system that are used to monitor Gavi HSS?

8. Describe the coordination function of Gavi HSS. What role do the different players play? How effective are the coordination mechanisms? To what extent is the location of coordination in Nairobi affecting the effectiveness of coordination—what mechanisms are the partners using to monitor programme implementation and support? How robust, do you think, are these mechanisms? How is the coordination structure able to monitor programmes and verify reliability of reports?

Sustainability

We would like to get your perspective about the sustainability of the programmes and activities supported by Gavi HSS in Somalia. What the challenges?

NB. We propose to use a variance analysis to determine programme implementation status, and associated explanatory factors, using documents and KII with WHO and zonal MOH implementers and UNICEF. These questions will not be in this topic guide.

A4: Focus Group Discussion/Interview Guide for LHWs members

Introduction

The Lady Health Workers Association has been an integral part of the Gavi HSS programme implementation team in the country. In this evaluation we seek to gather information on the experiences and lessons learned from the members of the Lady Health Worker Association members through a group discussion forum.

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1. Describe the roles have you play in immunization service delivery in your area. Do you feel that you have received sufficient training to perform your roles? If not, discuss any gaps?
2. How effective have you been in performing your roles according to your mandate in the Gavi HSS plan, or do you face any challenges in reaching out to the target population? If there are any challenges, please elaborate with specific cases? What is being done to alleviate these challenges?
3. Describe your relationship with the Ministry of Health? Are you receiving the support you anticipated? If not, what are the reasons for this situation?
4. What is your overall experience of increasing immunization coverage in your area? What kind of feedback have you received from women and parents in your communities regarding immunization?
5. To what extent is the zonal MOH able to effectively facilitate and monitor implementation in yourarea?
6. Do your members have specific concerns which have not been adequately addressed? If so, what are these challenges?
7. What lessons have you learned of the regional given that the District Health Office is not functional? (e.g. ability to identify gaps in implementation or service delivery challenges, work with the stakeholders in the district to solve any problems, nurture relationship with local stakeholders, etc.).

-END-