IFRC

Polio program transition in Somalia: an assessment of risks and opportunities

Leveraging civil society resources to scale up immunization

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Foreword

The collective goal of eradicating polio has faced many challenges, and the current landscape of the COVID-19 pandemic is no exception. As the Global Polio Eradication Initiative comes closer to achieving its eradication goal over the next few years, it will be imperative to ensure smooth integration of its experiences, lessons and health assets in high risk and endemic countries, especially in a post-pandemic world.

The assessment outlined in this report was carried out in 2019, prior to COVID-19. It focuses on the role of civil society organizations (CSOs) in the fight to end wild poliovirus and potential challenges and future opportunities. The conclusions and recommendations have become even more important considering the large-scale disruption of immunization services, both routine and campaigns, during the pandemic. COVID-19 has forced a diversion of resources towards the pandemic, and many immunization efforts have been paused. The pandemic has resulted in increases in vaccine preventable diseases and deaths; large scale vaccine stockouts; migration of health workers for pandemic work; and, enhanced community fears.

The pandemic has made it clear that the need to strengthen health systems has never been more urgent to prevent further increases in suffering from vaccine preventable diseases. The roles of all partners, including CSOs, to revamp, restore and sustain immunization delivery cannot wait for COVID-19 pandemic to end or significantly decline. GPEI's experience showed that in fragile countries and conflict settings, partnership with CSOs is crucial for immunization delivery and primary health care.

The COVID-19 pandemic provides many risks to the polio program, but also an opportunity to enhance GPEI's integration efforts, as strong health systems and close collaboration with related health initiatives will be vital to ensuring that polio eradication efforts can catch-up quickly post COVID-19. CSOs, in particular, will find the conclusions and recommendations relevant as they consider their future interventions in the countries.

Contents

Acronyms

BMGF	Bill & Melinda Gates Foundation
C4D	Communication for Development
CCEOP	Cold Chain Equipment Optimization Platform
CESVI	Cooperazione e Sviluppo (Italian development organization)
CSO	Civil society organization
cVDPV	Circulating vaccine-derived polio virus
DFID	UK Department for International Development
DPT3	Diphtheria-pertussis-tetanus (vaccine, three doses)
DRC	Danish Refugee Council
ECHO	European Civil Protection and Humanitarian Aid Operations
EPHS	Essential Package of Health Services
EPI	Expanded Programme on Immunization
FGS	Federal Government of Somalia
GPEI	Global Polio Eradication Initiative
Hib	Haemophilus influenzae type b (vaccine)
HSCC	Health Sector Coordinating Committee
HSS	Health systems strengthening
ICC	Interagency Coordinating Committee
IDP	Internally displaced person
IFRC	International Federation of Red Cross and Red Crescent Societies
IMC	International Medical Corps
INGDO	International nongovernmental development organization
IOM	International Organization for Migration
IPV	Inactivated polio vaccine (administered via injection)
IRC	International Rescue Committee
JSI	John Snow, Inc.
MCH	Maternal and child health
NGO	Nongovernmental organization
NRC	Norwegian Refugee Council
OFDA	Office of U.S. Foreign Disaster Assistance
OPV	Oral polio vaccine
PTP	Polio Transition Plan

SHINE	Sanitation, Hygiene, and Infant Nutrition Efficacy (DFID project)
SIA	Supplementary immunization activity
SRCS	Somali Red Crescent Society
SWOT	Strengths, weaknesses, opportunities, and threats (analysis)
TMG	Transition Management Group
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water, sanitation, and hygiene
WHO	World Health Organization
WPV	Wild poliovirus

Notes

Unless indicated otherwise, currency in this report is U.S. dollars (US$).

Civil society organizations (CSOs) are non-State, not-for-profit, voluntary entities formed by people in the social sphere that are separate from the State and the market. CSOs represent a wide range of interests and ties and can include national and international community-based organizations as well as nongovernmental organizations (NGOs).

Executive summary

Introduction

For over three decades, the Global Polio Eradication Initiative (GPEI) has funded the global polio eradication program. Somalia is one of the countries whose polio program depends exclusively on the GPEI. GPEI-funded activities in Somalia extend beyond the scope of polio eradication and include routine immunization, disease surveillance, social mobilization, and vaccine delivery. As the world approaches polio eradication, GPEI resources are progressively declining and will cease completely once global eradication is achieved. To ensure a smooth transition away from GPEI funding Somalia needs to sustain their national polio and immunization programs through other resources. This report describes an assessment of polio transition carried out in 2019.

Objectives

1. Analyze current funding for Somalia's immunization and polio programs
2. Document progress in transition planning and implementation
3. Determine risks the country faces with the wind down of GPEI funding
4. Identify opportunities for civil society engagement to support integration of polio program-funded activities and help sustain essential polio programming as well as other immunization activities.

Methods

Desk review

A desk review of key documents including Somalia's Polio Transition Plan, country health plans, the Essential Package of Health Services (EPHS), and reports from the World Health Organization (WHO) and other health sector organizations);

Key informant interviews

Country visits were done to conduct key informant interviews with representatives from the Ministry of Health, United Nations (UN) agencies, CSOs, and other stakeholders

Workshops

The consultant participated in the Gavi Joint Appraisal in November 2019.

Study limitations

The assessment involved a large proportion of government sector participants versus other stakeholders. A coordinating platform or mechanism coordination of CSO activities does not exist in Somalia. Such a forum could have generated more comprehensive and balanced information.

Key results

- Somalia's polio and immunization programs are supported exclusively by Gavi and GPEI funds, routed primarily through WHO and UNICEF. These programs received $28 million in direct funding in 2018 and $27 million ($15.6 million from GPEI and $11.4 million from Gavi) in 2019.
- Support from CSOs is mandated in the EPHS strategy, to help make immunization an integral part of community-level health service. Most CSO support for immunization is awarded through WHO and UNICEF.

- Current and projected support from Gavi is not expected to cover funding gaps resulting from the expiration of GPEI funding.
- Sustaining assets of essential polio program components and other immunization activities will require a separate continuation of technical and financial support for the medium to long term.
- The largest gaps in withdrawal GPEI resources will be in salaries and will affect a wide range of activities including:
    - service immunization delivery
    - surveillance of polio and other vaccine-preventable diseases,
    - capacity building
    - resource mobilization
    - community engagement

Major opportunities are also inherent in Somalia's polio transition, including scaled-up CSO engagement in advocacy and technical support to fill gaps and promote synergies between remaining polio activities and other health programs.

Recommendations

Somali government and UN system (primarily WHO/UNICEF)

1. Ensure that relevant GPEI assets are integrated effectively with a fully operational EPHS strategy.
2. Map implementing partners to improve coordination and efficiency across the health sector.
3. Invite CSOs (from the health and humanitarian sectors) to contribute more to immunization efforts.

Donors

1. Ensure that immunization becomes a central platform for assessing programmatic progress of the country's EPHS strategy.
2. Promote coordination across GPEI and Gavi to ensure full coordination of immunization-related financial and technical support.
3. Advocate for CSOs to be involved in the government and partner planning processes.

Civil society

1. Establish a CSO platform (nongovernment, non-UN) for all international nongovernmental development organizations (INGDOs) and national CSOs.
    a. Map CSO activities across all states.
2. Provide advocacy support to create an enabling environment for immunization-strengthening and effective integration of relevant GPEI assets.
3. Provide technical support for specific service delivery gaps within the context of the GPEI wind down.

Introduction

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1 Introduction

For over three decades, the Global Polio Eradication Initiative (GPEI) has funded the global polio eradication program. Somalia and other countries have relied on this global program for all financial support of their polio programs and some financial support for many other important public health activities outside the scope of polio eradication, including routine immunization, disease surveillance, social mobilization, and vaccine delivery. However, as the world approaches global polio eradication, GPEI resources are progressively declining and will eventually be phased out. Therefore, Somalia and other countries need to identify and develop alternate sources of funding to prepare for their transition away from the global polio program support ("polio transition"). GPEI has identified 16 countries[1] as high priority for active polio transition planning to ensure a smooth shift away from this support. The original requirement was for all 16 countries to complete their polio transition by 2019, but due to delays in global polio eradication the timeframe has been extended through 2023. Even with this 4-year extension, it is urgent that the high-priority countries, including Somalia, continue to proactively plan how they will manage the effects of the GPEI wind down, which has already begun.

To leverage all relevant human resources, global polio program partners recommended that additional stakeholders, including civil society, be engaged in each country's polio transition to speed progress toward identified goals, including integrating national polio programs with the broader health systems and moving them toward other sources of funding and leadership at the country level. This required data on 1) country progress in polio transition planning and implementation and 2) the ways in which additional stakeholders, particularly civil society organizations (CSOs), could provide support.

To fill these gaps for Somalia, an assessment was carried out by the International Federation of Red Cross and Red Crescent Societies (IFRC), in 2019. Study objectives were to 1) analyze current funding for Somalia's immunization and polio programs, 2) document progress in transition planning and implementation, 3) determine risks the country faces with the wind down of GPEI funding, and 4) identify opportunities for civil society engagement to support integration of polio program-funded activities and help sustain essential polio programming as well as other immunization activities.

[1] Afghanistan, Angola, Bangladesh, Cameroon, Chad, Democratic Republic of the Congo, Ethiopia, India, Indonesia, Myanmar, Nepal, Nigeria, Pakistan, Somalia, South Sudan, and Sudan, which collectively receive more than 90% of GPEI resources.

Country context

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2 Country context

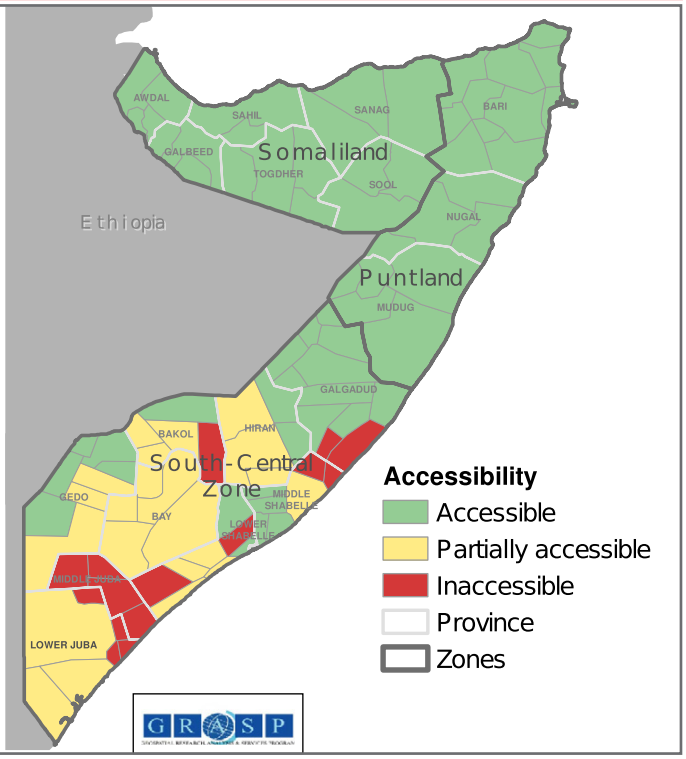
2.1 Health system

Due to years of prolonged conflict and political instability, Somalia's health system has remained weak, fragmented, fragile, and severely underfunded. The country's Essential Package of Health Services (EPHS) strategy was launched in 2014 as a major new scheme for providing a comprehensive range of free health services, delivered through maternal and child health (MCH) centers and health posts. However, due to the limited supply of trained human resources, fluctuating work hours, and other barriers, there is still a wide range in the quality of Somalia's health services. Other than a few government salaries, the health sector is fully funded by donors, as in-country resources for health are negligible. Service delivery is heavily dependent on CSOs and United Nations (UN) agencies, especially the World Health Organization (WHO) and UNICEF. The administrative structure is unusual, with three different "zones" (Somaliland, Puntland, and Central & South) operating as separate government entities, with their own ministries of health and health sector strategic plans. Implementing partners normally interact directly with the respective zonal government. Some of them work almost exclusively in one zone but maintain a tacit understanding with fellow organizations operating in other zones with regard to service delivery and immunization operations. Despite this administrative separation, vaccine delivery modalities are uniform countrywide, as all three zones depend on WHO and UNICEF for immunization. UN agencies and CSOs work collaboratively with each entity but there is a vacuum in coordination among the major health stakeholders, which are listed in Annex 1. For example, although CSOs are a major contributor to health service delivery, some players view them as subcontractors for government supporting work implemented by other players with more funding and reach and therefore do not invite them to participate in strategic

discussions. In addition, there is no active platform or mechanism for coordinating interaction among CSOs or between CSOs and other partners, which limits harmonization of strategies, information sharing, activity mapping, etc., and can result in an overlap of efforts and/or wasted resources.

Figure 1 **Political zones and level of children's access to immunization**

Political zones and level of children's access to immunization services by district – Somalia, October 2017. The categorization of partially accessible and inaccessible districts is based on security hazards and armed conflict in the district. Partially accessible means that some settlements or other areas within the district are accessible and others are inaccessible. Zonal and provincial boundaries of districts are highlighted.



Source: **"Assessment of in-Country Capacity to Maintain Communicable Disease Surveillance and Response Services after Polio Eradication—Somalia." Vaccine 38, no. 5 (2020): 1220–24.**

2.2 National immunization program

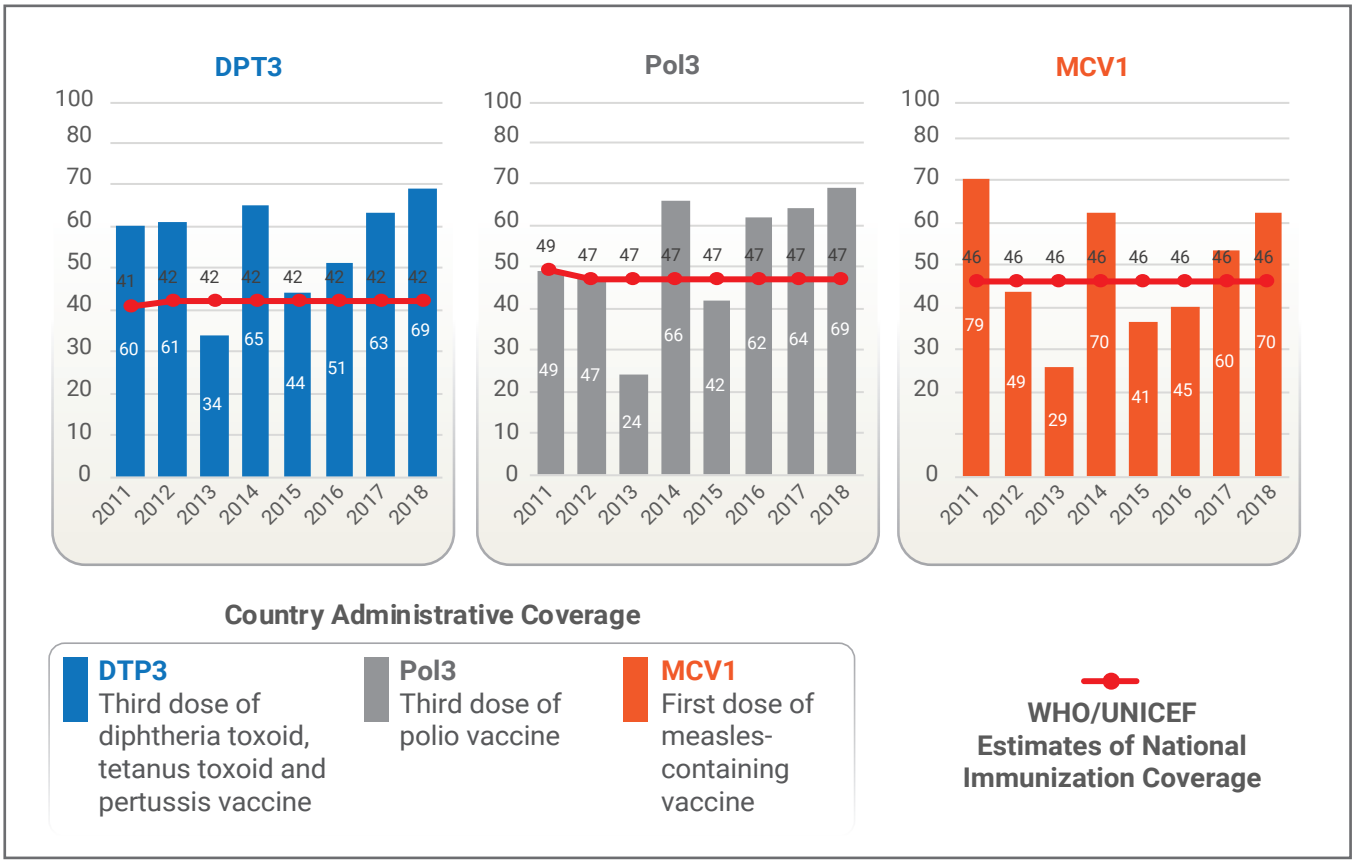
Somalia has one of the lowest immunization coverage rates in the world and was ranked 192 out of 195 countries worldwide for this indicator in 2018. An estimated 6 out of 10 Somali children do not receive the recommended three doses of the diphtheria-pertussis-tetanus vaccine (DPT3). For the last five years DPT3 coverage has remained at a low and stagnant rate of 42%, polio coverage has hovered at 47%, and measles coverage has remained at 46%, well below the global averages of 86% for DPT3 and measles and 85% for polio.[2] In addition, there are significant inequities in immunization across and within states. Only 49% of national health facilities provide immunization services, because Somalia's population settlements are widely dispersed, increasing the operational costs and time needed to reach all children. Immunization services are provided at more urban health facilities compared to rural health facilities (64% and 25% respectively) and only 10% of all health facilities offer

[2] WHO vaccine-preventable diseases: monitoring system. 2019 global summary. Last updated 10 December 2019. Available at: https://apps.who.int/immunization_monitoring/globalsummary

outreach immunization services. Private hospital involvement in routine immunization services is limited. A stark example of gaps in services is seen in the Middle Jubba region, which has no immunization facilities, due to inaccessibility.[3] More health facilities in the South-Central region offer immunization services compared to those in Somaliland state (66% versus 49% respectively). Analysis of coverage in both regions showed that in the Sanaag and Sool areas of Somaliland, less than 30% of health facilities provide immunization services versus more than 80% of health facilities in the Bay and Lower Jubba areas in the South-Central region. Most immunization services (74%) are delivered through fixed health clinics. Routine immunization services are delivered at MCH centers but there is a wide range in quality due to the inadequate and uneven mix and distribution of the skilled health workforce, and the high turnover. Some MCH centers do not have defined catchment areas or clear immunization targets, and most do not use immunization monitoring charts.

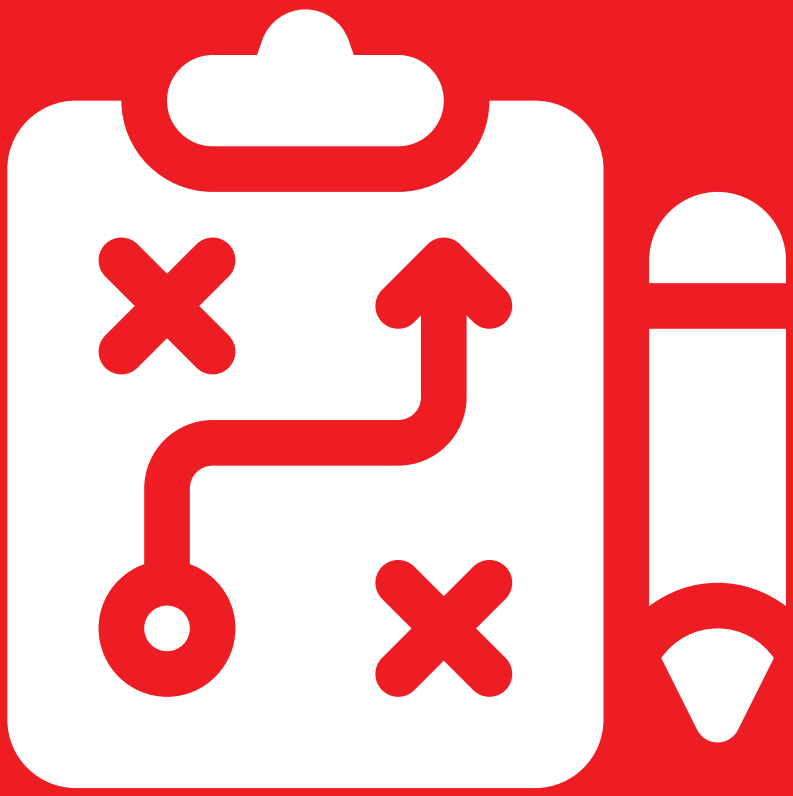
The country's reported administrative coverage data varies significantly from the WHO and UNICEF estimated national coverage. See below graph for the comparison of Somalia's immunization trends for DTP3, Pol3, and MCV1, 2011-2018.

Graph 1 **Somalia Immunization Trends for DTP3, Pol3, and MCV1, 2011-2018**



Source: Immunization, Vaccines and Biologicals Data, statistics and graphics; Available at: https://www.who.int/immunization/monitoring_surveillance/data/en/

[3] Insufficient safety for immunization workers due to conflict or other causes.



Methodology

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3 Methodology

The analysis of potential risks and opportunities in Somalia's polio transition included a desk review of key documents (Somalia's Polio Transition Plan (PTP), country health plans, the Essential Package of Health Services (EPHS), and reports from the World Health Organization (WHO) and other health sector organizations); country visits to conduct key informant interviews with representatives from the Ministry of Health, United Nations (UN) agencies, CSOs, and other stakeholders; and participation in the Gavi Joint Appraisal in Kigali in November 2019. The study was carried out by the International Federation of Red Cross and Red Crescent Societies (IFRC) in 2019.

Limitations included:

- the lack of a platform or mechanism for coordinating the CSOs that could have produced more comprehensive and balanced information.
- the large proportion of government sector participants compared to other stakeholder groups.
- the absence of a dedicated CSO focal point at Somalia's main health sector partner organizations.
- the limited number of country visits that allowed for collection of direct input from field workers.

Results

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4 Results

4.1 Polio and immunization funding

Somalia's polio and immunization programs are currently supported exclusively by Gavi and GPEI funds, routed primarily through WHO and UNICEF. In 2018, these two programs received $28 million in direct funding. The amount for 2019 was nearly the same at approximately $27 million ($15.6 million from GPEI and $11.4 million from Gavi). Funding from CSOs is not included in these figures because much of it comes from GPEI, Gavi, or a bilateral donor (the UK Department for International Development (DFID) Sanitation, Hygiene, and Infant Nutrition Efficacy (SHINE) project, European Civil Protection and Humanitarian Aid Operations (ECHO), the Office of U.S. Foreign Disaster Assistance (OFDA), CESVI (an Italian bilateral agency), and the Dutch bilateral agency SNV Netherlands Development Organisation). Funds received from these organizations are often allocated to broader health initiatives and cannot always be tracked specifically to immunization activities. Support from CSOs is part of the EPHS strategy to help make immunization an integral part of community-level health service. CSOs typically do not procure vaccines or devices but rely on bulk procurement by UNICEF.

4.1.1 GPEI support

GPEI provided more than $49.5 million to Somalia between 2017 and 2019. However, funding has been decreasing since 2017. Expenditure reports are difficult to obtain, but current, detailed budgets can provide insight on the assets at stake. As shown in Table 1 on the following page, total support for Somalia from GPEI was $17,922,000 for 2017, $16,032,000 for 2018, and $15,597,000 for 2019. These figures include outbreak response funds allocated for ongoing vaccine-derived poliovirus outbreaks. Current forecasts from GPEI indicate decreased and flatline amounts of funding in future that may create gaps in services, stall polio program transition efforts, and affect broader health services. GPEI funding for circulating vaccine-derived polio virus (cVDPV) outbreaks in Somalia will most likely continue through 2023, but given the ongoing circulation of wild poliovirus (WPV) in Pakistan and Afghanistan and the rising number of cVDPV outbreaks in both the African and Eastern Mediterranean regions, it is unclear what level of support Somalia will receive in the coming years.

Table 1 GPEI budget in Somalia by activity and agency, 2017–2019

Activity	WHO	UNICEF	Total
2017			
Vaccine procurement		$1,440,000	$1,440,000
Campaign operations	$5,952,000	$1,296,000	$7,248,000
Social mobilization		$1,404,000	$1,404,000
Surveillance	$2,834,000		$2,834000
Technical assistance	$2,246,000	$2,750,000	$4,996,000
Communications			
Technical assistance for communications			
Total	**$11,032,000**	**$6,890,000**	**$17,922,000**
2018			
Vaccine procurement		$1,000,000	$1,000,000
Campaign operations	$3,627,000	$900,000	$4,527,000
Social mobilization		$975,000	$975,000
Surveillance	$2,720,000		$2,720,000
Technical assistance	$4,166,000		$700,000
Communications		$700,000	$6,110,000
Technical assistance for communications		$1,944,000	
Total	**$10,513,000**	**$5,519,000**	**$16,032,000**
2019			
Vaccine procurement		$1,000,000	$1,000,000
Campaign operations	$2,627,000	$900,000	$4,527,000
Social mobilization		$975,000	$975,000
Surveillance	$2,720,000		$2,720,000
Technical assistance	$3,201,000	$2,750,000	$3,201,000
Communications		$508,000	$508,000
Technical assistance for communications	$965,000	$1,701,000	$2,866,000
Total	**$10,513,000**	**$5,084,000**	**$15,597,000**

Source: www.polioeradication.org.

4.1.2 GAVI support

Since 2002, Gavi has been an important funding and technical support partner for Somalia's Expanded Programme on Immunization (EPI), and since 2011 it has provided annual grants for health systems strengthening (HSS). Gavi also provides one-time grants for special activities. In 2018–2019, for example, Gavi provided a one-time Cold Chain Equipment Optimization Platform (CCEOP) grant to help revitalize cold chain infrastructure throughout the country. In 2019, in addition to its HSS allocation of $4 million, Gavi approved a grant of $12 million for a period of 18 months under its fragility policy. Both the HSS and fragility grants are earmarked for in-country activities, implemented by Somali's health sector partners. Gavi also provided $4.5 million to Somalia to conduct a measles follow-up campaign. This included $872,500 for vaccines and $3.63 million for operational costs. This support shows the unpredictability of immunization funds from year to year, and the much higher cost of vaccination delivery compared to vaccines and supplies alone. Gavi funding also has some special dynamics. For example, Gavi grants for vaccines, devices, and cold chain equipment are routed through UNICEF's Supply Division, which procures the supplies directly and ships them to Somalia. The only grants provided as cash are the HSS grants, which are routed through WHO and UNICEF country offices. Gavi allocations to Somalia from 2017–2021 are shown in Table 2 on the following page. In addition to the support described above, Gavi provides $1.8 million for technical assistance from WHO, UNICEF, the International Rescue Committee (IRC), and ACLAIM Africa Limited, a leadership and management consulting firm, to ensure efficient implementation of its grants. The partners' technical assistance is renewed each year.

Table 2 **Gavi allocations to Somalia, 2017–2021**

Subcategory	2017	2018	2019	2020	2021
HSS	$4,547,460	$8,084,246	$4,047,523	$4,170,441	$4,450,330
Pentavalent vaccine[a]	$702,652	$798,500	$453,500	$827,000	
IPV	$401,340	$747,000	$881,500		
Injection devices	$51,000	$66,500	$173,500	$61,000	
CCEOP		$1,222,211	$1,403,761	$10,614	$17,243
Measles					
Vaccine			$872,500		
Campaign			$3,634,791		
Total	$5,702,452	$10,918,457	$11,467,075	$5,069,055	$4,467,573

Source: **https://www.gavi.org/programmes-impact/country-hub/eastern-mediterranean/somalia**

[a] **5-in-1 vaccine protecting against diphtheria, tetanus, pertussis, hepatitis B, and Haemophilus influenzae type B (Hib).**

Gavi is actively engaged in the transition of the country's polio program and was a member of GPEI's Transition Management Group (TMG), which provided support and oversight to Somalia's country-level polio program transition planning process until June 2018. Polio program transition is included as an agenda item in the Gavi Joint Appraisals of the 16 priority countries. Polio program transition is also on Gavi's risk register, due to the potential risks to critical functions of immunization. In support of GPEI's 2019–2023 strategy, Gavi is funding the inactivated polio vaccine (IPV) through 2020 and potentially beyond.[4] As of 2019, Gavi will continue to support the rollout of IPV catch-up campaigns as IPV becomes available.

4.2 Polio transition progress

Somalia's polio transition plan has been drafted but has not yet been officially endorsed, and it may be significantly revised in the coming months. The plan outlines how polio assets will be integrated into routine health delivery to maintain optimal human resources and physical assets for primary health care delivery, and identifies immunization-related capacities (currently supported by GPEI) that could ideally be transferred to the government or other partners. It also addresses the possibility of integrating polio vaccination coverage with routine immunization and transferring outbreak response activities to health emergency personnel. However, uncertainty remains on how polio surveillance activities will be maintained. In a recent assessment, 70% of international relief agency representatives and 62% of domestic relief agencies representatives reported low capacity to conduct communicable disease surveillance without GPEI funds.[5]

4.3 Polio transition risks

Given the scope of activities funded by GPEI, described in detail above, the risks of GPEI resource wind down are not only financial but also programmatic. Surveillance, for example, is one important function for which alternative financial and human resources are not likely to materialize

[4] Subject to upcoming Gavi replenishment in June 2020, Gavi will commit to IPV support till end of 2025.
[5] Hsu, Christopher H., Bonnie Harvey, Abdinoor Mohamed, Eltayeb Elfakki, Derek Ehrhardt, and Noha H. Farag. "Assessment of in-Country Capacity to Maintain Communicable Disease Surveillance and Response Services after Polio Eradication—Somalia." Vaccine 38, no. 5 (2020): 1220–24. https://doi.org/10.1016/j.vaccine.2019.11.008.

soon in Somalia. The GPEI wind down will also limit the ability to 1) retain various human resource capacities and 2) successfully transition some staff to other positions. However, some essential polio program functions could be integrated with other, broader efforts. For example, polio vaccines—both the IPV and the oral poliovirus vaccine (OPV)—could be added to routine immunization services; polio supplementary immunization activities (SIAs) could be integrated with similar campaigns for other vaccines; and outbreak responses could be added to the mandate of health emergency operations. One of the most important findings was that Gavi will not be able to absorb the gap resulting from the ramp down and eventual closure of GPEI funding, and there is limited additional financing available from other donors for immunization activities. Therefore, the GPEI ramp down presents a direct threat to the Somalia's immunization activities. This is problematic given Somalia's already low immunization coverage, increasing occurrence of vaccine-derived polio cases, and ongoing outbreaks of other vaccine-preventable diseases.

4.3.1 Human resources

GPEI asset mapping for Somalia (May 2017)[6] identified a total of 4,719 GPEI-funded personnel countrywide, working on a wide range of immunization activities (implementation and services, monitoring, surveillance, communication and community engagement, capacity building, resource mobilization, policy and strategy, partnership and coordination, and management and operations).[7] A large proportion of them (88%) were trained in routine immunization activities. In addition, as shown in Table 3, about 42% of their time was spent on immunization-related activities outside the scope of polio, and about 4% of their time was spent on activities that were not related to immunization.

Table 3 Time allotment of GPEI-funded staff in Somalia

Polio eradication		**54%**
Polio related activities	54%	
Immunization-related activities beyond polio		42%
Routine immunization	18.40%	
Measles and rubella	11.10%	
New vaccine introduction	0.90%	
Child health days or weeks	2.80%	
Maternal, newborn, child health & nutrition	7.20%	
Health systems strengthening	1.10%	
Nonimmunization activities		4%
Sanitation and hygiene	0.40%	
Natural disasters and humanitarian crises	2.80%	
Other diseases or program areas	1.10%	
Total		100%

Source: Global Polio Eradication Initiative. Somalia Asset Map (At-a-Glance). 2017. Available at: http://polioeradication.org/wp-content/uploads/2018/01/polio-transition-somalia-asset-map-january-2018.pdf

[6] http://polioeradication.org/wp-content/uploads/2018/01/polio-transition-somalia-asset-map-january-2018.pdf
[7] The number of GPEI-funded personnel has most likely decreased since then due to the gradual wind down.

4.3.2 Social mobilization and communication

Social mobilization and Communication for Development (C4D) have been critical tools in GPEI effort to reach communities with key messages on polio and other vaccine-preventable diseases and to motivate families and communities to get their children immunized, and these activities account for a large portion of UNICEF's annual GPEI budget in Somalia. The ramp down of the GPEI polio program funding will create a large gap in both social mobilization and C4D if these activities are not integrated into broader efforts, which could, in turn, decrease activities related to generating vaccine demand and, therefore, immunization coverage rates.

4.3.3 Community mapping/ microplanning

According to in-country stakeholders, GPEI polio program asset mapping for Somalia is not being used widely by those working in routine immunization—a missed opportunity for planning and leveraging relevant GPEI assets. While individual CSOs have their own mapping data on clinics and catchment areas, there is a need for comprehensive mapping of all organizations (GPEI agencies and CSOs) down to the community level, using the polio program asset mapping (including the GPS data it contains) as a base. Broader mapping would allow for better understanding of where unimmunized children live. For example, the Gavi Joint Appraisal found that 22,000 of the 26,000 total unimmunized children live in five of Mogadishu's 17 districts.

4.4 Polio transition opportunities

The wind down of the GPEI global polio program provides opportunities for CSOs to help address gaps and promote synergies between remaining polio program activities and other health program activities through advocacy and technical support. Government health officials tend to prefer projects with large-scale impact versus small-scale interventions or pilots. However, with enhanced coordination, smaller CSOs could support ongoing large-scale efforts (implemented by UN agencies, government partners, and other CSOs) and CSOs with the required capacity could contribute on a larger scale. There are three main areas of potential engagement by CSOs: 1) organization and representation, 2) advocacy support, and 3) service delivery.

4.4.1 Organization & representation

CSOs could help ease transition of Somalia's polio program from GPEI resources, but there are two main challenges associated with this role: 1) the lack of coordination among CSOs and between CSOs and their partners (government and WHO/UNICEF, the central stakeholders for the immunization program) and 2) the fragmentation and time-limited nature of CSO activities and their overlap with those of other organizations, which wastes resources. The contribution of CSOs is not explicitly visible to the national government or to the major multilateral stakeholder organizations. This reduces their ability to influence strategy crucial for effective immunization outcomes. A CSO coordination platform is needed to address these issues and help CSOs collaborate effectively among themselves and with the government and UN partners. This platform could be used to map facilities, services, and CSO interventions, and to help streamline reporting and information sharing.

4.4.2 Advocacy support

There are many areas in which CSO participation could contribute to polio program transition within the context of the GPEI wind down areas, including advocacy support for immunization strengthening

and effective integration of relevant GPEI assets. Potential activities include:

a) Strengthening immunization financing

There is almost no domestic funding for immunization, and no Gavi cofinancing or domestic purchase of basic vaccines. CSOs could use a coordination platform to advocate, with a coordinated voice, for government allocation of some domestic funding for immunization, even symbolic amounts, to start. The Addis Ababa declaration on immunization[8] seeks this type of commitment from all governments.

CSOs are well positioned to advocate, with UN partners and donors, for increased investment in immunization. Potential activities include positioning immunization as a core indicator of progress on the EPHS strategy and promoting effective integration of relevant polio assets with other programs to ensure that these resources are not lost with the wind down of GPEI support.

b) Addressing low coverage

A 42% DPT3 coverage barrier has existed in Somalia for many years. CSOs could advocate, with government, partners, and donors, for large-scale use of mobile health clinics and other outreach to hard-to-reach communities to help break this coverage barrier and, at the same time, as outlined in the service delivery section below, support government in implementing these mobile clinics. As highlighted in presentations at the 2019 Gavi Joint Appraisal, 74% of Somalia's immunization delivery services are channeled through fixed versus mobile health clinics. CSO experiences in Somalia have shown that localized outreach and mobile immunization approaches yield more community participation than fixed facilities. For example, mobile outreach

> *"The wind down of the GPEI global polio program provides opportunities for CSOs to help address gaps and promote synergies between remaining polio program activities and other health program activities."*

can more effective for identifying zero-dose children.[9] Systematic adoption of polio program mapping and a shift to more outreach and mobile services would lead to better vaccine access by the population. Though this approach is more costly, the investment would undoubtedly be worth it.

c) Improving vaccination records

Maintaining accurate vaccination records is challenging. However, there is a real opportunity at present to introduce home-based records for all children. CSOs could advocate, with government, UN partners, and donors, for the introduction of home-based immunization records, supported by a strong education campaign, described below as a potential area of service delivery support.

d) Integrating services and linkages among stakeholders

Currently, there is a lack of integration of services and linkages among CSOs, health sector partners, and government. There is a need to coordinate these activities, share lessons learned, and synergize resources. CSOs could advocate for the integration of services and linkages among these stakeholders.

[8] In January 2017, Heads of State from across Africa endorsed the Addis Declaration on Immunization (ADI), a historic and timely pledge to ensure that everyone in Africa—regardless of who they are or where they live—receives the full benefits of immunization. https://immunizationinafrica.org/

[9] Children who have not received any vaccinations.

4.4.3 Service delivery

There are four areas for potential CSO participation in service delivery:

a) Tailoring immunization activities to reach vulnerable populations

With the GPEI wind down, there will be increased loss of resources to access the hardest-to-reach children and vulnerable communities, for both routine immunization and SIAs.

In Somalia, nearly 75% of immunization services are delivered through hospitals and fixed facilities; however, less than half of the population can access these facilities. There are three types of populations in Somalia:

- stable populations
- internally displaced person (IDP) camp residents,
- returnees from IDP camps outside and inside the country.

A mix of service delivery approaches is needed to reach these different groups. For example, IDPs are largely located in cities, so service delivery for this group must be tailored for urban areas. There are an estimated 1.5 million IDPs, and another 1.1 million protracted refugees[10]—a significant population that necessitates specialized services. Children living in IDP camps should be reached through one-time or periodic immunization campaigns. Returnees often require "catch up" vaccinations for any missed antigens first, and are then re-enrolled in the routine system of their respective communities.

CSOs often work with vulnerable populations and usually have experiences with interventions for specific at-risk and displaced populations. Therefore, CSOs could support the development of tailored tools and training of field teams on monitoring progress in targeted populations. They could also document and disseminate existing data and interventions that could be scaled up (e.g. mobile teams/outreach services accessing never-reached children).

As mentioned in the advocacy section, CSOs could also support the government and UN partners in implementing large-scale use of mobile health clinics and other outreach to hard-to-reach communities and populations, including children, to help break the 42% DPT3 coverage barrier that has existed for many years.

b) Building and scaling up HR capacities for service delivery

Historically, GPEI supported vast numbers of trained health workers and community-based vaccinators. Despite GPEI, Gavi, and CSO support, Somalia lacks trained vaccinators (for oral as well as injectable vaccines), and managers, for planning and supervision.

CSOs could support the government and UN agencies in training community health workers in the following skills: maintaining home-based immunization records; maintaining real-time immunization data by name and household location; defaulter tracking; social mobilization to create immunization demand; vaccination delivery; and community-based surveillance. These functions are consistent with what is carried out by community health workers currently funded by GPEI and those who are implementing the broader EPHS strategy.

[10] The Office of the United Nations High Commissioner for Refugees (UNHCR) describes protracted refugee situations as those in which refugees find themselves in a long-lasting and intractable state of limbo. Their lives may not be at risk, but their basic rights and essential economic, social and psychological needs remain unfulfilled after years in exile. Source: https://www.state.gov/other-policy-issues/protracted-refugee-situations/

"Community engagement is essential to ensuring strong demand for immunization services."

The Somali Red Crescent Society (SRCS) is a good example of this type of support. It has more than 8,200 volunteers on its roster, 70% of which are female. There are also a large number of polio volunteers actively working for SIAs and immunization delivery, some with a professional background. The SRCS has been recognized for its contributions in Somaliland (in a very limited area). Along with the polio volunteers, SRCS volunteers are good potential candidates for training in social mobilization linked to actual delivery of immunization services. These volunteer groups could be recruited for an intense, competency-based training program for community health workers/mobilizers. A proposed three-year project to train 500 volunteers in one zone to identify children's immunization status could help immunization services and strengthen health systems overall. Unlike the government or UN organizations, the SRCS is perceived as relatively neutral so more accepted by populations in areas of conflict. The main weakness of the SRCS is their lack of regular funding and long-term sustainability.

c) Building awareness and demand for immunization in communities

The wind down of GPEI has started to affect resources for social mobilization activities at the community level. Community engagement is essential to ensuring strong demand for immunization services. Many CSOs specialize in conducting robust social mobilization to enhance demand, boost confidence in vaccines, and reduce the spread of misinformation. CSOs could support the government and UN agencies in increasing immunization demand and conducting social mobilization activities by expanding the community-level health workforce and creating a cadre of village-based social mobilizers.

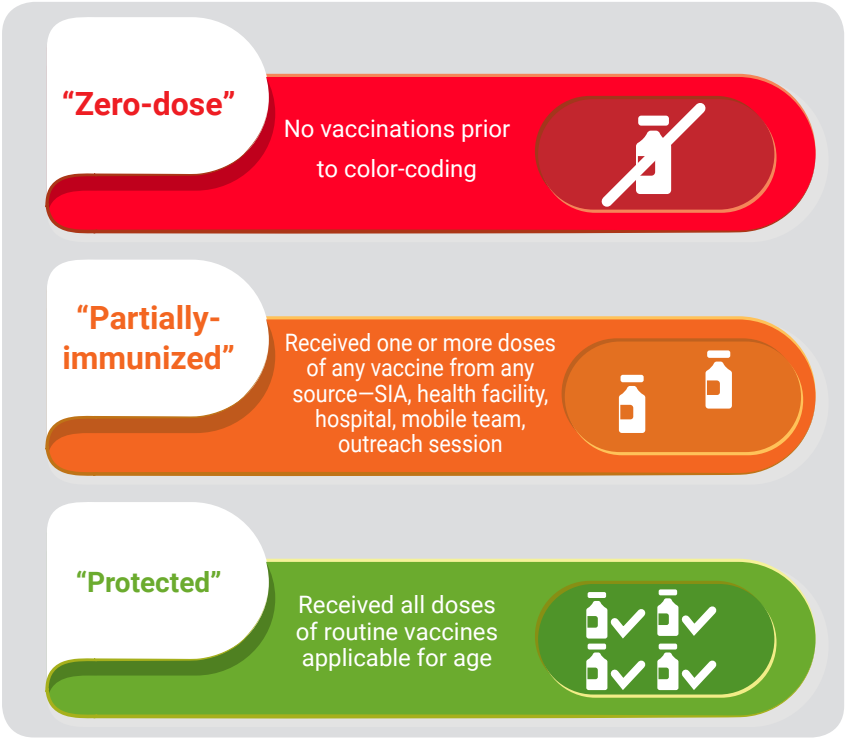
As recommended in the section above, CSOs could advocate for the introduction of home-based records. However, the mere printing and distribution of immunization cards is not sufficient and needs to be accompanied by a strong education campaign. CSOs would be well suited to support the government in educating communities and families on the importance of keeping home-based records.

d) Community-level monitoring

Innovative ways for community-based workers/volunteers to monitor the immunization status of individual children are needed. Two interventions are required:

- the introduction of home-based records
- the introduction of a tool for monitoring real-time progress and tracking defaulters. In Somalia, health sector partners are employing name-based monitoring efforts at the community level. An example of this type of tool (a color-coding system for child immunization status) is described in Figure 3 on the following page.

Figure 3 Example of a color-coding system for child immunization status



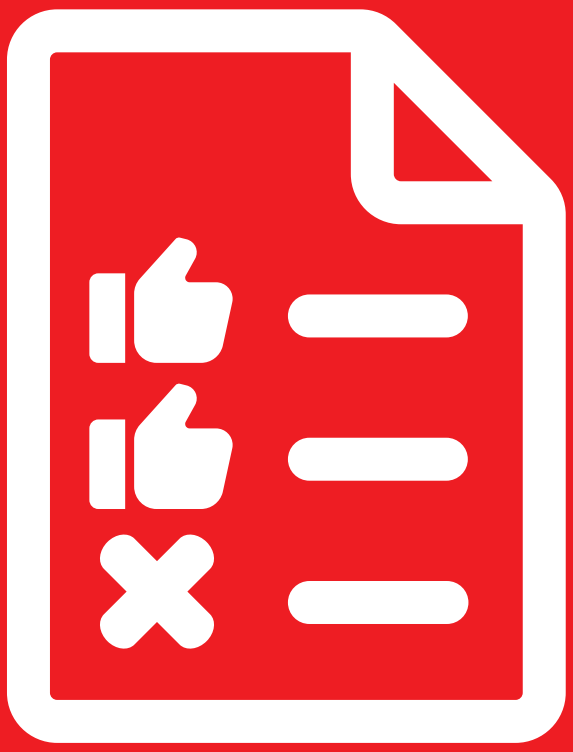
The goal of the community health worker/volunteer would be to move individual children from the red and orange categories to the green ("protected") category. At the aggregate level, the progressive percentages could be used to measure program performance in the village or community.

Figure 4 SWOT[11] analysis of CSO engagement in Somalia

Strengths	Weaknesses
• Able to build direct linkages with each of the respective government entities • Expertise in robust social mobilization activities • Access to "last mile" communities/unreached populations and IDPs in conflict settings	• Lack of experience in hands-on vaccination services • Current lack of mechanism for coordination among CSOs and between CSOs and UN/ government stakeholders
Opportunities	**Threats**
• Educate communities about immunization to increase confidence in vaccination and mitigate the spread of misinformation • Harmonize efforts among CSOs and other health stakeholders to scale up the impact of relevant interventions	• Limited ability to scale up • Duplication across health sector partners • Competition for resources

Source: Prepared by author, based on assessment

[11] Strengths, weaknesses, opportunities, and threats.



Recommendations for stakeholders

5

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5 Recommendations for stakeholders

As GPEI winds down its operations in Somalia, relevant GPEI assets and lessons learned should be effectively integrated into broader immunization and health programming. This section below provides recommendations for maximizing CSO potential, tailored for each of the three stakeholder groups: the Somali government and UN partners; donors, and CSOs. The chart below summarizes the recommended actions for each stakeholder group. Further details for each respective set of recommendations can be found on the following pages.

Stakeholder

Government/UN	Donors	Civil Society
Recommendations		
◤ Ensure that relevant GPEI assets are effectively integrated into a fully operational EPHS strategy. ◤ Map activities of implementing partners to improve coordination and efficiency across the health sector. ◤ Invite CSOs from the health and humanitarian sectors to contribute more to immunization efforts. This will be easier if the CSOs are organized as national and subnational platforms.	◤ Ensure financing mechanisms promote immunization as one of the primary indicators for assessing programmatic progress on Somalia's EPHS strategy. ◤ Promote coordination across GPEI and Gavi resources to ensure full coordination of immunization-related financial and technical support (Gavi resources are currently provided under different funding streams). ◤ Advocate for CSOs to be involved in government and partner planning processes.	◤ Establish a CSO coordination platform at the national level to enhance coordination and encourage CSO representation at relevant government, UN, and humanitarian fora. ◤ Provide advocacy support to create an enabling environment for immunization-strengthening and effective integration of relevant GPEI assets. ◤ Provide technical support for specific service delivery gaps within the context of the GPEI wind down.

5.1 Government/UN

Somali government and UN system (primarily WHO/UNICEF)

1

Ensure that relevant GPEI assets are integrated effectively with a fully operational EPHS strategy.

Government and UN partners should map donor resources across all states and countries and ensure that implementation partners do not deviate from the country's broader EPHS strategy. Vertical implementation of polio programming will not be feasible following the wind down of GPEI.

2

Map implementing partners to improve coordination and efficiency across the health sector.

Government and UN partners should conduct a detailed mapping of all implementing partners across government zones and regions based on programmatic strengths and geographic presence. Health and humanitarian focused organizations should be included in the mapping exercise and invited to join mutual coordination forums.

3

Invite CSOs from the health and humanitarian sectors to contribute more to immunization efforts.

With the wind down of GPEI (which funds the majority of UN's immunization staff), civil society stakeholders working on related health issues should be increasingly engaged to help cover gaps. This could include building the capacities of CSOs (particularly in microplanning, supportive supervision, supply management, immunization demand generation, and use of data for decision-making) and facilitating more direct links between established CSO partners and the government.

5.2 Donors

1

Ensure that immunization becomes a central platform for assessing programmatic progress of the country's EPHS strategy.

Immunization should be perceived as a delivery platform for health services and not just the delivery of vaccines to children. WHO has played a crucial role in this effort over the last decade by enhancing the technical capacities of health workers.

2

Promote coordination across GPEI and Gavi to ensure full coordination of immunization-related financial and technical support.

Improving coordination between major donors that provide immunization funding, specifically GPEI and Gavi, will lead to administrative efficiencies and reduce monitoring load.

3

Advocate for CSOs to be involved in the government and partner planning processes.

CSOs bring an important perspective and should be invited to contribute during joint planning exercises with the government and partners. Donors have a strong influence to ensure that CSOs are included.

5.3 Civil Society

Recommendations for civil society engagement in polio program transition activities are divided into three categories:

Organization & Representation

Advocacy Support

Service Delivery

Recommendations for civil society

Category	Gap	Recommendation
Organization & representation	Lack of coordination among CSOs, resulting in overlap, wasted resources, competition for funding, and low visibility	• Establish a CSO platform (nongovernment, non-UN) for all international nongovernmental development organizations (INGDOs) and national CSOs, and map CSO activities across all states.
	Lack of coordination between CSOs and partners (government and WHO/UNICEF)	• Ensure CSO representation at national- and state-level forums (e.g., Interagency Coordinating Committee, ICC) in an engaged and systematic manner versus ad hoc/token participation.
Advocacy support	Lack of immunization funding	• Advocate through a CSO platform for the government to allocate domestic funding for immunization. • Advocate with main funders (specifically those for UNICEF-/HPF-funded projects) and implementing organizations to use immunization performance as a core indicator for progress in carrying out the EPHS strategy.
	A 42% DPT3 coverage barrier that has existed for many years	• Advocate with government, partners, and donors to implement large-scale use of mobile health clinics and other outreach to hard-to-reach communities.
	Issues with maintaining immunization records	• Advocate, with the government, for home-based immunization records, supported by education campaigns.
	Lack of integration of services and linkages among CSOs, partners, and government	• Advocate for integration of services and linkages among CSOs, partners, and the government.
Service delivery	Lack of access to children in IDP camps and returnees from IDP camps (inside and outside the country)	• Develop effective, tailor-made approaches for reaching IDP camps and returnees with immunization services. • Develop tailored tools and train CSO field teams on monitoring progress in targeted populations. • Document and disseminate existing data and interventions that could be scaled up (e.g., mobile teams/outreach services accessing never-reached children).
	Human resource gaps at the community level	• Train community health workers to develop competencies[12] consistent with GPEI-funded community health workers and those implementing the BHI.
	Loss of resources for immunization demand generation and social mobilization activities at the community level	• Provide technical support for social mobilization, expanding the community-level health workforce, and promote the use of community-level tools for monitoring and program management. • Strengthen/create a cadre of village-based social mobilizers to educate communities on immunization services. • Educate communities and families on the importance of retaining home-based records.
	Loss of resources for community-level monitoring	• Identify innovative ways for community-based workers/volunteers to monitor individual children. • Create a user-friendly tool that could be used by community health workers to monitor children at the community level.

All CSO activities supporting the polio program transition should be aligned with the country's EPHS strategy.

[12] Maintaining home-based immunization records; collection of real-time immunization data by name and household location; defaulter tracking; social mobilization for immunization demand generation; vaccination delivery; and community-based

Conclusions

6

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6 Conclusions

Integrating Somalia's polio program with other broader health services and winding down its reliance on GPEI resources and support will require a massive scale-down of program technical personnel (or their transfer to other health programs). The funding ramp down has already begun, and the negative effects will be felt more acutely in the coming years. This poses a threat to the sustainability of the entire immunization program as well as polio-related activities.

Sustaining polio program essential assets and other immunization activities will require a separate continuation of technical and financial support for the medium to long term. The largest gaps will be in financial support for personnel currently funded by GPEI. This will affect a wide range of activities, including immunization delivery, surveillance of polio and other vaccine-preventable diseases, capacity building, resource mobilization, and community engagement. The transition away from global polio resources will also create a void in existing social mobilization activities. Inadequate community involvement has led to low demand for and low utilization of immunization services.

The wind down of the global polio program provides an opportunity for CSOs to help address gaps and promote synergies between remaining polio program activities and those of other health programs through advocacy and technical support. Maximizing their impact will require close coordination of CSOs with all major health stakeholders (government, UN agencies, and donors), ensuring that all activities conducted by CSOs are within the countries' EPHS strategy.

Annexes

Annex 1

Mapping of health sector stakeholders in Somalia	
Government	**Federal Government of Somalia (FGS)**—The FGS is the officially recognized national government. The FGS Ministry of Health has good control of program implementation in the South-Central region and, to a limited extent, in the Puntland region. EPI and polio activities are heavily supported by WHO and UNICEF, which also support a large number of professional staff at the zonal and regional levels. **Ministry of Health, Puntland**—Puntland is a better performing zone than other country health zones. This Ministry of Health prefers to interact and receive funds directly from WHO and UNICEF. **Government of Somaliland**—The Government of Somaliland functions independently, with an elected president and parliament. Its government authorities do not like to be monitored by the FGS and interact directly with all health sector partners. A number of development partners operate in Somaliland from its capital (Hargeisa). Note: As all three entities depend on WHO and UNICEF for immunization delivery, the modalities of vaccine delivery are the same countrywide. The implementing organizations normally interact directly with the respective zonal government. Some organizations work almost exclusively in one zone.
UN Agencies key to health Sector	**WHO**—Working closely with both national and zonal health ministries, WHO is a key influencer on health issues in Somalia, on both the strategy and implementation fronts. Funders like the Bill & Melinda Gates Foundation (BMGF) and Gavi work closely with WHO to coordinate implementation across Somalia's multiple government entities. WHO's polio program has the best mapping of resources and community microplans for Somalia. This asset has not been fully utilized by many implementing partners **UNICEF**—UNICEF steers core functions such as procurement and the distribution of vaccines, devices, and drugs countrywide. It also works with CSOs on service delivery through its clinics and mobile units. Both WHO and UNICEF manage Gavi cash grants in-country; they are not transferred directly to the government due to weak financial management systems.

Humanitarian organizations	**United Nations High Commissioner for Refugees (UNHCR)**—UNHCR works with refugees in Somalia who have been forced to flee their home. They help provide these populations with access to education, health, and community-based projects, which are designed to help integrate refugees, people living in IDP camps, and returnees from IDP camps with host communities. **International Organization for Migration (IOM)**—IOM works closely with the FGS, regional authorities, the UN, donors, government, and civil society, implementing preparedness and humanitarian response programs, recovery solutions, and migration governance and development projects. **Somali Red Crescent Society (SRCS)**—The International Federation of Red Cross and Red Crescent Societies (IFRC) works through the SRCS, which operates through two units in Hargeisa and Mogadishu respectively. There are 32 clinics in Puntland and Somaliland (19 and 13 respectively), 25 of which are static and seven of which are mobile units. The static clinics and mobile units deliver an EPHS that includes antenatal care, safe delivery, and immunization services. The vaccines and immunization supplies are received through UNICEF, which takes responsibility for their distribution on behalf of the government. The mobile units operate five days per week. Each unit has a midwife, three nurses, and support staff. They go out to the peripheral villages to provide these services. The mobile clinics often access populations that would otherwise never be reached. The 32 SRCS clinics have a coverage area comprising a population of 600,000. Its main strength is a roster of more than 5,000 volunteers who actively participate in social mobilization. **International Rescue Committee (IRC)**—With financial support from Gavi, IRC prepared an urban strategy for Somalia's three biggest cities: Mogadishu, Hargeisa, and Kismayu. It also manages one cold chain store in Karar district. Service delivery activities are taken up whenever UNICEF issues a Request for Proposals for specific tasks (e.g., social mobilization support during an SIA, or delivery of EPHS). UNICEF uses GPEI or Gavi funds for contracting these types of activities. **International Medical Corps (IMC)**—IMC supports a 42-bed maternity hospital, four health centers, and six primary care health units in Jowahar region. In Mogadishu, IMC supports two health centers in IDP camps, and one health center in Baidoa, which provides nutrition services; integrated health care service; and water, sanitation, and hygiene (WASH) services. In addition, 14 mobile medical teams serve difficult-to-reach communities. Immunization services are provided by the hospital as well as all health centers and primary health care units. **Norwegian Refugee Council (NRC) and Danish Refugee Council (DRC)**—The NRC and DRC respond to the massive drought situation and food shortages in Somalia, in addition to providing health services to IDPs. They are also part of the Somalia Return Consortium and the Somalia Resilience Program, which are designed to facilitate migrant resettlement from abroad or IDPs' return to their communities. Services for IDPs include immunization.

International CSOs	**Save the Children**—Save the Children has a large presence in the South-Central zone, covering about 220 of a total of 700 health facilities in Puntland and Somaliland. It is the most visible service delivery partner in four regions: Lower Jubba, Baidoa, Mogadishu, and Kismayu. Immunization is one of the services delivered; however, coordination with UN agencies is not sound. The perception of Save the Children is that some UN agencies may consider them (and other international CSOs) as competitors for the same resources from donors like Gavi and bilateral organizations, which can limit collaboration. Save the Children delivers services through 220 fixed facilities, periodic campaigns, regular outreach programs, and mobile units. The mobile units are costly to operate but have been successful in penetrating never-before-reached communities. The organization has good and reliable mapping of facilities that provide services that can help ensure widespread coverage.
Coordination forums	**NGO Consortium**—The Somalia NGO Consortium was established in 1999 and has since grown to become a network of NGOs working together to improve international aid coordination and raise the presence and profile of NGO representation within the aid coordination structure for Somalia. The Consortium maintains its presence through its offices in Hargeisa, Garowe, Mogadishu, and Nairobi. **Health Cluster**—Coordinated by WHO, the Health Cluster for Somalia was designed to relieve suffering and save lives in humanitarian emergencies while advancing the well-being and dignity of affected populations. There are 112 Health Cluster partners in Somalia, including national government, five UN agencies, three donors, and 103 NGOs, both international and national.
Immunization coordination forums	National ICC for Immunization Zonal ICCs (Somaliland, Puntland, and Somalia) National Health Sector Coordinating Committee (HSCC) Zonal HSCCs (Somaliland, Puntland, and Somalia)

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