

Type of Review: Annual Review
Project Title: Health Consortium for the Somali People (HCS)
Date started: July 2010
Date review undertaken: 1st to 30th June 2014

Instructions to help complete this template:

Before commencing the annual review you should have to hand:

- *the Business Case or earlier project documentation.*
- *the Logframe*
- *the detailed guidance (Howto Note)- Reviewing and Scoring Projects*
- *the most recent annual review (where appropriate) and other related monitoring reports*
- *key data from ARIES, including the risk rating*
- *the separate project scoring calculation sheet (pending access to ARIES)*

You should assess and rate the individual outputs using the following rating scale and description. ARIES and the separate project scoring calculation sheet will calculate the overall output score taking account of the weightings and individual outputs scores:

Description	Scale
Outputs substantially exceeded expectation	A++
Outputs moderately exceeded expectation	A+
Outputs met expectation	A
Outputs moderately did not meet expectation	B
Outputs substantially did not meet expectation	C

Acronyms

ANC	Antenatal Care
ANS	Amoud Nursing School
BEmONC	Basic Emergency Obstetric and Newborn Care
BIOHS,	Boroma Institute of Health Sciences
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHC	Community Health Committee
CHW	Community Health Worker
COC	Combined Oral Contraceptives
CMW	Community Midwives
CSPM	Conflict Sensitive Programme Management
CYP	Couple Years of Protection
DHB	District Health Board
EAUH)	Edna Adan University Hospital
EPHS	Essential Package of Health Services
FG	Federal Government
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender based Violence
HC	Health Centre
HCS	Health Consortium Somalia
HIOHS,	Hargeisa Institute of Health Sciences
HMIS	Health Management Information System
HSCO	Health Sector Coordination Office
HSAT	Health Systems Advisory Team
HPA	Health Poverty Action
HSSP	Health Sector Strategic Plan
HR	Human Resources
HW	Health Worker
IPC	Inter-Personal Communications
JHNP	Joint Health and Nutrition programme
JPLG	Joint Programme on Local Governance
MICS	Multi-indicator Cluster Survey
MoH	Ministry of Health
NHPC	National Health Professionals' Council
OCVP	Observatory on Conflict and Violence Prevention
OTP	Out Patient Therapeutic Programme
PES	Population Estimation Survey
PHU	Primary Health Unit
PL	Puntland
PSI	Population Services International
RHB	Regional Health Board
RHC	Referral Health Centre
RHO	Regional Health Office
SBA	Skilled Birth Attendant
SCI	Save the Children International
SDF	Somaliland Development Fund
SFN	Social Franchise Network
SIOHS,	Sool Institute of Health Sciences
SL	Somaliland
SMA	Somaliland Medical Association
SNMA	Somaliland Nursing and Midwifery Association
SOMLA	Somaliland Medical Laboratory Association
SSF	Somalia Stability Fund
THET	Tropical Health and Education Trust

Introduction and Context

What support is the UK providing?

The UK is providing a total budget of £38.09 million over a 5-year period (2010-2015). This budget comprises an initial financing of £13 million to the NGO Health Consortium Somalia (HCS), and an extension of £24.6 million to cover October 2012 to June 2015. £22.8 million of the current financing will be delivered during DFID Somalia's current operational plan period (up to March 2015) and £1.8 million will be delivered outside the operational plan period (April – June 2015)¹.

The NGO Consortium consists of five international NGOs working across Somaliland, Puntland and South Central. PSI is the lead agency and is operating in Somaliland, Health Poverty Action (HPA) is operating in Sahil, Somaliland, Tropical Health Education Trust (THET) is operating mainly in Somaliland, but across all three zones in certain sectors, Save the Children is operating in Kakaar, Puntland and Trocaire is operating in Gedo, South Central. One of the key purposes of the programme is to support the health sector in moving from a humanitarian response to health provision to a longer term developmental approach. The programme has been designed to be adaptive and responsive to changes in context, using innovative techniques and mechanisms to pilot interventions in order to set standards and provide evidence for wider health sector reform.

In September 2013, HCS requested an additional £950,000 to meet emerging health sector needs in 2013. In response, a cost extension of £418,000 was approved bringing the overall programme budget from £37.67m to £38.09m and a reallocation of £532,000 from underspend in the Somalia framework was allocated to the HCS programme.

The additional budget of £950,000 allowed the programme to; maintain the continuous and uninterrupted maternity services that had previously been established; to strengthen the referral mechanisms; to scale up immunization services to children under five years; as well as to develop the National Clinical Officers' training curriculum.

The HCS has completed four years of activity and this is the fourth annual review. The programme has consistently performed well with scores of 2 (2011), A+ (2012), and A (2013). This review covers the period between July 2013 and June 2014 is scoring an A.

What are the expected results?

The expected impact of the programme is: "Improved survival and health status of Somali people". The planned outcome is: Somali people, especially women, children and the most vulnerable in target areas increase utilisation of quality health services contributing to the Millennium Development Goals (MDGs) 1, 4, 5 and 6, by reducing the under 5 mortality rate and the maternal mortality ratio. The HCS aims to increase the range, quality and use of the Essential Package of Health Services (EPHS)² and contribute to community stability in targeted areas in three political zones. This includes the Sahil region of Somaliland, the Kakaar region of Puntland, and 5 districts in the Gedo region of South-Central Somalia.

The expected result after the 5 years of implementation is to have delivered EPHS through government facilities in selected pilot areas of Somalia by 2015. The business case headline results indicators included: number of additional women using modern contraceptives and number of births attended by a skilled birth attendant (SBA). Discussion held over the year concluded that HCS does not meet the DFID methodologies for both indicators and therefore these have been amended to measure 'number of family planning products distributed' and 'number of facility based deliveries attended by an SBA'.

The specific expected results by 2015 are summarised as:

- 100,000 modern birth spacing methods distributed in Somaliland;
- An additional 21,203 women having an HCS trained skilled birth attendant in target areas or a 16% increase;
- 72,538 children under 5 years fully immunised (DPT3) through routine services (18,972 children per year) equivalent to a 66% increase
- 68,406 children in target areas who receive emergency and basic nutrition services.

What is the context in which UK support is provided?

Somalia ranks amongst the Least Developed Countries (LDCs) and is considered the most fragile state in the world³ after 22 years of conflict, institutional, social and economic disruption and recurrent humanitarian emergencies. This reflects on the health status of the population and the most recent available data positions Somalia among the lowest ranking countries on all health indicators

¹ A cost extension request for £7.5m has been submitted to cover the transition period whilst a new health sector programme is being designed. If approved, this will take the total programme budget to £45.59m.

² The EPHS for Somalia was designed by UNICEF in 2009 and is divided into 10 service delivery programmes, 6 of which are core, delivered across four levels of service provision http://www.unicef.org/somalia/health_11682.html

³ Failed States Index 2013. <http://fp.statesindex.org/somalia>.

except life expectancy. Among the key indicators, the maternal mortality ratio is estimated at 850 maternal deaths per 100,000 live births (2013) and under-5 mortality at 180 child deaths per 1,000 live births (2010). The availability, quality and utilization of public health services are low, while a fast growing private-commercial sector increasingly provides health services. This unregulated private sector is filling the services gap for part of the population.

Since 2012 the health sector has been considered a model sector in the Somali context; government-owned Health Sector Strategic Plans are in place and being implemented, framed according to the WHO six building blocks for health systems strengthening; there is participatory coordination under the leadership of the Somali Health Authorities, leading to further alignment and harmonisation of all health sector stakeholders; greater emphasis is being placed on results and an M&E framework is being defined; the HMIS system is being strengthened along with supportive supervision tools; significant work has been undertaken on human resources (HR) and HR policies are in the process of being developed. Under the Joint Health and Nutrition Program (JHNP), the Essential Package of Health Services (EPHS) will be rolled out in a further 9 districts, from late 2013 to early 2014. There is still much to be achieved, particularly in strengthening health systems and ensuring adequate supplies and commodities are in place.

Section A: Detailed Output Scoring

Output score and performance description:

Output 1- Functioning institutional Frameworks and local governance systems to support improved health services in place in target areas

Output 1 score and performance description: A (Output met expectation)

Overall this output has performed well during the period of the Review. The Consortium has strengthened relationships with the MoHs, specifically in Somaliland and Puntland and has helped support the dissemination of the HSSPs and the National Health Policy (NHP). The Consortium has participated in the annual review and planning processes of the Health Sector in both Somaliland and Puntland and is now participating in health sector coordination meetings. Greater participation in the health sector planning process has reduced duplication of activities and ensured the activities of the Consortium are aligned with health sector priorities (output 1.1 A). Output 1.2 scored an A+ as coordination has also been strengthened at the district and regional level and the Consortium has supported monitoring and planning process at both levels. In addition, local governance and management structures at Regional and District level (RHO, RHBs, DHBs and CHCs) are fully involved in conflict sensitive programming to ensure do no harm principles are adhered to during implementation of activities and are responsible for resolution of conflicts arising at both health facility and community level. Output 1.3 has scored A. The first part of the milestone exceeded expectations while the second moderately did not meet expectations. This was due to limited capacity of the National Health Professional Council (NHPC) to deliver.

Output Indicator	Milestone 4 (2014)	Progress	Output Description
Indicator 1.1: Consultative Policy and Strategy development and review process in Somaliland (SL) and Puntland (PL).	<p>Somaliland</p> <ul style="list-style-type: none"> - Ministry of Health (MoH) with the support of its stakeholders disseminates the NHP and Health Sector Strategic Plans (HSSP) across the country. - Monitoring and review process agreed and functioning; - Consultative review and revisions to the Essential Packages of Health Services (EPHS) based on data 	<ul style="list-style-type: none"> - Somaliland: –Milestone met: MOH has printed both the NHP and HSSPs and disseminated both documents at the recent MoH conference in June. - Milestone met: MOH in conjunction with HCS members is providing supportive supervision to the Regional Health Offices (RHO) and Regional Health Boards (RHB) of Sahil and Awdal regions. - Milestone met: All HCS partners participated in health sector joint review and planning process in March 2014. This led to follow-up meetings with the Joint Health and Nutrition Programme (JHNP) 	A (met expectations)

	<p>Puntland - Dissemination of the NHP and HSSP across the country with the support of MoH</p>	<p>partners to review areas of overlap and ongoing discussions underway to avoid areas of duplication. JHNP.</p> <ul style="list-style-type: none"> - Milestone met: EPHS review of HCS Pilot conducted in September 2013. Recommendations from the review were actioned by partners. (see Annex D) <p>Puntland: Milestone partially met:</p> <ul style="list-style-type: none"> - HSSPs printed and disseminated, NHP still waiting to be disseminated - this has been delayed as it was decided that an NHP applicable to all zones should be developed. - EPHS review of HCS Pilot conducted in September 2013. Recommendations from the review were actioned by partners. (see Annex E) 	
<p>Indicator 1.2: Planning and monitoring structures and systems, reflecting gender issues, developed through stakeholder consultation and functioning in target areas at all levels.</p>	<p>Gedo – District Health Boards (DHBs) active in planning and monitoring of services using monitoring data, with active female involvement.</p> <p>Somaliland - Support MOH leadership and management to strengthen effective collaboration and harmonisation at both central and Sahil regional level</p> <p>Sahil - RHB supporting planning and coordination</p>	<ul style="list-style-type: none"> - Gedo; – Milestone met: Close working with DHBs continues. All DHBs were functional during the reporting period with female representatives in each DHB - a total of 16 female members. Quarterly review meetings with DHB conducted in Belet Hawa, Dolow, Luuq and Gabraharey. - Somaliland- Milestone moderately exceeded: Project Planning & Management training provided for 25 MoH staff at central level, plus 2 central MOH staff sent to Tanzania for training on Leadership, Management and Governance in Health Systems. - Milestone moderately exceeded; Planning meeting with RHB conducted and joint RHO and Health Poverty Action (HPA) planning and supervision structures are in place. 7 RHB members were trained in Leadership and Management in Sahil. RHB involved in the procurement process, planning and supporting through coordination with local council (i.e. gaining construction permissions from Mayor's office) 	<p>A+ (Moderately exceeded expectations)</p>

	<p>Kakaar – Community Health Committees (CHCs) involved in routine Monitoring and Evaluation (M&E) and supervision of delivery of EPHS</p>	<ul style="list-style-type: none"> - Kakaar – Milestone moderately exceeded: Monthly meetings at facilities with CHC conducted to: review the action plans/activities and discuss progress, gaps and challenges faced by the health facility; Monitoring drug supplies / consumption and service delivery; oversight of construction and rehabilitation of Health Facilities (HFs); dealing with staffing issues – absenteeism, disputes between staff and community; regional level quarterly and monthly workplans developed based on district plans. Conducted routine monitoring, Health Management Information System (HMIS) data review and supportive supervision. 	
<p>1.3 – Voluntary accreditation structures established for selected cadres of health personnel in Somaliland.</p>	<p>NHPC Regulatory framework and tools piloted in Sahil Region.</p> <p>At least 2 Health Training institutions and 2 health facilities accredited.</p>	<ul style="list-style-type: none"> - Milestone moderately exceeded: NHPC successfully piloted voluntary registration tools in Sahil then rolled out voluntary registration of health workers in Awdal, Togdheer, Sanaag and Sool regions. A total of 474 (260 Male and 214 Female) health professionals registered voluntarily. - Milestone partially met: NHPC conducted pre-assessment of health training institutions and facilities to determine the baseline and is currently developing minimum standards and guidelines for accreditation - The Board – including Chair and Vice-Chair were finally appointed in May. Capacity remains a concern especially given its expanded role and is a reason for the delay in the accreditation process. 	<p>A (Output met)</p>

Indicators revised since last Annual Review? (see Annex C) No revision recommended.

Impact Weighting (%): 10%

Revised since last Annual Review? No revision to indicator since last review.

Risk: Low

Revised since last Annual Review? *No revision recommended and the weighting is likely to remain at this level for the programme period.*

Output 2 - Capacity of local partners strengthened, including health personnel trained and employed to agreed standards in target areas.

Output 2 score and performance description: A+ (Output moderately exceeded expectation)

Good progress has been made in achieving all the milestones under Output 2 resulting in an overall score of A+.

Under output 2.1, progress continued in the development of Human Resource Development (HRD) and Human Resource Management (HRM) with sharing of guidelines and procedures across the three zones. Tropical Health and Education Trust (THET) continued to provide support to HRD and HRM in Somaliland and is working closely with JHNP to standardize across the zones. THET, despite a delayed signing of the Memorandum of Understanding (MoU) with the MoH, successfully completed data collection for a national health workforce survey, which is providing a platform and baseline for health workforce planning, development, deployment and retention for Somaliland.

Over 900 workers have been trained under output 2.2. This shows continued progress, with two milestones exceeding expectations.

THET developed standardized curricula for the different health cadres. In addition THET continues to build long term institutional capacity by supporting 2 MOH departments (Human Resources Development & Department of Planning (DoP), 3 Professional associations (Somaliland Medical Association (SMA), Somaliland Nursing and Midwifery Association (SLNMA) & Somaliland Medical Laboratory Association (SOMLA), 5 nursing and midwifery schools (Hargeisa Institute of Health Sciences (HIOHS), Sool Institute of Health Sciences (SIOHS), Boroma Institute of Health Sciences (BIOHS), Amoud Nursing School (ANS) & Edna Aden University Hospital (EAUH) and 2 medical faculties (Hargeisa and Amoud universities).

Under output 2.3 HCS has continued to strengthen training of Skilled Birth Attendants (SBAs), increasing the number of health professionals trained, reflected under output 2.3 significant work on FGM/C identification, management and treatment has been incorporated into all health worker curriculums and trainings as well as communication materials.

Output Indicator	Milestone 2 (2012)	Progress	Output Description
<p>Indicator 2.1: Gender aware Human Resources (HR) policy & management tools developed and adopted by partners in the target areas</p>	<p>Gedo - Management tools informing decisions in target area. DHBs minimise recruitment of unqualified staff</p> <p>Somaliland - Health Workforce survey carried out and HR policy and Long term plan developed informing decisions at national level, including gender consideration</p> <p>Kakaar - HR management tools fully integrated into routine health management system</p>	<p>- Gedo – Milestone moderately exceeded: DHB staff job descriptions reviewed with support of Trocaire. All DHBs now have Human Resources (HR) files in place which includes staff qualification, signed employment contracts and job description. DHBs are active in the selection of health staff and were involved in the selection of 18 Community Midwives (CMWs) sent to Mogadishu.</p> <p>- Somaliland (SL) – Milestone partially met: A countrywide health workforce survey has been completed. Preliminary findings available and final report is due in July / August 2014. Long term plan is being developed based on the findings.</p> <p>- Kakaar – Milestone met: HR management tools (job descriptions, contracts, evaluation form, HR induction, and performance based incentives guidelines) have been reviewed and translated into Somali</p>	<p>A (Output met)</p>

		language and being rolled out in all health facilities in the region.	
<p>Indicator 2.2: Proportion (number and percentage) of health workers trained in target areas in order to fulfil their job description.</p>	<p>Gedo -18 Local women sent for community midwifery training 5 Auxiliary Nurses sent for Registered nurse training 8 Nurses sent to IPC training</p> <p>Somaliland - Increase in number of health workers participating in CPDs to improve their knowledge and skills. - Nurses, midwives, Medical doctors trained. % of trainees by gender, new graduates tracking tools developed and operationalized Number of Volunteers and Experts coming for training by area of specialization. Number and type of In service trainings offered. Private Pharmacy Dispensers Private Pharmacy Dispensers trained (Pharmacy certification - 6 modules and No 30)</p> <p>Sahil: 100 health workers trained -50% female - 70% of total health workers</p> <p>Kakaar - 90 health workers trained -50% female - 70% of total health workers</p>	<p>- Gedo: Milestone met: Training held as outlined in the milestone.</p> <p>- Somaliland – Milestone moderately exceeded: (number up to end March): 150 health workers reported trained up from 110 in 2012 (102 of which were pre-service training – nurses, midwives, interns & medical graduates & 6 health workers sent to Ifakara, Tanzania) Training of 39 CHWs are in progress. 30 volunteers and experts visited and provide expertise in Mental Health Teaching, Biomedical Needs Assessment, Nursing CPD, Faculty Development and Support, Needs Assessment, Nursing/Midwifery stakeholders, Medicine Africa, External Examiners, Research Audit TA. Continuous Professional development (CPD) was conducted with 320 members of professional associations (SOMLA, SMA & SMLNA)</p> <p>- Support to Medical Internship programme resumed</p> <p>- PSI trained 14 private pharmacists (Delays in signing MOU with MOH impacted on achievement of target.</p> <p>- Sahil: Milestone substantially exceeded: 154 health workers trained (80 female = 51%,)</p> <p>- Kakaar: Milestone substantially exceeded: 243 health workers trained (157 female = 64%)</p>	<p>A+ (Moderately exceeded expectations)</p>
<p>Indicator 2.3: Number and percentage of additional health workers (HWs) trained as Skilled Birth Attendants, as defined by WHO</p>	<p>Gedo - Number of skilled birth attendants maintained (at least 15)</p>	<p>- Gedo: Milestone moderately exceeded: 18 Community midwives undergoing a two year course which began in September 2013 in School of Midwifery Somalia in Mogadishu. 5 Auxiliary Nurses being upgraded to qualified nurses in partnership with SOS Institute – 3 year training began September 2013.</p>	<p>A + (Outputs moderately exceeded expectation)</p>

	<p>Somaliland: Annual increase in number of Women and Men trained as SBA through pre-, post- and in-service training</p> <p>Sahil - 27 (50%) scholars will continue study in training institution to complete the courses</p> <p>Kakaar - no additional SBA trained - 20% of the existing SBA trained on job and refresher training =13 SBAs</p>	<ul style="list-style-type: none"> - Somaliland: Milestone substantially exceeded: Total no trained is 150 an increase of 42% from 2012 including 28 medical interns are currently attached to Hargeisa Group Hospital and A.F.Abraar Hospital Borama - Sahil: Milestone met: 12 women sent for community midwife training in collaboration with THET to Boroma X 24 months; 15 nurses in training in Boroma (HPA) - Kakaar: SCI –Milestone substantially exceeded: Refresher training provided to 30 SBA on BEMONC 	
<p>Indicator 2.4: All relevant training concerning the health of girls and women includes identification, management and complication of Female Genital Mutilation/ Cutting (FGM/C)</p>	<p>All curriculum developed or reviewed contains a chapter on FGM/C</p>	<ul style="list-style-type: none"> - Milestone moderately exceeded: All partner curriculums contain a chapter on FGM/C. New curriculums developed by THET (BSc nursing & Clinical Officers) contain module. SLNMA confirmed inclusion as module in training curricula and drafted FGMC anti-medicalisation policy; partners also reported inclusion of FGM/C in trainings and communication materials. 	<p>A+ (Moderately exceeded expectations)</p>

Indicators revised since last Annual Review? (see Annex C) No revision recommended.

Impact Weighting (%): 30%

Revised since last Annual Review? No change since the last Annual Review.

Risk: Low

Revised since last Annual Review? No revision recommended

Output 3- Access to quality health service delivery, appropriate and prioritised for poor and vulnerable people in target areas.

Output 3 score and performance description: A (Output met expectation)

Overall output score is A, reflecting continuous progress by the Consortium, in the delivery of health services.

Strong progress has been made in improving the access to health services in target areas. Some targets have been met or passed such as those for immunization, Antenatal Clinic (ANC) 2+ coverage, basic nutrition to children and Pregnant and Lactating Women (PLW) and work with private sector pharmacies. However in other areas targets have not yet been met. This is mainly due to the fact that services have had to be scaled down to only 3 accessible districts in Gedo due to insecurity.

Targets have been exceeded across the regions for basic nutrition services to children and pregnant lactating women. It was originally planned that HCS would cover Out Patient Therapeutic (OTP) services, however that has now been taken over by separate UNICEF funding and therefore HCS targets for OTP should be removed from the logframe. This also applies to Multi Social Marketing of Micronutrients (MMNs) for pregnant and lactating women for Somaliland which has also subsequently been taken up by UNICEF and therefore been suspended in agreement with DFID.

In the last annual review it was recommended that the fistula indicator be changed to FGM/C activity based targets focusing on advocacy rather than fistula repair. The indicator still relates to fistula but rather reports on the number of cases either referred (Gedo) or treated (Sahil).

Data quality and uncertainty over population data is still a concern for the entire health sector. Both MOH in Somaliland and Puntland have released population figures below the current estimates used by HCS partners. This makes population coverage figures uncertain and partners may be underestimating coverage for indicators under this output.

Output Indicator	Milestone 4 (2014)	Progress	Output Description
Indicator 3.1: % of under-ones, including poor and vulnerable vaccinated (received DPT 3) through health facility and outreach vaccination.	Gedo - 75% (6,356) Sahil - 65% (5,720) Kakaar - 55% (8,000) Total=20,076	Gedo : Met: 76% projected (69% actual to end May, projections show milestone will be met by end of June) Sahil: Moderately exceeded: 70% (milestone exceeded - actual to end May); Kakaar: Moderately exceeded: 62% (milestone exceeded - actual to end May) Total = 17116 (actual to end May);	A (met expectation)
Indicator 3.2: % of pregnant women having Antenatal care (ANC)2+ and/or ANC3+	Gedo - 80% (6,536) Sahil - 55% (4,840) Kakaar, 65% (7,583)	Gedo : Not met– 75% (ANC2+) (projected) Sahil – Substantially exceeded 100% (ANC2+) - (actual to end May) Kakaar – Moderately exceeded 71% (ANC2+) (actual to end May)	A (met expectation)
Indicator 3.3: Quality improvement score of health facility– MCHs and hospital (through EPHS criteria based, score cards)	Gedo - Scorecard assessments show an overall 20% improvement Sahil - Scorecard assessments show an overall 50% improvement Kakaar - Scorecard assessment show 25% overall improvement.	Gedo- Not met. – Improvement data not available, baseline now established. Sahil – Not met: Baselines have now been established. 25% improvement. Kakaar: Not met: Baselines have now been carried out - 17% improvement	B (Not met expectation)
Indicator 3.4: Proportion of births attended by an SBA	Gedo - 22% of births (1,864) Sahil- 30% (2,650) Kakaar - 30% (3,000)	Gedo: not met: 17% (1500) Sahil Moderately exceeded: 36% (3155) Kakaar: Met: 28% (2744) – expected to meet target at end	A (met expectation)

		of June based on previous quarters reporting Total = 7399 (actual to end May)	
	Total=7,514		
<p>Indicator 3.5: No. of Private sector franchise pharmacies in target areas where 4 agreed health products are consistently available</p> <p>Products are:</p> <ol style="list-style-type: none"> 1. Aqua tabs 2. Diarrhoea Treatment Kits 3. Oral contraceptives 4. 3 month Injectable contraceptives 	Somaliland - 200 Private sector pharmacies carrying at least 4 Products with no stock-outs	<p>Milestone met: 203 pharmacies in Somaliland Franchise Network (SFN). PSI reports that the number will soon rise as the programme was on hold pending MOH signing the MOU and now this has been resolved expansion to semi-urban areas will start.</p> <p>No stock outs reported.</p>	A (Met expectation)
<p>Indicator 3.6: Harmful effects of FGM being addressed</p>	<p>Gedo - number of patients referred for fistula repair annually</p> <p>Sahil - number of patients treated at Berbera hospital for fistula repair annually</p>	<p>Milestone met: Gedo: 1</p> <p>Milestone not met: Sahil; 0 HPA has been unable to treat patients in Berbera Hospital this year as the Hospital did not have the medical equipment required for this procedure. The equipment was procured at the beginning of June and a doctor was trained in fistula repair earlier this year and it is anticipated HPA will start reporting against this indicator in Year 5. HPA has in the meantime focused on developing a GBV management information database to report FGM, rape and other harmful practices in the region. An SGBV Forum was created to monitor and discourage acts of GBV in the community. During this year 111 cases of GBV were reported up to end March.</p>	B (Not met expectation)
<p>Indicator 3.7: Access to basic and emergency nutrition services</p>	<p>Gedo - 4,000 children 6-59 Months treated and cured for SAM in OTP/SC per annum ,</p> <p>2,000 Pregnant and lactating women given</p>	<p>Gedo: Milestone to be removed as now funded by UNICEF: 2223 children 6-59 Months treated and cured for SAM in OTP/SC per annum (actual);</p> <p>Milestone substantially exceeded: 6,868 Pregnant and Lactating Women (PLW)</p>	A++ (Substantially exceeded expectation for basic nutrition to children and PLW. However OTP targets not scored as they are now funded by UNICEF)

	<p>MMN</p> <p>Somaliland: in three major districts Micronutrients, nutrition supplements provided to 13,300 to Children < 5 and 300 pregnant women through CCM;</p> <p>Sahil - Hospital and 4 MCHs and 2 RCHS will provide basic nutrition services to 8,000 children and 12,000 PWL and OTP services to 1,250</p> <p>Kakaar - Supplementary nutrition services at all Maternal and Child Health (MCH) facilities and RHCs targeting 12,000 <5 children and 10,000 pregnant and lactating mother</p> <p>Total= 37,300</p>	<p>given Multi Social Marketing of Micronutrient (MMN).</p> <p>Somaliland: Milestone to be removed as now funded by UNICEF: MMNs for pregnant and lactating women were suspended in agreement with DFID.</p> <p>Sahil: Milestone to be removed as now funded by UNICEF: OTP services to 579 children Milestone substantially exceeded: Basic nutrition to 26,254 children and 20,253 PLW</p> <p>Kakaar: Milestone substantially exceeded: Children <5 basic nutrition – 23,239); Milestone partially met pregnant and lactating women – 6868</p>	
Indicator 3.8: Couple years protection (CYP) through social marketing in Somaliland	2300 CYP per annum through social marketing	Milestone moderately exceeded: 2589 CYPS generated through oral contraceptives and Injectables	A+(moderately exceeded expectations)

Indicators revised since last Annual Review? Yes (see Annex C). Recommend revisions to all milestones for Yr 5.

Progress against expected results:

Impact Weighting : 40%

Revised since last Annual Review? No revision since last review.

Risk: Low

Revised since last Annual Review? No Revision.

Output 4 - Citizens and services working together for accountability and increased awareness and access to good health (especially Mother and Child Health (MCH) best practice)

Output 4 score and performance description: A (Output met expectation)

The Consortium is making steady progress under output 4 with an overall score of A.

There were challenges in reaching the targets set for Indicator 4.1 for year 4. Female representation in Gedo is below target in 3 DHBs. However, elections for DHBs are only held once every three years with the next election due at the end of 2014. Therefore, this milestone could not be met for year 4. In Kakaar, CHCs have 7 members; therefore it is only possible to have over 50% female representation. The composition of the RHB is beyond the control of HPA as key members are influential businessmen who have access to resources from port levies therefore HPA is unable to directly influence this.

The programme has successfully introduced and supported health committees at different levels with appropriate gender balance. In Sahil CHC members through outreach programmes reach approximately 2500 community members per month with health messages and the promotion of health seeking behavior.

The indicator on number of women reached with BCC messaging was originally developed for PSI's IPC programme. However, this indicator is now also reported by HPA and SCI and a wide range of communications channels and approaches are being used by these partners.

Output Indicator	Milestone 4 (2014)	Progress	Output Description
<p>Indicator 4.1: % of members of functioning health committees/boards who are women or from vulnerable populations</p>	<p>Gedo - (33%) 4 women in each DHB, evidence of active engagement by female members</p> <p>Sahil - Evidence of active engagement by female members in RHB would be 30% and CHC would be 40%</p> <p>Kakaar - 50% of CHCs female, Evidence of significant decision making in health matters</p>	<ul style="list-style-type: none"> - Gedo: Milestone partially met Belet Xaawo and Dollow have met the target of 4 female members. Belet Xaawo has 4 members while Dollow has 5 female members. Burdhubo DHB has only 1 female member; Luuq and Garbahaarey have 3 members. Elections of DHB members takes place every three years and next elections due end 2014 therefore not possible to change female representation in DHBs not meeting target of 4 women. - Sahil: Milestone partially met HPA continued to support 21 fully functioning Community Health Committees (CHCs). HPA also works with the Hospital/Regional health board. Of the total members of health committees, over 40% members are female. 14% of RHB members female. Level of female membership of the RHBs in Sahil remains below the target. This is because the RHB has access to resources from Port levies and key members are influential businessmen therefore HPA is unable to directly influence this. - Kakaar: Milestone met: 45% of active Community Health Committee (CHC) members are women. CHCs have 7 members therefore only possible to have more than 50% female representation. <p>The reviewers held discussions with CHCs in Sahil and Kakaar that confirmed HCS reports of active participation of female members of committees.</p>	<p>B (moderately did not meet expectations)</p>
<p>Indicator 4.2: Number of women reached with at least one behaviour change communication message on how to reduce maternal and</p>	<p>Somaliland - 10,000 people reached with messages in all 4 key areas</p>	<ul style="list-style-type: none"> - Somaliland: Moderately exceeded PSI reaching 10,622 women through Interpersonal Communication (IPC). Mass media via radio, TV etc also conducted but not currently being reported. 	<p>A+ (Outputs exceeding expectations)</p>

child morbidity and mortality.	<p>Sahil: 15,000 women reached with messages in at least one of the 5 key areas</p> <p>Kakaar: 10,000 women reached with messages in at least one of the 5 key areas</p>	<p>- Sahil: Met 14,779 women reached by May 2014. Based on numbers of women in previous quarters this target will be met. HPA also broadcast through local radio as well as holding local meetings and outreach drama work. In addition HPA holds 5 day outreach at the end of each month in communities which includes a component of health education on maternal and child health.</p> <p>- Kakaar: Moderately exceeded 10,300 (until end March) numerous community dialogue sessions and mother-to-mother mentor sessions are held at village level. IPC sessions started in February 2014 in 9 HC/RHC's. From February to May 2014, SCI conducted 608 sessions and reached 2,000 WRA. SCI conducts FM radio messaging targeting WRA in Gardo which is estimated to reach 8,000 WRA.</p>	
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Indicators revised since last Annual Review? (see Annex C) Recommend revision to indicator 4.1 and milestones for Yr 5.

Impact Weighting: 15 %

Revised since last Annual Review? No revision since last review and none recommended

Risk: Low

Revised since last Annual Review? No revision recommended

Output 5 - Better harmonised and prioritised aid to the Somalia health sector

Output 5 score and performance description: A+ (Outputs moderately exceeded expectation)

Overall output score is A+ which includes 1 A+ and one with no score.

Indicator 5.1 had no milestone for 2013. DFID however supported some sector wide studies including 'Enhancing a Sector Wide Approach in Health' in conducted in September 2013 and a desk review of 'service delivery in a failed state' conducted in January 2014. HCS funding through DFID for Health Sector Coordination Office (HSCO) stopped in September 2013 following recommendations from the Health Sector Institutional Analysis report. These functions have since been moved to the JHNP.

HCS has made considerable progress in the area of dissemination of best practises and lessons learnt during the past year both internally amongst members of the consortium and DFID and externally with other key stakeholders especially the Joint Health and Nutrition Programme. In particular the Consortium has:

- Updated the SHARE website from an internal knowledge management website to an external information sharing website open to the public.
- Developed an internal strategic plan and communications strategy outlining key areas and channels for dissemination.
- Shared best practises and lessons learned through exchange visits, following a workshop hosted by the MOH in Puntland held in May for all EPHS partners contracted under JHNP in which SCI was asked to share its approach and best practises on EPHS service delivery

A new indicator on stability and peace was not developed due to challenges on measuring methodology and reporting.

Output Indicator	Milestone 4 (2014)	Progress	Output Description
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Indicator 5.1: Extent to which Health Systems Strengthening approach is implemented	NO LONGER RELEVANT TO THE PROGRAM – JHNP FOCUS	Support provided for sector wide studies including: 'Enhancing a Sector Wide Approach in Health and A review of Service Delivery in Fragile States.	
Indicator 5.2: Coordinated and harmonised, Bilateral and Multilateral funding	NO LONGER RELEVANT TO THE PROGRAM - MOVED TO JHNP	Support provided to HSCO and Health Sector Committee (HSC) and Health Authority Board (HAB) until Sept 2013. Following recommendations from a review of Institutional Arrangements for Health Sector Coordination, these functions were moved to the JHNP.	
Indicator 5.3: Models of health care delivery documented and disseminated with relevant stakeholders	Submission of at least one article to peer reviewed journal Dissemination of HCS best practices and lessons learnt, including EPHS review, with relevant health stakeholders	Peer review article based on Client Satisfaction underway. Article submitted to Global Health Action journal and pending approval. A poster presentation on the article has been accepted at the Third Global Symposium on Health Systems Research 2014 in Cape Town – 30 th September-3 rd October 2014. Presentations on HCS achievements and progress made to 1) Health Sector Committee in Nairobi, 2) Health and Nutrition meeting in Puntland, 3) MOH Conference in Somaliland, 4) Sharing lesson learnt from EPHS roll-out in Kakaar during workshop for all EPHS Partners in Puntland to inform new JHNP partners. Press release on HCS in Somali media.	A+ (Moderately exceeded expectations)
Indicator 5.4: New Indicator on Stability and Peace Building to be included	TBC	No milestone so no judgement can be made here. No action has been taken by the HCS on this topic.	Remove the indicator

Indicators revised since last Annual Review? (see Annex C) Recommend removing 5.1 & 5.2 and 5.4

Impact Weighting: 5%

Revised since last Annual Review? No

Risk: High

Revised since last Annual Review? This rating should be changed to low as the output is now only focusing on documentation and dissemination

Section B: Results and Value for Money.

1. Progress and results

1.1 Has the logframe been updated since last review? Yes

The logframe has been updated since the previous based on recommendations where indicators, milestones and assumptions could be improved through limited changes. Numerical targets were revised to make them more stretching to achieve as year 3

results were exceeding outer year targets. . In many cases new milestones were developed or added to logframe indicators to reflect changes. Revisions are attached in Annex C.

1.2 Overall Output Score and Description: A

Summary of performance scores for each output:

Output	Description	Score	Impact weighting
Output 1	Functioning institutional frameworks and systems to support improved health services in place in target areas	A	10%
Output 2	Health personnel trained and employed to agreed standards in target areas	A+	30%
Output 3	Quality health service delivery, appropriate and prioritised for poor and vulnerable people in target areas Somaliland	A	40%
Output 4	Citizens and services working together for accountability and increased access to good health	A	15%
Output 5	Better harmonised and prioritised aid to the Somalia health sector	A+	5%

The programme is scoring an A - meeting expectations. Now in its fifth year of implementation, many of the original issues have been addressed and the programme has concentrated on strong service delivery results whilst being able to try innovative approaches to help them meet their deliverables. However, some activities are not represented in the original logframe indicators but are nonetheless contributing to the overall programme impact. The additional budget of £950,000 allowed the programme to maintain the continuous and uninterrupted maternity services that had previously been established, to strengthen the referral mechanisms, to scale up immunization services to children under five years, as well as to develop the National Clinical Officers' training curriculum.

Additional achievements of the HCS:

These are additional achievements which are not in the current logframe but are worth noting:

In Somaliland

1. Medical skills laboratories and clinical coordination offices constructed in training institutions and teaching hospitals
2. Somaliland national Internship programme reinstated
3. Produced one off cohort of Nurse Training Tutors
4. Renovation of Berbera Hospital Mental ward
5. Ongoing support to Somaliland Nursing and Midwifery Resource Center
6. SOMLA now able to function as independent organization.

In Sahil

7. Several facilities have been upgraded to higher levels:
 - o Sheikh & Lacidle from HC to RHC
 - o Sheikh RHC to District Hospital
 - o Suuqsude PHU to HC
8. Expansion of solar energy in Sheikh and Berbera Hospitals. Berbera Hospital will be able to save \$20,000 per month on fuel/electricity costs which will feed back into services. This initiative is being extended under the ESRES project.
9. Construction of a regional cold chain building in Berbera. Four shops have also been constructed at the site which will generate income to support services.
10. Construction of a new pediatric unit at Berbera Hospital and OT building in Lacidle RHC
11. Construction of 2 new PHUs – Haayeti and Ceel-Shiekh
12. Revolving Drug Fund in Sheikh District Hospital which contributes towards support costs (staff salaries)
13. Referral system strengthening with a newly procured boat ambulance to serve hard-to-reach coastal populations
14. Jamalaaye HC is now open 24 hours with 8 hour 3 shifts managed by staff and this has successfully increased utilization to the vulnerable IDP population it serves.
15. Health facilities are disability friendly with wheelchair access
16. More focus on SGBV/FGM advocacy work
17. Women's Insurance Groups

In Kakaar

18. Cyclone Response: Outreach emergency health services covered 20 hard-to-reach villages affected by Puntland cyclone in Banderbayla and Hafun districts. Outreach health services provided lifesaving support to cyclone affected communities; 1,970 patients (29% <5yrs children and 35% PLW) were provided with complementary health activities; distribution of ORS, aqua tabs, vitamin A, and health education
19. Solar installation completed in Gardho Hospital and solar lights installed in 25 PHUs
20. Gardho Hospital maternity ward expansion and procurement of essential equipment: incubators, ultrasound, portable x-ray, anaesthetic and sterilization machines
21. Placenta pits and incinerators installed for Health Facilities
22. Rehabilitation and renovation of 2 PHUs, 2 RHCs and 3 HCs
23. Studies conducted on pastoralist communities, barrier analysis, cross-sector study, IPC KAP to inform evidence based programming
24. IPC Agents trained and conducting sessions at health facilities and linked to Female Health Promoters and to ensure follow-up in the communities.

In Gedo

25. Despite a complex operating context and security issues Trocaire has managed to change from a Remote Management Structure to a field operations structure with a strong staff presence providing on-the-job training and more structured and effective technical assistance and support
26. Recruitment & placement of technical staff in the field – HMIS, nutrition, Doctor & midwives
27. Close monitoring and supportive supervision of services by Trocaire team in three Major accessible districts (BX, DL & LQ)
28. Direct engagement of DHBs leading to placement of several local staff
29. Liaison office in Mogadishu leading to full participation of all MOH demands
30. IPC Agents have been trained by PSI and will start conducting sessions with women of reproductive age to promote key maternal and child health information and encourage utilization of services. This is also a major achievement as the majority of IPC Agents were male breaking through a preconceived cultural barrier which relied on only women discussing MCH issues with other women.

New Structure for HCS:

31. HCS has two new full time staff working on the project to provide support and assistance to the Consortium. A Grants Manager based in Hargeisa was hired in January and a full-time Technical Advisor recruited in February based in Nairobi who travels frequently to Somaliland and Puntland. The Technical Advisor is increasingly supporting more consortium wide working and better integration of data. Examples of the role includes: liaison with DFID and key stakeholders in Nairobi, Observer status granted at the JHNP Technical Coordination Group meetings, Civil Society Representative at the JHNP Steering Committee, better planning and coordination with Health Authorities in the zones, representation at HSC meetings in Nairobi, review and input into key health sector activities: coordination and planning with HSAT to ensure HCS input into HSS work in Somalia M & E Framework, Joint Annual Review and Annual Work Plan process with Health Authorities to align HCS activities with HSSPs, sharing information from global and regional literature; reviewing quarterly reports; The Technical Advisor also conducts joint quarterly supervision and monitoring of partners in conjunction with the HCS Grants Manager.

1.3 Direct feedback from beneficiaries

The reviewer travelled to Somaliland and Puntland and met with government officials and JHNP partners including the Joint Coordination Unit in Nairobi. This afforded the opportunity to meet and speak directly with ministry, regional and local officials as well as with the staff and clients at health facilities benefiting from the programme. Site visits were conducted to health facilities in Sahil and Kakaar Regions, and in Hargeisa the reviewer met with beneficiaries (pharmacists) from the Social Franchise Network "Bulsho Kaab" and women attending IPC sessions.

Senior health officials have expressed their full support to the HCS. However officials also stated that more government participation, collaboration and ownership of HCS is necessary to ensure the HCS aligns more closely with health sector priorities. The change in leadership of key Ministry officials has been a challenge for the Consortium. Despite this, the EPHS programme implemented by HCS in Somaliland has been cited by the Minister as a huge success and established the benchmark for the upcoming roll-out of EPHS under the JNHP.

The MOH in Puntland works extremely closely with SCI and their immediate and lifesaving support to communities following the cyclone in 2013 was seen as key. The Minister of Health in Puntland has also requested support from HCS partners such as THET and PSI to work more closely with MoH in areas of Human Resources development (especially clinical officers), Leadership and Governance and private sector work in line with MoH priorities.

A more positive relationship is now also developing with the Federal Government officials in Mogadishu. The Acting Director General of the MoH pointed out that not only were services improving in Gedo but that the new liaison office had greatly improved Trocaire visibility and collaboration with Mogadishu.

HCS has been acknowledged by all health authorities as an innovative implementing partner that is adaptive and responsive and has improved service utilization by mothers and children in Somalia. With the newly launched JHNP EPHS programme, stakeholders have also expressed interest in learning from HCS experiences and building on proven initiatives rather than trying to start untried and untested activities from scratch.

All officials expressed deep concern about the sustainability of the HCS EPHS. It was also noted that sustainability mechanisms for EPHS needs to be further explored outside of donor funding; for example cost-sharing activities providing complimentary support for EPHS services; use of funding mechanisms such as the World Bank MPF and the Somaliland Development Fund.

Discussions with local CHCs and women accessing services all included positive feedback on support provided by HCS partners – and in many cases this has inspired communities to take ownership and contribute towards EPHS. For example, health staff in Xingood Health Center (Kakaar region) are paying for the construction of a health education unit within the facility compound from their own salaries and the CHCs have helped to provide building supplies and cleaning equipment to support. More detailed beneficiary feedback is included in Annex A.

1.4 Summary of overall progress

Overall progress across the HCS has been strong and consistent across all outputs. The output objectives have all been largely met with some areas of substantial progress in advance of targets and a few that can be improved. The programme has continued to provide practical support to policy, strategy and HR systems. This is particularly evident in Somaliland where key achievements have included developing a HRMIS system, completion of the health work force survey in Somaliland, a focus on long-term health cadre development – BSc Nurses and Midwives, Clinical Officers, Community Health Workers, Nursing Tutors, medical internship programme, construction of medical skills labs in addition to support to Health Training Institutions, Professional Associations and NHPC. Innovation has continued as the cornerstone for service delivery in the EPHS in the three zones, referral systems have been strengthened through provision of ambulances and the transformation of TBAs into birth companions (Sahil), increased focus on FGM & SBV includes training of health staff, community advocacy, referrals for medical complications and psycho-social counselling, SGBV database in Sahil and linkages with access to justice. In addition the Consortium is now expanding into other core areas of the EPHS: mental, dental and eye care in Somaliland. Partners have increased outreach initiatives and health education through IPC sessions to increase access to services by communities that are harder to reach.

The five consortium partners are working well together and have continued to achieve results in a difficult and changing environment. All partners have strengthened their relationships with government counterparts and have helped to build the capacity of the Ministries of Health in Somaliland and Puntland as well as at the regional facility levels. HCS has proven to be good at implementing and delivering on its specific targets, and more recently has started to demonstrate its comparative advantage, share best practices and link up with other programmes and initiatives. HCS is now working closely with JNHP on planning and coordination to avoid duplication of activities which was noted as a weakness in the previous annual review.

The majority of the recommendations from the last annual review have been implemented (Annex D). There is still the need to strengthen the Consortium's approach to institutional development and further build on the dissemination of best practice and lessons learned. Following the 2012/13 AR, milestones were reviewed by all partners.

1.5 Key challenges

Political and social

1. Major changes in the security and political situation have taken place in the last year and this is rapidly changing the context in which the HCS is operating. The ever changing security situation, especially in Gedo, directly impacts service delivery. There has been a change in the leadership of the MoHs which has meant a lack of continuity and direction for the health sector. The HCS has had to raise awareness on the impact of its work in order to build relationships with the Ministries, in particular with the FGS, to ensure greater collaboration in supporting a government led health sector strategy. The HCS must continue to monitor, analyse, reflect on and respond to this changing context, taking into account government priorities whilst ensuring the views of the communities they serve are reflected to ensure its work provides optimal support to health sector development. This will be a challenge for each partner in different ways and close collaboration of the Consortium will be useful for sharing information and establishing new ways of working.

Planning and Management

2. The Consortium has historically struggled to plan and strategise as a single unit and this has meant that longer-term strategic planning has been difficult to achieve. With a strategy now in place the Consortium is now better placed to position itself in the health sector as a major player.
3. Sustainability planning is more than ever a high priority for the programme and more attention is needed in these areas if the HCS is to remain at the forefront of thinking in the sector. This will require careful positioning and a review of how the HCS links to the wider health sector discussions and programmes (JHNP) as well as the move to decentralised planning and management.

Technical

4. There have been challenges with duplication and overlap between the work of the Consortium and JHNP. The roll-out of the JHNP EPHS and overlap of support for HRH and Leadership and Governance in Somaliland in particular, requires agreement to avoid duplicative or unsustainable initiatives. Challenges remain in the area of workforce planning and payroll and this will grow as EPHS is rolled out with the ensuing need for expansion and retention of trained staffing in the public sector. Challenges exist and will increase on issues around quality of care and these will be increasingly highlighted as demandside work increases and more local accountability mechanisms are put in place through the JPLG
5. Specific technical and cultural challenges also remain such as: how best to increase the uptake of modern family planning methods; how to ensure abandonment of FGM/C practices; how to reach remote communities; and, how to ensure more sustainable financing across the sector. There is a lack of evidence and best practice to draw upon to tackle these challenges. The HCS in turn needs to add to the body of evidence.
6. The HCS has struggled to document and share information during the last year, due to a lack of technical capacity. Documentation and information sharing needs to be scaled up to ensure the development of a useable evidence base for better decision-making.

1.6 Annual Outcome Assessment

Targets for year 4 of the project were updated in the logframe following the 2013 annual review. In general the HCS is making good progress against outcome level indicators.

Outcome: Somali people, especially women, children and the most vulnerable, increase utilization of quality health services contributing to MDGs 1,4, 5 & 6 in target areas

Outcome Indicator	Milestone 4 (2014)	Progress	Assessment
Utilization rate (from number of outpatient visits per person per year) in project area health centres (Disaggregated by women and children under 5 years)	Gedo – 1.0 visit per person per year Sahil - 0.6 visits per person per year Kakaar - 0.6- visits per person per year	Gedo: 0.80 Sahil: 0.57 Kakaar: 0.67 Good progress across intervention regions. Targets for some data/denominator still remain questionable. In Gedo OPD attendance is now normalizing due to data correction by new HMIS team. Milestone for Gedo for year 4 was updated from 0.8 to 1.0 visit per person. However this may be unrealistic given previous data inconsistencies, population movement and scaling down of activities due to insecurity.	Good progress
Client satisfaction with services as a proportion of persons interviewed through exit poll	Gedo - 80% of all persons interviewed. Sahil - 80% of all persons interviewed Kakaar - 85% of all persons interviewed	No Consortium survey planned for this year, but partners conducted small scale exit surveys Sahil: Six indicators of client satisfaction (Welcoming, waiting time, cleanliness of facility, privacy of clients, consultation time and over all service) used. >87% of women rated aspects of service as good to excellent (Oct.-Dec 2013)	Good progress.

		Gedo. A repeat client satisfaction survey is planned to take place in July-Sept 2014. Kakaar: Exit Interviews were carried out with 100 women in April 2014. The initial data shows that 71% interviewed were satisfied. However, the scorecard questions need to be revised / updated to reflect questions used in the external client satisfaction survey.	
Average number of caesarean sections per month	Gedo - 5 per month Sahil - 7 per month (from Berbera Hospital and 2 RHCs) Kakaar -9 per month in Gardo Hospital	Gedo: 5 Sahil: 6.3 Kakaar: 7 In Sahil, data from Berbera hospital only. RHCs are currently being upgraded. . Gedo: In March 2014 Luuq hospital carried out the first C-Section Kakaar: C-sections only possible at Gardho Hospital. There is a need to upgrade RHCs.	Good progress
Modern Contraceptive Prevalence Rate (CPR) :modern methods women 15-49 years	No milestone (To be measured at the end of the programme)	MICS data from 2011 for Puntland and Somaliland shows extremely low CPR amongst women using modern methods. Somaliland 1.5% Puntland 0.2%	No milestone for year 4

2. Costs and timescale

2.1 Is the project on-track against financial forecasts: Yes

Although HCS is working in a highly complex environment, it has managed to stay on track against its financial forecast. The expenditure at March 2014 was £10.8m or 97% of the annual project budget for the 2013 financial year. The underspend of 0.34 was mainly due to two reasons:

1. Change in MoH leadership in Somaliland: between August 2013 and November 2013 the senior management of the MoH Somaliland has been replaced by a new team. This has delayed program implementation, mainly for PSI and THET, thus affecting the level of spending.
2. Security and challenges on the Kenya-Somalia border, impacting on Trocaire's capacity to deliver goods and commodities to the Gedo region.

2.2 Key cost driver:

The main cost driver is insecurity; a worsening security situation can cause significant challenges to programming and implementation. In addition the following key elements drive up costs within the HCS programme. While not exhaustive together they play an important role.

1. A large percentage of the population in Somalia live in **remote and hard to reach places and have pastoralist lifestyles**. This places a higher burden on the cost of delivering the EPHS to this population. Costs are driven up due to the need for transporting commodities, supplies and salaries long distances to remote facilities. The cost of supervision and emergency referral system are also affected and ultimately the overall cost of service delivery.
2. A report on **Human Resources for Health – Remuneration, HR and payroll process issues related to the introduction of the 'medium scenario'** was commissioned by the HR Donor Working Group as a follow-on from the 2013 HR payroll review to provide guidance on how to move towards the medium level scenario agreed by the Health Advisory Board in 2013. This scenario would see HCS salary scales increase substantially for some partners. HCS has been supporting government staff top ups primarily at facility level, and the health authorities are looking to HCS partners to consider paying their health workers in line with this medium level. This increase has not been programmed into the budget of the HCS and cannot be paid out without having a negative impact on other services. In addition, some HCS partners (SCI and HPA) have been subcontracted to implement EPHS under the JHNP. The JHNP PCAs will pay the medium level scenario for

staff – coming to approximately 40% of the overall budget which HCS partners will not be able to match. This may create backlash against HCS partners who are unable to pay the same rates in HCS regions due to lack of additional funding in the current budget.

3. In response to the **lack of reliable utility services** the HCS partners have invested in alternative supplies of electricity and water. Solar panels have been installed in health facilities necessitating substantial investment – for example installation of solar systems in Berbera and Sheikh Hospitals is \$195,000 per Hospital. Rainwater catchment structures built to ensure continuous and reliable supplies.
4. **Commodities:** HCS partners are procuring commodities for health facilities due to unreliable and inconsistent UNICEF supplies (this excludes vaccines and nutrition supplies). Each partner has its own procurement system and individual suppliers are selected based on individual partner organizational procedures. This, however, has led to higher costs for commodities.

2.3 Is the project on-track against original timescale: Yes

The HCS programme is on-track against the original timescale.

3. Evidence and Evaluation

3.1 Assess any changes in evidence and implications for the project

The Theory of Change and the assumptions used in the project design remain valid. There is no evidence that would challenge the original project design and rationale.

The overall paucity of data in Somalia remains and is a major concern in the health sector across all zones. The improvement in HMIS data in the HCS regions is a good example of the importance of having some data on progress. The results of the UNICEF multi-indicator cluster survey UNICEF MICS (4) 2011 provide some up to date national health statistics but this is for Somaliland and Puntland and does not cover South Central Somalia. To address this gap WHO has conducted a survey in three regions of central and southern Somalia. The results of the survey will be used to monitor progress and evaluate the impact of the JHNP. The main outcome of the survey will be to provide evidence-based decision-making and improve resource allocation for an equitable delivery of health services by providing baseline data on key MCH Indicators. Initial results are expected later this year. In addition, WHO and the University of Aberdeen, funded by DFID Somalia, have conducted a Maternal Mortality survey in Somaliland. Data collection has been completed and analysis and report writing is on-going. A UN Joint report on Trends in Maternal Mortality: 1990 to 2013 (Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division) released in 2014 has estimated that the Maternal Mortality Ratio is 850/100,000 in 2012, a reduction from 1,000/100,000.

Current reporting is still undermined by the lack of accurate population estimates as a basic denominator. The Ministry of Health in Puntland has recently sent out a revised list of population estimates to ensure that all partners are using the same data. However population data for Kakaar region has been estimated as 160,908 and SCI have been using 180,000 to calculate denominators. In Somaliland, the Ministry of Health has approved and released population estimates from 2010 onwards. The population estimates currently being used by HPA from 2013 for Sahil region are higher than those released by the MOH – 220,000 versus 206,903. Overestimation of population denominators will result in under-reporting of key indicators for HCS and this issue needs to be resolved at a broader health sector level. It may be advisable for HCS to wait for the results of the UNFPA Somalia Population Estimation Survey (PES) before updating population denominators in the project areas. The PES results will provide the Somali government with reliable population estimates and basic socio-demographic and socioeconomic characteristics of the population (age-sex distribution, marital status, mortality, literacy, education, economic activity, gender disparities, and immunization status). For HCS it will also enable more robust calculation of progress against coverage or population based indicators and milestones. The first report with population figures has been delayed and is currently being released and two subsequent technical reports will come out later.

Independent monitoring and verification has been conducted on two HCS areas of service delivery; Support to Berbera Hospital Somaliland; Support to Hingood Health Centre Puntland. The results of both have positively endorsed the implemented activities; objectives are being met and there are no concerns that activities have not taken place. One other HCS verification is currently taking place. Further verifications are planned.

A pilot 2 year cash transfer programme is being designed with HCS partners, to test and evaluate the impact of a cash or voucher based system on specific health outcomes. Lessons will be shared with key health stakeholders.

3.2 Where an evaluation is planned what progress has been made?

No evaluation was planned in the original Programme Memorandum. However in September 2013 DFID commissioned an independent review of the EPHS pilot implemented by HCS in three regions. The review presented some key lessons learned and innovations from the pilot phase and made recommendations moving forward (See Annex E). HCS developed a plan to address recommendations made in the review and follow-up on action points are being addressed by partners.

4. Risk

4.1 Log frame output Risk Rating: Medium

- Output 1: Low
- Output 2: Low
- Output 3: Low
- Output 4: Low
- Output 5: High

Risks are considered low as the programme has a strong management design, managed by an international NGO and implementation carried out only by INGOs. The risk rating for output 5 is to be changed to low as revisions will be made to the indicator.

The business case risk rating: Medium

Risk	Mitigation	Direction of Travel
<p>1. Governance and conflict related risks Operational, financial and political factors inhibit achievement of project purpose</p>	<ol style="list-style-type: none"> 1. PSI as lead agency has strong financial management systems in place. 2. Strong political support in general (with some issues faced regarding Gedo/JHNP now resolved) 3. There are quarterly meetings of all partners with DFID and quarterly narrative and financial reports on progress. 4. DFID leading work underway to review payment of Govt staff top ups (given significant cost to HCS), and need to ensure harmonisation with other partners and sustainable strategy for this. 5. NGOs play continual role of assessing changing risk situation and access 6. DFID support to some facilities in Gedo has reduced with problems of access. Trocaire decision to use own funds for certain areas. Remote management was also in use for some facilities. 7. HCS partners all have strong relationships with local communities, local government and Ministries of Health. (Gedo less so but improving) 8. Partners reporting format has been revised to help capture application of do no harm principles. 9. Research work done to assess health contribution to peacebuilding and statebuilding more discussion to be held across teams. 10. HCS Communications work is under review, with some external support to improve dissemination of best practices and results. 	Static
<p>2. Fiduciary/Financial risks</p>	<ol style="list-style-type: none"> 1. HCS spend is on track and extra funds are being programmed 2. Separate HCS audit for Jan-Dec 2012 conducted and a 2013 one planned mid-year. 3. VFM reporting mechanism in place with agreement on qualitative and quantitative indicators and regularity of reports. First report was submitted on 15th November (give evidence), Qualitative report due on 15th May 2014. 4. HCS spend is on track and extra funds are being programmed 5. The annual audit assessed the overall fiduciary risk as low, as the risk is spread between the implementing partners who are all INGOs. It identified higher risks related to logistics and supplies and places where remote management is in place (Gedo). HCS audit identified some areas of risk and the same were addressed by PSI. 6. 3rd party monitoring pilot is ongoing and is expected to identify any areas of risk. 	Static

3. Operational Risks	<ol style="list-style-type: none"> 1. The EPHS review conducted in October shows very positive results on the delivery of services for women and children 2. Revision of client satisfaction feedback tool will ensure continual and consistent monitoring of beneficiary satisfaction. 3. A new dash board is being introduced to monitor results and to provide an analysis to be used to address areas of weakness. 4. Ongoing 3rd party verification should highlight any risk areas 5. MoH leadership and capacity being strengthened by JHNP with strong HSSP in place with clear priorities for support. Work done by HCS through THET will be replicated across the zones to strengthen capacity. 6. MoH supportive of HCS in Somaliland and Puntland; the relationship with South Central needs to be strengthened. HCS is working on greater collaboration with all MoHs to ensure Gov ownership. 7. Links between JHNP and HCS are being strengthened and HCS is working to ensure representation at the zonal level. 8. A strategy to address improvement in health sector coordination has been developed and implementation will start in April 2014. 	Static
4. Risk of doing harm Capacity building and application of 'Do No Harm' principles. Provide continuous review of the local contextual analysis (socio-cultural, political, institutional, conflict, etc.)	<ol style="list-style-type: none"> 1. HCS partners review the local context every quarter and discussions are held at partner quarterly meetings to highlight any potential difficult situations or upcoming risks. 2. A political economy analysis has been conducted, which highlights areas of concern for key health stakeholders to consider. 3. HCS is improving its dissemination of best practices and sharing of lessons; facilitating exchange visits between health implementing partners. 4. HCS are reviewing the role of DHBs and RHBs in the health sector in relation to the wider health sector context. 	Static

4.2 Assessment of the risk level

The business case highlighted four principle risks namely; governance and conflict related risks; fiduciary/ financial risks; operational risks and risk of 'doing harm'. These were all considered by partners to remain relevant. Review of the risks is done in collaboration with the partners during the quarterly review meeting. Any change in the direction of risk travel is highlighted and documented for and follow up actions outlined.

4.3 Risk of funds not being used as intended

Overall fiduciary risk within the programme is low. The potential for the manipulation of logistics and supplies where remote management is in place is higher. The risk in the Gedo programme is therefore judged as higher than other parts of the programme where accessibility to international staff is lower. DFID has introduced a pilot third party verification process that should help identify any area of concerns.

Programme funds are channelled through Population Services International (PSI), the lead implementing agency for the HCS programme. There is little procurement under the programme and where undertaken it is under control of the Consortium partners and not channelled through government systems. PSI provides quarterly HCS narrative and financial reports incorporating all other implementing agencies, as well as the required annual financial audit reports. There are regular high quarterly review meetings that include aspects of management and financial control. The fiduciary risk is low due to the spread between 4 other INGOs with extensive experience of operating in the field in Somalia as implementers.

As we are not providing financial aid through government systems, the partnership principles do not apply in the detailed management and monitoring of this programme.

4.4 Climate and Environment Risk

The business case classified the climate and environmental risk for HCS as medium/manageable potential risk and high environmental opportunity. This remains the same. HCS has continued to use innovative facilities such as solar energy in Sahil and Kakaar regions, which is being extended under the ESRES programme funded under the ICF. They have demonstrated use of water catchment and safe and hygienic waste disposal.

5. Value for Money

5.1 Performance on VfM measures

Economy

HCS reported on unit costs for its main inputs for the first time in the Jan-March 2014 quarterly report. Unfortunately this was not done in a coordinated way and so each partner defined their input costs in different ways meaning that they are not comparable. Thoughts on how this can be done going forwards for each of the main inputs are below:

- Salary top-ups: HCS partners should ideally be complying with the new HR Policy 'medium scenario' monthly salary scales for Somali health workers. As discussed above (see Cost Drivers section) this may not be affordable under HCS, but the salary scales provide a benchmark to compare against. HCS partners should therefore report against the job titles in the HR Policy: a) what health workers in their zones are currently being paid by the government; b) what their salary top-ups are from HCS; c) the resulting total salary; d) the target salary in the HR policy; and e) the variance between c) and d).
- Commodities: partners should together choose a few drugs that they are all procuring and which are a high proportion of their commodities budget, and then just report on their prices. Their prices can also be compared with those of UNICEF.
- Training per-diem: these should be reported as per participant per day (see below for an initial discussion about how these vary).
- Vehicle rental: PSI and THET report this as per day, while SCI and Trocaire report it as per km. They also give different definitions as to the location. It is also unclear whether they are including the costs of fuel and a driver. Again it is necessary for them to agree among themselves how to do this in a consistent way.

Efficiency

It is in the estimation and reporting of service delivery output unit costs that HCS has been most innovative in terms of VfM, with help from VfM consultants funded by DFID in 2013. Data on the output unit costs for the first 6 months of the project (April – September 2013) and the second 6 months (Oct 2013 – March 2014) are given below.

Output unit costs (£)

Output unit cost	HPA		Trocaire		SCI	
	Apr-Sep	Oct-Mar	Apr-Sep	Oct-Mar	Apr-Sep	Oct-Mar
Cost per birth attended by a skilled birth attendant	14	32	95	44	39	35
Cost per ANC2+	2.1	4.8	3.3	10.4	12.1	12.1
Cost per Outpatient visit	1.1	2.0	2.2	2.1	4.2	3.4

Cost per community health worker trained (THET): fell from £4,078 to £3,493.

Cost per couple year of protection (PSI): increased from £238 to £346.

These output unit costs show significant variation over time: all of HPA's unit costs doubled; Trocaire's halved for births but trebled for ANC2+; while SCI's remained relatively constant. They also show significant variation between partners, although the differences are evening out over time. In the June 2014 partners meeting the reasons for the changes over time were discussed and appeared to be composed of four main types. Each is briefly discussed below:

- Lumpy expenditures: medical equipment (a key reason for the doubling of HPA's unit costs); training costs (Trocaire); salary increases (Trocaire); consultant costs (THET), and launch costs (THET). This is a problem with comparing output unit costs over short time periods. The suggested solution is to only compare output unit costs a) annually; and b) for the whole life of the project (which would be updated each year based on actual spending and results).
- Results: ANC results have fallen for HPA, increased slightly for Trocaire, and increased substantially for SCI. To fully assess the relative impact of changes in results compared to changes in costs, in future both should be presented next to the unit cost.
- Reallocation of spending: Trocaire said that they had stopped working with some facilities that were very inefficient in terms of the number of people served compared to operating costs, which had helped to lower their unit cost per birth. However, the decision to change had not been driven by VfM considerations. A greater understanding of how the efficiency of spending may differ between locations will result from the EPHS Costing Study and as HCS partners deepen their own analysis of their unit costs.
- Mistakes: Trocaire suggested that the very high unit cost per birth of 95 for the first period is likely to be a mistake. Analysis of the unit costs will be done to ensure consistency across partners.

Recommendations:

- Develop better methodologies to allow partners to harmonise reporting of input costs, taking into account the suggestions above.
- Output unit costs to be reported annually rather than six monthly and estimates made for the whole life of the project.
- Results and costs to be presented next to output unit costs to facilitate analysis.
- Differences between partners in output unit costs should be analysed to ensure consistency in how they are being calculated, and to generate lessons on how to promote VfM.

5.2 Commercial Improvement and Value for Money

In order to understand what processes the HCS partners have in place to promote VfM, HCS has been piloting a questionnaire developed in June 2013 by DFID-funded VfM consultants about their processes and actions related to VfM. The information from this has been summarised in the Table of Good VfM Practices below, in terms of the 3 Es of Economy, Efficiency and Effectiveness.

This reveals many good practices for each of the 3 Es that are saving costs and increasing results. The greatest weakness is that there is no joint procurement between partners to facilitate bulk procurement, such as of medical commodities. This should be discussed at the next partners meeting, once the data comparing input costs is available.

In order to learn lessons, the partner meeting in June 2014 focused on discussing VfM good practices in two areas:

- a) Incentive payments: these were divided into the following four types:
 - (i) Incentives for traditional birth attendants to refer women to deliver in health facilities: the discussion revealed a wide variation in the amount paid per referred delivery: HPA \$5 and Trocaire \$10. It was agreed that this partly reflects the needs of different locations - Gedo where Trocaire is operating is the poorest and traditional birth attendants receive the equivalent of \$10 when they assist a home birth, so at least \$10 is needed to compete with this. However, it was also agreed that the evidence base to justify these payments needs to be strengthened e.g. to check that payment is sufficient. In addition, more experimentation could be done to maximise their effectiveness and sustainability. It was agreed that Trocaire will lead on this given that they are developing their incentives policy at the moment, and will include consideration of using additional payments to incentivise antenatal and post-natal care.
 - (ii) Incentives for women to attend training: partners again provide different incentives and cover the cost of lunch: SCI provide nothing; Trocaire a snack worth around \$2; HPA a snack or \$5; and PSI a bucket and bowl worth around \$5 (a jar has been removed as it proved to make no difference). The SCI example of providing nothing made other partners agree to assess whether their incentives are appropriate.
 - (iii) Incentives for health workers to attend training: all partners paid similar amounts to cover the costs of health workers attending training.
 - (iv) Salary top-ups for health workers: due to lack of time, these will be discussed at the next partners meeting.
- b) Training: there was a discussion of best practices and a number of elements were agreed upon. It was decided that THET would turn these into a one pager outlining best practices by zone.

Compared to the VfM qualitative questionnaire designed by the consultants, the Table of VfM Good Practices developed internally by DFID Kenya and DFID Somalia is a simpler tool to gather information about the actions that partners take to promote VfM, and is also more comprehensive. It should therefore be used from now on by HCS instead of the questionnaire. However, the questions in the questionnaire on mistakes and lessons learnt are useful and so will be added to the VfM Good Practices template.

Table of VfM Good Practices

3 Es	Good practice	Example
Economy (Lowest price for Inputs of required quality)	Use of best practice procurement processes for big ticket items.	All: Common procurement rules that purchases above \$500 need at least three bids, and above \$5,000 need open tender. Purchases above £30,000 need the approval of PSI.
	Bulk procurement of goods and services to get discounts.	Consortium members are not doing any joint procurement between themselves. However, within their own organisations some have reported trying to buy in bulk. PSI: developed a procurement plan which allowed for bulk purchases of medical gowns. SCI: procures some health items in bulk internationally across all its country programmes.
	Procurement arrangements to get timely delivery.	All: have procurement plans to ensure timely supply of inputs.

	Reviewing salaries against the local market	All: reviewed salaries against the market in either 2013 or 2014.
	Building capacity of implementing partners in procurement	THET: adding procurement guidelines to partnership agreements and providing training on them.
	Conducting procurement jointly with partners when there are concerns over their capacity	THET: three staff members are part of the MoH Procurement Committee.
Efficiency (Inputs produce Outputs of required quality for lowest cost)	Selecting the most appropriate types of Inputs balancing cost and quality	HPA making all efforts to find appropriate local consultants before advertising internationally (minimising fees and transport costs, and language barriers). THET using NHS volunteer trainers rather than consultants (also sourced for HPA). SCI using fibreglass roofing sheets for coastal health centres to prevent corrosion, following consultation with MoH counterparts.
	Minimising transport costs	T rocaire: training community widwives in Mogadishu instead of Tanzania.
	Coordination with other providers to prevent duplication	All: have provided examples of other health service providers working in their regions that they are coordinating with closely.
	Piloting different types of input and/or delivery method to increase efficiency	See text above on incentive payments and training.
Effectiveness (Outputs achieve Outcomes)	Maximise impact of training	T rocaire: requires midwives to sign an agreement to stay in the community for 3 years after their training.
	Building capacity of government to deliver services to ensure sustainability	All: are training health workers. T rocaire, SCI & HPA: are building the capacity of Regional and District Health Boards to manage health services.
	Incentivising the private sector to deliver services to ensure sustainability	THET: is training trainers in Health Professionals Associations which can be sustainable sources of training in the future.
	Sharing programme information and lessons learnt with government and other key actors.	All: claim to be sharing information and lessons learnt with HCS partners and MoH through quarterly reports and coordination meetings. HPA: shared report and presentation on clinical auditing with partners including MoH. THET: best practices of work in Somaliland were shared with WHO for a presentation in Pakistan.
	Maximising wider socio-economic benefits beyond the measured Outcomes	HPA, THET & T rocaire: procuring items locally to save transport costs and benefit the local economy: HPA with IEC materials; THET with lab materials and books; T rocaire with materials for rehabilitating theatres and food for inpatients.

Recommendations:

- Discussion at next partners meeting of why there is no joint procurement of medical commodities.
- Implementation of actions agreed by partners on incentive payments and training.
- Salary top-ups for health workers should be discussed at the next partners meeting.
- The VFM Good Practice template should be used by partners for qualitative VFM reporting instead of the questionnaire.

5.3 Role of project partners

- Population Services International (PSI): As project coordination agency. PSI has negotiated an administrative fee of 12% and a procurement fee of 4%. This fee is on a par with fees currently being charged to DFID by PSI in other countries in Africa. All consortium partners have negotiated administrative charges of 8% as overhead costs.
- PSI is also involved in the HCS as a consortium partner and is responsible for the social marketing of water purification tablets, diarrhoea treatment kits and birth spacing products in Somaliland
- Health Poverty Action (HPA) is implementing the Essential Package of Health Services (EPHS) in Sahil Region, Somaliland.
- T rocaire is implementing the Essential Package of Health Services (EPHS) in Gedo Region, South Central Somalia.
- Save the Children International (SCI) is implementing the Essential Package of Health Services (EPHS) in Kakaar Region, Puntland.

- Tropical Health & Education Trust (THET) is providing capacity building and technical support to the Ministry of Health and supports training institutions and professional associations in Somaliland.

5.4 Does the project still represent Value for Money : Yes

The project still represents VfM for the following reasons:

- Results: it has scored A on its Outputs, has a number of additional achievements that are not recorded in the logframe, and is making good progress against its Outcome indicators.
- Costs: remain stable, although the Cost Driver section flags risks around security, the new HR policy, and lack of reliable utility services.
- Theory of Change: this remains valid.
- Risks: the overall risk rating remains at Medium, which each risk remaining static.
- VfM: HCS partners are following a number of good practices to maximise VfM, except for joint procurement. The VfM indicators of Economy and Efficiency are not yet being reported consistently enough to facilitate analysis, but the partners are committed to improving this.

5.5 If not, what action will you take?

N/A

6. Conditionality

6.1 Update on specific conditions

There are no specific conditions on this programme.

7. Conclusions and actions

The Consortium partners continue to make good progress and have provided considerable support to the health sector across the country. They continue to work well together when required and overall management of the Consortium by PSI is judged to have been effective and efficient even with the staff changes that have taken place. The overall performance is commendable given the considerable changes and challenges that have taken place during the year across the health sector and in each of the three zones. Relationships with government, even in some difficult political environments, were reported (by government officials) as very good, although some outstanding issues were mentioned. This is true at all levels of the system from Ministry, through Regional, down to Community Health Committees and CSOs.

The review has discussed a range of new and emerging challenges across the sector as new initiatives come into play, new government dynamics have been introduced as the programme starts its last year of implementation. The Consortium is now faced with the roll-out of the JHNP EPHS programme, and the JPLG pilot project on decentralization of health services and the increasing engagement of a range of bilateral donors. While further consolidation of the programme is important, so is navigating the new aid environment. Important work is needed to ensure the lessons from the pilot work under HCS are well documented and used to influence and support further roll-out of EPHS and decentralised district planning. There needs to be attention to key areas of the programme and avoidance of spreading too thinly. At the same time the programme now needs to start to tackle sustainability issues that will see the continuation of HCS supported work after the programme ends in 2015.

Emerging issues :

EPHS Costing: The EPHS was costed in late 2009 by UNICEF, but this was only based on estimates. The EPHS review conducted in September 2013 found that despite being donor funded, there have been other inputs from local sources that have been highly innovative and impressive. The EPHS review recommended that actual costs from the pilots be used to update these estimates, and if possible be compared with results/impacts. The lack of costing analysis hinders planning for expansion for EPHS especially given the roll-out of EPHS in a further nine regions through the Joint Health and Nutrition Programme. The upcoming review the EPHS cost evaluation will provide valuable information on the costing for EPHS roll out by defining unit costs and minimum package, plus distinguish costs of additional components. HCS should ensure sharing of these lessons with other implementers

HRH sustainability: HCS pays a considerable amount in staff salary top-ups at both central and regional level across the three zones. This is completely reliant on DFID funding and not sustainable in the long run. HCS should plan how to take forward the recommendations of the HRH top ups review work and explore whether service delivery staff can transition to government payroll and be taken on by New Deal recurrent costs funds (SL, separate from PL and FGS). THET should respond to recommendations made and propose how the recommendations can be taken forward under HCS

Given the successes achieved in a relatively short time through a myriad of innovative approaches, HCS can provide valuable lessons learned to help inform the further roll-out of the EPHS. HCS needs to continue to pilot, innovate and share learn lessons – e.g. the upcoming cash transfer pilot funded by DFID in Karkaar Region will provide evidence on the effectiveness of cash transfers to increase utilization of key maternal and child health services in hard to reach areas.

FGM / Fistula: HCS work on FGM has in the past primarily focused on fistula repair and treatment. HCS should consider linking into a wider sectoral approach in line with government priorities for FGM as opposed to a narrow focus. This is becoming more relevant with the increasing international focus on FGM and also shifting priorities in Somalia. An anti-medicalization policy has been drafted in Somaliland and a policy has recently been endorsed in Puntland. HPA has done considerable advocacy work in Sahil region and focused on increasing access to justice and support to victims of FGM/SGBV through linkages with Community Based Organizations. These areas should be expanded to other Karkaar and Gedo Regions. HCS is participating in the Reproductive Health Working Group in Nairobi which covers FGM and SGBV issues and should participate in zonal task force meetings on FGM.

Summary of Specific Recommendations by output:

Specific recommendations by output are in Annex B. Ownership and timings of specific tasks related to outputs to be agreed by the HCS after approval of the AR.

A summary of the main recommendations is:

Recommendation	Ownership for action	Timings
<p>Revisions to indicators: Certain indicators need to be revised or taken out to reflect the changing context.</p> <ul style="list-style-type: none"> - Indicator 3.2 needs to be changed to ANC2+ (more than 2 antenatal visits per woman) - Indicator 3.7 needs to remove reference to OTP nutrition services and marketing of multi nutrients - Indicators 5.1 and 5.2 need to be removed as these are objectives of the JHNP and no longer relevant to HCS. - Indicator 5.4 needs to be removed due to the challenge of measuring and determining a suitable indicator 	<p>HCS Technical Advisor</p>	<p>To be completed by end of September 2014.</p>
<p>Revisions to output milestones: Due to the length of the programme and the ever changing context of the health sector, revisions are needed to the milestones of each output to ensure they reflect the changing political environment and are stretching yet realistic and achievable.</p>	<p>HCS Technical Advisor directing input from HCS partners.</p>	<p>To be completed by end of September 2014.</p>
<p>HRH top ups: Explore and secure transition of service delivery staff onto Gov payroll and find methods of funding HR costs through recurrent cost provisions. Pilot HRH review recommendations.</p>	<p>HCS Technical Advisor to develop strategy.</p>	<p>By December 2014.</p>
<p>Costing: Take forward recommendations that will come from costing evaluation and disseminate lessons learned with</p>	<p>DFID Health Advisor with HCS Technical Advisor</p>	<p>By October 2014.</p>

health authorities and key stakeholders.		
FGM: <ul style="list-style-type: none"> - Build on the existing Girls clubs and GBV database and expand through the Consortium. - Use information from current analysis and follow up with UN Joint Programme to develop a consistent approach to tackling FGM. - Participate in zonal level FGM Taskforce meetings. 	HCS Technical Advisor to action with HCS partners.	By April 2015. By November 2014. By August 2014.

Lessons Learned:

The health sector is currently undergoing a 'paradigm shift' from a traditional humanitarian operating environment to a post recovery setting, where partners are supporting the government structures to deliver essential package of health services through implementing partners such as NGOs. This reflects the New Deal way of working; supporting a government led strategy.

Government leadership and oversight

- Government needs greater oversight of the implementation of EPHS as delivered by the HCS as it is key to promoting government legitimacy and strengthening the compact between state and citizens, through service delivery. The HCS has strengthened its relationships with government over the last year but needs to keep its focus on working at a more strategic health sector level using evidence and lessons learned from its programme to work more closely with government to achieve government priorities. This is especially relevant for relationship building with the Federal Government.

'Political factors' affecting the process:

- Follow "DO NO HARM" principles especially in a fragile country like Somalia. Regularly review political risks and allow local leadership/ authorities to reach on a conclusion through mutual consultation and without compromising on the principles. Functioning RHOs, RHBs and/or their district equivalents are vital.

Challenges faced to ensure "Delivery of Results":

- Continue to focus on delivery of results but the HCS needs to be able to provide technical support in addition to service delivery.
- Strengthen and support monitoring and review systems of the authorities rather than creating another vertical system.

Community Ownership and Income Generation:

- Community ownership via RHBs, DHBs and CHCs is a vital for effective sustainable gains
- Facility ownership by communities and local authorities should be encouraged while promoting the national authority of the MOHs.

Consistent Supplies:

- Humanitarian sources for supplies are reducing; Supply chains and procurement strategies need to be developed by the HCS and feed into a sector-wide approach, to ensure consistent and reliable supplies.

EPHS cost package:

- Greater understanding is needed to help define the minimum costs for infrastructure and delivery of essential health services to determine the most effective package.

8. Review Process

Data collection for the fourth annual review of the NGO Health Consortium Somalia programme took place from the 6th - 26th June 2014. This meant that data from three quarterly reports were available in addition to data for April and May. Supplementary data for the period June was provided by the Consortium where available. This actual and projected data has been provided where thought important by the reviewer. The review team visited Puntland and Somaliland in order to hold discussions with each Consortium partner and other stakeholders. Discussions were also held with all three Ministries from the Federal Government, Puntland and Somaliland. Site visits were made in Hargeisa, Berbera, Garowe and Gardho and visits made to selected institutions, health facilities, NGOs and CSOs. Discussions were held with Community Health Committees in Sahil and Kakaar Regions, and

Regional Health Board representative in Sahil Region. Unfortunately it was not possible to travel to Gedo Region to meet with the District Health Boards or community members due to insecurity. Discussions were also held with community members in rural areas of Sahil and Kakaar Regions). Value for Money review work was undertaken in Nairobi and included consultations with DFID and HCS Partners.

Documents reviewed:

- (i) Health Consortium Somalia 2011, 2012 and 2013 Annual Review Reports
- (ii) Programme Memorandum
- (iii) Programme Quarterly Reports
- (iv) HCS Programme Extension Business Case
- (v) Inception review report 2010
- (vi) Project proposal
- (vii) Revised Logframe
- (viii) Somalia RH Strategy
- (ix) Health Sector Strategic Plans (HSSP)
- (x) Somalia Essential Package of Health Services (EPHS)
- (xi) Joint Health and Nutrition Programme Business Case
- (xii) Female Genital Cutting Scoping Mission Report
- (xiii) Impact Feasibility Study Report
- (xiv) Value for Money Report- Georgia -2011
- (xv) Value for Money Report- HSLP -2012
- (xvi) Annual Review /PCR Template
- (xvii) How to Note: Reviewing and Scoring Annual Reviews
- (xviii) DFID Kenya/Somalia Twelve Tips for AR/PCRs

List of People Met

Nairobi:

1. Karen Stephenson DFID Health Advisor
2. Mr Duale Aden Mohamed - FG Director General Health
3. Mr Ibrahim Abdihamid - FG, Director Planning
4. Anirban Chatterjee – UNICEF
5. Boukhare Bongongou – UNICEF
6. Bernard Odera – UNICEF
7. Zivai Murira – UNICEF Nutrition
8. Shalini Guduri – UNICEF Nutrition
9. Francis Malweye – WHO
10. Dr Rizwan Humayun – WHO
11. Dr Raza Zaidi – JHNP
12. Esther Walters-Crane – JHNP
13. Lordfred Achu – UNFPA
14. Samia Muhumed- UNFPA
15. Dr Naidu – SCI Head of Health
16. Daun Fest – PSI Deputy Director East Africa
17. Ombretta Mazzaroni – Trocaire Health Programme Manager
18. Martin Dwan – Trocaire Country Director
19. Rosemary Mutie – Trocaire Grants Officer
20. Irene Mirambo – Trocaire Programme Support Officer
21. Betty Oloo – Health Information Liason Officer

Puntland:

22. Dr Enow – MOH Puntland – Minister of Health
23. Ahmed Awale - MOH Puntland – State Minister Planning
24. Abdirazak Hersi - MoH Puntland, Director General
25. Dr Abdirazaak Hassan Issa - MoH Puntland, Director of Planning
26. Abdilatif Mohamed – SCI Area Representative
27. Mohamed Takoy – SCI Health Programme Manager (Puntland)
28. Jama Mohamed – SCI Programme Manager Health (Gardho)

29. Sharmake Hassan Ali – MOH HMIS Director
30. Yasmin Ali – HSAT Technical Advisor
31. Gardho RHO Team
32. Staff and CHCs at Xingod Health Center

Somaliland:

33. Osman Warsame – MoH Somaliland, Director General
34. Faisa Ibrahim - MoH Somaliland, Director of Planning
35. Jama Mohamed - MoH Somaliland, Director Nutrition
36. Abdulahi - MoH Somaliland, Director HMIS
37. Dr Khadra – MoH Somaliland, Director Family Health
38. Dr Essa Jama - MoH Somaliland, Director of Human Resource and Development
39. Khadar Mahmoud Ahmed- MoH Somaliland, Director Medical Services
40. Abdurahman Adan – HSAT Technical Advisor
41. Donato Gulino – PSI Somaliland Country Representative
42. Chizo Ezem – PSI Technical Advisor
43. Christopher Montague – PSI Communications
44. Muna Abdilahi – PSI Maternal Health
45. Adan Qodex – PSI Research Manager
46. Abdilahi Hassan – PSI Sales & Distribution
47. Abdirahman Hirsi Ali – PSI SFN
48. Ahmed Younis – PSI
49. Site visit to Mohamed Moga HC and IPC sessions and SFN Pharmacies
50. Dr T adessa Kasaye – HPA, Regional Director
51. Mr Rohit Odari – HPA Health Programme Manager
52. Ahmed Shawky – HPA Nutrition Programme Manager
53. Staff of Professional Associations

SLNMA:

54. Hassan Nuh Abdillahi – Project Officer

NHPC:

55. Nimo Ahmed Ali – Acting Executive Director/Programme Development Officer
56. Dr Ahmed Hashi Oday – Chairperson
57. Dr Abdirahman Mohamed Ahmed-doodi – Vice Chair
58. Hussein Said – Technical Capacity Building Consultant

SMA:

59. Dr Abdirashid Hashi Abdi – Chairman of the Board
60. SOMLA:

THET:

61. Wario Guracha – THET Country Representative Somaliland
62. Thomas Okedi – THET Programme Manager
63. Emilien Nkusi – THET HSS Manager
64. Mohamud Abdallahi Yonis – THET Sn. Programme Officer

Sahil:

65. Regional Medical Officer
66. HMIS Officer
67. RHO Team
68. Dr Asha – Director Berbera Hospital
69. HPA Team:
70. Yassmin Mohamed – Sahil Programme Manager
71. Mr Mohamud Madar – EPHS Technical Officer
72. Ms Ayan Hussein – SGBV officer
73. Mr Ahmed Abdimuse – HIV & M&E officer
74. Staff and CHCs at Jamalaaye Health Center

Annex: A

Beneficiary Feedback

Discussions with local CHCs and women accessing services all included positive feedback on support provided by HCS partners – and in many cases this has inspired communities to take ownership and contribute towards EPHS.

For example, health staff in Xingod Health Center (Karkaar region) are paying for the construction of a health education unit within the facility compound from their own salaries and the CHCs have helped to provide building supplies and cleaning equipment to support.

“Our staff have been motivated to help the IDP community here and as we believe in the EPHS and the services we provide we are using our own money and incentives earned to build a room for health education so that mothers do not have to sit outside” (Iftin Officer in Charge, Xingod Health Center).

The CHCs play a pivotal role in linking the communities to the health facilities and encouraging mothers to use services.

Mahada, a CHC member of Xingod CHC expressed how important the HCS EPHS project is to the community “A lot of things have changed since the start of this project, construction has extended and more women are using the services. The staff are very committed and we support them by linking the community and actively find cases in the community, for example if a pregnant woman is not going to a health center we encourage her to seek ANC. I once saw 2 severely malnourished children in the camp and persuaded the mother to bring them to the health center and they survived and became healthy. The mother still thanks me when she sees me for saving her children”.

“We come everyday to check activities at the health center. We don't have much money as this is an IDP village but we have power in the community and see more women coming from our community everyday...” (Ahmed Ismail Muse, CHC Member Jamaalaye HC)

The PHC Coordinator at the Regional Health Office in Karkaar said the EPHS project is making a significant impact on women's health “since this project started we are seeing more and more women accessing services, the number of women who are coming for four ANC is increasing, more women are coming to deliver at health facilities and this is reducing the number of women who die during childbirth, we are also seeing more women coming for postnatal care as they see the benefits for their health”.

The support provided through the HCS project was cited as a major success in Sahil in providing quality health services to the population. Dr Abdirahman the Regional Medical Officer said “we have made very good achievements since the start of the programme. The work that HPA is doing with solar installation in Berbera Regional Hospital and Sheikh District Hospital, establishing the SGBV Unit, expanding now to eye, dental and mental health services in collaboration with communities and CHCs have created services that never existed before and we now have better services than those available in Hargeisa”.

Dr Asha the Director of Berbera Regional Hospital emphasized how the EPHS project had changed the pervasive trend of home births in the region “At the start of the project home delivery in Sahil was amongst the highest in Somaliland. Now we have seen a complete reversal and the majority of mothers are giving birth in health facilities. The EPHS programme is saving mothers lives.” Mothers who are accessing services under the HCS EPHS programme talked about how their lives had improved since they had started using health facilities.

Khadro a mother of three children who uses the Xingod Health Facility stated “there are qualified staff who treat me well, I get the medicines I want when I need them. I trust the health workers here and I also bring all my children here for vaccinations and to screen them so that they grow up healthy and strong”.

“The main benefit of this project is that this facility is able to provide services to IDPs and pastoralists who have lost their livelihoods ... we are very poor and have no income, but thanks to this project we can use services when previously we were unable to visit any facilities” (Fadumo, mother visiting Jamaalaye HC in Sahil).

“The main benefit is free delivery and also if a woman is sick the ambulance can pick her from home! This is very important as we live very far away in villages and have no other means of transport! (Layla, -19 years old and 3 months pregnant with her first child).

ANNEX B:

Specific Recommendations by Output from the current 2013/14 Annual Review

Ownership and timings to be agreed with the HCS by September 2014

Recommendation	Owner	Timetable
Output 1:		
1. Capacity building in this area of institution building and local governance is needed THET in particular will need to look at its role as other sources of support for key programmes of institutional development start to implement activities in relation to other health sector programmes. The rapidly changing political and aid dynamics needs to be considered.		
2. Consider undertaking a strategic review of the role of the HCS programme in the area of institutional development in particular in relation to the JHNP. This is needed as new programmes and donors are now either on the scene or about to start. THET in particular will need to find its position and core competencies within this new dynamic as more support is provided for policy and capacity building at central and regional levels.		
3. HCS should develop a detailed plan for support on key elements of institutional support to the health authorities in Garowe and Mogadishu. This will need to include consultation with JHNP and MOH representatives to ensure clear division of labour and resource allocation.		
4. Support to the NHPC and professional associations has been a core component of work in Somaliland. Further thought needs to be given to the next steps in this support to try to ensure continued capacity development and sustainability of the institutions.		
Output 2		
5. The HCS should continue supporting the development of workforce planning competencies within the health authorities. THET is planning a scoping mission to Puntland, which will provide THET with an understanding of the needs of the MOH and develop a plan to provide support to complement or address gaps not covered by JHNP.		
6. Staff retention after training remains a key concern in the health sector. The Consortium should conduct a trend analysis to determine retention and deployment of trained health workers. Results from the HWFS recently completed by THET should provide some insight into this area.		
Output 3		
7. The focus for the last year of the project requires a more strategic and focused approach to ensure maximum value obtained through service delivery.		
8. Continue and strengthen the use of the scorecard and regular joint supervision visits – the RHO should be fully involved to ensure ownership of this process by the MoHs.		
9. A review is required with MOH at both central and regional level to agree on the tools and the systems and structures required for		

supportive supervision HCS should also discuss with the MoH on how to collaborate in this process across all zones.		
10. Review of how indicators are derived from HMIS data should be conducted to ensure standardization by all partners		
11. Evidence based decision making sessions should be held during the quarterly supervision and monitoring visits with HCS partners to track progress against indicators and also to review if there is a need to change routine activities to help achieve targets and realign funding from redundant activities that no longer have an impact on improving service delivery.		
12. Most activities are still facility based. Expansion of outreach activities is key objectives of the HSSPs. Partners are conducting more outreach activities and lessons can be learned from the UNICEF ICCM programme piloted by SCI in Kakaar region. The ICCM programme is considered a success by the MOH to reach more remote pastoralist communities. Unfortunately even though ICCM has now been incorporated into JHNP EPHS throughout Puntland, UNICEF does not have funds to continue the programme in Kakaar region. DFID should consider supporting the continuation of the ICCM programme in Kakaar if additional funds become available.		
Output 4		
13. The consortium partners need to define how this indicator should be measured – i.e. which communication channels should be included. Although PSI conducts mass media campaigns this data is not reported as it is almost impossible to calculate the number of women actually reached with a message through a radio programme. SCI and HPA should justify estimates of women reached through the FM messaging. SCI should also capture women reached through the new IPC initiative in addition to community conversations and mothers to me groups.		
Output 5		
14. Output 5 is now solely focused on lessons learned and dissemination of best practices. The risk rating should be changed from “high” to “low” to reflect this. With the upcoming roll-out of EPHS under the JHNP the consortium should now have a more focused approach to information sharing. HCS is planning a series of exchange visits amongst consortium members and the scope of these visits should be expanded to include partners selected for JHNP EPHS roll-out to enable sharing of best practise. Case studies have been developed in the past, and these should be uploaded onto SHARE once it is fully functional. In addition new case studies should be written highlighting additional innovations of partner activities: Women’s Health Groups, SGBV data base and access to justice, ICCM through village health promoters etc. The Technical Advisor and Communications Focal Points are developing a set of case studies and best practises that will be uploaded on SHARE.		
Revisions to logframe		
<ol style="list-style-type: none"> 1. Revisit all targets set for Gedo region in light of reliable data now available as many targets appear to be based on results achieved prior to scaling down of operations, DQA and HMIS review 2. Indicator 1.1: Milestone for year 5 – change to “HCS partners” as opposed to “MOH Stakeholders” as HCS is not able to influence all MOH stakeholders 		

<p>3. Indicator 2.2: Gedo – change milestone for year 5 as training is ongoing. Remove “8 nurses sent to IPC training” as this was completed in year 4.</p> <p>4. Indicator 3.2 ANC: With shift to ANC3+ targets will need to be revised for year 5 – as previous targets still relate to ANC2+</p> <p>5. Indicator 3.6 FGM: Milestones need to be revisited in consultation with MOH and HCS partners to reflect MOH priorities (See recommendation above)</p> <p>6. Indicator 3.7: Remove OTP nutrition indicators and Multi Social Marketing of Micronutrients from HCS logframe as these activities are not funded through DFID.</p> <p>7. Indicator 4.1: Milestones should be revised based on actual composition of CHCs in Karkaar as not possible to have 50% female representation. Targets for RHB in Sahil should be changed as HPA has limited role to influence membership selection of RHB – change to advocacy for increased female representation.</p> <p>8. Indicator 4.2. Add milestone for Gedo as IPC programme will start in year 5.</p>		
HRH Top-Ups		
<p>9. Given the shift towards the medium rate scenario HCS will need to find additional funds to enable partners to meet the extra costs (i) explore and secure recurrent costs for salaries under new Deal funds. transition service delivery staff onto government payroll (ii) use HCS to pilot recommendations made in donor HRH review of top ups</p>		
Procurement:		
<p>10. HCS should consider having a pooled procurement plan as essential supplies for HFs are the same across each zone and pooled procurement could lead to greater cost-efficiencies</p>		

ANNEX C: Table of completed revisions to logframe resulting from the previous Annual Review of 2012/13

Revisions to logical framework	New Milestone	Previous Milestone	Reason for change
Output 1: Revised 2014 milestones.			
Indicator 1.1: Consultative Policy and Strategy development and review process in Somaliland and Puntland	Somaliland - MoH with the support of its stakeholders disseminate the NHP and HSSP across the country Puntland Dissemination of the NHP and HSSP across the country with the support of MoH	Somaliland MoH stakeholders implementing mandate as defined in National Health Policy and operational plans Puntland: TBC	Milestones changed to reflect the development of the HSSPs and alignment of HCS support to the HSSPs.
Indicator 1.2: Planning and monitoring structures and systems, reflecting gender issues, developed through stakeholder consultation and functioning in target areas at all levels	Somaliland - Support MOH leadership and management to strengthen effective collaboration and harmonisation at both central and Sahil regional level	Somaliland – MOH leadership sustained, increasing evidence of stakeholder harmonisation.	HCS cannot ensure MoH leadership is sustained therefore changed to supporting management strengthening and effective collaboration and harmonisation at both central and district level
Indicator 1.3: Voluntary accreditation structures established for selected cadres of health personnel in Somaliland	- NHPC Regulatory framework and tools piloted in Sahil Region. At least 2 Health Training institutions and 2 health facilities accredited.	NHPC and other stakeholders actively engage with implementation, monitoring and review of accreditation and regulation framework	Changed as accreditation and regulation framework in place and NHPC needs to take over and start implementing accreditation functions
Output 2: Revised 2014 milestones			
Indicator 2.1: Gender aware HR policy & management tools developed and adopted by partners in the target areas	Health Workforce survey carried out and HR policy and Long term plan developed informing decisions at national level, including gender consideration	Somaliland - HR policy and management tools utilised and rolling HR operational plan developed. Management tools informing decisions in target area.	Revised based on recommendations to support workforce planning
Indicator 2.2: Proportion (No & %) of health workers trained in target areas in order to fulfil their job description	Gedo -18 Local women sent for community midwifery training 5 Auxiliary Nurses sent for Registered nurse training 8 Nurses sent to IPC training, 63 CHW/ TBA	Gedo - Refresher training ongoing; Skilled Birth Attendants in MCHs and hospitals; CHW cadre functional as per EPHS; DHBs minimise	Revised based on recommendation to set clear targets and clarification of quantities for each zone

	<p>trained on SBA Somaliland</p> <p>- Increase in number of health workers participating in CPDs to improve their knowledge and skills.</p> <p>S, Nurses, midwives, Medical doctors trained.</p> <p>% of trainees by gender, new graduates tracking tools developed and operationalized</p> <p>Number of Volunteers and Experts coming for training by area of specialization. Number and type of In service trainings offered.</p> <p>Sahil: 100 health workers trained -50% female - 70% of total health workers</p> <p>Kakaar</p> <p>- 90 health workers trained -50% female - 70% of total health workers</p>	<p>recruitment of unqualified staff</p> <p>Somaliland – Annual increase in No of health workers from T Is;</p> <p>Sahil - Women (24) 60%, Men (24) 60%</p> <p>Kakaar</p> <p>Total No. health workers 90, Women 51%, Men 51%</p>	
Indicator 2.3: Number and % of additional health workers trained as Skilled Birth Attendants, as defined by WHO	<p>Sahil - 27 (50%) scholars will continue study in training institution to complete the courses</p> <p>Kakaar</p> <p>- no additional SBA trained</p> <p>- 20% of the existing SBA trained on job and refresher training</p>	<p>Sahil - Additional 12 community midwives</p> <p>Kakaar - (# 60 and 70%)</p>	Clarity on numbers and type of SBA training within targets.
Indicator 2.4: All relevant training concerning the health of girls and women includes identification, management and complication of FGM/C	FGM/C All curriculum developed or reviewed contains a chapter on FGM/C	FGM/C curriculum reviewed on regular basis and health worker refresher training being done	
Output 3: Revised 2014 milestones:			
Indicator 3.1: % and number of under-ones, including poor and vulnerable vaccinated (received DPT 3 and/or Pentavalent) through health facility and outreach (routine) vaccination	Now changed to Pentavalent		
Indicator 3.6: Harmful effects of FGM/C and other GBV being addressed	<p>Gedo - no of patients referred for fistula repair annually</p> <p>Sahil - no of patients treated at Berbera</p>	Gedo – at least 15 female patients referred for fistula repair annually	Revert to FGM/C activity based targets rather than fistula repair.

	<p>hospital for fistula repair annually</p> <p>Puntland – no milestone</p>	<p>Sahil - no of patients treated at Berbera hospital for fistula repair annually 10 cases of Obstetric fistula to be referred to Burao Hospital annually</p> <p>Puntland- 10 cases of patients referred with obstetric complications related to FGM annually</p>	
Indicator 3.7: Access to basic and emergency nutrition services	<p>Gedo- 2,000 Pregnant and lactating women given MMN</p> <p>Sahil - provide basic nutrition services to 12,000 PWL</p>		<p>Nutrition services added for Pregnant and lactating women to Sahil & Gedo regions. All HCS partners now report on this.</p>
Output 4: Revised 2014 milestones: Indicator 4.2: Number of women reached with at least one behaviour change communication message on how to reduce maternal and child morbidity and mortality.	Sahil & Kakaar: women reached with messages in at least one of the 5 key areas	Sahil & Kakaar: Women reached with messages in all 5 key areas	
Output 5: Revised indicators and milestones: Indicator 5.1: Extent to which Health Systems Strengthening approach is implemented Indicator 5.2: Coordinated and harmonised, Bilateral and Multilateral funding	Indicator 5.1 & 5.2 no longer relevant to the programme as moved to JHNP		DFID no longer funding HSAT / HILO through HCS
Indicator 5.3: Models of health care delivery documented and disseminated with relevant stakeholders	Addition: Dissemination of HCS best practices and lessons learnt, including EPHS review, with relevant health stakeholders		
Indicator 5.4: New Indicator on Stability and Peace Building to be included.	No milestone		

ANNEX D

Table of recommendations actioned by the HCS from the previous 2012/13 Annual Review

Recommendation	Owner	Timetable	HCS Comments 2013	April 2014
1. Policy, planning and aid effectiveness				
1.1 - Consideration is needed on how to balance the support of HCS across all three zones. One option is to ensure more sharing of experiences and methodologies from one zone to another through seminars, roundtables and other approaches. HCS should develop a detailed plan for support on key elements of institutional support to the health authorities in Garowe and Mogadishu.	HCS partners to discuss facilitated by Technical Adviser	ASAP	Included in the action plan of HCS Workshop	Developing expansion plan for Puntland; working more closely with UN agencies on institutional support
1.2 - Undertake a strategic review of the role of the HCS programme in the area of institutional development in particular in relation to the JHNP. This is needed as new programmes and donors are now either on the scene or about to start. THET in particular will need to find its position and core competencies within this new dynamic as more support is provided for policy and capacity building at central and regional levels.	THET (All Partners)	ASAP	Included in the action plan of HCS Workshop and being addressed (see THET meeting with WHO and JHNP)	THET developing closer relationship with WHO; HCS conducted strategic review, draft plan and concept note ready by April; all partners forging closer ties with JHNP
1.3 - HCS should engage more in the health coordination and technical working group meetings, in Nairobi and zones, in order to influence decisions on EPHS roll out and health systems issues.	All partners	ASAP	Included in the action plan of HCS Workshop	Now happening with Technical Advisor on board.
1.4 - HCS should develop a detailed plan for support on key elements of institutional support to the health authorities in Garowe and Mogadishu. This will need to include consultation with JHNP and MOH representatives to ensure clear division of labour and resource allocation.	All Partners	ASAP	Included in the action plan of HCS Workshop (see 1.1)	Dialogue has started with JHNP and HA on division of labour.
1.5 - Support to the NHPC and professional associations have been a core component of work in Somaliland. Further thought needs to be given to the next steps in this support to try to ensure both continued capacity development and sustainability of the institutions.	THET	October 2013	In progress: NHPC is facing some staff retention issues that are out of THET's control	Difficulties still with NHPC, THET to step back; closely working with other associations such as SLNMA and SMA
1.5 - HCS should support wherever possible the further development of zonal coordination committees and working groups and work with health authorities to ensure good practice in setting agendas, managing meetings, minutes and follow up.	All partners	Align with meetings schedule	HCS is not responsible for organizing coordination committees and the participation to	HCS now is able to participate in zonal working groups.

			the ZWG is still an issue: broader coordination and representation is part of the HCS Workshop action plan	
2. EPHS roll out and Quality of Care				
2.1 - The HCS should look at supporting the development of workforce planning competencies within the health authorities and supporting initial drafts. This should include working with local structures as well as central authorities. This area of work will need to be coordinated with JHNP to both avoid duplication and ensure progress in the FG and Puntland Health Authorities.	THET with HPA, SCI and Trocaire	October 2013	In progress. Included in the action plan of HCS Workshop	Workforce analysis currently being undertaken in SL. TA is ensuring no duplication with JHNP and lessons learning from SL to other zones.
2.2 – HCS should participate in the WHO-led exercise to develop a harmonised community health strategy that will reach out to the poor, marginalised and remote communities that are currently underserved or not utilising health services.	All Partners	Consult with WHO	The AR doesn't not make any difference between the EPHS based CHW and the GAVI HSS LHW. HCS is willing to engage in both streams: in Somaliland THET has already developed the CHW curriculum endorsed by MoH.	Encouraging greater participation of all stakeholders in defining the community health strategy, which is being led by JHNP.
2.3 – The system of follow up of persons trained whether pre- or post- service should be reviewed to ensure understanding of impact of training on availability of the trained staff for the public sector.	THET lead	October 2013	THET needs to review this internally	TBC – are THET doing this? Important point, not just for THET but across whole sector.
2.4 - Focus on SBA training needs to be reviewed to ensure supply side is able to respond as EPHS is rolled out into 3 new regions per zone (part of workforce planning above). There seems to be some uncertainty about the approach to midwifery training and what should be set as targets in Somaliland. A consultation led by the MoH should be considered to ensure all stakeholders and new entrants are working towards the same goals.	THET	Consult with MOH	To be addressed through the Health Workforce Survey in Q3 of Y4	Health Workforce survey currently being undertaken by THET in SL and JHNP in PL/SC, waiting recommendations from surveys.
2.5 - In response to this review's concerns about quality of MCH practices – The proposed review of supervision approach by WHO (under GAVI-HSS) should be supported to consider whether the current approach is the best option for improving elements of health service practice.	HPA, SCI and Trocaire.	Next quarter	EPHS partners need to focus on quality of care, but the proposed recommendation is not relevant. PSI	HCS suggesting alignment of supervisory approach for whole sector to

PSI should provide technical support in survey/review design to other HCS partners where applicable and this could be fed into the wider review.			support in research is part of the HCS workshop action plan.	WHO to learn from HCS approach and offer technical support.
2.6 - HCS partners should expand their focus on roll-out of mobile and outreach services to more remote pastoralist communities based on best practice from across the HCS and other programmes in the Horn of Africa region.	Technical Advisor to lead. All Partners	Consult with MOH	Included in the action plan of HCS Workshop	SCI recently conducted analysis of barriers of reaching pastoralist communities in PL. HCS strategy will address.
2.7 - Ensure PSI's understanding of private sector providers is fed into HSSP related planning in all zones.	PSI	On-going	Included in the action plan of HCS Workshop	HCS now involved in JAR and AWP processes with the HAs.
3. Evidence-based planning and decision-making				
3.1 - Data quality and representativeness remains a concern. The HCS should consider including some basic low-cost options for surveys to crosscheck HMIS/population based progress data. One option is to undertake EPI cluster sample surveys in each target region to verify DPT 3 (or pentavalent vaccine in future) coverage.	HPA, SCI, Trocaire with technical support from PSI	2013 last quarter	Sample survey may be possible in Somaliland and Puntland but not within the proposed timelines	No action on this other than strengthening HMIS with DHMIS; possible collaboration for sector through GFATM?
3.2 - HCS should develop a strategy on how its experience and expertise can be used to influence and improve the roll out of EPHS under the JHNP. This to include a series of policy/briefing notes.	All HCS Partners	July 2013 onwards	Included in the action plan of HCS Workshop. EPHS review recommendation are to be examined in November meeting	More regular collaboration with HAs and JHNP to share experience.
3.3 - Recording and regular reporting on stock outs is recommended and these should be discussed with UNICEF when stock outs occur.	HPA, SCI, Trocaire	July 2013 onwards	Stock out are to be reported in the statistics report	Stock outs are being reported (?)
3.4 - A more detailed evaluation of EPHS roll out in the three pilot regions should be undertaken together with MoH and results disseminated.	HPA, SCI, Trocaire with support from THET and PSI	October 2013 start	Done. Poor involvement of MoH Mogadishu can be an issue	EPHS review undertaken and cost analysis to be undertaken.
4. Analysing Risk, conflict and sustainability				
4.1 - The HCS should undertake a more detailed (and on-going) programme-wide risk analysis and start more detailed dialogue with local authorities related to sustainability of EPHS.	Technical advisor and HCS Partners	October 2013 onwards	Develop a risk analysis matrix for HCS and review quarterly. Dialogue with MoH: included in the action plan of HCS Workshop	Risk analysis matrix developed and reviewed quarterly. Increased dialogue with HAs.

4.2 - HCS should undertake work on CSPM as part of its programme planning to ensure principles such as “do no harm” are adhered to.	HCS to engage technical support	October 2013 onwards	CSPM is reported by using the Conflict Sensitivity check-list.	Ongoing
5. HCS Collaboration and Learning				
5.1 - More proactive sharing of expertise across HCS in areas of research methodology and communications should be undertaken to ensure consistency and maximum use of consortium expertise.	PSI, THET to lead	On-going	Included in the action plan of HCS Workshop	Increase in lesson learning and strengthening comms.
5.2 - The HCS Partners should undertake a review of communications channels and messages across the programme to ensure cross learning and sharing of successes. The review will also help to ensure harmonised and consistent messages and language on key issues such as family planning, birth spacing, breast-feeding, GBV, FGM/C.	All Partners	October 2013 onwards	Included in the action plan of HCS Workshop. IPC messages are to be harmonized across the HCS	Harmonising IPC and sharing messaging, both between Consortium members and JHNP. Strengthening SHARE.
6. HCS Management Issues				
6.1 - The HCS should be open to suggestions on contracting arrangements and management of the HSCO and HSAT that could include moving this component outside the overall HCS envelope. However no proactive action is needed on this point from PSI management until recommendations of the Institutional review have been considered.	PSI/ HSCO/HSAT TL/DFID	At appropriate time.	HCSO is currently closed: funds have been moved to JHNP	
6.2 - The HCS Consortium should discuss how best to respond to the new health staff remuneration framework and requests from government linked to this. A Consortium wide negotiation (with inputs from DFID as appropriate) should be considered to ensure a common approach with each Health Authority.	PSI to lead/ All partners (DFID)	ASAP	Trocaire is able to meet the requirements. SCI has negotiated with MoH the increase to mid-level For Somaliland, the agreement is that no increase will be made on current project. Furthermore, discussion on MoH salary top-ups is to be initiated	HCS reporting into ongoing analysis of top-ups.
7. Revisions to logical framework				
7.1 – Output 1: Review of 2014 milestones. Indicator 1-3 – focus on demonstrating alignment of HCS support to HSSPs; Institutional review of role of HCS partners in new policy and aid environment; Plan for support to PL and FG; Initiatives linked to supporting professional associations in PL and FG; Evidence of NHPC taking over accreditation functions.	DFID, HCS Partners, HAs	Next quarterly HCS meeting	Log-frame revisions	Done

<p>7.2 – Output 2: Review of 2014 milestones. Indicators 1-3: evidence of support to workforce planning in three zones and workforce plan for SL; setting of clear training targets and clarification of quantities for each zone; Clarity on numbers and type of SBA training within targets.</p>	As above	As above	Log-frame revisions	
<p>7.3 – Output 3: Review of indicators and milestones: Indicator 1: Change to pentavalent3 targets. Also require short surveys to verify data from routine reporting. Raise Kakaar target to 50%. Indicator 3: Link improvement to 2013 baselines e.g. 20% uplift. Indicator 4: revise 2014 targets based on achieved 2013 data. Indicator 5: Raise 2014 milestone, e.g. 250 pharmacies. Indicator 6: Reconsider milestones. Revert to FGM/C activity based targets rather than fistula repair. Indicator 7: The milestones seem to combine too many aspects of nutrition/malnutrition. Better to now look to more precise targets such as % successful treatment of severely malnourished children presenting to health facilities. Needs to be further considered with support of nutritionist. Indicator 8: SL milestone – raise to 2500 CYPs/ PL milestone 100 CYPs.</p>	As above	As above	Log-frame revisions	
<p>7.4 – Output 4: Review of milestones: Indicator 2: consider changing this to a survey based indicator that shows a percentage of women knowing e.g. 3 danger signs in pregnancy/ correct course of action for children with diarrhoea.</p>	As above	As above	Log-frame revisions	
<p>7.5 – Output 5: Review of indicators and milestones: Indicators 1 and 2: reconsider pending decision on whether funding of HSCO and HSAT remains under HCS. Log-frame revisions Indicator 3: remove peer review publication. Change to at least 4 best practice papers written and disseminated. Indicator 4: Reconsider to make possible e.g. each partners should demonstrate evidence of adherence to the “do no harm” principle through a short case study of its work.</p>	As above	As above	Log-frame revisions	

ANNEXE

Recommendations actioned by the HCS from EPHS Review – October 2013.

	EPHS REVIEW FOLLOWUP ACTIONS	COMMENTS	RESPONSIBILITY
1	Roll out EPHS across the region to whatever level is possible using available resources.	THET is leading on the mental health for Somaliland and the cost implications are within the partner's capability. SCI needs to look at the resources TROCAIRE TBD	THET SCI TROCAIRE
2	Potential new partners should draw from lessons of existing partners and establish coordination.	3 PCAs have already been signed; most of the PCAs will be signed by the end of January. The plan is to have a workshop and will ask partners to nominate representative to be present at the ZWG.	JHNP to determine a way to enable sharing of best practices among JHNP partners and HCS
3	Strengthen commitment and cohesion in coordination mechanisms between partners and MoHs	It's part of HCS SP, so it's on-going; we need to make sure that HCS and JHNP are both part of the Health Coordination Mechanism at zonal level	HCS JHNP
4	Ensure systematic sharing of results and innovations from one zone to another.	On-going, it's part of the current process	HCS
5	New funding should be sought to finance all core EPHS programme areas.	HCS needs to make sure that this recommendation is taken into account as we draft the SP and CN. Also, this needs to be part of the joint planning process with MoH. HCS needs to also look at diversifying funding opportunities Based on annual review and gaps identifies coordinate with other actors in the Health Sector (Gavi, GF)	HCS
6	Pilot the roll out of EPHS areas 8-10 through specialised training programmes, guidelines and protocols.	See point 1	
7	Funding for specific areas of the EPHS should be sought from other relevant revenue streams eg for EPHS area 6, GFATM or GAVI or JPLG.	See point 5	
8	Reprint, disseminate, hold an EPHS workshop and train health staff, communities etc	JHNP to involve the ZWG to make sure HCS partners and JHNP do this together	JHNP/HCS
9	Hold workshop on success of EPHS with MoHs and set up an EPHS roll out taskforce and detailed strategy.	See point 5 This could be integrated in point 8	JHNP/HCS
10	Ensure strong technical oversight of the EPHS across all three zones.	HCS TA recruitment on-going	HCS (PSI/DFID)
11	Use findings from the EPHS pilot to establish evidence based targets for Zonal strategic plans.	We need to be able to show more impact and use it to help the SP process at zonal/national level. A first step on this is being taken	HCS

		under SO3 of the HCS SP	
12	Develop HSSP's M&E framework and establish standardised indicators.		JHNP 1. consultant to support development of M&E 2. 3 senior M&E advisors to help the MoH to implement this
13	Ensure data quality audits are conducted regularly.	GF is running a review on HMIS	Karen
14	Further develop the HMIS and ensure accurate reporting.	See point 13	Karen
15	Carry out a more systematic approach to coverage and geographically map it.	It's about being able to map the coverage of HCS and help JHNP to see where the coverage is. HSAT has a new team leader, we can liaise with them as this seems their task	HCS
16	Conduct a cost analysis in each zone of all EPHS components vs impact and outcomes.	This is also to be discussed with JHNP	DFID
17	Strengthen regional supplies and distribution.	There is an assessment going on the supply chain (Unicef supplies)	Karen
18	Pilot the use of municipal funding or other revenue sources, to fund auxiliary health staff.	Can the resources be used to fund the auxiliary staff?	EPHS partners
19	Pilot diversified funding models such as: community health funds/insurance schemes, contributions from diaspora, local government and municipalities, private sector		DFID to look at the way it can be finances HCS to look for alternative funding (see point 5)
20	Expand existing HR tools into other zones in Somalia.		THET
21	Commission a governance/social development consultancy to look at objective and subjective indicators of fragility/stability, citizen representation, gender empowerment and poverty/prosperity in communities with EPHS roll-out facilities to see if there is any measurable impact from health-specific inputs.	In the process of conducting a desk review, looking at the role of health in a conflict environment.	DFID
22	Conduct a specific impact evaluation of the EPHS.	In conjunction with JHNP (including cost-effectiveness)	DFID
23	Review the options to measure nutrition status of young children, health seeking behaviour, infant and under five and maternal mortality rates in the three pilot regions	There is an attempt to align the indicators and this will probably be highlighted during the AR	DFID
24	Conduct more in-depth analysis using existing HMIS data	HSAT to be involved.	DFID

ANNEX F:

Strengthening Referral Health Systems:

The EPHS recommends innovating referral systems that are based on 'simplicity, sustainability and ownership.' The HCS has supported very positive initiatives outlined below:

HPA (Sahil):

The referral system is based on the Essential Package of Health System and consists of four tiers (referral hospitals, referral health centres, health centres and primary health units) all working together to ensure that quality health care is available across Sahil, even in remote places such as Bulahar where the terrain is especially challenging.

HPA supports the referral system through the provision of four wheeled drive ambulances to reach people in remote areas. To ensure the availability of emergency medical care HPA also supports a motorcycle service which enables health workers to quickly access patients in their homes. Each health centre has motorcycles and medical kits that are available for emergency cases.

Improvements to the health services across Sahil has enabled health facilities to drastically increase the number of patients they are able to treat, and the new referral system means complicated cases can be transferred to Regional Health Centres (RHCs) or Berbera Regional hospital. HPA has also procured a boat ambulance to serve hard to reach coastal populations. It is anticipated that services will begin in the second half of 2014.

The changing role of a Traditional Birth Attendant (TBAs)

HPA in Sahil has successfully piloted a new referral system which entails the use of TBAs as Birth Companions (with mobile phones) (from home to BEmONC centre), The companions can ring for ambulances from the RHC. The TBA receives \$5 for each woman who is referred to a health center. Since September 2013 almost 1900 women have been referred by TBAs. This system has contributed to rapid increase in in-facility deliveries and a (non-measured) reduction in maternal deaths.

When Hibak went in to labour with her seventh child, Sidciyo (TBA) didn't think she would make it. After four days in labour Hibak was in agonising pain. When Sidciyo was called to assist with the delivery she knew there was nothing she could do.

But there was something the new nearby health centre could do. By Hibak's seventh labour Sidciyo had been trained in spotting danger signs and referring women to the new local health centre, which by then was well equipped to attend to women in labour.

Hoping it wasn't too late, Sidciyo referred Hibak to the health centre, where she could be looked after by trained health workers who had the equipment and medicines she needed. Though there were still some challenges ahead.

During her labour, health centre staff noticed that Hibak was malnourished and weak, and bleeding severely. She delivered a healthy baby but because she had been in labour for so long she developed a postpartum hemorrhage (PPH), the most common cause of maternal deaths.

For a while it looked like Hibak would not make it, her family would lose her. Thanks to the trained midwives, Hibak survived. They were able to treat and monitor her closely until she was well again.

Sidciyo and the midwives had saved Hibak's life. Sidciyo was the one Hibak called for when she was in labour, and it was because she had been trained to refer Hibak on to the health centre that Hibak was in the safe hands of the midwives.

Hibak said: *"I am glad with my safe delivery in here. Now I am getting food. They neither charge me anything nor treat me differently. I am sure that this health facility played a great role in saving our lives. I am pleased with free services at this facility."*

Hibak recovered well. She now has a seventh healthy baby boy whom she named him Hoodale, which means fortunate in Somali.

Sidciyo continues to help women in her community through child birth, by playing a vital role in the referral system and encouraging her community to use the health centre.

Trocaire (Gedo):

Trocaire in Gedo transports emergency cases by rented vehicle (4X4) to transfer women with difficult labour to the one CEmONC site in Gedo but also across the border to Mandera in Kenya. Baby kits (blankets and baby items) are also given to the mothers. In

addition, donkey carts have been used for transfers from PHs to health centres and for transporting medicines. Trócaire provides donkeys and carts, but communities are entirely responsible for managing the upkeep of the programme.

Zeinab Mohamed knows the pain of losing a child, only too well. Her daughter Amina had had recurrent disease, which Zeinab tried to cure with traditional home remedies. With the situation worsening, Zeinab had to walk two hours to the area's health centre and seek medical attention, if only to save her daughter's life.

"There was no other way to reach the hospital but to walk," Zeinab recalls. "I had to carry Amina when the journey became too exhausting, imploring her to take one more step. It was too much; I lost her shortly after arriving," she trails off.

Families here have little choice but to brave the long distances by foot, even in ill-health.

"We only live 20 kilometers (12 miles) away from the town, but yet we feel so far away and disconnected from everything because we can hardly reach there, especially when you need to see a doctor or get medicine. You live with the fear of losing your loved one if you don't get there fast enough," Zeinab reiterates.

Trócaire has purchased and distributed 29 donkey carts to remote health posts for referrals and transportation of essential medical supplies, in inaccessible areas. Community-managed, these carts are readily available and, most importantly, affordable for patients who need urgent medical attention.

Zeinab recently used this service, free-of-charge, when she had to seek specialized care for her six-year old daughter, Fatima suffering from grade 1 Odema.

"I was so worried thinking that I might lose Fatima as I did my previous girl. But I'm grateful to Trócaire for providing the donkey cart that really helped in saving my daughter's life. I don't want to imagine what would have happened, otherwise," Zeinab said.

For Trócaire, accessing medical care on time is a key component in saving the lives of thousands of vulnerable families living in Gedo region.

"The donkey carts are a simple, affordable yet highly effective means of transport for families desperate for medical help," said, Trócaire Somalia's Country Director. "It is a local solution benefitting the entire community that goes a long way in saving numerous lives."

SCI (Karkaar):

SCI in Karkar reimburse private transport providers for referring women and children, authorised by HC & PHU staff. Referral vouchers encourage mothers with birth complication to seek early medical support to regional hospital and contributed to have saved timely to mothers and their babies. Since June 2013 almost 140 cases of mothers with birth complications have been referred to Gardo hospital and provided with timely support.

When Jawahir went into labour, her mother (a traditional birth attendant) tried to help her but the labour continued for three days. Jawahir's pelvis was too small to deliver the baby and she was in danger of losing her life and that of her baby. Eventually she was transferred to Gardo hospital, where she received a caesarean section and gave birth to a healthy daughter. After giving birth, she stayed in the hospital for seven days while she received postnatal care. Jawahir received free medical services and transportation home from the hospital.

"Before they transferred me to Gardo hospital I felt pain in my stomach. My mother is a traditional birth attendant and tried to help me but she doesn't have enough knowledge. I was in labour for about three days. Then my husband contacted the Regional Health Office, and they sent an ambulance to transfer me to Gardo hospital where I got the free service. After I was admitted to the hospital, I was unconscious and after hours of caesarean section I delivered a healthy daughter. Now I'm feeling healthy and I'm very happy because Allah has given me a healthy daughter, and she is very beautiful." (Jawahir)

"Firstly, thanks to Allah and second to all those who assisted us, including the Ministry of Health, hospital staff and Save the Children. Jawahir is now feeling well again. She can work and sit." (Jawahir's mother)

ANNEX G:

Focus on Girls and Adolescents

HCS partners are doing considerable work with girls and adolescents to provide health education on key health issues. Although many of these initiatives are funded by other donors they provide value added to the consortium as these activities are taking place in the HCS pilot regions. Some key initiatives by partner organization are listed below.

Trocaire (Gedo Region):

Girls Support.

A girls education programme started in 2011 with support from Irish Aid, Misereor and Trócaire funds. The Education programme aims at improving access to basic quality primary education in 15 schools targeting 4000 children in Luuq, Dollow and Belet Xaawo districts.

Through the programme, emphasis has been laid on the girls in order to improve their enrolment, attendance and retention. By promoting girls education and creating an environment whereby girls continue with their schooling, early marriages will be reduced. Girls will also learn life skills in school which will make them more effective mothers.

As of May 2014, the education programme had reached 4063 children of which 1862 are girls. This is an increase from 3628 (1672 girls) in November 2013. The increase is attributed to the School feeding project currently supported by WFP and Trocaire which began in March 2014. Further to encourage girls enrolment and attendance, they are given vegetable oil as take home ration.

Girl's forums

A Girls Forum is a school based girls' initiative whose aim is to give girls an opportunity to share experiences, exchange ideas, mentor one another, create awareness and address issues affecting their education in order to enhance their participation and academic performance. The Girls forum was initiated in 2013 and is currently being implemented in 3 schools in Waberi, Dollow and Luuq.

Specifically, the forum aims:

- To enable girls identify and address socio-cultural issues affecting their access, retention, completion and performance in education by providing them an opportunity to mentor one another on religious and cultural issues as well as to create awareness and sensitize the community on the importance of education and the impact of negative social-cultural practices;
- To equip girls with appropriate skills to help them build their self-confidence and self-esteem;
- To equip girls with appropriate life skills that would help them manage health related challenges and other emerging issues;
- To encourage girls to communicate their issues/messages to a wider audience.

The club has members and officials drawn from the school. Membership is voluntary. The process is girl led, its school based with participation and respect for girls' views. There is information sharing and education among the members with female teacher as a patron. In school where there are no female teachers, the forums are managed with the support of female Community Education Committees (CECs). The girls' forum in the school has been an entry point in educating of adolescent girl child in the use and disposal of sanitary pads. This is done by Trócaire technical staff based at the health facilities. The distribution of the pads is done by female CECs and the club officials.

The children are also provided with one nutritious meal per day. Provision of lunch in school not only allows children to continue their education which is important for their future but it also helps ease the burden of care on households while also maintaining their nutritional levels.

To promote hygiene at the schools, all pupils are provided with one bar of soap on a monthly basis. Clean and treated water for drinking and preparing lunch is also provided. De worming is also conducted every six months by the health staff.

Recently a training of the adolescent girl child on use and disposal of sanitary pads was conducted and 85 girls reached. They were also issued with sanitary pads.

HPA (Sahil Region):

HPA has established six girls club (two for girls outside of formal education and four for girls enrolled in school in Berbera and Sheikh). The purpose of this was to involve the adolescent girls in the EPHS project to increase demand and awareness on Sexual Reproductive Health and Rights. Areas of focus for the clubs include birth spacing, deterrence of FGM, STIs and HIV preventative measures and safe motherhood. These SRHR training put an emphasis on youth participation as well as community mobilisation and awareness raising through a peer to peer learning approach. 20 girls from four secondary schools (two in Berbera and two in Sheikh) make up the number of in school members within this initiative, which strives towards educating youths about their rights to accessing sexual reproductive health services.

In addition, HPA also trained 40 out of school girls school clubs from the GAVO youth centre and YOVENCO in Berbera. The girls' clubs play an active role for community mobilization in terms of youth and shared their experiences with each other and have enough information on SRHR.

In total there are 160 girls' club members based in schools and within the community of Sahil who share SRH messages with approximately of 1500 girls and young women who would otherwise remain untouched and unaware of essential health related information at a time when they themselves are considering marriage and becoming sexually active. Girls' clubs are an initiative that is taking off in Sahil, demand for membership has increased so much so that HPA are now in the process of establishing a club in the Mandeera district of Sahil.

Implemented activities:

- Conducted community mobilization activities to promote health SRH behaviour and to promote access to health services through peer to peer education
- Provided life skill trainings for youths in areas such as HIV preventative measures, family planning and safe motherhood
- Promoting conversation and communication on areas that would otherwise remain largely undiscussed, i.e. FGM/C. Thus providing young girls with the opportunity to share experiences and opinions
- Conducted awareness raising on FGM at primary schools
- Actively participated the international events including the World AIDS day, FGM, breastfeeding and SGBV through drama performance and community mobilisation on such issues
- Providing out of school girls with the opportunity to contribute to a positive cause, in an area where unemployment is extremely high, participation in the girls' clubs provides out of school girls with a sense of ownership and pride in their roles

SCI (Karkaar Region):

SCI uses a variety of outreach activities to educate communities on maternal and child health issues and includes girls and adolescents.

SCI has created forums called Community Dialogue Sessions for Health by encouraging local solutions to local health challenges, outreach dramas for disseminating maternal and health messages using culturally acceptable poems, songs and role plays. SCI conducts regular community dialogue sessions in villages with significant participation of caregivers, elders, CHC member, youth and children. Since July 2013 over 500 care givers and community representatives have participated in the sessions.

SCI is also using the MOTHERS AND ME approach. This is a twice-monthly discussion between mothers and the health workers (midwives) to bridge gaps in service utilization. Similarly, female health promoters organize mother-to-mother support groups in their villages, each FHP is assigned a target of organizing 2-4 MTMSG meetings depending size of the village, and conduct 3 sessions per month for three months on IYCF, danger signs of pregnancy, birth preparedness, and birth spacing. Although this programme does not specifically target adolescent girls, given the young age at marriage in Karkaar, adolescent mothers are one of the main beneficiaries of this programme.

More recently SCI, has also started working on FGM issues in the community. SCI, has recently held workshops and trained 100 youth participants [58 female and 43 male] in Gardho on HIV prevention and FGM eradication. It is anticipated that trained youth will further cascade skills and knowledge gained to their peers.

An awareness campaign on FGM/C eradication was conducted in 2 IDP camps in Gardo town and 7 villages in Gardo and Waiye districts of Karkaar region. A total of 1,130 mothers and caregivers, including 223 adolescent girls were reached on FGM/C eradication campaign with use of diversified methodologies, this included participatory lecturing of health professional and sheikhs, question and answers sessions, distribution of leaflets, poems and role-plays. Communities had declared their willingness to FGM/C eradication and appreciated to have shared right information to take right decisions. All the communities cited importance of regulatory actions against those practicing FGM/C in the community and had shown their motivation to approach government officials on this. A Commemoration held on FGM/C eradication day reached 119 girls.

Community based organizations that include CHCs, youth groups, women groups, WAT SAN committees, prominent elders and religious imams participated in a child rights workshop for three days in Gardo. Participants understood basic principles of human rights, UNCRC convention, child development and problems faced to children in different stages, roles of dutybearers to materialize basic child rights, also shared their experience on violation of children's rights in Somalia and Islamic views on child rights that include combating FGM/C and encouraging breast feeding.

SCI has started some initiatives in schools targeting adolescent girls:

- Distribution of sanitary pads to 423 girls in the first quarter of 2014
- Health education in schools and deworming following the Puntland Cyclone in 2013 for 187 girls