REPUBLIC OF SOMALILAND

NATIONAL IMMUNIZATION STRATEGY 2026-2030

NOVEMBER 2025

Gavi
The Vaccine Alliance

unicef
for every child

Republic of Somaliland

National Immunization Strategy 2026-2030

November 2025

Citation: MoHD (2025). *Somaliland National Immunization Strategy (NIS) 2026–2030.*
Prepared by Dr. Mohamed Mukhtar Ali (Lead Consultant) and Dr. Hamdi Issa (Assistant Consultant)

Table of Contents

Foreword

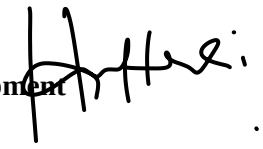
Immunization remains one of the most effective and life-saving public health interventions. It protects children, families, and communities from vaccine-preventable diseases and contributes significantly to achieving universal health coverage and national development goals. The Somaliland National Immunization Strategy (NIS) 2026–2030 represents a renewed national commitment to ensuring that every child, woman, and community in Somaliland has equitable access to safe, effective, and quality vaccines.

This strategy builds upon the lessons learned from the previous Comprehensive Multi-Year Plan (cMYP 2021–2025) and aligns with the key strategic documents including National EPI Policy (2020), Immunization Agenda 2030 (IA2030), the WHO-EMRO Regional Immunization Strategy, and the Somaliland National Health Plan. It serves as a roadmap for revitalizing routine immunization, strengthening system performance, and achieving sustained gains in coverage and equity. The NIS emphasizes country ownership, data-driven decision-making, partnerships, and people-centered approaches, ensuring that immunization services reach every community, including those in hard-to-reach, nomadic, and underserved areas.

The development of this strategy was guided by a comprehensive Situation Analysis (SitAn) conducted in 2025, which identified key barriers affecting programme performance. These include governance and financing challenges, human resource gaps, aging cold chain and logistics systems, weak data quality, and limited community engagement. The NIS 2026–2030 provides practical, phased interventions to address these challenges and outlines the resource requirements, financing mechanisms, and monitoring frameworks needed to translate vision into measurable results.

As we embark on this new phase, the Ministry of Health Development (MoHD) puts forward this ambitious strategy with the emphasis given on to continuing scaling-up of new vaccine introduction, zero-dose agenda and system strengthening approaches. I reaffirm the Ministry's commitment to leading, coordinating, and ensuring accountability in immunization efforts. We invite all stakeholders, government institutions, development partners, civil society, the private sector, and communities, to collaborate in putting this strategy into action. Through collective effort, innovation, and shared responsibility, Somaliland will safeguard its population from vaccine-preventable diseases and advance towards the vision of "leaving no one behind."

Hon. Hussein Bashir Hirsi
Minister of Health Development
Republic of Somaliland



Acknowledgement

The Ministry of Health Development (MoHD) extends its sincere gratitude to all individuals and institutions that contributed to the development of the Somaliland National Immunization Strategy (NIS) 2026–2030. This strategy is the outcome of a collaborative and participatory process led by the MoHD's Expanded Programme on Immunization (EPI), with the technical and financial support of UNICEF, World Health Organization (WHO), and Save the Children. The process included an extensive situation analysis, consultative workshops, and technical reviews that provided the evidence base for the NIS 2026–2030.

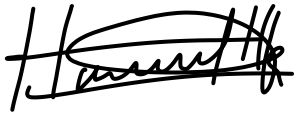
Special recognition is extended to the Director of Child Health & Immunization Programme Department (Mohamed Abdi Hussein), regional and district health officers, and members of the Inter-Agency Coordinating Committee (ICC) and the National Immunization Technical Advisory Group (NITAG) for their leadership, participation, and guidance. The Ministry also acknowledges the valuable contributions of development and implementing partners — including Gavi, the Vaccine Alliance, UNICEF, WHO, Save the Children, Population Services International (PSI), Alight, and representatives from the private health sector — whose technical inputs and continued collaboration have been essential in shaping this strategic plan.

The Ministry of Health Development expresses its deep appreciation to Dr. Mohamed Mukhtar Ali, Lead Consultant, and Dr. Hamdi Issa, Assistant Consultant, for their outstanding technical leadership, analytical rigor, and dedicated support throughout the process. Their work in conducting the Situation Analysis, facilitating national stakeholder consultations, and leading the drafting and validation of the NIS document was instrumental in producing a high-quality, evidence-based strategy that reflects the realities and aspirations of Somaliland's immunization programme. Their commitment, professionalism, and collaboration with MoHD teams and partners ensured that the strategy is both technically sound and operationally feasible.

We also recognize the tireless efforts of regional and district health teams, community health workers, and frontline vaccinators who continue to deliver vaccines to children and families across Somaliland, often in challenging environments. Their dedication remains the foundation of the national immunization program's success and resilience.

Finally, the Ministry extends heartfelt thanks to all technical experts and partner representatives who contributed data, insights, and peer review to this process. The Somaliland National Immunization Strategy 2026–2030 stands as a collective achievement — a testament to the shared vision of protecting every child from vaccine-preventable diseases and strengthening the health system for future generations.

Dr. Ahmed Mahmoud Jama
Director General
Ministry of Health Development
Republic of Somaliland



Acronyms

AEFI	Adverse Events Following Immunization
AOP	Annual Operational Plan
BCC	Behaviour Change Communication
CCE	Cold Chain Equipment
CHW	Community Health Worker
cMYP	Comprehensive Multi-Year Plan
CRS	Congenital Rubella Syndrome
DHIS2	District Health Information System, Version 2
DQA	Data Quality Assessment
DQIP	Data Quality Improvement Plan
EPI	Expanded Programme on Immunization
EVM	Effective Vaccine Management
Gavi	Gavi, the Vaccine Alliance
HBsAg	Hepatitis B Surface Antigen
HBV	Hepatitis B Virus
HPV	Human Papillomavirus
HR	Human Resources
ICC	Inter-Agency Coordinating Committee
IA2030	Immunization Agenda 2030
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education and Communication
IPV	Inactivated Poliovirus Vaccine
KAP	Knowledge, Attitudes and Practices
LQAS	Lot Quality Assurance Sampling
MCV	Measles-Containing Vaccine
MNCH	Maternal, Newborn and Child Health
MoF	Ministry of Finance
MoHD	Ministry of Health Development

NIL	National Immunization Law
NIS	National Immunization Strategy
NITAG	National Immunization Technical Advisory Group
PCV13	Pneumococcal Conjugate Vaccine (13-valent)
PHC	Primary Health Care
Penta	Pentavalent Vaccine (DTP-HepB-Hib)
PPP	Public–Private Partnership
PSI	Population Services International
REC/RED	Reaching Every Community / Reaching Every District
RI	Routine Immunization
RMNCH	Reproductive, Maternal, Newborn and Child Health
SBCC	Social and Behavior Change Communication
SIA	Supplementary Immunization Activity
SitAn	Situation Analysis
SMT	Stock Management Tool
SOP	Standard Operating Procedure
Td	Tetanus–Diphtheria Vaccine
TWG	Technical Working Group
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
VPD	Vaccine-Preventable Disease
WHO	World Health Organization

Executive Summary

The Somaliland National Immunization Strategy (NIS) 2026–2030 outlines a five-year roadmap aimed at strengthening and improving immunization coverage and equity, reaching zero-dose and under-immunized children, and establishing a resilient, sustainably financed programme aligned with the Immunization Agenda 2030 (IA2030) and the national health priorities. The 2025 Situation Analysis revealed declining immunization coverage (Penta3 54%, MCV1 50%, MCV2 19%), a significant zero-dose burden (43% of target children), and widening regional inequities. These challenges stem from weak governance and financing, workforce shortages, aging cold chain infrastructure and transport systems, limited outreach, poor data quality, and inadequate risk communication. The NIS addresses these issues through three phases: (1) **Urgent enablers**; establishing a national Immunization Law (NIL), ICC/NITAG functionality, scaling up rapid outreach, expansion of cold chain infrastructure and equipment (CCE) rehabilitation, IDSR/AEFI strengthening); (2) **System strengthening**: implementing an EPI Human Resource plan that integrated Community Health Workers, expanding fixed and outreach sessions, improving IDSR–DHIS2 integration and data use, and enhancing social behavior and communication change (SBCC) . (3) **Financing**: creating a dedicated EPI budget line, improving partner coordination, and developing a sustainability roadmap for current and new vaccines. The strategy is grounded in core principles: country-owned, data driven action, strong partnerships, and a people-centered approach guiding both design and implementation.

Resource requirements: Implementing the NIS will require an estimated USD 46.38 million over five years. The largest share (USD 32.8 M; 70.7%) covers vaccine supply and related logistics to ensure uninterrupted access. Complementary investments fund service delivery (USD 3.42M), surveillance (USD 2.19M), human resources (USD 2.77M), monitoring (USD 1.15M), demand generation (USD 0.85M), and programme management (USD 0.71M). Capital investment priorities include solar CCE, vehicles for distribution, SMT roll-out, laboratory upgrades, and digital tools; recurrent investment priorities cover outreach sessions, supervision, data reviews/DQAs, CHW engagement, and SBCC.

Financing approach: The strategy will be financed through a combination of partner contributions and increasing domestic investment. Gavi will remain the main contributor for vaccines and core operations, complemented by UNICEF and WHO (cold chain, capacity, demand generation) as well as the World Bank, Somaliland Goverment and NGOs (systems and outreach). To promote long term sustainability, the MoHD will: (i) establish and expand an EPI budget line within the MoHD budget; (ii) adopt a multi-year financing roadmap for current and new vaccines (including co-financing and transition planning); and (iii) institutionalize financial tracking and joint ICC reviews to align resources, monitor execution, and close gaps. The objective is to move from 0% domestic allocation at present to a phased increase by 2030, while protecting equity and service quality.

Monitoring, evaluation, and learning: The strategy's results-based M&E framework, aligned with IA2030, will track impact, outcomes, and outputs. Key 2030 targets include ≥90% Penta3, ≥80% MCV2, 100% districts with updated micro-plans, 100% facilities with functional cold chain, ≥90% AEFI investigated within 48 hours, and a 50% reduction in zero-dose children. Measurement will rely on DHIS2/IDSR dashboards, quarterly data validation and DQAs, supervision scorecards, and annual/biannual reviews (including mid-term and end-strategy evaluations). Evidence generated through this system will drive adaptive management, enabling the redirection of outreach, deploying surge support to low-performing districts, and updating of micro-plans, all under the oversight of ICC/NITAG

1. Positioning the NIS in a changing environment

Somaliland's health system continues to grapple with post-pandemic recovery, financial constraints, and population mobility including nomadic and displaced groups which complicate equitable service and delivery. Simultaneously, significant opportunities exist: the expansion of digital health (DHIS2), strong partner commitment to primary health care (PHC) and universal health coverage (UHC), and community networks that can accelerate uptake when effectively engaged.

The NIS positions immunization as a foundational PHC service and a smart investment for human capital, linking routine services with SIAs, nutrition, antenatal care (ANC), and school-based platforms. It prioritizes resilience (solar CCE, local maintenance capacity), precision targeting (micro-plans, zero-dose mapping), and domestic capacity (policy, HR, financing) to reduce donor dependence over time.

Implementation is country-led through the MoHD with governance from the ICC/NITAG, data driven via integrated IDSR–DHIS2 dashboards and routine DQAs, partnership-based with defined roles for UNICEF, WHO, Gavi, World Bank and NGOs, and people-centered, designing services around caregivers' access barriers such as distance, timing, trust, while actively engaging religious and community leaders, and maintaining strong AEFI communication.

1.1. Immunization Agenda 2030 and National Health Plan

The NIS operationalizes IA2030's vision—**leave no one behind**—through Somaliland-specific targets and investments that also advance the National Health Plan's PHC/UHC goals. Alignment includes:

- **Strategic priorities:** life-course vaccination (e.g., Td, HPV assessment), equity (zero-dose reduction), outbreak prevention (measles, cVDPV2), and sustainability (domestic financing roadmap).
- **Core principles: country-owned** policy (NIL), **data-guided** decision-making (coverage, zero-dose, and surveillance analytics), **partnerships** for efficiency (single national work plan, joint reviews), and **people-centered** demand generation (SBCC, crisis communication, social listening).
- **Measurement:** IA2030 impact/outcome/output indicators embedded in the NIS M&E framework, with biennial reviews and an end-strategy evaluation.

This alignment ensures coherence across planning, budgeting, implementation, and reporting, and enables access to partner support tied to IA2030 benchmarks.

1.2. From cMYP to NIS

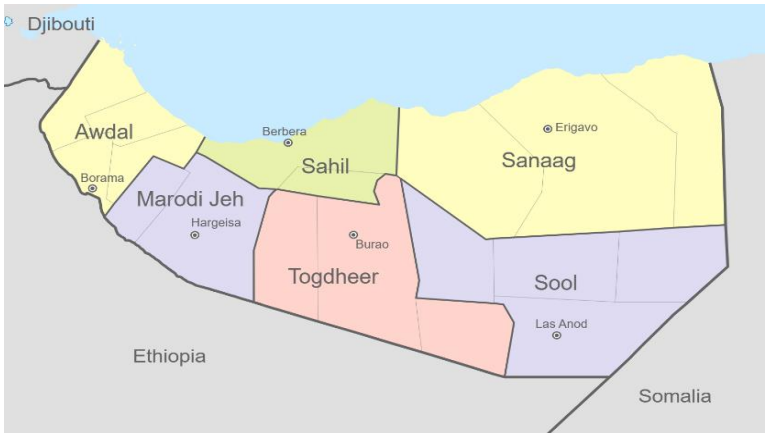
The cMYP (2021–2025) provided a broad programme plan but lacked a robust legal framework, sustainable financing pathway, and sufficiently targeted approaches to zero-dose and equity. The NIS advances beyond the cMYP by:

- Establishing an enabling policy and financing architecture (National Immunization Law; EPI budget line; accountability framework).
- Moving from generic plans to precision micro-planning (RED/REC, zero-dose mapping, integrated PHC outreach) and modern logistics (solar CCE, SMT).
- Institutionalizing human resources (EPI HR plan, CHW integration, standardized supervision, digital tools).
- Engagement and establishing partnerships with private sector Clinics/Hospitals to join with immunization service delivery

- Upgrading surveillance and data use (IDSR–DHIS2 integration, regular DQAs, actionable dashboards, AEFI strengthening).
- Embedding a phased sustainability roadmap, from partner coordination to increasing domestic co-financing over time.

In summary, the NIS transforms lessons from the cMYP into a focused, measurable, and sustainable agenda to achieve 2030 immunization goals.

1.3. Country Context



The Republic of Somaliland is a self-governing state in the Horn of Africa. It is bordered by Djibouti to the north-west, Ethiopia to the west and south, Somalia to the east, and the Gulf of Aden to the north, with an estimated coastline of about 850 km. Somaliland is administratively organized into six regions with Hargeisa as the capital and largest urban center. Somaliland declared independence from the rest of Somalia on 18 May 1991 following the collapse of the Somali central government and has since maintained its own political and administrative institutions, including an elected government, parliament and constitution.

For over three decades, Somaliland sought formal international recognition of its sovereignty. Historically, it operated largely as a de facto state without formal diplomatic relations or recognition from the wider international community. However, in December 2025, the State of Israel became the first United Nations member state to formally recognize the Republic of Somaliland as an independent and sovereign state, establishing mutual diplomatic ties with plans for cooperation across multiple sectors. While international recognition remains limited, Somaliland continues to engage with bilateral and multilateral partners on development and public health cooperation, including immunization and disease surveillance.

The health system in Somaliland is led by the Ministry of Health Development (MoHD) and is implemented through a decentralized structure at national, regional, district and facility levels, with service delivery provided by public, private and non-governmental actors. Immunization and vaccine-preventable disease surveillance are implemented within the broader primary health care and Integrated Disease Surveillance and Response (IDSR) framework. The country faces persistent operational challenges related to geographical access, mobile and nomadic populations, infrastructure gaps and health workforce constraints, while at the same time benefiting from strong community structures and long-standing collaboration with development partners.

For the planning horizon of this National Immunization Strategy (NIS) 2026–2030, Somaliland's total population is projected to grow from an estimated 6.2 million in 2025 to 6.39 million in 2026, 6.58 million in 2027, 6.77 million in 2028, 6.98 million in 2029 and 7.19 million in 2030. These population projections form the basis for vaccine forecasting, service delivery planning, cold chain and logistics requirements, and monitoring of coverage and equity. The NIS 2026–2030 is therefore developed in alignment with the Immunization Agenda 2030 (IA2030) and national health sector priorities, with a strong focus on strengthening routine immunization, closing equity gaps, improving surveillance, and building resilient and sustainable immunization systems.

2. Situation analysis

2.1. Background

The situation analysis (SitAn) for the Somaliland National Immunization Strategy (NIS) 2026–2030 was completed between 5th September and 6th October 2025. The process was led by the consultant team under the direction of the Ministry of Health Development (MoHD), with technical support from UNICEF, WHO, and Save the Children.

The SitAn aimed to:

- Assess the current status and performance of the national immunization programme.
- Identify key barriers and bottlenecks affecting immunization coverage, equity, and quality.
- Prioritize challenges and determine their root causes.
- Develop context-specific interventions to inform the NIS 2026–2030 development.
- Align Somaliland's immunization priorities with IA2030 and the WHO-EMRO Regional Immunization Strategy.

The findings serve as the foundation for the NIS document and guide programme implementation, resource allocation, and monitoring for the next five years (2026–2030).

2.2. Information Sources

The situation analysis for the Somaliland National Immunization Strategy (NIS) 2026–2030 was conducted using a comprehensive mixed methods approach that incorporated both primary and secondary data sources. . Primary data were collected from key informant interviews (KIIs) with Ministry of Health Development (MoHD) officials, regional EPI officers, development partners (UNICEF, WHO, Save the Children, PSI, Alight), and private sector representatives, as well as a national stakeholder workshop held in Hargeisa on 5–6 October 2025 with over 40 participants from all regions. Secondary data included DHIS2 administrative coverage data (2022–2024), WHO VPD surveillance and campaign reports, the Somaliland EPI Policy (2020), cMYP (2021–2025), UNICEF's EVM assessment, the National SBCC Strategy (2024–2026), and IDSR tools and guidelines. However, the analysis faced several limitations, including the absence of the finalized 2025 Immunization Programme Review, lack of recent household survey data for coverage validation, reliance on administrative sources for equity analysis, and incomplete documentation from past review meetings

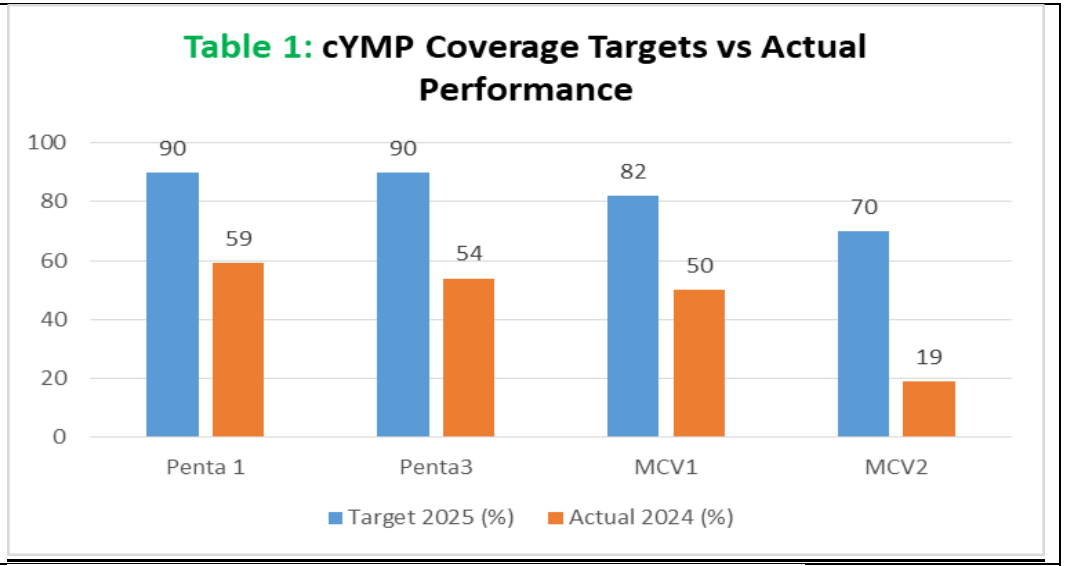
2.3. Immunization Coverage and Equity Overview

cMYP 2021–2025 Targets: ≥90% Penta3 & MCV1 by 2025, new vaccine introductions, elimination goals (measles, MNT, polio).

Current Performance (DHIS2 2024):

- Penta1: 59% (Target 90%)
- Penta3: 54% (Target 90%)
- MCV1: 50% (Target 82%)
- MCV2: 19% (Target 70%)

Gap: Coverage targets not being met; new vaccines at low scale-up and no available data so far.

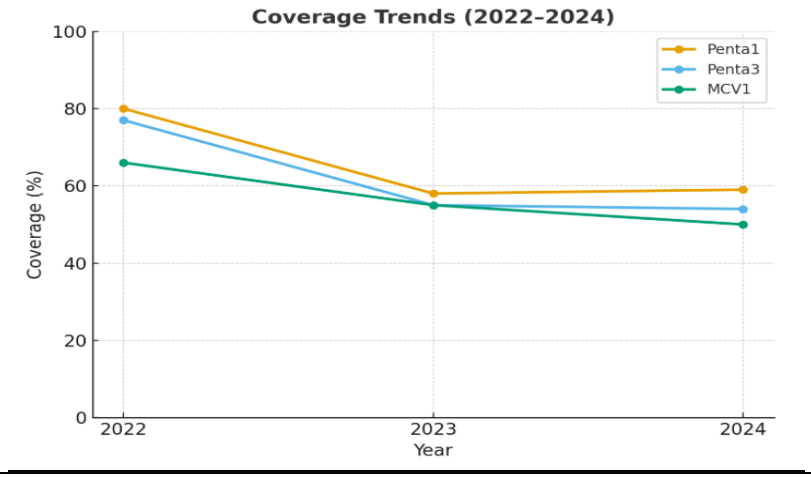


Declining coverage across all antigens:

- Penta1: 80% (2022) → 59% (2024)
- Penta3: 77% (2022) → 54% (2024)
- MCV1: 66% (2022) → 50% (2024)

The decline is systemic, reflecting challenges in service delivery, workforce shortages, outreach gaps, and funding constraints.

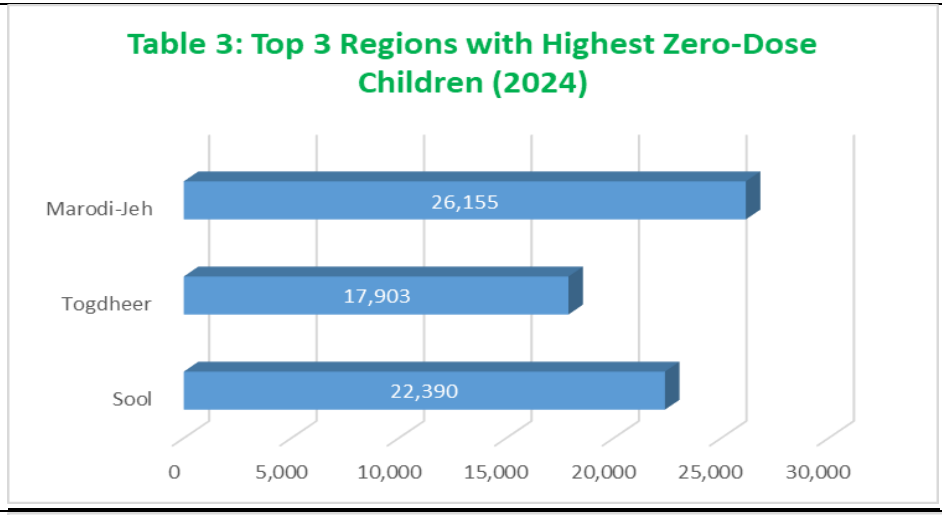
Dropout Rates: 8% (2024) — within acceptable range. However, low Penta1 access indicates many zero-dose children who never enter the system.



Zero-Dose Children:

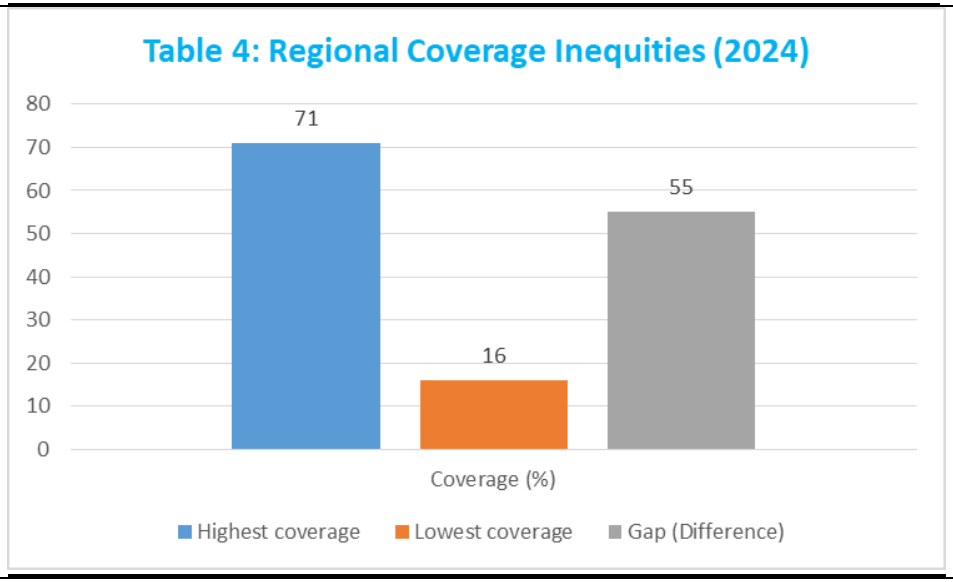
- Estimated 43% of target children (approximately 101,759) remain unvaccinated (2024).
- Concentrated in Sool (22,390), Marodi-Jeh (26,155), and Togdheer (17,903).

The data point to serious access and equity issues — largely driven by remoteness, conflict, nomadic lifestyles, weak infrastructure, and limited outreach capacity.



Equity: Regional disparities widened sharply between 2022 and 2024:

- Highest regional coverage: 71% (Sanaag)
- Lowest: 16% (Sool)
- Gap: 55 percentage points (up from 17 in 2022).
- Urban–rural inequities significant; gender gaps minimal.
- All districts below 80% for Penta3; 17% below 50%.



2.4. List of Barriers and Documented Evidence

The identification of barriers to immunization programme performance in Somaliland followed a systematic, evidence-based process combining document review, administrative data analysis, and stakeholder consultations, and the process used:

I. Desk Review Phase

The desk review was conducted by the consulting team in collaboration with the Ministry of Health Development (MoHD) Expanded Programme on Immunization (EPI) and Planning team. Documents reviewed included EPI policies, plans, data reports, and partner assessments covering the period 2020–2024. The review focused on identifying barriers across the seven thematic categories of immunization system performance as per the WHO SitAn framework:

- Programme Management & Financing
- Human Resources Management
- Vaccine Supply, Quality & Logistics
- Service Delivery
- Coverage & Equity
- Disease Surveillance
- Demand Generation

II. Evidence Availability and Gaps

Evidence was available and adequate to identify most barriers through administrative data (DHIS2), existing reports (e.g. EVM, cMYP, policy documents), and qualitative inputs from stakeholders. However, there were significant research gaps due to absence of recent immunization review documentation (latest incomplete 2025 review), lack of triangulated data (no recent household or coverage surveys), incomplete documentation from regional and facility-level assessments, and limited published studies on behavioral and social determinants of immunization. To address these gaps, the team relied on consensus-based validation through key informant interviews (KIIs) and workshop group discussions.

III. Determining Whether a Barrier Exists

Each potential barrier identified from the literature and data was tested against field evidence and stakeholder validation. The Guiding Framework for Prioritization was applied to verify the existence and relevance of each barrier through the following eight diagnostic questions:

- Is the impact on coverage and equity large or small?
- Will addressing this barrier lead to measurable improvement in coverage or equity?
- Does the barrier affect catch-up vaccination?
- Has it been addressed previously with success?
- Is it modifiable through programme interventions?
- How feasible are corrective actions?
- Are there more urgent competing barriers?

These questions were applied by group consensus during the consultative workshop to validate and categorize barriers.

IV. Context-Specific Barriers Considered Beyond the Global Template

In addition to standard WHO/IA2030 barrier categories, the Somaliland SitAn incorporated context-specific barriers emerging from national realities:

- Weak regional financing and dependence on partners for operations.
- Frequent turnover and low retention of EPI staff due to non-permanent employment.
- Nomadic populations, insecure/remote areas, and difficult terrain limiting outreach.
- Limited private sector engagement and absence of a national immunization law.
- Data quality gaps at all levels (poor DQA, delayed reporting, limited validation).
- Growing misinformation and vaccine hesitancy influenced by religious and social beliefs.

Together, these processes ensured that the barriers identified reflect the real operational and contextual challenges faced by Somaliland's immunization programme.

2.5. Prioritized barriers in the country context

The prioritization of barriers was conducted through a national stakeholder consultative workshop held in Hargeisa from 5–6 October 2025. The process was jointly led by the Ministry of Health Development (MoHD) and the consulting team.

Stakeholders Consulted

Over 40 participants took part, representing:

- MoHD Central Level: Director Generals, EPI Managers, M&E and Surveillance officers.
- Regional and District Health Teams: Representatives from all six regions (Marodi-Jeh, Togdheer, Sool, Sanaag, Awdal, Sahil).
- Development Partners: UNICEF, WHO, Save the Children, Alight, PSI.
- Private Sector: Representatives from private hospitals and clinics.
- Consultants and Technical Advisors: National and international immunization experts.

Format of Consultation

Participants were divided into five thematic working groups, each assigned one or more barrier categories:

- Group 1: Programme Management & Financing, Human Resources
- Group 2: Vaccine Supply, Quality & Logistics
- Group 3: Service Delivery, Coverage & Equity
- Group 4: Disease Surveillance & AEFI Monitoring
- Group 5: Demand Generation & Community Engagement

Each group reviewed

- The long list of barriers from the desk review.
- The findings and supporting evidence.
- The Guiding Framework for Prioritization (8 questions).

They then scored each barrier as High (3), Medium (2), or Low (1) priority. The following criteria guided how participants determined priority:

- Magnitude of impact on immunization coverage and equity.
- Feasibility and modifiability within Somaliland's current resource and policy environment.
- Potential to improve access and quality for zero-dose and under-immunized populations.
- Alignment with IA2030 and EMRO regional strategic priorities.
- Urgency and dependency: Barriers whose resolution enables progress in other areas were ranked higher.

2.6. Summary Table of Immunization System Components

Component	Key Findings
1) NIP (EPI) Management within Health System	• No National Immunization Law • Fragmented SOPs • Weak coordination of ICC/NITAG • Heavy donor dependence.
2) Human Resource Management	• Shortages and mal-distribution of vaccinators • Low motivation • Non-integrated CHWs • Weak supervision and training systems.
3) Vaccine Security, Cold Chain & Logistics	• Aged and insufficient cold chain • Stock-outs due to poor forecasting • Inadequate transport • Limited waste management infrastructure.
4) Service Delivery & New Vaccine Introduction	• Long distances to health facilities • Limited outreach • Weak micro-planning • Few functional centers • Early roll-out with improving uptake
5) Immunization Monitoring & Data Systems	• Reliance on DHIS2 administrative data • Poor DQA and feedback loops • Limited use of data for decision-making.
6) VPD Surveillance & Outbreak Response	• Weak measles and polio surveillance • Lack of lab capacity and reagents • Poor AEFI reporting • No surveillance focal points at regional levels.
7) Demand Generation & Communication	• Misinformation, vaccine hesitancy, and weak social mobilization for RI • Advocacy and communication limited by funding.

2.7. Financing components

Component	Findings
1. Macro Fiscal Situation	Health sector receives <5% of total government expenditure.

2. National Budget	Immunization funding almost entirely dependent on external partners (UNICEF, WHO, Gavi).
3. National Health Sector Finances	Weak regional budgeting for immunization; no earmarked EPI lines.
4. Non-State Health Sector Finances	Private sector underutilized; minimal contribution to RI.
5. Immunization Program Financing	No domestic allocation for new vaccines; sustainability at risk if donor funding declines.

3. Priorities, objectives, strategies: "3 phase approach"

3.1. Urgent priorities, objectives and strategies

3.1.1. Urgent priority # 1: Strengthen Immunization Governance & Financing

- **Objective:** Establish a sustainable, well-governed national immunization program integrated within the health system.
- **Strategy:** Develop and adopt a National Immunization Law (NIL) and strengthen governance structures (ICC, NITAG).
- **Main interventions:**
  1. **Draft NIL and related policies that is supportive of immunization as a public good**
     - Conduct desk review of current health legislation and EPI policy environment.
     - Form a technical working group (TWG) on immunization governance (MoHD, MoJ, Parliament, WHO, UNICEF).
     - Draft and validate the National Immunization Law (NIL) ensuring provisions for vaccine security, financing, accountability, and mandates for immunization.
     - Conduct national consultation and validation workshops with stakeholders.
     - Submit NIL to the Council of Ministers and Parliament for endorsement.
     - Develop and disseminate implementing regulations and operational guidelines.
  2. **Regular ICC/NITAG meetings**
     - Revise and update the Terms of Reference for ICC and NITAG.
     - Develop annual meeting calendar with regular quarterly meetings.
     - Build capacity of ICC/NITAG members on evidence-based decision-making.
     - Ensure documentation and follow-up of action points from each meeting.
  3. **Integrate EPI into national health planning**
     - FD Embed EPI activities and indicators in the Health Sector Strategic Plan and Annual Operational Plans.
     - Include immunization in district health plans and budgets.
     - Align EPI monitoring with PHC performance reviews.
  4. **Increase government budget allocation**
     - Advocate for EPI budget line within MoHD and MoF frameworks.
     - Conduct fiscal space analysis and cost-benefit studies to support advocacy.
     - Present annual investment cases to Parliament and Cabinet.
     - Establish a predictable flow of funds for EPI operations.
  5. **Define responsibility, accountability and authority framework at each level and for every immunization body**
     - Map EPI roles and responsibilities across all administrative levels.
     - Develop an accountability and performance management framework for immunization staff.
     - Institutionalize quarterly performance reviews at national and regional levels.

3.1.2. Urgent priority # 2: Restore coverage and equity

- **Objective:** Restore national immunization coverage (≥90%) and district-level coverage (≥80%) for all basic antigens, and reach zero-dose and under-immunized children.
- **Strategy:** Scale up outreach/mobile services, target nomadic and rural populations, and ensure equitable access to all basic vaccines.
- **Main interventions:**

1. **Develop micro-plans for hard-to-reach areas**
    - Conduct district-level mapping to identify underserved and nomadic populations.
    - Train EPI teams on micro-planning using WHO RED/REC approach.
    - Update micro-plans annually with population estimates, session plans, and logistics needs.
    - Integrate micro-plans into DHIS2-based monitoring systems.
2. **Integrate RI with PHC and outreach**
    - Deliver immunization services alongside maternal, nutrition, and growth monitoring services.
    - Conduct joint outreach missions combining EPI, MNCH, and nutrition activities.
    - Integrate immunization during health campaigns and community health days.
3. **Introduce performance-based incentives**
    - Develop EPI performance scorecards for regional and district teams.
    - Pilot incentive schemes (non-financial and financial) in low-performing districts.
    - Evaluate pilot results and scale up based on effectiveness.
4. **Strengthen coverage for all basic antigens**
    - Ensure continuous vaccine supply and monitor antigen-specific coverage:
    - BCG – improve coverage at birth through facility-based delivery linkage.
    - Pentavalent (DPT-HepB-Hib) – ensure timely 3-dose completion via follow-up and defaulter tracing.
    - bOPV/IPV – synchronize schedules and maintain surveillance for AFP.
    - Measles (M) – improve second dose uptake through school-based and outreach vaccination.
    - Td – target women of reproductive age through ANC and school campaigns.
    - PCV13, Rota, Hep-B – ensure availability and strengthen cold chain for new vaccines introduction.
5. **Scale up immunization service delivery through Public–Private Partnerships (PPP)**
    - Expand PPP agreements with additional private hospitals and clinics across all regions.
    - Train private-sector vaccinators on EPI standards, safety, data reporting, and AEFI procedures.
    - Integrate private health facilities into national micro-planning, supervision, and DHIS2 reporting systems.
    - Supply participating private facilities with vaccines, recording tools, and IEC materials based on performance and compliance.

- Conduct joint MoHD–private sector review meetings to monitor service delivery, coverage results, and quality assurance.

3.1.3. Urgent priority # 3: Enhance Cold Chain & Logistics Systems

- **Objective:** Ensure uninterrupted vaccine supply and maintain quality across all levels.
- **Strategy:** Rehabilitate and modernize cold chain and logistics systems for vaccines and related supplies.
- **Main interventions:**

1. **Deploy solar Cold Chain Equipment (CCE)**
    - Conduct national cold chain inventory and gap analysis.
    - Prioritize facilities lacking reliable power or storage capacity.
    - Procure and install WHO PQS-approved solar CCEs.
    - Ensure preventive maintenance plans and functionality assessments.
2. **Recruit cold chain technicians**
    - Recruit regional cold chain officers for all regions.
    - Establish maintenance contracts or service hubs for timely repairs.
    - Strengthen reporting lines and TORs for cold chain staff
3. **Introduce electronic stock management tool (SMT)**
    - Roll out SMT at national and regional vaccine stores.
    - Integrate SMT outputs into national vaccine logistics dashboards.
    - Conduct quarterly stock data reviews to improve accuracy and forecasting.
    - Strengthen stock visibility across all levels of the system.
4. **Strengthen transport and distribution system for vaccines and supplies**
    - Purchase vehicles for central vaccine distribution (Phase 1)
    - Purchase vehicles for regional and district-level vaccine transport (Phase 2)
    - Vehicle operation & maintenance (fuel, servicing, insurance)
    - Driver salaries for regional/district vehicles
5. **Build Capacity in Vaccine & Supply Forecasting and Quantification**
    - Train cold chain officers in forecasting, quantification, and supply planning.
    - Introduce modern forecasting tools/platforms (e.g., WHO/UNICEF tools, electronic forecasting models).
    - Train logisticians and storekeepers on temperature monitoring, maintenance planning, and SMT usage.
    - Conduct regular capacity refresher sessions and mentoring support.
    - Develop forecasting SOPs and integrate them into national logistics management procedures.

3.1.4. Urgent priority # 4: Strengthen Surveillance and Outbreak Response

- **Objective:** Improve early detection, confirmation, and rapid response to vaccine-preventable diseases (VPDs).
- **Strategy:** Integrate immunization surveillance within the Integrated Disease Surveillance and Response (IDSR) framework.
- **Main interventions:**

1. **Train surveillance officers**
    - Conduct refresher training on VPD surveillance and outbreak detection for all districts.

- Provide updated case definitions and reporting tools.
- Conduct joint EPI–IDSR supportive supervision.

2. **Establish laboratory capacity**
   - Equip regional laboratories with basic diagnostic tools and sample collection kits.
   - Strengthen referral linkages to WHO-accredited reference laboratories.
   - Train lab staff on biosafety, specimen handling, and quality assurance.
3. **Strengthen AEFI monitoring**
   - Develop national AEFI policy, guidelines, and SOPs.
   - Train vaccinators and supervisors on AEFI identification and reporting.
   - Establish AEFI review committee and crisis communication protocols.

3.2. Immunization priorities, objectives and strategies

3.2.1. Immunization system priority # 1: Human Resources Capacity Building

- **Objective:** Strengthen the immunization workforce for effective and high-quality service delivery.
- **Strategy:** Institutionalize EPI training and capacity development within the national health system.
- **Main interventions:**
  1. **Develop HR plan for EPI**
     - Conduct workforce mapping of vaccinators and supervisors.
     - Develop EPI HR strategic plan (recruitment, retention, redistribution).
     - Integrate EPI competencies in MoHD HR policy.
  2. **Institutionalize CHWs into EPI structure**
     - Define CHWs' EPI roles (defaulter tracing, outreach mobilization).
     - Include CHWs in EPI supervision and reporting chain.
     - Provide basic EPI training and IEC tools.
  3. **Standardize supervision tools**
     - Develop and roll out standard supervision checklists.
     - Conduct quarterly joint supervision visits.
     - Digitize supervision tools using mobile apps.

3.2.2. Immunization system priority # 2: Service Delivery Strengthening

- **Objective:** Expand equitable access to quality routine immunization (RI) across all districts.
- **Strategy:** Increase the number and quality of fixed and outreach immunization sessions.
- **Main interventions:**
  1. **Upgrade and map health facilities**
     - Conduct a national mapping of functional and non-functional EPI sites.
     - Upgrade infrastructure in priority underserved districts.
     - Ensure each district has adequate fixed and outreach points.
  2. **Develop integrated micro-plans**
     - Conduct micro-planning workshops with PHC and EPI teams.
     - Integrate immunization with nutrition, ANC, and outreach plans.
     - Update and validate micro-plans annually.

3. **Implement defaulter tracing**
    - Introduce defaulter tracking registers and reminder tools.
    - Engage CHWs and local leaders to identify missed children.
    - Use SMS reminders where feasible.

3.2.3. Immunization system priority # 3: Surveillance and M&E Strengthening

- **Objective:** Enhance detection, reporting, and response for VPDs with reliable data for decision-making.
- **Strategy:** Strengthen IDSR integration, laboratory capacity, and M&E systems.
- **Main interventions:**
    - Train and deploy surveillance focal points at all levels.
    - Equip regional labs and ensure specimen transport mechanisms.
    - Integrate immunization indicators within DHIS2 and IDSR platforms.
    - Conduct quarterly data quality audits (DQAs).
    - Establish M&E dashboard and feedback mechanisms.

3.2.4. Immunization system priority # 4: Demand Generation & Communication

- **Objective:** Increase community trust, awareness, and demand for immunization.
- **Strategy:** Implement Social and Behavior Change Communication (SBCC) and proactive media engagement.
- **Main interventions:**
    1. **Update SBCC strategy**
        - Review and expand SBCC framework for 2025–2030.
        - Develop targeted messages for different audiences (parents, adolescents, and women).
    2. **Engage religious/community leaders**
        - Train imams, elders, and community champions.
        - Organize community dialogue sessions to dispel myths.
        - Strengthen collaboration with local media for vaccination campaigns.
    3. **Develop AEFI crisis communication plan**
        - Create a media and risk communication SOP.
        - Establish rapid response communication team.
        - Monitor and counter misinformation through social media tracking.

3.2.5. Immunization system priority # 5: Data Quality & Use

- **Objective:** Improve accuracy, completeness, and use of immunization data at all levels.
- **Strategy:** Strengthen DQA and digital tools
- **Main interventions:**
    - Conduct monthly data validation meetings at district level.
    - Train health workers on data entry, verification, and analysis.
    - Conduct annual DQA and feedback workshops.
    - Use data for micro-planning and targeted supervision.
    - Routine data validation

3.3. Financing priorities, objectives and strategies

3.3.1. Financing priority # 1: Increase Domestic Financing for EPI

- **Objective:** Ensure sustainable national funding for immunization services.
- **Strategy:** Advocate for a dedicated EPI budget line within the national health budget.
- **Main interventions:**
    - Establish EPI line item under MoHD recurrent budget.
    - Conduct advocacy meetings with MoF, Parliament, and partners.
    - Prepare annual investment cases to justify allocations.
    - Monitor budget execution and report utilization quarterly.
    - Establish EPI line item

3.3.2. Financing priority # 2: Partner Coordination and Efficiency

- **Objective:** Ensure harmonized and transparent use of partner resources.
- **Strategy:** Strengthen coordination and accountability through ICC and joint reviews.
- **Main interventions**
    - Conduct annual joint EPI review meetings with all partners.
    - Align donor support through one national work plan and resource map.
    - Establish partner tracking dashboard (funds, activities, coverage impact).
    - Conduct joint field supervision missions.

3.3.3. Financing priority # 3: Resource Mobilization for New Vaccines

- **Objective:** Secure predictable and long-term funding for new vaccine introduction and sustainability.
- **Strategy:** Develop a multi-partner financing roadmap for future vaccine introduction (HPV, Hep-B, etc.) and strengthen domestic and external resource mobilization for evidence generation and innovation.
- **Main interventions**
    - Conduct fiscal space and cost-effectiveness analysis for new vaccines.
    - Develop vaccine sustainability and transition plan (post-donor support).
    - Engage private sector and NGOs in corporate social responsibility (CSR) contributions.
    - Advocate for regional resource pooling and cross-border partnerships.
    - Strengthen immunization research and innovation
        - Conduct routine and end-line immunization coverage surveys to validate administrative data and measure equity.
        - Implement community knowledge, attitudes, and practices (KAP) studies to understand behavioral and social drivers of vaccination.
        - Support operational research on strategies to reach zero-dose children, nomadic communities, and insecure/remote areas.
        - Establish a national immunization research agenda and partner with universities and research institutions for technical capacity.

4. Resource requirements and financing

5.1. Resources requirements

The successful implementation of the Somaliland National Immunization Strategy (NIS) 2026–2030 requires adequate and sustainable resources to strengthen all components of the immunization system. The total estimated cost for the five-year period is USD 46.38 million, covering key programmatic areas such as vaccine supply, cold chain and logistics, service delivery, human resources, surveillance, demand generation, and program management.

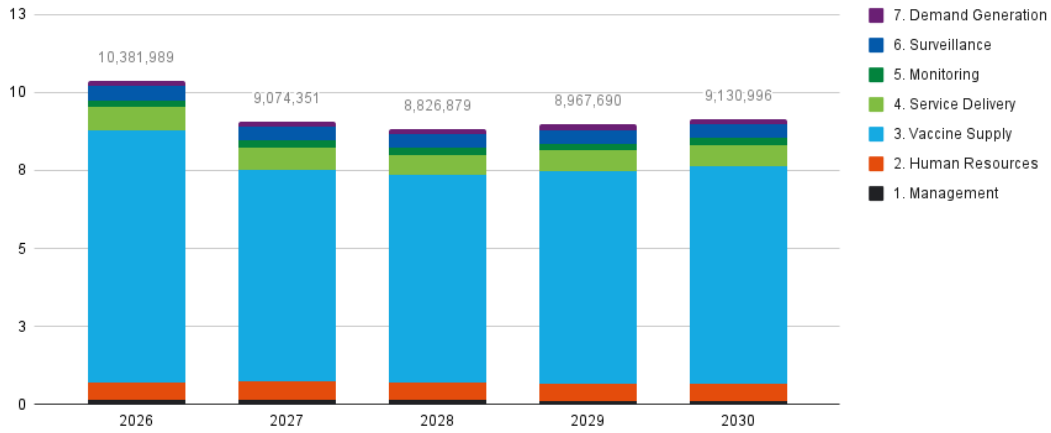
The largest share of the budget—approximately 70.7% (Table 5.1.3) —is allocated to vaccine procurement and supply chain management to ensure uninterrupted access to quality vaccines for all target populations. Other critical investments include strengthening human resources through training and institutionalization of community health workers, improving service delivery through outreach and integration with PHC, upgrading cold chain infrastructure, and enhancing data systems for evidence-based decision-making. The resource projections are aligned with the phased implementation roadmap, focusing on restoring coverage, improving equity, and ensuring program sustainability.

In addition to direct service delivery costs, the budget includes resources for governance, monitoring, and demand generation activities that are essential for maintaining public trust and accountability. These investments will enable the Ministry of Health Development (MoHD) and its partners to achieve the NIS targets, strengthen system resilience, and improve immunization coverage and quality across all regions of Somaliland.

5.1.1. Resource requirement by EPI component

Resource Requirements by EPI Component projected over 5 years, US dollars						
EPI Program Component	**2026**	**2027**	**2028**	**2029**	**2030**	**Total 5 years**
1. Management	144,850	169,750	153,850	128,450	119,450	**716,350**
2. Human Resources	563,377	563,377	563,377	541,527	541,527	**2,773,185**
3. Vaccine & other Supplies	8,074,112	6,775,621	6,623,949	6,812,010	6,984,316	**35,270,008**
4. Service Delivery	733,800	733,800	653,900	653,900	653,900	**3,429,300**
5. Monitoring	230,050	230,050	230,050	230,050	230,050	**1,150,250**
6. Surveillance	461,000	432,552	432,552	432,552	432,552	**2,191,208**
7. Demand Generation	174,800	169,201	169,201	169,201	169,201	**851,604**
Total all components	**10,381,989**	**9,074,351**	**8,826,879**	**8,967,690**	**9,130,996**	**46,381,905**

5.1.2. EPI component projected by year, US dollars, million



5.1.3. Budget by Government Expense Heads

Budget By Government Heads						
Government Budget / Expense Heads	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Grand Total	**10,381,989**	**9,074,351**	**8,826,879**	**8,967,690**	**9,130,996**	**46,381,905**
Vaccines & other Supplies	7,366,212	6,086,013	6,268,591	6,456,652	6,650,340	**32,827,808**
Cold chain	517,100	544,600	210,350	210,350	196,600	**1,679,000**
Fuel, transport	190,800	145,008	145,008	145,008	137,376	**763,200**
Printing/child health records/immunization cards	15,900	31,800	15,900	15,900	15,900	**95,400**
Research/guidelines/SOPs	131,100	131,100	131,100	105,700	105,700	**604,700**
Disease Surveillance and Response	407,300	386,852	386,852	386,852	386,852	**1,954,708**
Health Promition / Communication	174,800	169,201	169,201	169,201	169,201	**851,604**
Service Delivery	701,800	701,800	621,900	621,900	621,900	**3,269,300**
Program Management & Human Resource	135,550	144,550	144,550	144,550	135,550	**704,750**
Human Resource Development	513,577	513,577	513,577	491,727	491,727	**2,524,185**
Monitoring/Supervision/ Evaluation	227,850	219,850	219,850	219,850	219,850	**1,107,250**

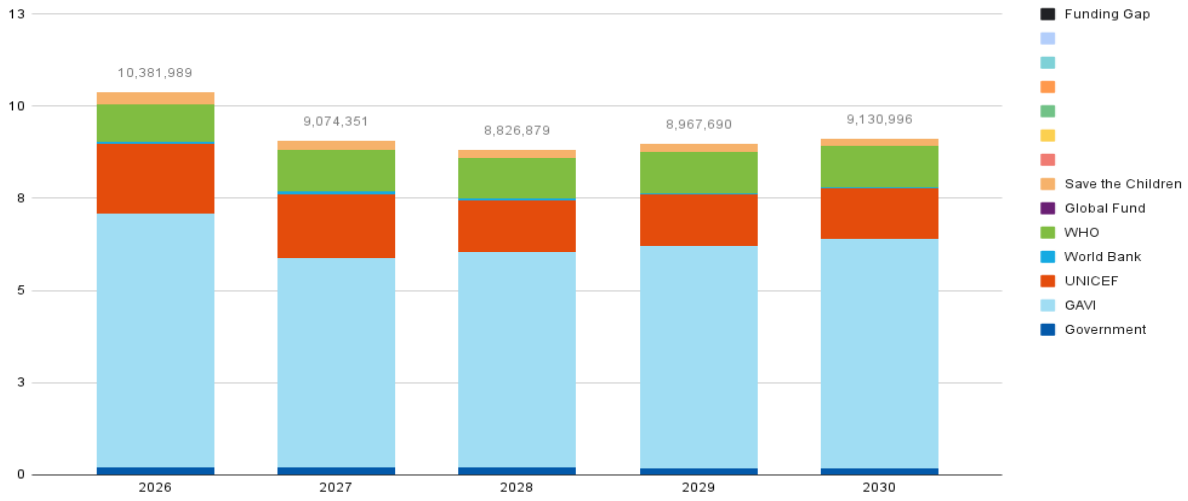
1.2. Financing

The implementation of the NIS will be financed through a combination of partner contributions and domestic commitments, with a strong focus on sustainability and resource mobilization. Over the five-year period, the total projected financing requirement amounts to USD 46.38 million, expected to be supported primarily by Gavi, UNICEF, WHO, the World Bank, and other partners, while the government progressively increases its contribution.

Gavi is projected to remain the main financial contributor, covering vaccine procurement and related operational costs, followed by UNICEF and WHO, which will support cold chain, service delivery, capacity building, and communication activities. The World Bank and other partners such as Save the Children are expected to provide complementary support for health systems strengthening and community outreach.

To ensure long-term sustainability, the MoHD will advocate for the establishment of a dedicated EPI budget line within the national health budget and progressively increase domestic financing over the strategy period. A key priority will be to develop an EPI financing roadmap that outlines a transition plan from external to domestic funding, ensuring predictable and sustainable investment in immunization. Regular financial tracking, joint reviews, and partner coordination through the ICC will help ensure transparency, alignment, and efficient use of resources throughout the implementation of the NIS.

Funding Source Projected over 5 years, US dollars, Million					
Projected Funding Sources	**YEAR 1**	**YEAR 2**	**YEAR 3**	**YEAR 4**	**YEAR 5**
	2026	**2027**	**2028**	**2029**	**2030**
Government	187,792	187,792	187,792	180,509	180,509
GAVI	6,897,364	5,693,247	5,864,044	6,039,967	6,221,155
UNICEF	1,908,907	1,740,551	1,386,148	1,382,536	1,370,654
World Bank	48,283	56,583	51,283	42,817	39,817
WHO	1,018,359	1,151,578	1,119,644	1,103,894	1,100,894
Save the Children	321,283	244,600	217,967	217,967	217,967
Total funds required	**10,381,988**	**9,074,351**	**8,826,878**	**8,967,690**	**9,130,996**
Funding Gap	**0**	**0**	**0**	**0**	**0**



2. Special considerations

1.1. Supplementary immunization activities

Supplementary immunization activities (SIAs) will be used to close immunity gaps, rapidly raise population protection and prevent or control outbreaks, while systematically linking missed children to routine services. Planning will be risk-based, using annual measles and polio risk assessments to prioritize districts and guide detailed micro-plans for fixed, outreach and mobile teams, including strategies for nomadic and hard-to-reach communities. Each round will integrate appropriate child health interventions such as Vitamin A, deworming and nutrition screening where feasible, and will be preceded by readiness assessments of cold chain, transport and staffing. Surge teams will be trained for safe vaccination, daily monitoring, AEFI detection and rapid corrective action. Real-time monitoring (daily tallies, rapid convenience checks and, where feasible, LQAS) will inform same-week mop-ups. Post-campaign reviews will document coverage, AEFI, independent monitoring results and a named list of zero-dose and under-immunized children referred to RI. Over 2026–2030, Somaliland will conduct a nationwide measles/rubella SIA in 2026 with targeted follow-ups as indicated by surveillance, maintain readiness for rapid polio response rounds, and, where risk dictates, implement focused Td activities for women of reproductive age. Communication will combine mass media, social media listening and community engagement through religious and traditional leaders to build trust and counter misinformation.

1.2. New Vaccine Introduction

Somaliland will sustain the PCV13 and rotavirus programmes and introduce additional vaccines in a phased, system-ready manner that protects equity and financial sustainability. Decisions will follow NITAG review of disease burden, cost-effectiveness and delivery feasibility, with ICC endorsement and a multi-year financing plan. Hepatitis B birth dose will be prioritized by linking delivery rooms and community birth notification to timely vaccination and by strengthening cold chain and last-mile supply. HPV introduction will be assessed in 2026–2027, with a pilot using school platforms and tailored outreach for out-of-school girls before national scale-up. All introductions will include updated SOPs and job aids, pre-/in-service training, configured DHIS2 and stock tools, strengthened safety monitoring and crisis communication, and a post-introduction evaluation at 12 months. Financing will blend partner support and a domestic co-financing roadmap, with vaccine and device forecasts integrated into the MoHD budget and medium-term expenditure plans.

2. Monitoring and evaluation

2.1. Monitoring and evaluation of NIS

The monitoring and evaluation (M&E) framework for the Somaliland National Immunization Strategy (NIS) 2026–2030 is designed to track progress toward achieving the immunization goals, ensure accountability, and promote data-driven decision-making. It aligns with the Immunization Agenda 2030 (IA2030), the EMRO Immunization Strategic Framework, and national health sector performance mechanisms. The framework uses a three-tier structure — impact, outcome, and output indicators — covering all immunization system components and key performance areas. Annual and mid-term reviews will measure progress, while biennial performance reviews and end-of-strategy evaluations will assess overall impact.

2.2. Monitoring and evaluation framework

2.2.1. Health impact indicators

Impact Goal	Indicator	Baseline (2024)	Target (2030)	Source of Data	Frequency
Prevent disease and save lives	Number of future deaths averted through immunization	NA	To be determined by Gavi/WHO model	WHO/UNICEF model	Every 5 years
Control, eliminate and eradicate VPDs	Number of VPD outbreaks (measles, cVDPV2, diphtheria, meningitis)	≥5 outbreaks/year	<2 outbreaks/year	IDSR, surveillance reports	Annual
Promote equity and leave no one behind	Number of zero-dose children	43%	50% reduction	DHS, DHIS2, coverage surveys	Annual
Provide access to all vaccines	Number of new/under-utilized vaccines introduced (HPV, Hep-B birth dose)	2	4	MoHD reports, Gavi JRF	Annual
Contribute to PHC/UHC	UHC Index of Service Coverage	26	≥40	WHO/World Bank UHC data	Every 2 years

2.2.2. Immunization outcomes indicators

Domain	Indicator	Baseline (2024)	Target (2030)	Source of Data	Frequency
Immunization Coverage	Penta3 coverage	54%	≥90%	DHIS2, coverage survey	Annual
	MCV2 (MR) coverage	19%	≥80%	DHIS2, coverage survey	Annual
Demand and Utilization	Dropout rate	18%	<5%	DHIS2, facility data	Quarterly
	% of caregivers with positive attitude toward vaccination	TBD	30%	KAP survey	Biennial
Equity	% of districts achieving ≥80% coverage	35%	100%	DHIS2	Annual

2.2.3. Immunization output indicators

Component	Indicator	Baseline (2024)	Target (2030)	Source of Data	Frequency
Program Management & Financing	EPI line item established in MoHD budget	No	Yes by 2028	MoHD/MoF budget reports	Annual
	% of MoHD budget allocated to EPI	0%	≥5%	MoHD/MoF records	Annual
Human Resources Management	% of regions implementing EPI HR plan	0%	100%	HR/EPI reports	Annual
	# of CHWs engaged in immunization	500	1,200	EPI reports	Annual
Vaccine Supply, Quality & Logistics	% of facilities with functional cold chain	63%	100%	EVM assessment, logistics reports	Annual
	# of CCE technicians trained and deployed	0	20	MoHD/UNICEF reports	Annual
	% of storage levels using SMT	0%	100%	DHIS2/logistics system	Annual
	# of vehicles available for vaccine transport and service delivery	0	30	Logistics & transport records	Annual
Service Delivery	% of districts with updated microplans	40%	100%	District reports	Annual
	# of integrated outreach sessions conducted	500	2,000	PHC/EPI reports	Annual

Immunization Data Quality & AEFI Monitoring	% of facilities submitting complete data	40%	100%	DHIS2 reports	Quarterly
	% of AEFI cases investigated within 48h	20%	≥90%	AEFI database	Quarterly
VPD Surveillance & Control	% of districts with trained surveillance focal points	40%	100%	Surveillance reports	Annual
	# of regional labs functional for VPD testing	1	6	MoHD/WHO lab assessments	Annual
Advocacy, Communication & Demand Generation	SBCC strategy updated and implemented	Outdated	2026 version operational	MoHD/UNICEF	Once
	% increase in caregiver knowledge and vaccine acceptance	TBD	30%	KAP survey	Biennial

2.2.4. Regional & Global Disease Control Targets

Disease	Target by 2030	Indicator	Source
Polio	Maintain zero wild poliovirus cases	cVDPV2 cases	AFP surveillance
Measles	Eliminate endemic transmission	Measles incidence <1 per million	Measles surveillance
Rubella	Eliminate congenital rubella syndrome	Rubella incidence <1 per million	CRS surveillance
Tetanus	Sustain elimination of maternal & neonatal tetanus	<1 case per 1,000 live births	Tetanus surveillance
Hepatitis B	≤1% HBsAg prevalence among children	Sero-survey	WHO
Diphtheria & Pertussis	Reduce morbidity and outbreaks	Annual case reports	IDSR, EPI

3. Implementation and operationalization

Implementation of the Somaliland National Immunization Strategy (NIS) 2026–2030 will be led by the Ministry of Health Development (MoHD) through the Department of Child Health and Expanded Programme on Immunization (EPI), working in close coordination with regional and district health teams. The strategy will be operationalized through annual, costed operational plans (AOPs) that translate the NIS objectives into concrete activities, budgets, and measurable targets. These plans will guide day-to-day execution, with national-level teams focusing on coordination, resource mobilization, procurement, and monitoring, while regional and district teams oversee service delivery, supervision, and data reporting. Integration with primary health care (PHC) services will ensure that immunization is consistently delivered alongside maternal, child health, and nutrition interventions.

Strong coordination and governance will be maintained through the Inter-Agency Coordinating Committee (ICC) and the National Immunization Technical Advisory Group (NITAG), supported by relevant subcommittees. These bodies will ensure partner alignment, policy guidance, and oversight of implementation progress. The forthcoming National Immunization Law (NIL) will provide a legal foundation for immunization financing, accountability, and sustainability. Annual and quarterly ICC meetings will review performance, funding flows, and progress toward NIS milestones, while joint supervision and partner coordination mechanisms will promote efficiency and transparency.

Monitoring and accountability will be anchored in a results-based framework using quarterly scorecards, field supervision, and data quality reviews. Annual reviews will assess progress toward coverage, equity, and system-strengthening goals, while mid-term and end-of-strategy evaluations will measure overall impact. Lessons learned from implementation will be integrated into subsequent annual plans to promote continuous improvement, resilience, and equitable access to immunization services across all regions of Somaliland.

3.1. Risk, assumption and mitigation

Risk	Assumption	Mitigation
Donor funding reduction	MoHD advocates for budget inclusion	Develop EPI financing roadmap
HR attrition	CHW integration improves retention	Institutionalize EPI positions
Conflict/insecurity	Stable political support	Decentralize immunization to local teams
Cold chain breakdowns	Maintenance capacity built	Train regional technicians

3.2. From NIS to AOP

The NIS will be operationalized through annual, costed operational plans that translate multi-year priorities into concrete activities, budgets and measurable targets. Each year, planning will begin in the fourth quarter with a review of NIS progress, the M&E dashboard and district bottleneck analyses. National, regional and district teams will then negotiate coverage, equity and zero-dose targets; confirm SIA needs; schedule outreach and mobile sessions; and align procurement, training and supervision. Activities will be costed with the NIS.COST tool and mapped to government expense heads and partner contributions, producing a consolidated plan with a clear funding gap for ICC resource mobilization. Monitoring arrangements—monthly district data reviews, quarterly supervision and ICC performance reviews, scheduled DQAs and feedback—will be embedded in the plan, enabling adaptive management such as re-programming funds to underperforming districts, deploying surge teams or adjusting outreach frequency. End-year assessments will document outputs, budget execution and lessons learned, update the risk register and feed directly into the next AOP cycle, ensuring a continuous learning loop from strategy to implementation to results.

4. Annexes

4.1. Annex 1: Reference Documents and Data Sources

1. Gavi, the Vaccine Alliance (2020*) Gavi Analysis Guidance 2020*. Geneva: Gavi, the Vaccine Alliance.
2. Ministry of Health Development (MoHD) (2020) *Somaliland Expanded Programme on Immunization (EPI) Policy 2020*. Hargeisa: Ministry of Health Development.
3. Ministry of Health Development (MoHD) (2021) *Somaliland Comprehensive Multi-Year Plan (cMYP) 2021–2025*. Hargeisa: Ministry of Health Development.
4. Ministry of Health Development (MoHD) (2023) *List of priority IDSR diseases: Implementation of the Integrated Disease Surveillance and Response (IDSR) Strategy.* Hargeisa: MoHD.
5. Ministry of Health Development (MoHD) (2023) *National technical guidelines for Integrated Disease Surveillance and Response (IDSR): Tools and standard operating procedures (SOPs).* Hargeisa: MoHD.
6. Ministry of Health Development (MoHD) (2024) *District Health Information System (DHIS2) administrative data on immunization coverage and equity, 2022–2024*. Hargeisa: MoHD.
7. Muse, A. and Warsame, O. (2024) *National Integrated Social and Behaviour Change Strategy 2024–2026*. Hargeisa: Ministry of Health Development.
8. United Nations Children's Fund (UNICEF) (2023) *Somaliland Effective Vaccine Management (EVM) Assessment Report*. Hargeisa: UNICEF Somalia/Somaliland Office.
9. World Health Organization (WHO) (2019) *A guide for conducting an Expanded Programme on Immunization (EPI) review*. Geneva: World Health Organization.
10. World Health Organization (WHO) (2020) *Guidance and workbook for conducting a situation analysis of immunization programme performance*. Geneva: World Health Organization.
11. World Health Organization (WHO) (2021) *Guidelines for developing a National Immunization Strategy (NIS): Frequently asked questions, key concepts and terms.* Geneva: World Health Organization.
12. World Health Organization (WHO) (2021*) Immunization Agenda 2030: Monitoring and Evaluation Framework.* Geneva: World Health Organization.
13. World Health Organization (WHO) (2021) *Implementing the Immunization Agenda 2030: A framework for action through coordinated strategies and partnerships*. Geneva: World Health Organization.
14. World Health Organization (WHO) (2024) *Somaliland immunization campaign data and post-campaign reports.* Hargeisa: WHO Country Office for Somalia/Somaliland.
15. World Health Organization (WHO) (2024*) Somaliland Vaccine-Preventable Disease (VPD) surveillance data.* Hargeisa: WHO Country Office for Somalia/Somaliland.

4.2. Annex 2: Complete list of identified barriers and their priority level

High Priority Barriers			
Category	**Barrier**	**Findings Suggesting Barrier**	**Root Causes**
1. **Programme Management & Financing**	Inadequate national immunization laws and policies	Policies exist but fragmented, outdated, not aligned; weak governance	No National Immunization Law (NIL); lack of SOPs; high staff turnover; limited capacity building
	Missed opportunities due to regulatory restrictions	Policy allows private sector, but regulatory gaps & unclear roles	Shortage of qualified staff; inadequate training
	Poor NITAG/ICC functionality	Irregular meetings, unclear TORs	Weak coordination; no meeting calendar
	Inefficient planning processes	Not aligned with health sector & financial planning	Donor dependence; lack of government contribution
	Insufficient national & subnational financing	Allocation <5%; weak commitment	Donor dependence; poor domestic funding
	Reduction in immunization funding & uncertainty for new vaccines	Gavi-dependent; no sustainability	Lack of domestic financing mechanism
2. **Human Resources Management**	Inadequate supply of health staff	Shortages & maldistribution; donor-reliant	No long-term HR plan; high turnover
	Poor staff motivation	Delayed pay, weak working conditions	Donor dependence; poor financial management
	Vaccinator hesitancy / misunderstanding of multiple vaccine policy	Reluctance due to policy confusion	Lack of SOPs; poor training and selection
	Zero-dose barriers due to insufficient EPI staff	Underserved remote areas	Lack of relocation policy; project dependence
3. **Vaccine Supply, Quality & Logistics**	Inadequate cold chain capacity and weak vaccine management	Weak vaccine management, limited storage	No cold chain technicians; poor maintenance and vaccine management
	Stock management and vaccine stock-outs	Poor forecasting and record-keeping	No SMT use; push system from central level

	Waste management challenges	Lack of policy, bins, and training	Poor waste management unit; no incinerators
4. **Service Delivery and Coverage**	Long distances to health facilities	Remote/nomadic populations underserved	Insufficient health facilities; poor mapping
	Displacement/conflict disrupts services	Security barriers in some areas	Blocked access, displacement
	Few functioning facilities	High population per center	Poor microplanning; resource gaps
	Inadequate defaulter tracking	Policy exists but weakly applied	No standard forms or SOPs
	Low-quality session management	Weak data, poor IPC	Limited DQA, low staff skills
	Weak EPI integration into PHC	Limited integration with RMNCH	Lack of integration policy
	Large zero-dose burden (43%)	Coverage gaps in Sool, Togdheer, Maroodi-Jeh	Limited outreach; few facilities
5. **Disease Surveillance**	Weak outbreak detection (VPDs)	Delayed detection & reporting	Low immunization coverage; limited trained staff
	Inadequate data and weak use for action	Weak validation, irregular reviews	No focal persons; limited tools
	Dysfunctional polio surveillance	Reliance on partners; no domestic plan	Lack of lab capacity, staff, and reagents
	Zero-dose-related surveillance gaps	Poor tracing of home births, nomads	Low community awareness; poor access
6. **Demand Generation**	Weak social mobilization & advocacy	Limited communication & IEC	Low funding; focus only on campaigns
	Inconvenient service access	Nomadic/remote populations underserved	Scattered settlements; low resources

4.3. Annex 3: NIS Roadmap Framework

NIS Roadmap Framework		
Level	**Serial Number**	**Description**
Objective	**1.0.0**	**Establish a sustainable, well-governed national immunization program integrated within the health system.**
Main intervention	**1.1.0**	**Develop and adopt a National Immunization Law (NIL) and strengthen governance structures (ICC, NITAG).**
Activity	1.1.1	1. Draft NIL and related policies that is supportive of immunization as a public good • Conduct desk review of current health legislation and EPI policy environment. • Form a technical working group (TWG) on immunization governance (MoHD, MoJ, Parliament, WHO, UNICEF). • Draft and validate the National Immunization Law (NIL) ensuring provisions for vaccine security, financing, accountability, and mandates for immunization. • Conduct national consultation and validation workshops with stakeholders. • Submit NIL to the Council of Ministers and Parliament for endorsement. • Develop and disseminate implementing regulations and operational guidelines.
Activity	1.1.2	2. Regular ICC/NITAG meetings • Revise and update the Terms of Reference for ICC and NITAG. • Develop annual meeting calendar with regular quarterly meetings. • Build capacity of ICC/NITAG members on evidence-based decision-making. • Ensure documentation and follow-up of action points from each meeting.
Activity	1.1.3	3. Integrate EPI into national health planning • Embed EPI activities and indicators in the Health Sector Strategic Plan and Annual Operational Plans. • Include immunization in district health plans and budgets. • Align EPI monitoring with PHC performance reviews.

Activity	1.1.4	4. Increase government budget allocation • Advocate for EPI budget line within MoHD and MoF frameworks. • Conduct fiscal space analysis and cost-benefit studies to support advocacy. • Present annual investment cases to Parliament and Cabinet. • Establish a predictable flow of funds for EPI operations.
Activity	1.1.5	5. Define responsibility, accountability and authority framework at each level and for every immunization body • Map EPI roles and responsibilities across all administrative levels. • Develop an accountability and performance management framework for immunization staff. • Institutionalize quarterly performance reviews at national and regional levels.
Objective	**2.0.0**	**Restore coverage & equity (≥90% national and ≥80% district coverage for all basic vaccines) and Reach zero-dose and under-immunized children**
Main intervention	**2.1.0**	**Scale up outreach/mobile services, target nomadic and rural populations, and ensure equitable access to all basic vaccines.**
Activity	2.1.1	1. Develop micro-plans for hard-to-reach areas • Conduct district-level mapping to identify underserved and nomadic populations. • Train EPI teams on micro-planning using WHO RED/REC approach. • Update micro-plans annually with population estimates, session plans, and logistics needs. • Integrate micro-plans into DHIS2-based monitoring systems.
Activity	2.1.2	2. Integrate RI with PHC and outreach • Deliver immunization services alongside maternal, nutrition, and growth monitoring services. • Conduct joint outreach missions combining EPI, MNCH, and nutrition activities. • Integrate immunization during health campaigns and community health days.
Activity	2.1.3	3. Introduce performance-based incentives • Develop EPI performance scorecards for regional and district teams. • Pilot incentive schemes (non-financial and financial) in low-performing districts. • Evaluate pilot results and scale up based on effectiveness.

Activity	2.1.4	4. Strengthen coverage for all basic antigens • Ensure continuous vaccine supply and monitor antigen-specific coverage: • BCG – improve coverage at birth through facility-based delivery linkage. • Pentavalent (DPT-HepB-Hib) – ensure timely 3-dose completion via follow-up and defaulter tracing. • bOPV/IPV – synchronize schedules and maintain surveillance for AFP. • Measles (MR) – improve second dose uptake through school-based and outreach vaccination. • Td – target women of reproductive age through ANC and school campaigns. • PCV13, Rota, Hep-B – ensure availability and strengthen cold chain for new vaccines introduction.
Activity	2.1.5	5. Scale up immunization service delivery through Public–Private Partnerships (PPP) • Expand PPP agreements with additional private hospitals and clinics across all regions. • Train private-sector vaccinators on EPI standards, safety, data reporting, and AEFI procedures. • Integrate private health facilities into national micro-planning, supervision, and DHIS2 reporting systems. • Supply participating private facilities with vaccines, recording tools, and IEC materials based on performance and compliance. • Conduct joint MoHD–private sector review meetings to monitor service delivery, coverage results, and quality assurance.
Activity	2.1.6	BCG-20
Activity	2.1.7	BOPV-20
Activity	2.1.8	MCV (MR)
Activity	2.1.9	DTP-HepB-Hib-1 (Penta)
Activity	2.1.10	PCV13-1
Activity	2.1.11	IPV-1
Activity	2.1.12	RV1-10
Activity	2.1.13	Td-10
Objective	**3.0.0**	**Ensure uninterrupted vaccine supply and maintain quality across all levels.**
Main intervention	**3.1.0**	**Rehabilitate and modernize cold chain and logistics systems for vaccines and related supplies.**

Activity	3.1.1	1. Deploy solar Cold Chain Equipment (CCE) • Conduct national cold chain inventory and gap analysis. • Prioritize facilities lacking reliable power or storage capacity. • Procure and install WHO PQS-approved solar CCEs. • Ensure preventive maintenance plans and functionality assessments.
Activity	3.1.2	2. Recruit cold chain technicians • Recruit regional cold chain officers for all regions. • Establish maintenance contracts or service hubs for timely repairs. • Strengthen reporting lines and TORs for cold chain staff
Activity	3.1.3	3. Introduce electronic stock management tool (SMT) • Roll out SMT at national and regional vaccine stores. • Integrate SMT outputs into national vaccine logistics dashboards. • Conduct quarterly stock data reviews to improve accuracy and forecasting. • Strengthen stock visibility across all levels of the system.
Activity	3.1.4	4. Strengthen transport and distribution system for vaccines and supplies • Purchase vehicles for regional vaccine distribution (Phase 1) • Purchase vehicles for district-level vaccine transport (Phase 2) • Vehicle operation & maintenance (fuel, servicing, insurance) • Driver salaries for regional/district vehicles
Activity	3.1.5	5. Build Capacity in Vaccine & Supply Forecasting and Quantification • Train cold chain officers in forecasting, quantification, and supply planning. • Introduce modern forecasting tools/platforms (e.g., WHO/UNICEF tools, electronic forecasting models). • Train logisticians and storekeepers on temperature monitoring, maintenance planning, and SMT usage. • Conduct regular capacity refresher sessions and mentoring support. • Develop forecasting SOPs and integrate them into national logistics management procedures.

Objective	**4.0.0**	**Improve early detection, confirmation, and rapid response to vaccine-preventable diseases (VPDs).**
Main intervention	**4.1.0**	**Integrate immunization surveillance within the Integrated Disease Surveillance and Response (IDSR) framework.**
Activity	4.1.1	1. Train surveillance officers • Conduct refresher training on VPD surveillance and outbreak detection for all districts. • Provide updated case definitions and reporting tools. • Conduct joint EPI–IDSR supportive supervision.
Activity	4.1.2	2. Establish laboratory capacity • Equip regional laboratories with basic diagnostic tools and sample collection kits. • Strengthen referral linkages to WHO-accredited reference laboratories. • Train lab staff on biosafety, specimen handling, and quality assurance.
Activity	4.1.3	3. Strengthen AEFI monitoring • Develop national AEFI policy, guidelines, and SOPs. • Train vaccinators and supervisors on AEFI identification and reporting. • Establish AEFI review committee and crisis communication protocols.
Objective	**5.0.0**	**Strengthen the immunization workforce for effective and high-quality service delivery.**
Main intervention	**5.1.0**	**Institutionalize EPI training and capacity development within the national health system.**
Activity	5.1.1	1. Develop HR plan for EPI • Conduct workforce mapping of vaccinators and supervisors. • Develop EPI HR strategic plan (recruitment, retention, redistribution). • Integrate EPI competencies in MoHD HR policy.
Activity	5.1.2	2. Institutionalize CHWs into EPI structure • Define CHWs' EPI roles (defaulter tracing, outreach mobilization). • Include CHWs in EPI supervision and reporting chain. • Provide basic EPI training and IEC tools. • Incentives for national and regional EPI teams

Activity	5.1.3	3. Standardize supervision tools • Develop and roll out standard supervision checklists. • Conduct quarterly joint supervision visits. • Digitize supervision tools using mobile apps.
Objective	**6.0.0**	**Expand equitable access to quality routine immunization (RI) across all districts.**
Main intervention	**6.1.0**	**Increase the number and quality of fixed and outreach immunization sessions**
Activity	6.1.1	1. Upgrade and map health facilities • Conduct a national mapping of functional and non-functional EPI sites. • Upgrade infrastructure in priority underserved districts. • Ensure each district has adequate fixed and outreach points.
Activity	6.1.2	2. Develop integrated micro-plans • Conduct micro-planning workshops with PHC and EPI teams. • Integrate immunization with nutrition, ANC, and outreach plans. • Update and validate micro-plans annually.
Activity	6.1.3	3. Implement defaulter tracing • Introduce defaulter tracking registers and reminder tools. • Engage CHWs and local leaders to identify missed children. • Use SMS reminders where feasible.
Objective	**7.0.0**	**Enhance detection, reporting, and response for VPDs with reliable data for decision-making**
Main intervention	**7.1.0**	**Strengthen IDSR integration, laboratory capacity, and M&E systems**
Activity	7.1.1	1. Train and deploy surveillance focal points at all levels.
Activity	7.1.2	3. Integrate immunization indicators within DHIS2 and IDSR platforms.
Activity	7.1.3	4. Conduct quarterly data quality audits (DQAs).
Activity	7.1.4	5. Establish M&E dashboard and feedback mechanisms.
Objective	**8.0.0**	**Increase community trust and demand for immunization**
Main intervention	**8.1.0**	**Implement Social and Behavior Change Communication (SBCC) and proactive media engagement.**

Activity	8.1.1	1. Update SBCC strategy • Review and expand SBCC framework for 2025–2030. • Develop targeted messages for different audiences (parents, adolescents, and women).
Activity	8.1.2	2. Engage religious/community leaders • Train imams, elders, and community champions. • Organize community dialogue sessions to dispel myths. • Strengthen collaboration with local media for vaccination campaigns.
Activity	8.1.3	3. Develop AEFI crisis communication plan • Create a media and risk communication SOP. • Establish rapid response communication team. • Monitor and counter misinformation through social media tracking.
Objective	**9.0.0**	**Improve accuracy, completeness, and use of immunization data at all levels.**
Main intervention	**9.1.0**	**Strengthen DQA and digital tools**
Activity	9.1.1	• Conduct monthly data validation meetings at district level. • Train health workers on data entry, verification, and analysis. • Conduct annual DQA and feedback workshops. • Use data for micro-planning and targeted supervision. • Routine data validation
Objective	**10.0.0**	**Increase Domestic Financing for EPI**
Main intervention	**10.1.0**	**Advocate for a dedicated EPI budget line within the national health budget**
Activity	10.1.1	• Establish EPI line item under MoHD recurrent budget. • Conduct advocacy meetings with MoF, Parliament, and partners. • Prepare annual investment cases to justify allocations. • Monitor budget execution and report utilization quarterly. • Establish EPI line item
Objective	**11.0.0**	**Partner Coordination and Efficiency**

Main intervention	**11.1.0**	**Strengthen coordination and accountability through ICC and joint reviews.**
Activity	11.1.1	• Conduct annual joint EPI review meetings with all partners. • Align donor support through one national workplan and resource map. • Establish partner tracking dashboard (funds, activities, coverage impact). • Conduct joint field supervision missions.
Objective	**12.0.0**	**Secure predictable and long-term funding for new vaccine introduction and sustainability.**
Main intervention	**12.1.0**	**Develop a multi-partner financing roadmap for future vaccine introduction (HPV, Hep-B, etc.).**
Activity	12.1.1	• Conduct fiscal space and cost-effectiveness analysis for new vaccines. • Develop vaccine sustainability and transition plan (post-donor support). • Engage private sector and NGOs in corporate social responsibility (CSR) contributions. • Advocate for regional resource pooling and cross-border partnerships.
Activity	12.1.2	• Strengthen immunization research and innovation - Conduct routine and end-line immunization coverage surveys to validate administrative data and measure equity. - Implement community knowledge, attitudes, and practices (KAP) studies to understand behavioral and social drivers of vaccination. - Support operational research on strategies to reach zero-dose children, nomadic communities, and insecure/remote areas. - Establish a national immunization research agenda and partner with universities and research institutions for technical capacity.

4.4. Annex 5: Detailed Monitoring & Evaluation Framework

	Phase 1: Urgent Priorities							
Priority Area	**Activities**	**SMART Indicators**	**Source of Data**	**Baseline (2024/2025)**	**Milestones (Y1–Y2)**	**Target (2030)**	**Potential Actions Based on Indicator Results**	**Responsible Actor(s)**

1. Strengthen Immunization Governance & Financing	Draft and adopt National Immunization Law (NIL)	**Output:** NIL endorsed and implemented	Policy and MoHD records	None	Y1-Y2: Draft completed Y3: Endorsed	NIL enacted by 2028	Expedite parliamentary endorsement. Conduct advocacy meetings	• MoHD • MoF • Parliament • WHO • UNICEF
	Conduct regular ICC/NITAG meetings	**Process:** # of ICC/NITAG meetings held annually	ICC/NITAG minutes	1 per year	Y1: 3	≥4 per year	Strengthen coordination and ensure follow-up actions	• MoHD • ICC/NITAG
	Integrate EPI into national health planning	**Output:** EPI reflected in national health and financial plans	HSSP, AOPs, DHIS2	Partial	Y2: Fully integrated	Fully aligned by 2030	Engage MoHD Planning and Finance units	• MoHD • Partners
	Increase government budget allocation for EPI	**Outcome:** % of MoHD budget allocated to immunization	MoHD/ MoF budgets	None	Y1 (EPI line item included in draft MoHD budget). Y2 (1% of MoHD budget allocated to immunization). Y3 (2% allocation). Y4 (3.5% allocation)	≥5% allocation (of total MoHD budget)	Continue advocacy and evidence-based investment case. Sabin Vaccine Institute could support the vaccine advocacy for domestic funding	• MoHD • MoF

	Define accountability and performance framework	**Process:** Accountability framework approved and implemented	MoHD HR and governance reports	None	Y2: Finalized	Approved and used by 2030	Conduct capacity building on accountability tools	• MoHD, HR Department
2. Restore Coverage and Equity	Develop and implement outreach micro-plans for hard-to-reach areas	**Process:** % of districts with updated micro-plans	DHIS2, District reports	40%	Y2: 70%	100%	Strengthen district-level micro-planning and supervision	• MoHD • RHO • UNICEF
	Integrate RI with PHC and outreach services	**Outcome:** # of integrated outreach sessions conducted	PHC/EPI records	500	Y2: 1,000	2,000	Increase joint missions and resource pooling	• MoHD, PHC Department • WHO
	Introduce performance-based incentives	**Process:** # of regions implementing incentive scheme	HR and EPI reports	0	Y1: 2 regions	6 regions	Expand incentive coverage to all regions	• MoHD • HR Department
	Ensure continuous coverage of all basic antigens (BCG, Penta, bOPV/IPV, MR, Td, PCV13, Rota, Hep-B birth dose)	**Outcome:** Pent 1, Penta3, MCV1 coverage rates	DHIS2 reports	Penta3: 54% MCV1: 50%	Y2: ≥70%	≥90%	Intensify outreach, defaulter tracing, and social mobilization	• MoHD, EPI
3. Enhance Cold Chain & Logistics Systems	Deploy solar CCE and rehabilitate cold chain	**Output:** % of facilities with functional cold chain	EVM, Logistics reports	63%	Y2: 90%	100%	Replace obsolete equipment; train technicians	• MoHD • UNICEF • WHO
	Train cold chain technicians	**Process:** # of trained technicians deployed	Training and	0	Y1: 6	20	Establish national CCE	• MoHD, EPI

			logistics reports				maintenance plan	Logistics
	Introduce electronic Stock Management Tool (SMT)	**Output:** SMT functional at all levels	Logistics info system	None	Y2: Implemented in 6 regions	100% rollout	Link SMT to DHIS2 and train users	• MoHD • Partners
	Procure and deploy vehicles for vaccine distribution (6 regional + phased district-level expansion)	# of vehicles procured and operational for EPI	Logistics & transport records	0	Y1-2: 6 regional vehicles	30 total (6 regional + 24 district)	Ensure fuel and maintenance budget lines included; develop vehicle replacement plan	• MoHD
4. Strengthen Surveillance and Outbreak Response	Train surveillance officers and integrate with IDSR	**Process:** % of districts with trained focal points	Surveillance reports	40%	Y2: 90%	100%	Conduct refresher training and supervision	• MoHD • WHO
	Establish laboratory capacity for VPD testing	**Output:** # of regional labs functional	Lab assessments	1	Y2: 3	6	Mobilize resources for lab equipment and supplies	• MoHD • WHO • UNICEF
	Strengthen AEFI monitoring	**Outcome:** % of AEFI cases investigated within 48h	AEFI database, reports	20%	Y2: 70%	≥90%	Conduct refresher trainings and regular AEFI committee reviews	• MoHD, AEFI Committee
Phase 2: Immunization System Strengthening								
Priority Area	**Activities**	**SMART Indicators**	**Source of Data**	**Baseline (2025)**	**Milestones (Y1–Y3)**	**Target (20230)**	**Potential Actions Based on**	**Responsible Actor(s)**

							Indicator Results	
1. Human Resources Capacity Building	Develop and implement EPI HR plan	**Output:** % of regions implementing HR plan	HR and EPI reports	0%	Y1: 50%	100%	Follow up on HR plan adoption and implementation	• MoHD • WHO • UNICEF
	Institutionalize CHWs in EPI	**Process:** # of CHWs engaged in EPI	EPI reports	500	Y2: 800	1,200	Include CHWs in micro-plans and incentive schemes	• MoHD • Partners
	Conduct supportive supervision	**Process:** % of facilities supervised quarterly	Supervision checklists	40%	Y2: 70%	100%	Strengthen supervision transport and review systems	• MoHD, EPI
2. Service Delivery Strengthening	Upgrade & map health facilities for RI	**Output:** # of upgraded EPI sites	Facility inventory	80	Y2: 100	150	Mobilize partner and donor support	• MoHD • Partners
	Implement defaulter tracing	**Outcome:** Dropout rate (Penta1–Penta3)	DHIS2, registers	4 - 8%	Y2: <5%	<4%	Expand SMS and CHW tracing	• MoHD, EPI
3. Data Quality & Use	Conduct DQA and DHIS2 capacity building	**Process:** % of facilities submitting complete data	DHIS2 reports	40%	Y2: 75%	100%	Conduct quarterly data validation and DQA reviews	• MoHD, M&E Unit
4. Demand Generation & Communication	Update SBCC strategy and engage leaders	**Outcome:** % increase in caregiver knowledge/acceptance	KAP surveys	TBD	Y2: +10%	30%	Strengthen communication campaigns	• MoHD • UNICEF
	Phase 3: Financing Priorities (2028–2030)							

Priority Area	Activities	SMART Indicators	Source of Data	Baseline (2025)	Milestones (Y3–Y5)	Target (2030)	Potential Actions Based on Indicator Results	Responsible Actor(s)
1. Increase Domestic Financing for EPI	Establish EPI budget line	**Output:** EPI line item established in MoHD budget	MoF/MoHD budget documents	None	Y3: Drafted	Approved by 2028	Maintain advocacy and monitoring with MoF	• MoHD • MoF
2. Partner Coordination & Efficiency	Conduct annual ICC partner reviews	**Process:** # of annual reviews conducted	ICC minutes	0	Y2: 1 per year	Annual	Disseminate results and align partner support	• MoHD, ICC
3. Resource Mobilization for New Vaccines	Develop vaccine sustainability plan	**Output:** Vaccine financing roadmap approved	MoHD, Gavi, WHO reports	None	Y4: Draft developed	Approved by 2030	Align roadmap with fiscal space and transition planning	• MoHD • Gavi • WHO
	Mobilize private sector contributions	**Outcome:** % increase in domestic/partner financing	Financial tracking reports	TBD	Y4: +10%	25%	Develop PPP models and private-sector engagement	• MoHD • MoF • Partners

4.5. Annex 6: List of Contributors

1. **Ministry of Health Development (MoHD) – Leadership**
   - Hon. Hussein Bashir Hirsi – Minister of Health Development
   - Dr. Ahmed Mahmoud Jama – Director General
   - Dr. Mohamed Abdi Hussein – Director of Child Health & Immunization Programme
   - Dr. Khalid Ali Ahmed – Directory of Planning & Policy
2. **Expanded Programme on Immunization (EPI) Team**
3. **Regional and District Representatives**
4. **Technical Consultants**
   - Dr. Mohamed Mukhtar Ali – Lead Consultant
   - Dr. Hamdi Isse – Assistant Consultant
5. **Development Partners**
   - Gavi, the Vaccine Alliance
   - United Nations Children's Fund (UNICEF)
   - World Health Organization (WHO)
   - Save the Children International (SCI)
   - Other International NGOs
   - National and local NGOs and CSOs

Prepared by Dr. Mohamed Mukhtar Ali (Lead Consultant) and Dr. Hamdi Issa (Assistant Consultant)


WASAARADDA HORUMARINTA
CAAFIMAADKA SOMALILAND


Gavi
The Vaccine Alliance


unicef
for every child

Gavi
The Vaccine Alliance

unicef
for every child