



GAVI/14/129/dlc

The Minister of Public Health and Population  
Ministry of Public Health and Population  
P.O. Box 299  
Sana'a  
Yemen

10 April 2014

Dear Minister,

*Yemen's Proposal to the GAVI Alliance*

I am writing in relation to Yemen's proposal to the GAVI Alliance for Health System Strengthening (HSS) cash support which was submitted to the GAVI Secretariat in October 2013.

In November 2013 your application was reviewed by the GAVI Independent Review Committee (IRC) which recommended your Health Systems Strengthening application for "Approval with Clarifications". We have since received your response to these clarifications, that were deemed satisfactory. Consequently, and following the approval of the funding envelope by the GAVI CEO, I am pleased to inform you that the GAVI Alliance approved Yemen for GAVI support as specified in the Appendices to this letter.

The same appendices are also used in the Partnership Framework Agreement (PFA) – a new simplified arrangement that we are working to agree with your colleagues – that will replace this 'decision letter' format.

We would like to highlight that Yemen received a Partnership Framework Agreement in March 2013. To date, we have not received the signatures of the Ministry of Health and Ministry of Finance on the Partnership Framework Agreement. Please be advised that the GAVI Alliance will no longer disburse subsequent tranches of HSS/ISS funds until the Partnership Framework Agreement has been signed between the GAVI Alliance and Yemen.

The Appendices includes the following important information:  
Appendix A: Description of approved GAVI support to Yemen  
Appendix B: Financial and programmatic information per type of support  
Appendix C: A summary of the IRC Report  
Appendix D: The terms and conditions of GAVI Alliance support.



The following table summarises the outcome for each type of GAVI support for Yemen:

Type of support	Appendix	Approved for 2014
Health Systems Strengthening Support	B-1	US\$4,200,000

Please do not hesitate to contact my colleague Anne Cronin ([acronin@gavialliance.org](mailto:acronin@gavialliance.org)) if you have any questions or concerns.

Yours sincerely,

A handwritten signature in black ink that reads "Hind Khatib".

Hind Khatib-Othman  
Managing Director, Country Programmes

cc: The Minister of Finance  
The Director of Medical Services  
Director Planning Unit, MoH  
The EPI Manager  
WHO Country Representative  
UNICEF Country Representative  
Regional Working Group  
WHO HQ  
UNICEF Programme Division  
UNICEF Supply Division  
The World Bank

**Description of GAVI support to *Yemen* (the “Country”)****New Vaccines Support (NVS)**

The GAVI Alliance has approved the Country’s request for supply of vaccine doses and related injection safety material which are estimated to be required for the immunization programme as set out in Appendix B. Financing provided by GAVI for vaccines will be in accordance with:

- The GAVI Alliance Guidelines governing Yemen’s proposal application; and
- The final proposal as approved by the the Independent Review Committee (IRC), including any subsequent clarifications.

The vaccines provided will be used as the country has proposed. The principles of the WHO-UNICEF-UNFPA joint statement on safety of injections (WHO/V&B/99.25) shall apply to all immunisation provided with these vaccines.

Item number 11 of Appendix B summarises the details of the approved GAVI support for vaccines in the years indicated.

Any required taxes, customs, toll or other duties imposed on the importation of vaccines and related supplies can not be paid for using GAVI funds.

The Country shall be solely responsible for any liability that may arise in connection with: (i) the implementation of any programmes in the Country; and (ii) the use or distribution of vaccines and related supplies after title to such supplies has passed to the Country. GAVI shall not be responsible for providing any additional funding to replace any vaccines and related supplies that are, or became, defective or disqualified for whatever reason.

***Country Co-financing***

In accordance with the GAVI Co-financing Policy, the Country has agreed to make the required contribution to co-financing vaccine doses as indicated in Appendix B. Item number 14 of Appendix B summarises the budget and the quantity of supply that will be procured with country’s funds in the corresponding timeframe. The total co-financing amount indicates costs for the vaccines, related injection safety devices (only applicable to intermediate and graduating countries) and freight.

Countries may select to co-finance through UNICEF Supply Division, PAHO’s Revolving Fund, or self-procure their co-financing requirement following their own procedures, except for the Pneumococcal vaccine that needs to be procured through UNICEF.

If the purchase of the co-financed supply is carried out through UNICEF or PAHO, the payment is to be made to UNICEF or PAHO (whichever is applicable) as agreed in the Procurement Services Memorandum of Understanding between UNICEF or agreements between PAHO (whichever is applicable) and the country, and not to the GAVI Alliance. Please keep in contact with UNICEF or PAHO (whichever is applicable) to understand the availability of the relevant vaccine(s) and to prepare the schedule of deliveries.



The total co-financing amount expressed in item number 14 of Appendix B does not contain costs and fees of the relevant Procurement Agency, such as contingency buffer and handling fees.

Information on these extra costs and fees will be provided by the relevant Procurement Agency as part of the cost estimate to be requested by the country. UNICEF/PAHO will share information with GAVI on the status of purchase of the co-financed supply. In accordance with the GAVI Co-financing Policy (<http://www.gavialliance.org/about/governance/programme-policies/co-financing/>), the co-financing contribution is payable annually to UNICEF/PAHO.

If the purchase of the co-financed supply is carried out by the Government, following its own procurement procedures and not procuring from UNICEF Supply Division or PAHO's Revolving Fund, the Government must submit to GAVI satisfactory evidence that it has purchased its co-financed portion of the vaccines and related supplies, including by submitting purchase orders, invoices, and receipts to GAVI. GAVI encourages that countries self-procuring co-financed products (i.e. auto-disable syringes and syringe and needle disposal boxes) ensure that products appear on the applicable WHO list of pre-qualified products or, for syringe and needle disposal boxes, that they have obtained a certificate of quality issued by a relevant national authority.

**GAVI support will only be provided if the Country complies with the following requirements:**

Transparency and Accountability Policy(TAP): Compliance with any TAP requirements pursuant to the GAVI TAP Policy and the requirements under any Aide Memoire concluded between GAVI and the country.

Financial Statements & External Audits: Compliance with the GAVI requirements relating to financial statements and external audits.

Grant Terms and Conditions: Compliance with GAVI's standard grant terms and conditions (attached in Appendix D).

Country Co-financing: GAVI must receive proof of country co-payment from the Country such as invoices or shipment receipts if neither UNICEF nor PAHO is the procurement agent for country co-financed vaccine for the prior calendar year.

Monitoring and Annual Progress Reports: Country's use of financial support for the introduction of new vaccinations with the vaccine(s) specified in Appendix B is subject to strict performance monitoring. The GAVI Alliance uses country systems for monitoring and auditing performance and other data sources including WHO/UNICEF immunization coverage estimates. As part of this process, National Authorities will be requested to monitor and report on the numbers of children immunised and on co-financing of the vaccine.

Country will report on the achievements and request support for the following year in the Annual Progress Report (APR). The APR must contain information on the number of children reported to have been vaccinated with DTP3 and 3 doses of pentavalent vaccine by age 12 months, based on district monthly reports reviewed by the Immunisation Coordination Committee (ICC), and as reported to WHO and UNICEF in the annual Joint Reporting Form



(JRF). The APRs will also contain information on country's compliance with the co-financing arrangements outlined in this letter. APRs endorsed by the ICC, should be sent to the GAVI Secretariat no later than 15 May every year. Continued funding beyond what is being approved in this letter is conditional upon receipt of satisfactory Annual Progress Reports and availability of funds.



## DECISION LETTER FOR HSS CASH SUPPORT

### Appendix B

This Decision Letter sets out the Programme Terms of a Programme.

<b>1. Country:</b> Yemen
<b>2. Grant number:</b> 1418-YEM-10a-Y
<b>3. Date of Decision Letter:</b> 07/04/2014
<b>4. Date of the Partnership Framework Agreement:</b> not applicable
<b>5. Programme Title:</b> Health Systems Strengthening (HSS)
<b>6. HSS terms:</b>  <p>The ultimate aim of HSS support is to ensure increased and sustained immunisation coverage through addressing health systems barriers in Country, as specified in:</p> <ul style="list-style-type: none"><li>• The relevant GAVI HSS guidelines – please contact your CRO at <a href="mailto:acronin@gavialliance.org">acronin@gavialliance.org</a> for the guidelines.</li><li>• The relevant GAVI HSS application form - please contact your CRO at <a href="mailto:acronin@gavialliance.org">acronin@gavialliance.org</a> for the form.</li><li>• Country's approved grant proposal and any responses to the HSS IRC's request for clarifications.</li></ul> <p>Any disbursements under GAVI's HSS cash support will only be made if the following requirements are satisfied:</p> <ul style="list-style-type: none"><li>• GAVI funding being available;</li><li>• Submission of satisfactory Annual Progress Reports (APRs) by the Country;</li><li>• Approval of the recommendation by an High Level Alliance Review Panel' for continued support by GAVI after the second year;</li><li>• Compliance with any TAP requirements pursuant to the TAP Policy and under any Aide Memoire concluded between GAVI and the Country;</li><li>• Compliance with GAVI's standard terms and conditions (attached in Appendix D or as set out in the PFA); and</li><li>• Compliance with the then-current GAVI requirements relating to financial statements and external audits, including the requirements set out for annual external audit applicable to all GAVI cash grants as set out in GAVI's grant terms and conditions.</li></ul>

## DECISION LETTER FOR HSS CASH SUPPORT

The HSS cash support shall be subject to GAVI's performance-based funding (PBF). Under this, the HSS support will be split into two payments: the programmed payment (based on implementation of the approved HSS grant) and the performance-based payment (based on improvements in immunisation outcomes). This means that in the first year, Country will receive 100% of the approved ceiling, or programme budget if different (the initial Annual Amount), as an upfront investment. After the first year, countries will receive 80% of the ceiling, or programme budget if different, based on implementation of the grant, and additional payments will be based on performance on immunisation outcome indicators. Note that countries whose total grant budget would fall below US\$3 million are exempt from this 80% rule.

Country will have the opportunity to receive payments beyond the programme budget amount, for exceptional performance on the same immunisation outcomes. The maximum programmed payment plus performance payment may be up to 150% of the country ceiling.

Given that Country's DTP3 coverage was **below 90%** in 2012 based on WHO/UNICEF estimates, Country will be rewarded for improving coverage with:

- \$30 per additional child immunised with DTP3, if DTP3 coverage increases and
- \$30 per additional child immunised with first dose of measles containing vaccine, if measles coverage increases.

The performance payments under the performance-based funding shall be used solely for activities to be implemented in the country's health sector.

### 7. Programme Duration<sup>1</sup>: 2014 to 2018

### 8. Programme Budget (indicative) (subject to the terms of the Partnership Framework Agreement, if applicable):

Note that with PBF, annual disbursements may be more or less than these endorsed amounts after the first year (see section 6 above).

	2014	2015	2016	2017	2018	Total <sup>2</sup>
Programme Budget (US\$)	4,200,000	3,360,000	3,359,958	3,359,954	3,359,922	17,639,834

### 9. Indicative Annual Amounts (indicative) (subject to the terms of the Partnership Framework Agreement):

The following disbursements are subject to the conditions set out in sections 6, 10, 11 and 12:

Programme Year	2014	2015	Total <sup>3</sup>
Annual Amount (\$US)	4,200,000	3,360,000	7,560,000

<sup>1</sup> This is the entire duration of the programme.

<sup>2</sup> This is the total amount endorsed by GAVI for the entire duration of the programme. This should be equal to the total of all sums in the table.

<sup>3</sup> This is the amount approved by GAVI.

## DECISION LETTER FOR HSS CASH SUPPORT

**10. Financial Clarifications:** The Country shall provide the following clarifications to GAVI<sup>4</sup>:

If the bank account information most recently provided to GAVI has changed or changes prior to disbursement, the country will need to complete a bank account information form. Please contact [gavihss@gavialliance.org](mailto:gavihss@gavialliance.org) for the form.

**11. Documents to be delivered for future HSS cash disbursements:**

The Country shall deliver the following documents by the specified due dates as part of the conditions for approval and disbursements of the future Annual Amounts.

Reports, documents and other deliverables	Due dates
Annual Progress Reports (APRs) or equivalent. The APRs shall provide detail on the progress against milestones and targets against baseline data for indicators identified in the proposal, as well as the PBF indicators as listed in section 6 above. The APRs should also include a financial report on the use of GAVI support for HSS (which could include a joint pooled funding arrangement report, if appropriate) and use of performance payments, which have been endorsed by the Health Sector Coordination Committee (HSCC) or its equivalent.	15 May 2014 or as negotiated with Secretariat
Interim unaudited financial reports. Unless stated otherwise in the existing Aide Memoire between GAVI and the Country, the Country shall deliver interim unaudited financial reports on the HSS cash support no later than 45 days after the end of each 6-month reporting period (15 February for the period covering 1 July – 31 December and 15 August for the period covering 1 January – 30 June). Failure to submit timely reports may affect future funding.	15 February and 15 August
In order to receive a disbursement for the second approved year of the HSS grant (2015), Country shall provide GAVI with a request for disbursement, which shall include the most recent interim unaudited financial report.	As necessary

**12. Other conditions: The following terms and conditions shall apply to HSS support.**

Cash disbursed under HSS support may not be used to meet GAVI's requirements to co-finance vaccine purchases.

In case the Country wishes to alter the disbursement schedule over the course of the HSS programme, this must be

<sup>4</sup> Failure to provide the financial clarifications requested may result in GAVI withholding further disbursements



## DECISION LETTER FOR HSS CASH SUPPORT

highlighted and justified in the APR and will be subject to GAVI approval. It is essential that Country's Health Sector Coordination Committee (or its equivalent) be involved with this process both in its technical process function and its support during implementation and monitoring of the HSS programme proposal. Utilisation of GAVI support stated in this letter will be subject to performance monitoring.

Signed by,



**On behalf of the GAVI Alliance**

By : Hind Khatib-Othman

Title: Managing Director, Country Programmes

Date: 14/04/2014

## Appendix C

### NEW PROPOSALS IRC COUNTRY REPORT GAVI Secretariat, Geneva, 7 – 22 November 2013

Country: Yemen

#### 1. Type of support requested

Type of support requested	Planned start date (Month, Year)	Duration of support	Vaccine presentation(s) (1 <sup>st</sup> and 2 <sup>nd</sup> choice, if applicable)
MR campaign	May 2014	2 years	MR, 10 dose(s) per vial, LYOPHILISED
HSS	Jan 2014	5 years	Requested US\$17,637,380

Yemen is requesting funds for an MR campaign (by providing a response to conditions from the 2012 IRC) and for HSS.

#### 2. In-country governance mechanisms (ICC/HSCC)

The cMYP states that an ICC was established in 1996. This was then expanded in 2007 to become the Health Sector Coordination Committee (HSCC) to include wider health representation. This comprises membership from Ministries including Ministry of Public Health and Population (MoPH&P) and Ministry of Finance, UNICEF, USAID, WHO, and an NGO (National Society for Women & Child Development). Terms of reference for this committee are in the cMYP and were also provided as a separate document. Just 2 of the 9 aspects of the terms of reference are related to health systems strengthening: 'To advise on national strategic and financial planning' and 'To ensure co-ordination among partners and government in planning and implementation of EPI'.

A NITAG was established in 2008 and meets quarterly. This is chaired by a member of the Yemeni Medical Board with secretariat services provided by the DG of Family Health. Other members include public health experts, an economist from the MOH planning sector, representatives from the MOE and Religious Affairs researchers/clinicians based in an academic centre and representatives from the Supreme National Council for Motherhood and Childhood.

**MR campaign:** The 2012 application stated that a joint ICC-NITAG meeting was held on 29 August 2012 to review and endorse the proposal and endorsement of the GAVI application, including future use of MMR in place of MR, increasing the target age in the campaign to 20 years of age, and alternatives to targeting teenage girls with rubella-containing vaccination.

The 2013 Response to Conditions proposal states that the MoPH&P continues to want support from GAVI to conduct a MR national campaign. Yemen plans to introduce MR vaccine into national immunisation programme in April 2014 and the campaign will be conducted in May 2014. The cabinet in Yemen has approved the support to MoPH&P for the cost of MR vaccine, AD syringes and safety equipment for



the routine vaccination. MOPH&P is also committed to its share of the operational cost of the campaign. The budget for the MR vaccine for the routine programme in 2014 will be transferred to MoPH&P in the last two months of 2013. In their meeting on 29th September 2013, HSSCC and NITAG approved the plans for the MR introduction in April 2014 and for conducting an MR campaign in May 2014.

**HSS:** The Ministry of Public Health and Population (MoPH&P) led the process of proposal development through a joint committee headed by the deputy minister for PHC and deputy minister for Planning. Of the 13 people listed as members, 9 are from the MoPH&P, one person each from UNICEF and the YFCA and 2 people from WHO. All the meetings seem to have been held in Sana'a, among Sana'a based institutions with no mention of governorate and district level representation. A NITAG meeting was held on 4 September 2013 to endorse the HSS proposal. The signature list has a heading that implies that the meeting was a combined with both HSCC and NITAG members (it is in Arabic except for the 2 acronyms). Financial statements for two CSO partners have not been included with the proposal.

### **3. Situation analysis (burden of disease and health system bottlenecks)**

Part C, Section 1 has been completed with key statistics from just one source dated 2012 (mainly a mix of administrative data and that from WHO and UNICEF). Mention is made of a disparity for fully immunised child coverage but there is a difference of 6 years; the administrative data is for 2012 and the MICS data is 2006.

2012 Vaccine coverage: DTP3 (WHO/UNICEF) 82%; country estimate 82%. Polio WHO/UNICEF: 89%. Measles 1<sup>st</sup> dose: 2012 (admin coverage) 71%. MCV2 coverage is relatively low at 48% in 2012. MCV2 is offered at 18 months of age. Measles SIAs were done in 2006 and 2009 and achieved 94% and 96% coverage so above the 90% administrative coverage requirement in the GAVI application.

There is evidence of new vaccine introduction experience. Yemen introduced Hepatitis B and Hib vaccines through a pentavalent vaccine in March 2005, PCV in January 2011, and rotavirus vaccine in August 2012. There are quarterly outreach activities in Yemen that are estimated to contribute to 25% of vaccination coverage.

**MR campaign:** This application is a response to conditions from a previous application in 2013 and includes costs for rubella vaccine introduction. Yemen is requesting support for an MR catch-up campaign (MR, 10 dose/vial, lyophilised) of children 9 month-14 years. This follows the country's goal to eliminate Rubella and CRS by 2020. The country estimates around a measles case rate of 2.3/100,000 and 700-3,600 cases of GRS per annum. At the time of the 2012 application, the country had planned to introduce rubella vaccine into the routine EPI schedule starting July 2013 and to implement a nationwide MR catch-up campaign in a "phased" manner in November and December 2013. In view of the revised timelines, the MR catch-up campaign will now take place in May 2014 and introduction of rubella into routine immunisation in April 2014.

MR vaccine will replace both doses of the current single antigen measles vaccines given routinely at 9 and 18 months.



**HSS – health systems bottlenecks:** The proposal comprehensively covers a number of bottlenecks in detail related to access to PHC including EPI services as a result of:

- **Socio-political issues** - high population growth (30%), rural scattered population, conflict, internally displaced, refugees, migrants, nomads, poverty, food insecurity, literacy levels in women.
- **Health system factors** - lack of access to fixed health services in 30% of population, non-functioning health facilities as a result of the conflict (particularly evident in 2011 when EPI coverage decreased from 87% in 2010 to 81% in 2011), deficiencies in health system performance, human resource issues including poor health worker (HW) performance, inadequate supervision, and demotivated staff, especially in rural areas, weak collaborations between the private and public sectors, weak HMIS (especially in terms of data analysis and reporting); need for expanded surveillance of vaccine-preventable diseases.
- **Inequities** – Yemen is ranked at 117/177 countries in terms of gender equality and socio-economic inequities in access to health services. Other factors mentioned in relation to stagnation of Penta3 coverage include rumours influenced by “religious ideologies”. The country has started a programme of Community Health Workers but recognises the need for women to be seen by female health workers.
- **HMIS and surveillance** – both also require strengthening. Data collection is onerous, often inaccurate and slow to be submitted and there is a lack of training and supervision. A review of surveillance by MOPH7P, UNICEF and CDC found that strengthening is needed for early detection of polio virus importation and that community level surveillance is needed.
- **Community participation and awareness** - participation and awareness of health issues, including immunisation, is generally low.

**Lessons learnt:** Good consideration of these was made for all 3 objectives. The country has learnt to offer integrated outreach with GAVI HSS support and the country is proposing expanding the services offered through this approach. Communication has been stressed as an important lesson for ongoing cooperation between services. Vaccination coverage has reached a plateau and the country is now considering working with CSOs. Integrated supportive supervision was considered helpful in getting programmes to work together. Empowering communities through Community Health Volunteers (CHVs) has started. Expansion, training, securing supplies and retaining CHVs are challenges.

There have been two recent major health strengthening grants:

- 1) GAVI HSS (2007-2013; US\$6,500,000) which aimed to reduce child and maternal mortality, and to halt/reverse the spread of malaria and TB building on the success of the EPI (programme outreach model with functional integration of seven vertical health programmes [EPI, Reproductive Health (RH), Malaria, TB, IMCI, nutrition, and bilharzias in 64 districts in 17 governorates. There were increases in Penta3, MCV and TT coverage.
- 2) The World Bank Health & Population Project (HPP; 2011-2017; US\$35,000,000) which delivers outreach services for MNCH. The HPP aimed to build on the outreach service delivery model initially developed during the first GAVI HSS to expand the delivery of outreach services beyond areas covered by GAVI HSS and to expand services to include reproductive health and nutrition. The HPP project appraisal document included with the





application explained that UNICEF's community based services are based on the GAVI HSS delivery design. The proposal reports no financial management issues.

There are no specific lessons learned about the current HSS implementation. The IRC was informed that the end of project assessment report is expected in November 2013 and looks forward to seeing the lessons learnt. The proposal states that 'lessons learnt will be integrated into the annual report'. It is hoped/presumed that this means end of GAVI HSS support.

#### **4. Overview of national health documents**

There is a National Health Strategy (NHS) 2010-2025 which is structured on the six WHO building blocks of the health system but is not costed. While control of communicable diseases is briefly mentioned under health service provision in the strategy, there is nothing on immunisation except for highlighting the importance of integrating the national immunisation programme and other vertical programmes within the national health system. The health strategy objectives are reflected in the country's current 5-year development plan 2011-2015, which does include the policy and strategy of EPI. There is also a Plan for Health Development 2011-2015 and, because of the emergence of the security situation in the country since about 2011, the MoPH&P has developed a two-year transitional plan 2012-2014; this was not sent with the proposal documentation.

The cMYP is dated 2011-2015 and to date has subsequently been updated 3 times. Firstly, in 2011 to introduce rota vaccine and to update the cMYP costing, financing tool and some data. Subsequently it was updated twice in 2012 (first to introduce rubella vaccine and secondly for the national MR campaign). The 5 main cMYP objectives do not address any aspect of health systems strengthening. The focus is mainly on different aspects of vaccines e.g. DTP3 coverage, interruption of polio and measles viruses, and MNT elimination, with the 5<sup>th</sup> objective addressing safe vaccination.

**MR campaign:** The time period of the cMYP (2011-2015) is in line with the current application. National objectives and planning strategies are appropriately defined and take into consideration the introduction of routine MR and the MR catch-up campaign.

**HSS:** The cMYP covers the period 2011-2015 so is not aligned with this proposal. However, the National Health Plan (NHP) covers 2010-2025 and covers the period of the HSS. Synergies between immunisation and other key health interventions occur through the delivery of the integrated outreach package of PHC services in addition to immunisation activities and provision of Vitamin A during routine MCV doses and measles SIAs. The proposed HSS activities are in line with the objectives of national priorities. A Joint Assessment of National Health Strategy (JANS) has not been conducted and there is no Joint Annual Health Sector Review.

**Other points:** M&E activities (including EPI) in the country are vertically organised with individual M&E systems. The MOPH&P is initiating a process to unify these systems and to have 16 core indicators routinely reported every year. CSOs are reported to use government indicators but do not share these data with the Ministries.

The country is just starting a DHS. Yemen is considered a high performer for its co-financing obligations.

## 5. Proposed activities, budgets, financial planning and financial sustainability

**MR campaign and rubella introduction:** The budget is in line with the maximum allowable financing under GAVI guidelines. Total campaign costs are estimated to be US\$9,416,775, with US\$7,533,420 being requested from GAVI (80% of total campaign costs). As in the 2012 budget, the proposed GAVI grant is dominated by volunteer incentives (43%), transport (22%), and training (16%). These three items account for more than 80% of the GAVI budgets. Percentage cost allocations are in line with those seen for campaigns.

US\$767,234 is requested for routine introduction of rubella vaccine (at US\$0.8 per birth for 959,043 births). This will be used for training, social mobilisation, cold chain, transportation and to establish CRS surveillance. Rubella will be offered with measles vaccine at 9 and 18 months and costs of rubella vaccine will be covered by the government. The cMYP states that surveillance for congenital rubella syndrome will be established in late 2013.

**HSS:** The budget requested is US\$17,639,234 (maximum allowed US\$17,640,000) from 2014-2018, split up between the three implementers (Table 1).

**Table 1: Summary of annual fund allocation (USD) according to implementers**

	2014	2015	2016	2017	2018	Total	Share
Government	2,676,596	2,349,724	2,500,621	2,661,552	2,520,085	12,708,578	72.0%
CSOs	394,767	654,074	119,500	100,000	100,000	1,368,341	7.8%
Development partners	1,128,637	356,202	739,837	597,802	739,837	3,562,315	20.2%
	<b>4,200,000</b>	<b>3,360,000</b>	<b>3,359,958</b>	<b>3,359,354</b>	<b>3,359,922</b>	<b>17,639,234</b>	<b>100.0%</b>
Max. annual amount	4,200,000	3,360,000	3,360,000	3,360,000	3,360,000	17,640,000	

The breakup of the cost according to the programme objectives that have been derived from the bottleneck analysis is shown in Table 2. The table also provides the break-down under each objective for each year.

**Table 2: Summary of annual fund allocation (USD) across program objectives**

	2014	2015	2016	2017	2018	Total	Share
1. <b>Objective 1:</b> Enhancing equitable access to immunization and integrated PHC services.	3,493,333	1,562,026	2,462,058	2,362,754	2,095,922	11,976,093	67.9%
2. <b>Objective 2:</b> Improving the integrated health information including surveillance, monitoring and evaluation system and research.	142,900	764,900	345,400	301,600	679,000	2,233,800	12.7%
3. <b>Objective 3:</b> Community empowerment and civil society participation in provision of immunization and essential health services including and not limited to community health volunteers.	394,767	864,074	383,500	526,000	346,000	2,514,341	14.3%
4. Program management	169,000	169,000	169,000	169,000	239,000	915,000	5.2%
	<b>4,200,000</b>	<b>3,360,000</b>	<b>3,359,958</b>	<b>3,359,354</b>	<b>3,359,922</b>	<b>17,639,234</b>	<b>100.0%</b>

Funds for M&E comprise US\$70,000 (4% -slightly below GAVI recommendations of 5-10%). Performance based incentives come to approximately US\$1,000,000 with no clear indications of how this will be covered by country over time. Two areas of concern were raised that require further details from country: 30% of the budget is for





training, covering all objectives (1-3); Incentives for staff are high (~US\$1.3 million) but no details are given on what the guidelines in country are for these incentives.

**Financial planning.** Arrangements for managing HSS funds will follow the same arrangements as used for the previous HSS (depositing cash in a bank account certified by UNICEF). The Integrated Management Unit (IMU) will administer the fund. Annual external audits will be done.

The country used the GAP analysis provided by GAVI. Total resource requirements were US\$382,850,000. The amount requested from GAVI US\$17,639,234 with a funding gap of US\$205,282,085. The proposal explains that GAVI funding will be used to achieve nation-wide coverage for EPI and integrated services. Integrated outreach support will be delivered to 293 of 333 districts (Table 3) with GAVI covering 114 districts. This integrated support has already started in some districts through funding from DPs. In addition to the government support, UNFP and GIZ are covering other areas relating to CHV package of tasks e.g. reproductive health. KFW is supporting contraceptive services and voucher schemes and USAID is involved in CHV training and mobile service provision for women and girls. Other partners include the EU. Many donor partners have support that ends before the end of the GAVI HSS support. The application does mention sub-national performance based incentive schemes that Yemen will implement with GAVI HSS funds.

In consideration of sustainability, the MoPH&P is in discussions with the MoF about additional funds to cover recurrent costs in the proposal once GAVI funds end. Added value from this requested HSS support includes permitting the country to scale up the interventions described above and strengthening of surveillance and HMIS systems.

## 6. Gender and Equity

Yemen is ranked in 135th (last) place in the 2011 Global Gender Gap Index with a score of 0.4873. There is evidence of higher under 5 mortality rates by socio-economic status. Gender discrimination is widespread and entrenched in the country's legislation, religion, cultural, social and political environment. There are two gender indicators among the indicators for intermediate results: number of female staff who gets integrated training increases by 50% and 60% of targeted females attending the awareness sessions in communities with CHVs. Neither of the two mandatory geographic equity indicators is in the results chain.

Sex disaggregated data were presented in the HSS proposal from the 2006 MICS and suggest fairly good balance between the sexes for childhood vaccinations. For measles 1<sup>st</sup> dose, coverage was 65.7% in males and 64.5% in females. Coverage per fully immunised child was 34.6% in males and 38.6% in females.

Equity for hard to reach populations was raised as an issue in the 2012 review. Overall both proposals provide a comprehensive analysis around barriers related to gender and equity in relation to access and utilisation of immunisation services. A large part of the HSS proposal specifically deals with equity issues and strategies to reach remote and marginalised populations and areas of conflict and strategies to reach women with PHC and EPI services. The proposal also provides a link from that analysis to programmatic actions to address gender or equity issues. One missing barrier was the issue of early child marriages.

## 7. Specific comments related to requested support

**MR campaign** – The country is applying for GAVI support for the target population between 9 months and 14 years (11,589,877 individuals) and a coverage target of 95% has been used (rather than 100% which CRO commented is usual for these proposals), which is in line with coverage levels achieved in previous campaigns. The country aims to expand the target group for the campaign to 20 years by obtaining support from other donors (World Bank, Saudi Arabia). The country has addressed the conditions requested by the GAVI IRC in 2012 in detail as follows:

**Condition 1:** *Submit the EVM planned for March 2013. It is a mandatory requirement that the submitted EVM or equivalent must have been conducted within 36 months prior to the application date.* **Response:** An external EVM assessment was conducted from 5 – 26 July 2013 and the report was provided. This confirmed mapping of IDP and refugees has been done. Most of the previous assessment recommendations had been implemented. Areas highlighted with weaker scores were the vaccine arrival procedures, temperature monitoring at the central level and distribution.

**Condition 2:** *Submit plans for how the campaign will be conducted in areas of insecurity, and among displaced and refugee groups.* **Response:** These have been adequately addressed and focus on the following sections:

- **Pre-campaign phase:** steps include mapping of hard-to-reach populations, microplanning, links with local authorities, community leaders and armed groups if required, working with most experienced staff, health workers and volunteers, training, good coordination and social mobilisation.
- **Implementation phase:** steps include advanced preparation, working with selected community members, CSOs that have good relationships with communities in insecure areas, daily progress meetings.
- **Post-campaign phase:** evaluation meetings at the district level and house hold Independent Monitoring will be done by WHO with mop up if needed.

In terms of strengthening routine immunisation, the **Response to Conditions** states that during the MR campaign, routine immunisation will continue with special efforts to ensure this in low coverage areas.

**Vaccine management and cold chain capacity:** An EVM plan is in place for 2014-18. Of note the EVM makes no comment/assessment about future CC needs. The IRC advised that this should perhaps be communicated to WHO.

Cold chain capacity was expanded in 2009 after an EVSM assessment in 2008 and again after the introduction of rota vaccine. 2013 admin data confirms that 90% of all health facilities have functioning cold chain equipment. The remaining 10% are either new facilities to be equipped or facilities with obsolete equipment to be replaced. The proposal states that WHO-EPI\_Log\_Forecasting\_Tool in 2012 showed that there is sufficient capacity to accommodate the MR vaccine. There will be 4 shipments of vaccine as discussed in the original report of the 2012 proposal. Training for MR vaccine delivery will include cold chain capacity, storing, and administering the vaccine.



Objective 1 of the HSS application includes a key activity of improving vaccine management and increasing cold chain capacity to address equitable access issues. 95% of targeted HFs already have cold chain however. HSS funds will be used to purchase CC equipment through UNICEF for the remaining locations. US\$630,400 (3.5% of budget) is earmarked for this purpose. Procurement of 243 refrigerators planned for December 2014 and 151 units in 2017 at a unit cost of US\$1,600 each. The HSS application is for US\$17.6million.

Overall Yemen cold chain and logistics performance is outstanding. There are no critical issues relating to equipment or maintenance. Plans are in place to equip remote locations targeted under the HSS grant application. All previous conditions by IRC have been addressed as requested by country satisfactorily.

### **HSS activities**

**Objective 1: Enhancing equitable access to immunisation and integrated PHC services (US\$12,008,838):** This objective builds on previous work funded by GAVI in 2008 and WB on integrated service delivery. This aims to address equity of access, one of the key bottlenecks to achieving immunisation outcomes.

**Objective 2: Improving the integrated health information including surveillance, monitoring and evaluation systems and research centrally and at the health facilities in the targeted district (US\$2,209,300):** This objective attempts to improve HMIS performance in order to better document the impact of EPI on morbidity and mortality.

**Objective 3: Community empowerment and civil society participation in provision of immunisation and essential health services including and not limited to community volunteers (US\$2,504,242):** This objective focuses on awareness-raising including community involvement, better communication of health messages, providing basic services package by Community Health volunteers, and increasing demand for utilising health services using community based initiatives. CSO will be involved in training and monitoring of CHVs and task shifting to community based interventions (e.g. positive household childcare practices) and will focus on areas not reached by traditional public health services “(conflict areas, nomadic, refugees, marginalised, displaced, potential returnees from neighbouring countries) using innovative approaches (private health care providers, supporting unemployed midwives, training persons from nomadic and marginalised groups to provide basic health services with focus on EPI, and adopting sponsor child strategy in schools)”. Mass media will also be used to raise awareness.

**Results chain and M&E Framework:** The results chain clearly shows a link from each proposed objective to improve immunisation outcomes but not as measured by all six mandatory GAVI indicators. Clearly defined and useful intermediate results are included in the results chain but not in the M&E framework. The M&E framework includes the six mandatory indicators. It also gives relevant data sources. The framework does not give a plan for data collection, analysis and use; this is explained in the proposal.





Some targets seem to be quite moderate given the duration of the support. e.g., % targeted communities having a CHV: 50% by 2018; % of targeted schools have at least 50% of students receiving documentation for EPI, Hygiene, and nutrition: 50% by 2018; % of targeted females by CHVs are attending the awareness sessions in communities with CHVs: 60%. This may be based on experience from the past HSS but no information is given about how these targets were estimated.

**Linkages to immunisation outcomes, action plan for immunisation results and added value:**

The HSS proposal demonstrates a good understanding of health system constraints for immunisation outcomes as evidenced by the socio-political and health bottlenecks outlined earlier in this report. The cMYP has a systemic analysis of the performance of the immunisation program. A number of relevant, potentially effective key activities are planned to enable positive immunisation outcomes. The challenge will be, and what is not described, is how they will be implemented given the wider contextual challenge of insecurity and all the other bottlenecks highlighted in the proposal and also given earlier in this report.

**Engagement of civil society, including for implementation:** CSOs have an integral role in Objective 3. The YFCA works through Sana'a and 6 fixed RH centres in the country. Unnamed local CSOs may be involved where health delivery is difficult. There is a CSO network to coordinate activities in the country.

**Technical assistance needs:** Only a limited number of activities in the HSS require technical assistance. Technical assistance support for surveys and studies (done by local expertise where possible) will be through WHO and UNICEF in country office. Technical support to develop the integrated HMIS system will be provided by the EU.

## **8. Country document quality, completeness, consistency and data accuracy**

**MR campaign:** Details are complete for the Response to Conditions.

**HSS:** Overall there is adequate consistency between the proposal and country documents such as the national health strategy and cMYP. There are some minor inconsistencies with respect to incentives to staff. Under executive summary: incentives to the government key staff involved in EPI, Surveillance and HMIS then Objective 1.8 mention funds will be given to motivate GHOs, DHOs, private providers, SCOs.

## **9. Overview of the proposal**

### **MR campaign**

**Strengths:** a very well-presented response that addressed the concerns raised at the IRC.

**Weaknesses:** The planned start dates for both MR routine introduction (April 2014) and the campaign (May 2014) may be tight for disbursement of GAVI support.

**Risks:** Increasing conflict and insecurity could potentially undermine the strategies described to reach children living in conflict / insecure areas. Sustainability after GAVI funding ends will need consideration.



**Mitigating strategies:** The country has strong community linkages and micro-planning

### **HSS**

**Strengths:** an excellent proposal with a thoughtful and detailed bottleneck analysis combined with transparent and detailed openness about the many challenges. The HSS is building on innovative outreach integrated activities and other strategies designed to address the bottlenecks. These will potentially impact both immunisation and other health outcomes.

#### **Weaknesses:**

- No reference to the current/previous GAVI HSS grant and any lessons learnt e.g. through annual review reports
- The performance based incentives for staff involved in EPI activities, US\$916,000, are not adequately justified
- No adequate justification all for the funds requested for training health personnel at a cost of US\$3,516,068 or 20% of the total budget e.g. who will do the training and how it will be undertaken and evaluated
- The proposal plans to measure percentage of people receiving information on other health problems but no evaluation of the impact of this on those health related problems. This is a missed opportunity

**Risks:** The risk assessment only focuses on the proposed support and past experience with implementing GAVI grants giving a low risk rating. Consideration should also be given to the wider political and security context that will affect outcomes. Providing incentives to HW may prove unsustainable.

**Mitigating strategies:** Strong community linkages in these areas and micro-planning. The CSO network will help to implement activities.

## **10. Conclusions**

**MR campaign:** An excellent response to the conditional approval given in 2012. All conditions have been adequately answered.

**HSS:** An excellent proposal where the objectives address key bottlenecks and are building on lessons learnt from previous GAVI funding. The proposal aligns with the country situation analysis. The budget seems reasonable for the proposed activities.

The openness of the discussions about bottlenecks, the gender and equity sections and the innovative strategies to address these issues are examples of best practice for HSS applications.

One comment for GAVI - The EVM makes no comment/assessment about future CC needs. The IRC advised that this should perhaps be communicated to WHO.

## **11. Recommendations**

### **NVS: MR campaign**

**Recommendation:** Approval with clarifications

#### **Clarifications:**



- Confirm feasibility of timeline for MR vaccine introduction and campaign start dates with respect to GAVI timelines for disbursement of funds.
- Clarify rationale for vaccine coverage estimates.

**Rationale:** Timing may be tight for preparing for both MR vaccine activities. Vaccine coverage usually estimated at 100% for vaccine dose estimates.

**HSS:**

**Recommendation: Approval with Clarifications Level 1**

**Clarifications Level 1:**

- Please include intermediate results for the M&E Framework
- Please provide some lessons learnt on HSS implementation
- Please clarify how the quality of activities for intermediate outcomes in objective 3 will be monitored (e.g. quality of awareness sessions in communities with CHVs to females; quality of teacher-led health education programmes).
- Please clarify why such moderate increases over the 5 year HSS period were assumed for objective 3: (% targeted communities having a CHV – 50% by 2018; % of targeted schools that have  $\geq$ 50% of students receiving documentation for EPI, Hygiene, and nutrition – estimated at 50% by 2018).
- Please justify the performance based incentives for staff involved in EPI activities which have been costed at US\$916,000
- Please explain who will do the training and how it will be undertaken and evaluated.
- Please confirm if there will be monitoring will be done to examine changes in the percentage of women accessing health services over the HSS period.
- Yemen has indicated problems of power failures. Please clarify why the country is considering purchasing compression electric refrigerators rather than solar refrigerators.

**Rationale:** Delivery of integrated activities may not be enough to make an impact for awareness and education sessions and it will be important to look at quality. Training and placing female staff members in the mobile out-reach teams is a major activity in objective 1 but beyond monitoring the number trained there is no planned monitoring of whether female access to health services changes with this initiative. Training and incentive costs are high and require more details. The country would seem an ideal setting for solar fridges so it would be interesting to know why electric fridges are being considered.

**Table 1: Approved budget for HSS**

	Jan – Dec 2014 (or other annual period	Jan – Dec 2015 (or other annual period	Jan – Dec 2016 (or other annual period	Jan – Dec 2017 (or other annual period	Jan – Dec 2018 (or other annual period	<b>TOTAL</b>





	depending on country budget)	depending on country budget)	depending on country budget)	depending on country budget)	depending on country budget)	
	Year 1	Year 2	Year 3	Year 4	Year 5	
5-year annual ceilings provided by GAVI (\$) <i>[country annual budget cannot exceed this amount]</i>	4,200,000	3,360,000	3,360,000	3,360,000	3,360,000	17,640,000
Budget request from Country Proposal (\$)	4,200,000	3,360,000	3,359,958	3,359,954	3,359,922	17,639,234
Budget approved by IRC-if different from proposal budget (\$)						



## Appendix D

### **GAVI Alliance Terms and Conditions**

Countries will be expected to sign and agree to the following GAVI Alliance terms and conditions in the application forms, which may also be included in a grant agreement to be agreed upon between GAVI and the country:

#### ***FUNDING USED SOLELY FOR APPROVED PROGRAMMES***

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

#### ***AMENDMENT TO THIS PROPOSAL***

The Country will notify the GAVI Alliance in its Annual Progress Report if it wishes to propose any change to the programme(s) description in this application. The GAVI Alliance will document any change approved by the GAVI Alliance, and this application will be amended.

#### ***RETURN OF FUNDS***

The Country agrees to reimburse to the GAVI Alliance, all funding amounts that are not used for the programme(s) described in this application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the GAVI Alliance, within sixty (60) days after the Country receives the GAVI Alliance's request for a reimbursement and be paid to the account or accounts as directed by the GAVI Alliance.

#### ***SUSPENSION/ TERMINATION***

The GAVI Alliance may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in this application, or any GAVI Alliance-approved amendment to this application. The GAVI Alliance retains the right to terminate its support to the Country for the programmes described in this application if a misuse of GAVI Alliance funds is confirmed.

#### ***ANTICORRUPTION***

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

#### ***AUDITS AND RECORDS***

The Country will conduct annual financial audits, and share these with the GAVI Alliance, as requested. The GAVI Alliance reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how GAVI Alliance funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last



disbursement of GAVI Alliance funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the GAVI Alliance in connection with any audit.

***CONFIRMATION OF LEGAL VALIDITY***

The Country and the signatories for the government confirm that this application is accurate and correct and forms a legally binding obligation on the Country, under the Country's law, to perform the programmes described in this application.

***CONFIRMATION OF COMPLIANCE WITH THE GAVI ALLIANCE TRANSPARANCY AND ACCOUNTABILITY POLICY***

The Country confirms that it is familiar with the GAVI Alliance Transparency and Accountability Policy (TAP) and will comply with its requirements.

***ARBITRATION***

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

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

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

***USE OF COMMERCIAL BANK ACCOUNTS***

The eligible country government is responsible for undertaking the necessary due diligence on all commercial banks used to manage GAVI cash-based support, including HSS, ISS, CSO and vaccine introduction grants. The undersigned representative of the government confirms that the government will take all responsibility for replenishing GAVI cash support lost due to bank insolvency, fraud or any other unforeseen event.

