

1. Brief Description of Process

This Appraisal was developed by Technical Expert, Assad Hafeez in collaboration with Anne Cronin, CRO for Yemen. It is based on the 2013 APR submitted by the country, and related documentation. The internal appraisal has been developed with inputs from the programme and country partners.

2. Achievements and Constraints

Republic of Yemen has made progress in achieving the overall goals and objectives of its programme in the last years. There is strong political commitment at highest echelons and health leadership level towards immunization services, depicted by keen involvement of all the government officials in the respective processes and fulfilment of financial commitments by the state. The country has been putting in efforts in implementing strategies to contain dropouts and wastage as per its planning. The hard to reach populations have also been addressed through its innovative outreach program in some districts and the initial assessments have shown encouraging results for integration of services in these rounds through training of Community Health Volunteers (CHV). The integrated outreach approach has also helped in bridging gender gap among clients however there is still a long way to go in balancing service uptake among rich and the poor.

2013 coverage targets show a general trend of near misses in most indicators. BCG coverage is 71% against target of 80%, DTP-Hep B-Hib coverage is 88% against 93%, however this reflects a marked increase from 2012 estimate of 82%, Rota virus is 71% against 93% and Measles coverage is 78% against a target of 90%. TT coverage has been the worst i.e. 18% against expected 65%. Wastage rates in general have been contained though drop outs were still missing the targets that of 7% compared to a target of 3% with small margins. Reported coverage (based on administrative data) is 88% compared to the 93% target. The country highlights slight gains since 2012, when coverage was 82%. While the DHS estimates for 2013 will only be available in 2014, recent trends suggest steady progress is under way.

The review of documents suggests that there is cognisance of the challenges being faced in this area and these have been addressed by realistic planning. Targets have been revised, existing services are being strengthened keeping in mind financial resources and innovations are being rolled out. MLM trainings enhanced supervisory visits, expansion of cold chain facilities, increased outreach activities and strengthening of surveillance have been carried out to improve the outcomes. The HSS component has played a significant role in the progress so far and the new phase will build upon the existing developments. However the role of civil society and community is not prominent in the planning and delivery of services which could be improved by capacity building and inclusive processes at every level. The management of the HSS and immunization services at the highest level has also been brought under discussion in HSSC and some recommendations for streamlining have been documented.

Gender disaggregated data are not routinely available and no plans to collect such information is available in the APR. The report does not give much information on equity issues. This is of concern given the significant equity gaps in relation to access to health services that are likely to arise in the country, based on its size, geography, and conflict areas, and on well-documented income quintile based disparities in service delivery. UNICEF has prepared a comprehensive plan of action for Yemen (July 2013).

The prevailing security situation and political unrest have been cited as major factors hindering the achievement of the targets in the years 2011-2012. Scattered populations, geographical diversity and human resource are some of the other factors which have been identified as restraints.

3. Governance

The various governing tiers are in place for overseeing GAVI related projects. The level and seniority of participation is as per prescribed criteria including deputy ministers of various ministries and reps from international organisations. HSSCC, NITAG and others have clear TORs and shared relationships. The documents provided show that these are robust forums which meet almost regularly and discuss all pertinent issues, coming out with crisp recommendations. The HSSC met 5 times since May 2013 whereas NITAG met twice in this period. The critical issues like ensuring bridging of gender gap, reaching out to marginalised groups and management reforms have been discussed here thoroughly.

The participation of CSOs is not prominent and only a few organisations have been taking part in the process at planning level over the last years. Moreover the involvement of CSOs at community level is also not clearly depicted. New initiatives talk of involving CSOs, private sector and schools for the implementation where as some of the places are already doing it. This is an area where further progress will help improve the quality and transparency of the systems.

4. Programme Management

The cMYP is a dynamic document in place covering the period from 2011-2015, which has been amended as per requirements and has costing estimates embedded in it. It gives an excellent overview of the EPI and its place within the health system, as well as of plans for vaccine delivery and coverage. The document is in line with national priorities as identified in the National Health Strategy which puts emphasis on primary health care and reaching the marginalised communities. The baseline and future targets are realistic as reported in APR and evidence of evaluation/reviews is available in the attached documents. The current management arrangement has been successfully implementing earlier grants including HSS and NVS within expected timelines

The programme management comprises of multiple tiers in the country. The ministry has the EPI housed with PHC sector which allows effective integration at the highest level of HSS component as well. Other development partners like WHO, UNICEF, JICA, WB and USAID are also integrated with the program at this level. The burden of work has progressively increased and additional technical/human resource will help improve the quality of outputs. The districts and health facilities management capacity varies extensively all over the country. In the evaluations carried out over the last years the variance in capacity has been specifically highlighted and remedial measures have been suggested.

5. Programme Delivery

The program delivery in Yemen comprises of 3 components; Fixed, outreach and mobile services. New vaccines have been introduced through this multiple tiered program and Yemen has shown fairly good compliance. The recent introduction of integrated services outreach through community health volunteers, supported through GAVI HSS, has shown promising results in districts. The last EVM assessment was carried out in July 2013. Most scores at central, district and facility level were above the target of 80% with generally good vaccine management systems. However temperature monitoring at central level (49%), distribution at provincial level (57%) and MIS support system at district level (74%) scored below the targets. Specific recommendations are provided for improvements and a new improvement plan is provided for 5 years. The next EVM assessment is planned in 2016.

The country has an injection safety plan however incinerators are not available in every facility and the procedure adopted at such places is burning followed by burying. There is an AEFI system as reported in the APR. The reports are discussed in the NITAG meetings and there is also a surveillance system for rotavirus diarrhoea and paediatric meningitis, but no specific surveys have been conducted. It is important to have the surveillance system up and running following the new vaccine introductions.

The variability among districts is marked in service delivery with some districts below critical level coverage though there is now planning with clear targets to achieve district performance improvement. The role of GAVI HSS support has been important in introducing integrated outreach activities for marginalised communities and has shown increased uptake of immunization services. The new HSS support will be helpful in further strengthening the approach and its sustainability in the existing systems. The major challenges in service provision are conflict areas and scattered populations.

6. Data Quality

The WHO-UNICEF and JRF DTP3 coverage estimates are 88% in 2013 as compared to 82% for 2012. No coverage survey has been done in the last few years and administrative data is the only available source for all the current figures. The quality of coverage data was addressed in Jan 2014 by promoting DQS which showed national verification factor of 106% due to under reporting in 7 governorates. The main quality indexes at the governorate level showed a mixed trend with “using data for action” as lowest with score of 66% and “availability of demographic information” at the highest level i.e. 97%. The data quality was improved by trainings, regular meetings, use of DQS checklist as supervisory tool and regular monitoring. DQS was also implemented in 2011 and 2012. Data quality and information management system is one of the components of the new HSS proposal and adequate steps have been proposed in the document to address the gap.

Planned activities to revitalize the data management system include:

- Sustaining the already established activities
- DQS will be conducted again in last quarter of 2014
- Standardising the data base at the governorate level
- Inclusion of data quality topics in all trainings
- Sustaining the regular supervisory visits at all the levels
- Sustaining the DQS checklists in the supervisory visits

7. Global Polio Eradication Initiative, if relevant

Five rounds of Polio SIAs were conducted in 2013, and the last one was in Dec 2013. The coverage in most of the governorates was 94% and above in this round. The country intends to maintain a polio free status and would carry out 2 rounds of NIDs every year. The program has been approved to introduce IPV in quarter 4 this year.

8. Health System Strengthening

Yemen's first HSS grant of \$6,335,000 was approved for 2007-2010 (with a revised end date: 2012) this grant has been fully disbursed and implemented. The objectives of HSS1 was

1. To improve the accessibility quality and utilization of district health systems to underserved populations through the provision of targeted integrated and results-based outreach interventions and through strengthening and creating demand for the fixed site services that support them. "
2. To improve the efficiency and coordination of vertical programs for greater impact and sustainability through their functional integration
3. To improve central governorate and district level managerial systems to support these two process of outreach and integration
4. To develop through piloting in 64 districts and building national consensus for country-wide implementation of the results-based model of district health service provision

The last tranche of HSS1 was disbursed in 2011, and funds were carried forward into 2012 and 2013, which is what the country is reporting on in the APR. They report that the last 2 planned activities for 2013: outreach program and pre and post intervention surveys and the evaluation report was completed. The Evaluation report was shared with GAVI and lessons learned will be brought forwards in the new HSS2 grant.

The new HSS grant was recommended for approval with clarifications by the IRC in November 2013. The new HSS grant has a budget of \$17, 69,234; the first tranche of \$4.2 million was disbursed to Yemen in May. The second year tranche has already been approved in accordance with GAVI's new policy of two year approval. The objectives of the current HSS2 grant are:

1. Enhance equitable access to immunisation and integrated PHC services.
2. Improving the integrated health information including surveillance, monitoring and evaluation systems and research centrally ad at the health facilities in the targeted districts.
3. Community empowerment and civil society participation in provision of immunisation and essential health services including and not limited to community volunteers.

The performance of Yemen HSS component has been satisfactory in last few years. The major outcome has been reportedly successful outreach integrated activities in selected districts. The uptake of immunization has improved as a result of these activities in addition to enhanced utilisation of other services like reproductive health etc. The costs have also gone down though there is no substantial evidence or data for this claim. The concept of Community Health Volunteers has been imbibed by the health system with tangible dividends. The financial and programmatic sustainability is being warranted by the government through its budgetary support and incorporation into mainstream health systems.

The innovation has resulted in certain stresses on the existing system and issues like stock outs of supplies were encountered more frequently. The trainings of the CHVs carried out through trickle down methodology also needs further strengthening. Moreover the integration of services lacked nutrition interventions and active involvement of CSOs. The APR reports that planning of HSS activities are part of the annual sector plan. The reporting systems were present but did not capture the required depth and breadth of the canvas being more fragmented and working in their own respective silos. The performance based financing system could not take off and would need more robust structuring in addition to possible legislative actions. The internal documents and minutes of meetings do show that most of these issues have been discussed with appropriate solutions for future planning put in place.

The HSS evaluation has brought out the above weaknesses and has suggested remedial measures as well.

The HSCC discussed the conclusions and recommendations to be integrated into the new HSS phase as lessons learned for improving HSS. The recommendations of the evaluation report were addressed in the HSCC meeting last May, integration of them in the current phase were concluded, they are mentioned in the meeting minutes. In table **9.5 Planned activities for 2014**, the country writes that the activities planned for 2014 is the same plan as included in the proposal approved by GAVI (\$4,200,000).

The current proposal has been adequately adjusted to accommodate the concerns of the evaluation. The next HSS proposal has service delivery, information system strengthening and HR capacity as major components of the 3 pronged approach with strong involvement of CSOs in implementation. It will consolidate the gains made in the earlier phases and ensure sustainability of the innovative strategies in the system.

9. Use of non-HSS Cash Grants from GAVI

Yemen did not receive ISS award in 2013 however USD 1,159,721 were carried over from 2012. Out of this USD 159,850 were spent on reinforcing EPI programme activities, including supervisory visits from central and governorates to lower levels. A total of USD 999,871 has been carried over to 2014. The country is not eligible to receive an ISS award for this year.

10. Financial Management

The GAVI FMA was conducted in 2010 and its recommendations were implemented according to the reported data in APR. These included fund disbursement to governorates through bank transfers, implementation of financial manual, financial reporting to HSSC annually and internal audit mechanism was put in place. However transfer of cash to beneficiaries through bank accounts was not found to be practical where no bank branches were available especially at district level.

The accompanying documents show that two external audits were conducted in 2013 and 2014 on the HSS, NVS and ISS support received. **PFO Comments (IT)**

Country to take appropriate and remedial action and inform GAVI on all of the following items for ISS, HSS, and NVS:

- 2011 detailed Expenditure report for each cash program
- bank statement with opening and closing balances for 2012
- For HSS -to explain discrepancy of \$ 90,943

Country is invited to take the following additional actions (from 2013 APR review):

- Maintain Books of accounts instead of use of spread sheets;
- Keep proper monthly payroll sheets not;
- Provide Supporting Documents for Receipts of funds which were not available to auditors;
- Clear with 3rd party proper documentation, the amount of \$ 47,422 advanced under ISS and inform the secretariat;
- Provide other bank statements for grant funds. Only one bank statement has been provided but opening and closing balances do not reconcile with any of the programs;
- Provide and implement an action plan to remedy the weaknesses in accounting and controls over advances.
- Provide banks Statements for 2013 showing balances at 1/1/2013 and 31/12/2013.

11. NVS Targets

Coverage target with the third dose of DTP-HepB-Hib was missed in 2013, reaching 88% compared to the 93% target. The PCV targets were also missed, 88% vs 93%. Target for PCV for 2015 has been adjusted in line with Penta and with 2013 performance. Country is estimating to vaccinate 858,145 and 830,453 infants with 1st and 3rd dose of PCV, respectively, which an increase in 8% from 2013 achievements (within GAVI guidelines). Wastage rate for 2015 of 5% is acceptable even though country reported 3% for 2013) Dropout rate for 2015 of 3% is also acceptable however, drop out was 7% in 2013

For Rota virus vaccine the target was also missed from 71% vs 96% respectively. Target for Rota should be adjusted further downwards given 2013 achievement for 1st and 3rd dose. Country has already done it to an extent, but increase from 2013 to 2015 is still higher than 10% as set in the GAVI guidelines. Wastage rate for 2015 of 5% is acceptable even though country reported 3% for 2013)

The wastage was controlled by introducing single dose vials in these vaccines.

PIE for Rota virus was conducted in 2013 as part of EPI review. The issues highlighted were longer training requirements, age restriction for administration of rota virus vaccine and lack of freeze watch monitors. No major problems related to vaccine management were reported to the national program.

The introduction of IPV and MR has been planned for 2014. With a modest coverage performance in 2013, the ambition of the program to take on more new vaccines in 2014 and subsequent years looks challenging. The weakness of the cold chain and lack of human resources for health at peripheral levels are major obstacles to further improvements in coverage and to the ability to take on additional vaccines, however it is being expanded at all levels with the support of WB, UNICEF and GAVI.

12. EPI Financing and Sustainability

The government has fulfilled its budgetary commitments as per GAVI's requirements. There is an incremental increase in the co-financing in the new vaccine category, traditional vaccines are funded by the government itself and there is an adequate budgetary allocation for immunization in the health budget. There is ample likelihood based on the available documentation and performance that EPI progress is likely to continue.

13. Renewal Recommendations

Topic	Recommendation
NVS	Penta: renewal of support PCV: Renewal of support for 2015. Rota: Renewal of support for 2015
HSS	Second tranche previously approved

14. Other Recommended Actions

Topic	Action Point
	<ul style="list-style-type: none"> The country to take action to finalize and implement the 2014 EVM improvement plan recommendations. PCV and Rota targets may need to be adjusted downwards based on stock analysis The country to ensure robust reporting systems and data quality The country to develop mechanism for gathering gender desegregated data The country to ensure more robust involvement of CSOs at all levels HSS component to ensure sustainable involvement of CHV and their quality training with effective supervision
	<p>PFO Comments (IT)</p> <p>Country to take appropriate and remedial action and inform GAVI on all of the following items for ISS, HSS, and NVS:</p> <ul style="list-style-type: none"> 2011 detailed Expenditure report for each cash program bank statement with opening and closing balances for 2012 For HSS -to explain discrepancy of \$ 90,943 <p>Country is invited to take the following additional actions (from 2013 APR review):</p> <p>Maintain Books of accounts instead of use of spread sheets; Keep proper monthly payroll sheets not;</p> <p>Provide Supporting Documents for Receipts of funds which were not available to auditors;</p> <p>Clear with 3rd party proper documentation, the amount of \$ 47,422 advanced under ISS and inform the secretariat;</p> <p>Provide other bank statements for grant funds. Only one bank statement has been provided but opening and closing balances do not reconcile with any of the programs;</p> <p>Provide and implement an action plan to remedy the weaknesses in accounting and controls over advances.</p> <p>Provide banks Statements for 2013 showing balances at 1/1/2013 and 31/12/2013.</p>