Joint appraisal report

Country	Yemen
Reporting period	*Month/Year of the current appraisal: 2014*
cMYP period	*2011-2015*
Fiscal period	*Jan- Dec*
Graduation date	*Only relevant for graduating countries*

1. EXECUTIVE SUMMARY

(MAXIMUM 2 PAGES)

1.1. Gavi grant portfolio overview

[With reference to the overall portfolio of Gavi grants in the country and the overall scope and funding of the national immunisation programme, briefly describe how Gavi's vaccine and health systems strengthening support fits within the overall context of the national immunisation programme and contributes to improved outcomes. Refer to the guidance for more details]

- GAVI is the main financer of EPI with around 65% of the total expenditure on EPI while the country, UNICEF, WHO and WB are funding around 13%, 10%, 7%, and 5% respectively. This pattern of support has prevailed over the last five years.
- The Government of Yemen has a separate budget line for EPI and for the cost of the vaccines. The country also has very good record of paying its share of the co-financing in a timely manner. The Government continued to provide funds for operational costs till the 2nd half of 2014 when they were stopped as a result of the political situation.
- The vaccines and cash support from GAVI are reflected in the national health sector budget.

Requests to GAVI's HLRP:

- Renewal of Pentavalent vaccine in the existing presentation
- Renewal of Pnemococcal vaccine in the existing presentation
- Renewal of Rota vaccine in the existing presentation
- Renewal of IPV vaccine a new presentation of single dose.
  Reprogramming of the HSS support to be in three years instead of four years and the amount as following: For 2015: $3,783,127 For 2016: $5,958035 For 2017: $5,468,716

1.2. Summary of grant performance, challenges and key recommendations

Grant performance (programmatic and financial management of NVS and HSS grants)

Achievements

- The main targets: Penta3 coverage target was achieved (target 86% vs actual 88%) while targets for measles (80% target Vs 75%) were not achieved and this was because of conducting the MR national campaign since mothers are reluctant to bring their children for due routine doses after the campaign. The targets for objective 2 and 3 in the proposal were not achieved because of the delay of implementation of the activities.
  Most of the intermediate indicators were achieved as for the following indicators: (Table attached)
  1- The percentage of penta1 coverage increased from 89% to 94%
  2- 96% of targeted districts conduct 4 rounds of outreach activities annually
  43% of newly functioning public health facilities
  report on immunization .
  3- 1413 female staff provided integrated training increased by 50%

Challenges

- Lack of access due to the coalition airstrike, Active AQAP/ISIS in the south east part, armed conflict, in many areas especially in Aden, Lahj, Al Dhalee, Taiz and Maarib.
- The outages of the power and fuel shortage are likely to affect the storage of the vaccines. Currently, the cost of the available vaccines in the country is around USD 9 million and their appropriate storage needs to be ensured.
- Distribution of the vaccines to the health facilities is also affected due to the fuel shortage and electricity outages in the outlying areas There is an overall need to ensure that the requirements of vaccines are met to meet demands.
- There were no issue in releasing the HSS fund but the situation in the country hindered the implementation.

Key recommended actions to achieve sustained coverage and equity (list the most important 3-5 actions)

- Re-programing of the fund of GAVI to respond to the current emerging situation. GAVI already agreed in principle on this.
- Support the district level with operational cost for supervision and vaccines transportation to improve their ability to improve the routine coverage in light of the great need to rely on decentralization amid the described situation.
- Partners to support securing the cost of traditional vaccines and the co-financing share of the government of the new and under used vaccines. In addition, partners to support the operational cost which the government was not able to pat since the 2nd half of 2014.
- Support replacing of the damaged cold chain and use the solar system at all levels. Most of refrigerators used in EPI in Yemen relyi on electrical or gas power. EPI Yemen has only around 400 solar refrigerators in the HFs (3200 HFs functional)
- Continue the WB support through WHO and UNICEF
- Improve the equity through targeting the low quantile via sustain Implementation of the outreach activities.

1.3. Requests to Gavi's High Level Review Panel

Grant Renewals

New and underused vaccine support

- Renewal of Pentavalent vaccine in the existing presentation
- Renewal of Pneumococcal vaccine in the existing presentation
- Renewal of Rota vaccine in the existing presentation
- Renewal of IPV vaccine a new presentation of single dose as 1st choice and 5 dose vial with VVM on the vial to allow applying the open vial policy.

Health systems strengthening support

- *e.g. Approval of a new tranche of HSS funding of $Z million, no cost extension, reprogramming, or re-allocation*

The Government and partners are developing a plan to meet the immediate needs of the country to ensure that immunization activities are minimally affected in the current political situation. These activities will include ensuring viability of stored vaccines, delivery and

supervision of immunization services through outreach activities where required aiming to mitigate damage inasmuch as possible. Immediate cold chain needs through provision of solar powered equipment will also form a part of this plan. This plan will be developed and shared by the end of July 2015. These activities will be carried out using available Gavi resources in the country (US$5.1 million).
Re-allocation of allocated resources with Gavi will be addressed subsequent to this and tabled in the October 2015 HLRP.

1.4. Brief description of joint appraisal process

[More details can be provided in an Annex]

Early discussion started between GAVI secretariat and MoH, WHO and UNICEF to start the joint appraisal process. The discussion started early March 2015 prior to the evacuation of the UN staff from Yemen due to the coalition airstrikes.

The discussion continued through several tele-conferences. The MoH constituted a Task force committee to prepare for reprograming of the activities which involved MoH (all related departments), CSO (Yemen Family Health Care), WHO and UNICEF. Another smaller committee was constituted to prepare the JA report with representation from MoH, WHO and UNICEF. The whole process was through a consultative process with ownership and effective leadership of the MOH.

All discussions were based on available reviews and assessment including DQS, EVM, in depth EPI review and national health system review. All partners were keen to reach to realistic and actionable plans and recommendations.

APR and the JA was sent to the HSSCC members for review and comments and a meeting had been convened on 29th June. Another meeting held on 6th July to review the final version of the JA and it was endorsed in this meeting.

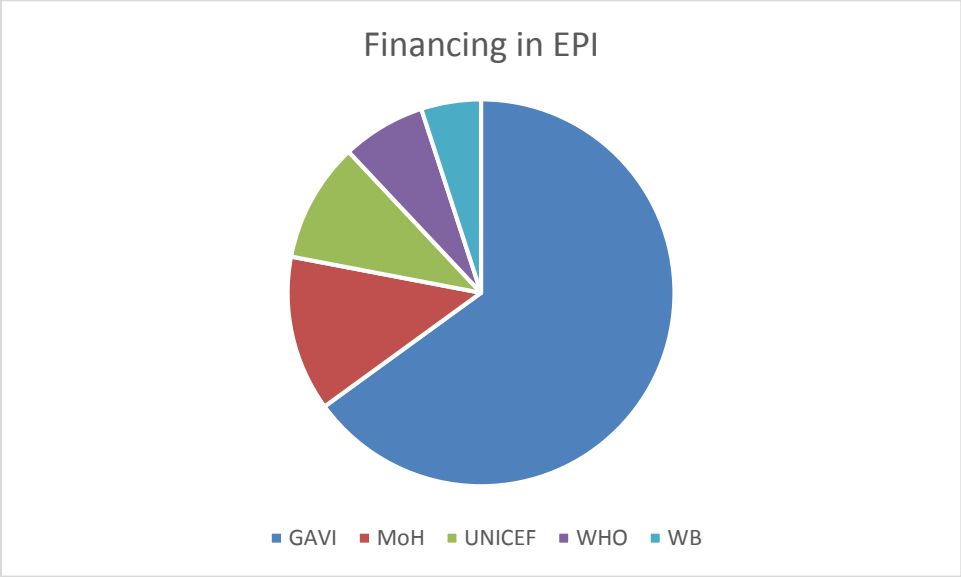
2. COUNTRY CONTEXT

(MAXIMUM 1-2 PAGES)

2.1. Comment on the key contextual factors that directly affect the performance of Gavi grants.

[See guidance document for more details]

1- The HSSCC (equivalent to ICC) is the main body that provdes oversight and endorses the plans for GAVI support. The HSSCC convenes on a quarterly basis to review and discuss the achievements of the program and endorses any changes in the plans. HSSCC met three times in 2014 and the last one held on 23rd September 2014. HSSCC also reviews on annual bases the achievements and the next annual plan through review of the APR and endorses it. The HSSCC reviews the program activities in addition to the financial issues.
2- The PHC sector leads the planning and implementation through the Family Health Directorate who, in its turn, coordinates among the programs within the PHC sectors and programs in other relevant sectors in MoPHP.
3- The GoY has been very committed to the EPI program and continued to contribute a substantial proportion (%) of the cost of EPI till 2014, but has now become unable to fulfill this commitment because of the current political and financial crisis.
4- GAVI is the main financer of EPI with around 65% of the total expenditure on EPI while the country, UNICEF, WHO and WB are funding around 13%, 10%, 7%, and 5% respectively.



The GoY has a good track record of paying its share of co-financing against the new vaccines in timely manner but unable to do so in the present circumstances
Due to the current political circumstances, the World Bank (WB) has suspended its support (HPP project) to Yemen since February 2015. In June 2015, however, WB agreed to channel their support through WHO and UNICEF and the process is being finalized.

5- HR is still sufficient at all levels but there is a need to continue to be supported. The governorate and district EPI supervisors are supported by the government to cover their cost of transportation for the field visits. The central and governorate EPI supervisors are also supported through GAVI funds based on criteria of performance. The good performing districts are also awarded. At present MoH is not able to pay for these operational cost and there is a need that the partners to support them.
6- The cold chain capacity was expanded in 2014 with the addition of seven cold to the central vaccine store. In addition 1024 refrigerators were provided to the new HFs anjd through replacement of non-functional refrigerators. The CC was able to accommodate the new vaccines including the IPV.
Due to serious shortages of fuel for generator and lack of electricity supply arosing from the prevailing situation in Yemen, there is a plan to gradually shift the cold chain to the solar system in most affected areas. The plan will start by installing solar refrigerators in all the 333 district vaccine stores and will then be extended to the 3200 HFs.
7- Vaccinations are delivered mostly through public HFs in addition to some private clinics in Sana'a city. In 2014, about 29% of the total vaccination coverage was achieved through the outreach activities. Reporting of the vaccination is made on monthly basis from HFs to the districts which compile the reports and send them to the governorate and then to the central level. Feedback from central to the governorate is done on quarterly basis and on monthly basis from governorates and district to the lower level. This system is being sustained during the current crisis, with less frequent feedback.
8- In 2014, integrated disease surveillance was expanded nationwide and the completeness of the weekly reporting reached 82%. In addition, measles case based and AFP surveillance are functioning very well and achieving high level of performance indicators. AEFI is well established and functioning through the integrated disease surveillance.
9- Comprehensive MYP is planned to be finalized by the end of 2015 to refelect another cycle from 2016-2020.
10- Yemen has been suffering from protracted political unrest since 2011 and the situation has progressively worsened in 2014 through 2015. Since Septemebr 2014, the Houthis have been in control of Sanaa. Separatist movements in the sSouth of the country are

also more active.. The situation has led the country to face severe economic problems.In addition,

11- Despite the the political unrest in Yemenover the last two years the immunization program has been able to achieve a high coverage of 88% for the Penta3/OPV3 through fixed sites and outreach activities. The districts achieving a coverage of 80% and more increased from 71% in 2013 to 79% in 2014. One of the main factors of the success of EPI in Yemen is that it has been functioning as an integral part of the health system. All these gains are under threat due to the intensification of fights and aerial bombing by the coalition forces since March.

12- As a aresult in many areas, access has severely decreased/reduced in some governorates (Sa'ada, Aden, Abyan, Lahj, Al Dhalee, Taiz, and Marib) which constitute a population of around 7.6 million (28% of the total population), hence most of the basic social services have been suspended there. About 15.2 million people lack access to basic healthcare. At least 160 health facilities have closed down due to insecurity and shortages of fuel and medicines. More than 50 security incidents have directly affected health facilities, including damage, attacks and commandeering by armed groups. Lack of fuel threatens the cold chain of perishable medicines, 62 district vaccine stores stopped but the vaccines have been shifted to the governorate stores. At present, very rare incidents of destroyed vaccines have been reported (4800 doses, Rota vaccines were destroyed in Lahj governorate due to heat exposure as a result of the the armed conflict which prevented access to the vaccine store)

13- The humanitarian situation in Yemen has become critical affecting over 21 million people, including 9.9 million children. This represents 80 per cent of the overall population – up from 61 per cent before the escalation of the conflict. Intense fighting, insecurity and food and fuel shortages are pushing the nation towards a complete collapse. Some 20 out of the country's 22 governorates now face a food crisis with over 12 million people without adequate access to food – and the situation is expected to steadily worsen. One million people have become internally displaced. The number of deaths and injuries is on the rise, with an estimated 2,800 people killed, including 279 children and 12,000 people injured including 402 children.

14- The Yemen Humanitarian Response Plan (HRP) was launched on 19 June calling for $1.6 billion to reach a target 11.7 million people with immediate assistance. Health cluster needs $151.84 million to meet the target of 10.3 million out of the total 15.2 million people who need immediate lifesaving health services.

15- All UN international staff were evacuated from Yemen on 28th March when the coalition airstrikes started. However, the national staff continued to be functional. International staff started to return to Yemen with very robust security mitigation measures in May 2015.

3. GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS

(MAXIMUM 3-5 PAGES)

3.1. New and underused vaccine support

3.1.1. Grant performance and challenges

[Comment on all bolded areas listed in the table in this section of the guidance document]

1- EPI achieved routine coverage of 88% for both penta3 and Pneumococcal3 vaccines and 72% for rota2
The planned coverage in the cMYP was to achieve 94% for Penta3 and Pneumo3 and 97% for rota2, however, due to the political unrest and the armed conflict in some areas, it was very difficult to achieve these targets.

2- Due to the political unrest especially in the 2nd half of 2014 and 2015 prevented from introducing the IPV while the MR introduction was postponed until the Measles vaccine has finished from the stores in order not to waste big amount of measles. Training on MR started in Nov 2014 during the training on MR campaign which was implemented in Nov 2014. More detailed training will be happening along with the training on IPV when it will be introduced initially in Sep 2015. IPV will be initially introduced in September 2015 and all activities will be implemented as in the VIG plans for both IPV and MR. Postponement of the IPV and MR introduction was due to the political unrest and managerial and administrative issues led to temporarily suspension of the authorization of signing cheques and there were no challenges in financial management
EPI has sufficient experience in managing VIG grants for new vaccine introduction reflected in the activities around the introduction of Penumo and Rota vaccines.

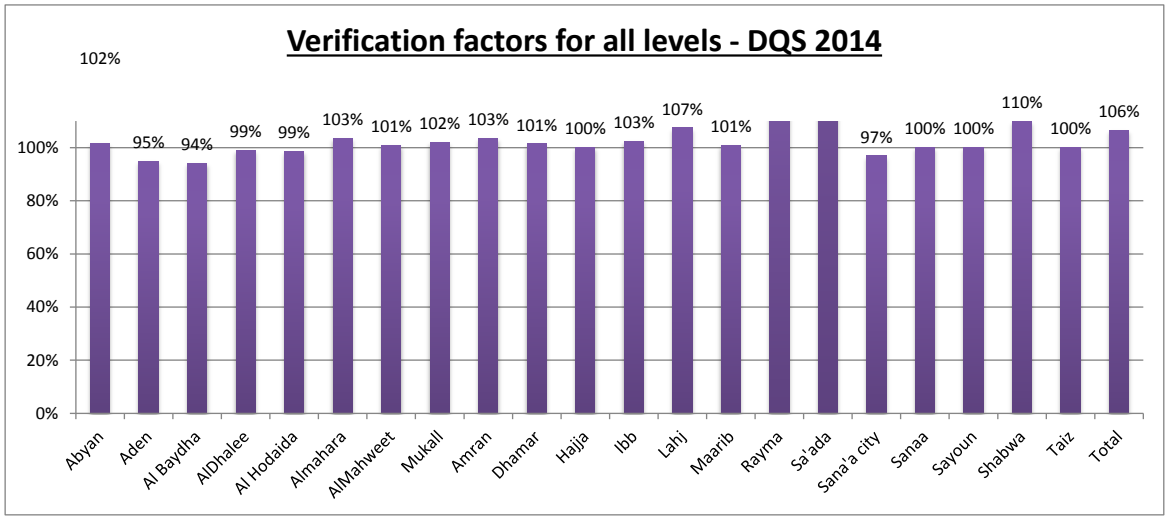
3- National MR Campaign was implemented in November 2014 with an administrative coverage of 93% while the coverage through the household survey was 90%.

4- AEFI has been established and enhanced by training of Trainers at governorate level and AEFI has been included in the weekly reporting form from all HFs. Disease surveillance has improved by enhancing the integrated disease surveillance by modifying the reported disease forms and expanding them to all HFs (including public, private and military in addition to the traditional healers). The completeness of the weekly reports reached upto 81% in 2014.
The sentinel sites surveillance network for meningitis, pneumococcal and rota diseases has been sustained at 9 sites with improvement of the main indicators especially in the percentage of reported cases. More than 100 suspected meningitis cases were reported from all the nine sites in 2014 and csf samples were collected from 85% of the cases in 2014 with 98% of samples reaching the laboratory within one hour of collection.
Rota surveillance sites increased from two to three in 2014. Therefore, tested rota cases increased from 689 in 2013 to 1081 cases in 2014. The positivity in the suspected cases was as following: 34%, 22% and 21% in 2012, 2013 and 2014 respectively which indicate the positive impact of rota vaccine which was introduced I n 2012.

5- Data quality was improved by conducting DQS in which the verification factors were at 100%. The DQS feedback was provided to all governorates. Data quality was the main topic in the training of vaccinators which was provided to all vaccinators. These activities were supported through Gavi funds.
Supportive supervision has also been conducted during which more than 80% of the districts and HFs were visited.

Summary of the DQS result - verification Factor (VF)
2014

Governorate	VF at governoarte level	VF for HFs	VF for districts	VF for all levels
Abyan	100%	100%	101%	102%
Aden	101%	99%	95%	95%
Al Baydha	100%	100%	94%	94%
AlDhalee	100%	99%	100%	99%
Al Hodaida	100%	98%	101%	99%
Almahara	100%	101%	102%	103%
AlMahweet	100%	101%	100%	101%
Mukall	100%	101%	101%	102%
Amran	103%	100%	100%	103%
Dhamar	100%	101%	100%	101%
Hajja	100%	100%	100%	100%
Ibb	100%	103%	100%	103%
Lahj	100%	110%	97%	107%
Maarib	100%	101%	100%	101%
Rayma	100%	172%	97%	166%
Sa'ada	196%	97%	132%	251%
Sana'a city	101%	100%	96%	97%
Sanaa	100%	100%	100%	100%
Sayoun	100%	100%	100%	100%
Shabwa	100%	110%	100%	110%
Taiz	100%	103%	97%	100%
Total	**103%**	**102%**	**100%**	**106%**



6- GAVI fund was used for improving the data quality through funding the training, supervision and DQS.
7- DHS was implemented in Yemen for the year 2013 and the report has not yet been finalized
8- There is a plan to implement EPI coverage survey in 2016 2015

Bottlenecks and corrective actions:

1- Access to PHC including EPI services: because of geographical, social and political barriers, reflected by remoteness, huge disparities in health service utilization between urban and rural areas, access of women and children to basic health services, in-sufficient inclusion of marginalized and refugee communities, and difficulties in service accessibility to nomad communities.
2- Implementation of the outreach activities in the remote areas and for the vulnerable communities decreased the inequity among these groups. There is a need to continue and strengthen the outreach vaccinations in these areas through improving the microplans at the delivery level. The access due to security issues is better in the rural areas where these groups are concentrated. Additionally IDPs have been given high priority in 2015. Freeze watch has been widely incorporated in all refrigerators. There is a need to expand this usage during the transportation andin addition, electronic devices are being provided to monitor the vaccine during storing or transportation.
3- There were difficulties in paying the operation cost of the 2nd half of 2014. However, supporting additional supervision through partners (GAVI, WHO and UNICEF) helped in achieving the target.
4- The vaccination demand is high in Yemen in general except in very limited places where there are some religious groups that oppose vaccination practices. Proper approach to religious leaders has helped in resolving most issues.

Financial Performance and challenges:

1- The VIG for IPV and MR have not been spent since the introduction of IPV was postponed due to the political unrest while the MR was introduced in Feb 2015 as explained above.
2- Postponement of the IPV and MR introduction was due to the political unrest and managerial and administrative issues led to temporarily suspension of the authorization of signing cheques and there were no challenges in financial management
3- All plans for the VIG, NVS and operations were developed on a complementary basis ensuring that among others the cold chain equipment is divided among these plans based on vaccine requirements and according to the cold chain master plan.
4- MR campaign support was implemented in Nov 2014 and the remaining fund will be used for Mop up MR campaign.

3.1.2. NVS renewal request / Future plans and priorities

[Comment on all bolded areas listed in the table in this section of the guidance document]

1- The proposed targets in 2015 for penta3, Pneumo3 are 88%.
2- The proposed targets in 2015 for Rota2 is 75%
3- These targets are different from that planned in the APR 2013 because, while the programme is aiming to attain the coverage planned for 2015 it also wants to be pragmatic in meeting the achievements. The actual coverage in 2013 and 2014 was 88% despite the the political unrest in the country. Due to the continuous political unrest which has further deteriorated in 2015 as explained above, the program prefers to aim to sustain the same figure of 2014 for Penta3 and Pneumo3 which is 88% and to increase the rota2 coverage from 72% in 2014 to 75% in 2015.
4- In the current situation EPI will try to keep it the same level of 2014 and strive not to let the coverage decrease.
   If the situation allows, EPI will try to make it in the agenda of the NITAG to lift the age restriction of Rota vaccine hence Rota2 might be increased to reach very close to Penta2.
5- IPV was supposed to be introduced in the last quarter of 2014 but again due to the political unrest it has not been yet introduced and the plan is to introduce it in the 3rd quarter of 2015 if the situation allows and the coverage will be 67% as two third of the year.

6- We request to change the presentation of IPV to be single dose as first choice and then the 5 dose vial as second choice with VVM on the vial to apply the open vial policy in order to decrease the wastage rate and enable of increasing the coverage.
7- MR vaccine was introduced in February 2015 since the stock of measles vaccines was finished. Training on MR started in Nov 2014 during the training on MR campaign which was implemented in Nov 2014. More detailed training will be happening along with the training on IPV when it will be introduced initially in Sep 2015.
8- There is a need to shift to the solar system especially at the district level. The plan is to focus on the district vaccine store in 2015 and in 2016 onward to focus more on the HF Level.
9- MR mop-up campaign is planned to be conducted in September 2015 according to results of post campaign house hold coverage survey.
10-

3.2. Health systems strengthening (HSS) support

3.2.1. Grant performance and challenges

[Comment on all bolded areas listed in the table in this section of the guidance document]

Achievements of the programme:

Health system specifics in Yemen:

Yemen is among the less developed countries that confronts many challenges in various areas.

Based on the projections of the last census conducted in 2004, the total population of Yemen is 24,477,511 as of the year 2011. A major demographic challenge is represented by the very scattered population estimated to exceed 130,000 population settlements all over the country which makes accessibility of health services a challenge. 70 % of the population lives in rural areas. Administratively, the country is divided into 22 governorates, which are further divided into 333 districts. The level of funding to the health system has not been substantial; the share of the MoPH&P from the total government budget is around 3.58%.

Maternal and child mortality are still among the highest in the region.

The National Health System in Yemen is composed of public and private health services in addition to a number of NGOs providing health services at community level. Preventive care is provided almost completely by public and some CSO facilities.

The MOPH&P has the mandate to supervise and oversight the service provision,

Despite there are More than 3000 registered local NGOs only few of them are providing health care. There are, also, 39 international NGOs supporting provision of health care services, and their support is focused on limited health services in specific geographical areas mainly in the areas suffering from emergency situations, these services mainly focused on primary health care (malnutrition treatment) and partially some secondary health care services.

The assumed physical coverage of public health services is around 64% (MOPH&P annual statistics report 2011, P. 22, Arabic version) of the population where actually it is not expected to cover more than (45-60%). Four levels of health facilities are providing the primary and secondary health services (2871Health Units, 841Health Centres, 180 District Hospitals, and 56 Governorate Hospitals). Tertiary care services are provided in 2 referral hospitals in the Capital Sana`a.

Yemen performance in health system strengthening, focusing on specificity of integrated service delivery and outreach, mobile clinics, family practice model……..

The main targets: Penta3 coverage target was achieved (target 86% vs actual 88%) while the

target for the measles (80% target Vs 75%) was not achieved due to the MR national campaign.
The mandatory indicator achieved the following results:

- DTP3 coverage: 88%
- MCV1 coverage: 75%
- Geographic equity of DTP3 coverage: 78% of the districts achieved more than 80%
- Socio-economic equity in immunisation no final survey to give such indicator
- Dropout rate: 5%
- Proportion of children fully immunized: 75%

The targets for intermediate results for activities under objective 2 and 3 in the proposal were not achieved because of the delay of implementation of the activities.

The implementation rate was 68%, 2% and 0% for objective 1 & 2 & 3 respectively.

The CSO has not started implementation of their activities due the situation and managerial issues since it's the 1st time to have joint collaboration between MoH and CSO. |It is aimed to have this CSO implementation start in 2015.

Most of the intermediate indicators for objective 1 were achieved (table of intermediate indicators attached):

- % of penta1 coverage increased from 89% to 94%: achieved 94%
- 96% of targeted districts conduct 4 rounds of outreach annually: All districts implemented at least 4 rounds
- 43% of newly functioning public health facilities reporting on immunization services for the year of introducing the service: achieved
- 1413 of female staff got integrated training.
- 71% of targeted HFs have appropriate cold chain achieved

External evaluation of HSS1 (Report of the HSS1 evaluation attached)

1. Requirements for scaling up: Integrated outreach has proven to be an efficient and cost effective method to provide services to deprived populations. This methodology, should be further refined and implemented nation-wide. This can happen rapidly because a strong institutional basis is already in place in most governorates in the country
2. Strengthening integrated outreach reach and impact: Despite its proven strengths, the full potential of integrated outreach has not been reached. This is particularly apparent when looking at the large performance differences among districts, and between components, and when reviewing the coverage data for each component
3. Expansion of service package: Begin a gradual expansion of the package of services provided through integrated outreach to encompass the remaining four HSS programs Intensification of project management
4. Project management was very well integrated into the PHC system. However, the number of management staff were insufficient for the scope and objectives of the project, particularly the data management and monitoring aspects of the work
5. Integrated supervision: The great value of the data collected in the integrated supervision exercise will be to have it fully analyzed) and to feed back the data to the HSS stakeholders including the various programs, the district and governorate level health offices, and donors.

Work in insecure/underserved areas:
EPI has been working in all areas without any discrepancies with focus on the remote areas through four visits of the outreach activities which achieved around 29% of the total coverage of Penta3. In addition, vulnerable groups were also focused on such as the marginalized populations, refugees, IDPs and Mobile populations. Microplanning of the outreach activities at HF level includes special plans for these groups including mapping them and detailed data on their populations and their movements.

Programmatic challenges and implementation bottlenecks of HSS

- HR issue; Staff working in the health sector in general need to be supported especially under the prevailing situation.
- Insecurity situation: Staff working under prevailing situation asin the southern governorates or in Sa'ada need to be motivated and supported so that they can continue working.
- Since some of around 777 of the HFs are not functioning due to the security and war issues, MoH is trying to address the issues. as much as they can. Cold chain is required to be provided based on a comprehensive plan. However, as atemporary measure, the catchment areas of these areas might be included in the outreach activities and therefore, updating the micro plans is essential.
- Security barriers: Since there would be some security barriers due to the armed conflict, negotiation with local community will be maintained and supported at the local and central level. National NGOs and INGOS might be used to reach to some of these insecure areas.
- Geographic: the difficult geographic areas would be reachable by allocating more resources like staff from the same areas, increased budget for transport to be rented.
- Data quality and reporting mechanism: The data quality is given high priority, however, it would be sustained and improved through tailored training and supportive supervision especially for the insecure areas. Feedback of the data analysis will be sent to the lower level on regular bases. The good performing staff can be awarded and competition can be created for the sake of improving the data quality. Reporting mechanism will be the same as followed in the national system (from HF to district to governorate the to center), however, different way of reporting might be accepted in the insecure areas like SMS, verbally by telephone…etc. DQS will be conducted twice in 2015 at all levels and the feedback will be extracted and sent to all levels as well.
- Coordination and governance: HSSCC will be convened on more regular basis. and priority items will be on their agenda.
  In addition, EPI Task force which is constituted of the main partners meet on a weekly basis to resolve many issues in this emergency situation and raise their unresolved issues to higher levels. with specific recommendations.

Role of CSO in the health system:

It is envisaged to involve CSO to play an essential role in covering the insecure areas through their interactionwith the local people and leaders. They will also work on increasing the demand of immunization in the emergency situation. The coordination/monitor officer at the HSS management can potentially play a role in coordination between the CSOs and the management of the HSS grant.

Corrective actions and lessons learned:

1- Lack of monitoring of the plans implementation
2- Quarterly meeting of the respective programs to review and monitor the implementation of the activities.
3- HSSCC will play an essential role in the coordination and monitoring level.
4- The management of the HSS program will be strengthened through increasing their capacity in the coordination and monitoring
5- EPI Task Force constituted from the main partners will meet on weekly bases during the emergency and will strengthen the implementation rate of the planned activities.
6- A small group from different partners and departments including the CSO to be formulated and met on monthly bases to monitor and push for the implementation of the HSS-supported activities.
7- Fuel and electrical shortages to be tackled collectively with all partners. GAVI, WHO and

UNICEF support is very much needed to resolve these issues at all levels.

Compliance with data quality:
1- DQS was conducted for 2014 and the verification factor was 103%. Feedback was sent to all governorates on the findings of the DQS to improve it.
2- EPI is planning to carry out EPI coverage survey in 2016.
3- GAVI support was instrumental in improving the data quality by supporting the DQS, supervision and training.

Programmatic Challenges:
1- Lack of access due to the coalition airstrike, Active AQAP/ISIS in the south east part, armed conflict, in many areas especially in Aden, Lahj, Al Dhalee, Taiz and Maarib.
2- The outages of the power and fuel shortage which might affect the storing of the vaccines. At present very few incidents of destroying vaccines have been reported.
3- Distribution of the vaccines to the lower levels including the health facility level.
4- The need to tackle the demand issue amid the current the security concern.

All departments which have role in the HSS, are capable to implement all the HSS grant activities and has a good experience in the previous HSS.

Financial performance and challenges:
1- The implementation rate was 68%, 2% and 0% for objective 1 & 2 & 3 respectively.
2- The low implementation rate was not due to the financial management of the HSS but it was due to the overall situation the country passing through and as consequence there was a period of no one authorized to sign cheques but this issue was resolved.

HSS recommendations

- A detailed work plan for six months to be developed by all partners to accelerate the implementation of the HSS grant and improve the routine coverage.
- Data quality plan within the humanitarian performance monitoring to improve the quality of data and tackle the issue of the discrepancies among the different level of reporting and with any of the surveys. One DQS already started in the 2nd half of June. Tailored training and supportive supervision at all levels to be supported by partners.
- Mapping of population – demand generation activities: mapping the population according to the recent displacement is very important to develop special plans for them. In addition the population in the closed HFs should be included in the outreach activities until the problems are resolved and they are made functional.
- Strengthen CSO involvement in planning implementation and third party monitoring: CSO will be involved in the planning for the next period to enable of reaching the unreached populations.
- integration and complementarity of other partners and actors (Cross sector) in immunization and health system strengthening: All the plans of all partners and departments will be on complementary bases that consider the maximum use of the fund and increasing he coverage with achieving sustaining good level if equity and accessing the vulnerable population as described above.
- HSS fund to be used outside the geographical areas identified for GAVI support in order to enable coping with the current emergency situation and give more flexibility for complementarity with other partners.

3.2.2. Strategic focus of HSS grant

[Comment on the extent to which the HSS grant contributes to improve and sustain coverage and equity in access to immunisation. See guidance document for more details]

1- The fund of HSS was used to implement the integrated outreach activities which contributed to decreasing the gap of inequity. During the outreach activities the following

health service are provided in the remote areas and to vulnerable groups: immunization, IMCI, RH (Family planning and ante-natal care), Nutrition, and health education.
The outreach activities were funded by other partners who along with GAVI covered in complementary manner all the districts with the integrated outreach activities.

2- HSS fund played the biggest role in implementing the integrated outreach and other immunization and non-immunization activities which directly strengthen the immunization coverage. HSS fund which financed the integrated outreach activities played essential role in closing the gap of coverage between the socioeconomic classes because they targeted the remote rural areas, low quantile, marginalized, IDPs and refugees camps.
3- The integrated outreach activities will continue to provide backbone for serving the vulnerable populations that will potentially increase.
4- Secure areas will also be covered though this fund through implementation of the integrated outreach activities in these areas through local CSO or through negotiation with the local community and leaders. Additional measures might be needed to implement the outreach in these areas.
5- Gender discrimination would be closely monitored especially in the above mentioned vulnerable groups where gender discrimination might be occurring. Increase the awareness on this issue among these groups needs additional activities to be funded.
6- HSS and partners fund will be the main source for tackling the issue of the damaged or closed health facilities through substituting the cold chain, support or motivate the HWs.

3.2.3. Request for a new tranche, no-cost extension, re-allocation or reprogramming of HSS funding / Future HSS application plans

[Indicate request for a new tranche of HSS funds (and the associated amount) or no-cost extension, or any planned changes in terms of re-allocation or reprogramming. Also describe future HSS application plans]

- Reprogramming of the HSS support to be in three years instead of four years and here is the fund requested every year:

  For 2015: $3,783,127
  For 2016: $5,958035
  For 2017: $5,468,716

The main focus areas of the future plan:

1- The main focus will be on achieving equity through implementation of the integrated outreach activities along with all partners on complementarity bases.
2- Enhance the CSO role in reaching more communities.
3- Cold chain expansion and replacement and EVM support where required. is very important following its damage during the airstrike and armed conflict and the need to convert to solar system on phases manner starting from the district vaccine stores. Along with that the EVM will be improved at all levels.
4- In order to maintain the immunization services in this emergency situation, supportive supervision to be enhanced through increased frequency times and enhancement of the incentive considering the high cost of transportation.
5- Support the operational cost of EPI at all levels to sustain the vaccine storage and transportation and supervision for the period Jan-Dec 2015.
6- Enhance the coordination mechanism of the HSSCC and EPI task force in addition to the increase coordination capacity of the HSS grant management.
7- Enhance the integrated manner of implementation the activities especially the outreach activities and supervision.
8- Improve the surveillance of the new vaccines and the other VPDs. In addition, data

quality improvement will be main area of support.

3.3. Graduation plan implementation *(if relevant)*

[Comment on all bolded areas listed in the table in this section of the guidance document]

3.4. Financial management of all cash grants

[Comment on all bolded areas listed in the table in this section of the guidance document]

HSS and NVS funds management has been effective and compliant to PFA.. No major constraints in financial management and hence no modifications required at this stage. We will consider routing funds through partners dependent on the country situation by end of 2015.

- Currently the HSS and NVS funds are transferred to a special governmental account in the name of the ICC. The Ministry of Finance, represented by the General Director of Finance approves all the disbursements and the DG of Finance is a major signatory on all the financial documents. MoF is also represented in the HSSCC which approves all the budgeted activities. MoPHP authorizes the spending according to the approved plan of action following the defined financial procedures.

- Financial auditing is done by the MOF and an international firm. - Documentation of financial procedures is done according to GAVI-supported Financial Manual procedures.

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- Disbursement modality of funds to GHOs is through Bank accounts.and cash of amounts $2000 or more is disbursed by a cheque.

Funds received by Gavi in 2014 and remaining balance:

HSS program received US$ 4,200,000 for HSS. The encumbrances wereUS$ 2,202,965 as of 31 December there was a balance US$ 2,089,194.4 .

ISS program had encumbrances of US$221,773 the closing balance of 31 December 2014 is US$778,089.

NVS received US$8,915,000 for the introduction of new vaccines (IPV &MR) and the MR campaign. The encumbrances were US$5,028,522.00 with a closing balance of US$3,896,368.00.

The delayed NVS activities will take place in the coming months. They are anticipated to be more expensive given the cost of the fuel etc. The catch up outreach campaigns planned under HSS are also anticipated to be more expensive than previously.

3.5. Recommended actions

Actions	**Responsibility** (government, WHO, UNICEF, civil society organisations, other partners, Gavi Secretariat)	**Timeline**	**Potential financial resources needed and source(s) of funding**
• Re-programing of the fund of GAVI to respond to the current emerging situation.	GoY, GAVI secretariat	July 2015	GAVI Total of **$13,388,279** For the year 2015-2017
• Partners to support securing the traditional vaccines and the government share of the new and under used vaccines.			GoY: already paid the co-financing share for Pneumo and rota vaccines UNIECF & WB is requested to finance the penta of around 1.6 million and for traditional vaccines cost of around $1 million for the 2nd half of 2015. For 2016: $2.5 for new vaccines and 42 million for the traditional vaccines.
• Improve the equity through sustain Implementation of the outreach activities and tailored activities especially in the low quantile groups, IDPs and refugees.	GoY & all partners	2015-2017	At least USD17,713,00 for the years 2015 through 2017 Partners: GAVI, WHO, UNICEF, WB
• Support replacing of the damaged cold chain and use the solar system for the districts vaccine stores level and in the health facilities.	GoY & all partners		GAVI: $263,000 in 2015 WHO: $400,000

• Support the District level to improve their ability to improve the routine coverage in light of the great need to rely on decentralization in this emergency situation.	GoY and GAVI	2015	- GAVI for operational cost $426,000 and $113,000 for supervision - WHO and UNIECF for supervision $229,000
• Continue the WB support through WHO and UNICEF	GoY, WB, WHO and UNICEF	2015-2017	In process.

4. TECHNICAL ASSISTANCE

(MAXIMUM 1 PAGE)

4.1 Current areas of activities and agency responsibilities

[Comment on technical assistance received and the responsibilities of the different agencies which provided the support. See guidance document for more details]

WHO and UNICEF have an essential role in supporting MoH in implementation of the GAVI support through technical support via the national and international staff from different specialties like immunization, PHC and social Mobilization.

4.2 Future needs

[Comment on all bolded areas listed in the table in this section of the guidance document]

Partners required to support mainly in the areas of:

1- Develop a detailed work plan for the next six months to implement all the activities required in this emergency situation
2- Annual planning and microplanning at all level down to the HF level.
3- Improve the effective vaccine management at all levels
4- Improve the data quality at all levels
5- Assist in enhancing the integration manner of implementation of the activities and enhance the coordination with all partners
6- Assist in establishing the integrated HMIS.

5. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT & ADDITIONAL COMMENTS

(MAX. 1 PAGE)

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism:
Issues raised during debrief of joint appraisal findings to national coordination mechanism:
Any additional comments from 1- Ministry of Health: 2- Partners: 3- GAVI Senior Country Manager:

6. ANNEXES

[Please include the following Annexes when submitting the report, and any others as necessary]

- **Annex A. Key data** (this will be provided by the Gavi Secretariat)

- **Annex B. Status of implementation of the key actions from the last joint appraisal and any additional High Level Review Panel (HLRP) recommendations**

Key actions from the last appraisal or additional HLRP recommendations	Current status of implementation

- **Annex C. Description of joint appraisal process** (e.g. team composition, how information was gathered, how discussions were held)

- **Annex D. HSS grant overview:**

General information on the HSS grant

1.1 HSS grant approval date			Nov-13					
1.2 Date of reprogramming approved by IRC, if any			n/a					
1.3 Total grant amount (US$)			$ 17,639,234					
1.4 Grant duration								
1.5 Implementation year			month/year – month/year					
(US$ in million)	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015 (January-June)**
1.6 Grant approved as per Decision Letter							4,200,000	
1.7 Disbursement of tranches							4,200,000	
1.8 Annual expenditure							2,202,965	226,391
1.9 Delays in implementation (yes/no), with reasons			Due to the political unrest and armed conflict which resulted in some managerial and administrative problems like the temporary suspension of the authorization of signing the cheques.					
1.10 Previous HSS grants (duration and amount approved)			Amount, start and end of HSS1 , and details of the HSS1 evaluations. HSS1 Grant closure is attached as Annex D1					
1.11 List HSS grant objectives (HSS2)								
1.12 Amount and scope of reprogramming (if relevant)								

- **Annex E. Best practices (OPTIONAL)**