

**Health System Strengthening (HSS) Cash Support**

**Application Package –Proposal Form**

This proposal form is for use by applicants seeking to request Health Systems Strengthening (HSS) cash support from the GAVI Alliance. Countries are encouraged to participate in an iterative process with GAVI Alliance partners, including civil society organisations, in the development of HSS proposals prior to submission of this application for funding.

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A completed application comprises the following documents. Countries may wish to attach additional national documents as necessary (see list at the end of this form).

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| **HSS Proposal Forms and Mandatory GAVI attachments**  *→ Please place an ‘X’ in the box when the attachment is included* | | |
| *No.* | *Attachment* | ***X*** |
|  | HSS Proposal Form |  |
|  | Signature Sheet for Ministry of Health, Ministry of Finance and Health Sector Coordinating Committee (HSCC) members |  |
|  | HSS Monitoring & Evaluation Framework |  |
|  | Detailed work plan and detailed budget |  |

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| **Existing National Documents - Mandatory Attachments**  Where possible, please attach approved national documents rather than drafts. For a highly decentralised country, provide relevant state/provincial level plan as well as any relevant national level documents.  *→ Please place an ‘X’ in the box when the attachment is included* | | |
| *No.* | *Attachment* | ***X*** |
|  | National health strategy, plan or national health policy, or other documents attached to the proposal, which highlight strategic HSS interventions |  |
|  | National M&E Plan (for the health sector/strategy) |  |
|  | National Immunisation Plan |  |
|  | Country cMYP |  |
|  | Vaccine assessments (EVM, PIE, EPI reviews), if available |  |
|  | Terms of Reference of Health Sector Coordinating Committee (HSCC) |  |

All applicants are encouraged to read and follow the accompanying guidelines in order to correctly fill out this form. Each corresponding section within the Guidelines provides more detailed instructions and illustrative instructions on how to fill out the proposal form.

**GAVI’s Approach to Health System Strengthening**

The following bullets outline GAVI’s approach to health system strengthening and should be reflected in an HSS grant:

* One of GAVI’s strategic goals is to *“contribute to strengthening the capacity of integrated health systems to deliver immunisation”.* The objective of GAVI HSS support is to address system bottlenecks to achieve better immunisation outcomes, including coverage and equity. As such, it is necessary for the application to be based on a strong bottleneck and gap analysis, and present a clear results chain demonstrating the link between proposed activities and improved immunisation outcomes.
* GAVI’s approach intends to deliver and document results. The performance of the HSS grant will be measured through intermediate results as well as immunisation outcomes such as diphtheria-tetanus-pertussis (DTP3) coverage, measles coverage, and percent of districts reporting at least 80% coverage. Therefore the application must include a strong Monitoring & Evaluation (M&E) framework aligned with the national M&E plan or national M&E processes.
* Performance based funding is a core approach of GAVI HSS support. All applications must align with the new GAVI performance based funding (PBF) approach introduced in 2012. Countries’ performance will be measured based on a predefined set of PBF indicators against which additional payments will be made to reward good performance in improving immunisation outcomes.
* GAVI supports the principles of alignment and harmonization (in keeping with Paris, Accra and Busan declarations and the International Health Partnership, IHP+). The application must demonstrate how GAVI support is aligned with country health plans and processes, complementary to other donor funding, and uses existing country systems, such as for financial management and M&E. The IHP+ Common Monitoring and Evaluation Framework is used as a reference framework in these guidelines.
* GAVI supports the use of Joint Assessment of National Strategies (JANS). A JANS assessment is not a requirement for a GAVI HSS application. If a country has conducted a JANS assessment the findings can be included in the HSS application. The Independent Review Committee (IRC) will use the findings of a JANS assessment to gain an understanding of the policy and health sector context that will inform their assessment of the credibility and feasibility of the HSS proposal.
* GAVI encourages a consultative and participatory approach for developing this HSS proposal, particularly across relevant departments in the Ministry of Health (including Planning, EPI, HMIS, M&E), across development partners, and civil society. While the HSCC (or equivalent) is required to sign off on this application, the ICC (or equivalent) also needs to be consulted and involved in the proposal development process.
* GAVI encourages countries to request funding for technical support in their HSS application for grant implementation, monitoring and capacity building.
* GAVI encourages countries to identify and build linkages between HSS support and new vaccine introduction support (as GAVI New Vaccines Support). These linkages must be demonstrated in the application. Countries will need to demonstrate systems readiness[[1]](#footnote-2) for new vaccine introductions in the context of routine immunisation services. GAVI HSS support will be for strengthening these routine immunisation services.
* GAVI’s approach to HSS includes support for strengthening information systems and improving data quality. Strong information systems are of fundamental importance both to countries and to GAVI. Countries are strongly encouraged to include in their proposals actions to strengthen data systems, including surveys and the institutionalization of routine mechanisms to track data quality improvements over time.
* GAVI supports innovation. Countries are encouraged to be innovative in their identification of activities which will have a catalytic effect on addressing HSS bottlenecks to improving immunisation outcomes.
* GAVI encourages applicants to include funding for Civil Society Organisations (CSOs) in implementation of HSS support to improve immunisation outcomes. CSOs can receive GAVI funding through two channels: (i) funding from GAVI to MOH and then transferred to CSO, or (ii) direct from GAVI to CSO. Please refer to Annex 4 of the guidelines for further details.
* Applications must include details on lessons learned from previous HSS grants from GAVI or support from other sources.
* Applications must include information on how sustainability and equity (including geographic, socio-economic, and gender equity) will be addressed.
* Applications will need to show the additionality of GAVI support to reducing bottlenecks and strengthening the health system, relative to support from other partners and funding sources.
* Cash disbursed for HSS support must be used solely to fund HSS activities. These funds may not be used to purchase vaccines or meet GAVI’s requirements to co-finance vaccine purchases, and shall not be used to pay any taxes, customs, duties, toll or other charges imposed on the importation of vaccines and related supplies.

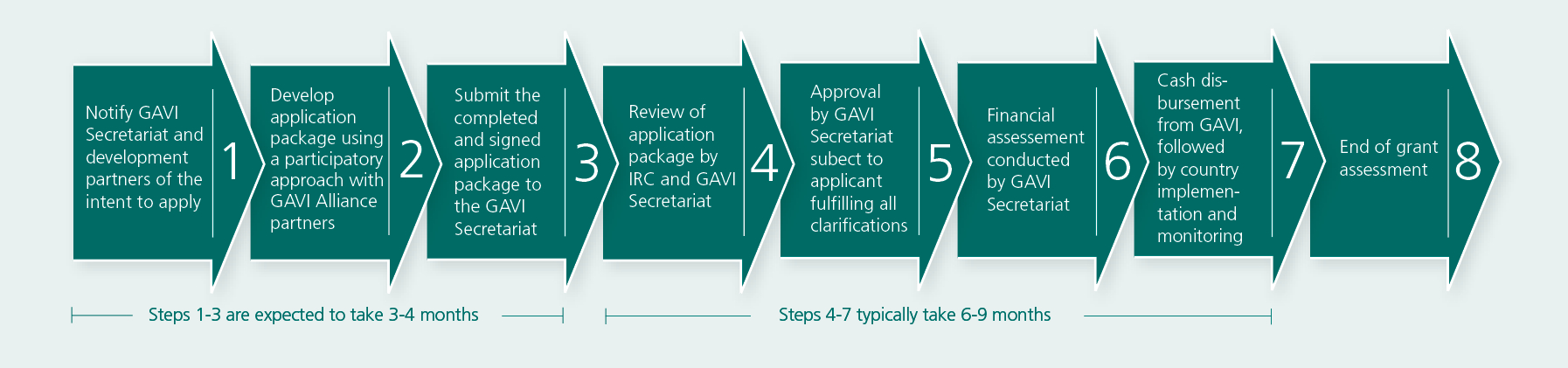
**Application and Implementation Process**

This application form has key instructions, but for more detailed information please see the attached guidelines for completing a GAVI HSS proposal. The application process for GAVI HSS proposals is similar to the process of applying for new and underused vaccines. The process of taking a decision to apply for GAVI funding and work with GAVI Alliance partners to develop a proposal (Steps 1 and 2 in Figure 1 below) will require adequate time; as much as possible, it should be planned to link with existing country planning processes.

Countries are encouraged to participate in an iterative process with GAVI Alliance partners, CSOs and development partners in the development of HSS proposals prior to submission of this application for funding. Steps 1-7 indicate the standard steps for GAVI HSS application process. Countries should allow 9-12 months for these steps. Steps 1-3 are expected to take 3-4 months, while steps 4-7 typically take 6-9 months.

Please note that if approved your application for HSS support will be made available on the GAVI website and may be shared at workshops and training sessions. Applications may also be shared with GAVI Alliance partners and GAVI’s civil society constituency for post-submission assessment, review and evaluation.

**Figure 1: Application and Implementation Process**



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| PART A - SUMMARY OF SUPPORT REQUESTED AND APPLICANT INFORMATION | |
| **For further instructions, please refer to the Guidelines for Completing the HSS Application** | |
| **Applicant:** | ***Ministry of Public Health and Population*** |
| **Country:** | ***Yemen*** |
| **Proposal title:** | ***Expanding EPI coverage through health system’s development in Yemen*** |
| **Proposed start date:** | ***01/January/2014*** |
| **Duration of support requested:** | ***5 years*** |
| **Total funding requested from GAVI:** | ***USD 17,637,380*** |
| **Contact Details** | |
| **Name** | ***Dr.Majid Al-Jonaid*** |
| **Organisation and title** | ***Deputy Minister for Primary Health Care*** |
| **Mailing address** | ***Alhasabah, Ministry of Public Health & Population, Sana`a, Yemen*** |
| **Telephone** | ***00967-733477477*** |
| **Fax** | ***009671252234*** |
| **E-mail addresses** | [***maljonaid@hotmail.com***](mailto:maljonaid@hotmail.com) |

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| **Signatures: Government endorsement** |
| Please note that this application will not be reviewed or approved by GAVI without the signatures of both the Ministers of Health & Finance and their delegated authority.  Minister of Health Minister of Finance  Name: Dr Majid Al-jonaid Name: Mr Abdulkarim Al-Wali  Signature: Signature:  Date: Date: |
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**HSCC SIGNATURE PAGE**

**For submission with GAVI HSS application**

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| |  | | --- | | **Health Sector Coordination Committee**  Country \_\_\_\_\_\_\_Yemen\_\_ Date of HSS application \_September 2013\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| |  | | --- | | We the members of the HSCC, or equivalent committee [1] met on \_\_\_\_\_\_\_\_\_\_\_ to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. | | | |
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| |  | | --- | | **[ ]** Health Sector Coordination Committee or equivalent committee which has the authority to endorse this application in the country in question. |   Name of the HSCC in country \_\_Health System Strengthening Coordination Committee | | |
| |  | | --- | | **Health Sector Coordination Committee** | | | |
| |  |  |  |  | | --- | --- | --- | --- | | **Name/Title** | **Agency/Organisation** | **Signature** | **Date** | | Dr. Majed Yahia Al Gunaid | Deputy Minister of Primary Health Care Sector |  |  | | Mr. Motahar Al-Abasi | Vice Minister of Planning &International Cooperation |  |  | | Dr. Jamal Thabet Nasher | Deputy Minister of Planning Sector MOPHP |  |  | | Mr. Hussain Al-Hadar | Deputy Minister of Religious Affairs |  |  | | Mr. Mohammed Taoaf | Deputy Minister of Education |  |  | | Mr. Ameen Al-Arhabi | Deputy Minister of Local Administration |  |  | | Dr. Nafisa Aljaifi | Secretary General of the Supreme Council for Motherhood and Childhood |  |  | | Mr. Ahmed Al Ashari | Deputy Minister of Youth and  Sports |  |  | | Mr. Ahmed Al Hamati | Deputy Minister of Information |  |  | | Mr. Yahia Saleh Alansi | Deputy Minister of Finance |  |  | | Dr. Ali Mohammed Jahhaf | DG of Family Health |  |  |  |  |  | | Dr. Abdulhakim Ali Alkohlani | DG of Surveillance |  |  |  |  |  | | Dr. Ghada Al-Habob | Director of National Immunization Program |  |  |  |  |  | |  | DG of Reproductive health |  | Post is vacant |  |  |  | | Dr. Mosleh Al Toali | DG of Planning |  |  |  |  |  | | Dr. Adel Al- Muaid | DG of Health Policy Unit |  |  |  |  |  | | Dr. Ahmed Shadool | WR- WHO |  |  |  |  |  | | Dr. Nawal Ba’abad | USAID |  |  |  |  |  | | Dr. Arwa Baidar | Child Health Officer-UNICEF |  |  |  |  |  | | Dr. Kai Stietenroth | RH Program Manager-GIZ |  |  | | Dr. Arwa Aldram | SOUL |  |  | | Dr. Ali Al-Muhdwahi | Senior Health Officer-WB |  |  | | Mr. Nabeel Al- Amari | DG. Of Yemen Family Care Association |  |  | | Dr. Mohammed Aidrous | Dutch Embassy |  |  | | | |
| Please tick the relevant box to indicate whether the signatories above include representation from a broader CSO platform: Yes × No 🞎    Individual members of the HSCC may wish to send informal comments to: [gavihss@gavialliance.org](mailto:HSFP@gavialliance.org)  All comments will be treated confidentially. |  |  |
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| PART B – EXECUTIVE SUMMARY |

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| **For further instructions, please refer to the Guidelines for Completing the HSS Application** |
| *→*  *Please provide an executive summary of the proposal, of no more than 2 pages, with reference to the items listed below:*   1. *The main bottlenecks for achieving immunisation outcomes addressed within this proposal and how proposed objectives in this application will address these bottlenecks and improve immunisation outcomes.* 2. *Objectives and the related budget for each objective.* 3. *The proposed implementation arrangements including the role of government departments and civil society organisations. Please include a summary of financial management, procurement and M&E arrangements.* |
| ***TWO PAGES MAXIMUM***  Among the many challenges Yemeni Health System is confronted with, the following main bottle necks to achieving immunization outcome are addressed by this proposal:  Access to PHC including EPI services: because of geographical, social and political barriers. Deficient performance of health care delivery system particularly expansion of EPI services into more health facilities. Un-satisfactory skills of health care providers, inadequate supervision, and the de-motivation of staff. The weak collaboration/partnership between public and private health sectors in service delivery. Weak and fragmented HMIS, particularly skills of analysing and reporting data, fragmentation of service reporting particularly PHC services, and the need to expand coverage of surveillance for vaccine preventable disease. Low awareness and growing misconceptions about the importance of vaccination, weak community participation in raising awareness, planning and providing community based health services.  To address those bottle necks, the proposal has got three objectives:  **Objective 1: Enhancing equitable access to immunization and integrated PHC services (12,008,838$) 68% of budget.**  This objective is focusing on addressing equitable access to integrated basic health and EPI services by targeting population in remote areas, inclusiveness of marginalized groups and refugees using variable approaches to reach them, expanding EPI service provision to more public health facilities and improving partnership with the private health sector in that aspect. The outreach teams will include at least a female staff to satisfy the needs of women. Health services will be looked at through the eyes of supportive supervision and giving feedback to the lower level with the purpose of achieving better performance. Also, providing incentives to the government key staff involved in EPI, Surveillance and HMIS based on a set of performance criteria and in a minimal amount in order to motivate them and to encourage better performance. The health system has gained an extended experience in planning and implementing integrated outreach services starting in 2008 through the previous GAVI fund, which has been inspiring to the WB, UNICEF and others whom are funding integrated outreach activities in districts not targeted by this proposal.  **Objective 2:- Improving the integrated health information including surveillance, monitoring and evaluation systems and research centrally and at the health facilities in the targeted districts**  **(2,209,300$) 13% of budget.**  This objective attempts to address the long lasting problem of poor performance of the HMIS in the country in order to serve the needs of the EPI programme in understanding and documenting the impact of EPI on morbidity and mortality. It, also, aims at expanding the surveillance network in order to reach all districts targeted by the grant and establishing Community Based Surveillance.  This will be done through increasing the availability of resources (trained personnel, logistics, IT support and regulations and frameworks) needed for a strong surveillance and information systems as well as updating the sources of information (SARA, EPI coverage survey).  It will gradually initiate the efforts towards building an integrated electronic HMIS in the GHOs and DHOs using available resources and upgrading it at the different levels.  It will complement all the efforts currently undergone by the information department in the MOPHP and at peripheral level in the governorates and districts that are either supported by the government or development partners.  **Objective 3: Community empowerment and civil society participation in provision of immunization and essential health services including and not limited to community volunteers**  **(2,504,242$) 14% of budget**.  This objective tries to increase the demand side through awareness raising using variable approaches and multiple channels, improving capacity to communicate health messages, targeting multiple strata of communities, involving the community in raising awareness, providing basic services package by Community Health volunteers, and increasing demand for utilizing health services using community based initiatives. CSOs role will target two levels, raising awareness will be nationwide and service delivery will be targeting challenging areas not or insufficiently covered by public health services (conflict areas, nomadic, refugees, marginalized, displaced, potential returnees from neighbouring countries) using innovative approaches (private health care providers, supporting un-employed midwives, training persons from nomadic and marginalized groups to provide basic health services with focus on EPI, and adopting sponsor child strategy in schools).  **Program management (915,000$) 5% of total budget.**  **Implementation and financial arrangement:**  The main implementing body is Ministry of Public Health and Population; it will follow the same arrangements as for the previous GAVI fund, where the fund is deposited in the same bank account, which has been opened for HSS and ISS funds since 2008 and certified by UNICEF. Based on GAVI – TAP requirements, the financial management of the fund and the bank account (FMA) had been assessed by GAVI in September 2010. Recommendations of the FMA were included in the Aide Memoire and implemented accordingly. The already established Integrated Management Unit (IMU) will be responsible for administering the fund. Relevant departments from the PHC, planning, population sub-sectors in the ministry, and Governorate Health Offices (GHOs) are the main implementers. Other implementing partners are local and international CSOs, WHO and UNICEF. Tools developed and followed throughout the previous experience and integrated into the health system are going to be used.  The proposal budget and work plan is the guiding reference to the process, implementing bodies meet annually to revise the plan based on updates of implementation at all levels and adjust plan accordingly, plan will be reviewed technically and financially by the IMU, then submitted to the HSCC for approval.  Funds are disbursed to the bank account of each GHO as instalments based on work plans that specify agreed activities to be carried out within the governorate, using the current system of advances used by the Ministry for government/donor funds. Governorates, where possible, will use the same mechanisms for dispersing funds to districts.  There is supervision on implementation of activities from the local and central levels, funds disbursed are subject to the internal control mechanisms at central and local levels, annual external audit is done by Central Organization of Control and Audit (COCA), and another external audit is done annually by an independent auditor who is linked to an international audit firm.  The HSS program current FM is the reference for procurement procedures, it is already approved by HSCC and GAVI, it is based on the MOPH&P procurement regulations. It, also, allows for procuring through WHO and UNICEF according to their procurement regulations.  **M&E arrangements:**  There are multiple methods and sources of data for M&E of the grant.  National Demographic and Health Survey (NDHS), which will update the baseline data for impact indicators, EPI coverage and other morbidity and mortality indicators.  Mandatory immunization outcome indicators o f penta3 coverage, measles coverage, districts with ≥ 80% penta3 coverage, and dropout rate between penta1 and penta3 will be measured annually by EPI administrative data. Socio-Economic equity in immunization coverage will be assessed through surveys (MICS, DHS).  Proportion of fully immunized children will be measured annually through the administrative data, and through the surveys (DHS, EPI coverage survey and MICS).  An intermediate result indicator for each objective has been selected to be measured on annual basis to track progress of implementation. |

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| PART C– SITUATION ANALYSIS |

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| **For further instructions, please refer to the Guidelines for Completing the HSS Application** | | | | | | | | | |
| 1. Key relevant health and health system statistics | | | | | | | | | |
| *→ Please complete the table below providing the most recent statistics for the key health, immunisation, and health system indicators listed.*  *→ Where possible, data on the key statistics should be presented showing wealth quintile differences, and disaggregated by sex.*  *→ If available disaggregated data for the key statistics indicators showing differences by geographic location (region / province) and urban / rural should be included in the space provided after the table.*  *\*Where possible, GAVI asks for both country administrative data as well as from ‘other’ data sources. Please state the source of ‘other’ data in brackets after entering the value. ‘Other’ recommended data sources are DHS/MICS or recent coverage estimates from WHO/UNICEF. If the difference between these reported data are more than 5% points, the country should include an explanation as to how they plan to strengthen data quality as part of the HSS grant.* | | | | | | | | | |
| **Key Statistics** | | | | | | | | | |
| **Indicator** | **Source** | **National Average** | **Percentage difference between highest & lowest quintiles** | | **Sex**  *(Please provide disaggregated data where available)* | | | | **Year** |
| **M** | **F** | **Total** | |
| DTP3 coverage | Administrative Data (2012) | **82%** |  | |  |  |  | |  |
| Other\*  (WHO-UNICEF estimates 2012) | **82%** |  | |  |  |  | |  |
| Measles 1st dose coverage | Administrative Data (2012) | **71%** |  | |  |  |  | |  |
| Other\*  (WHO-UNICEF estimates 2012) | **71%** | **85.5-52.4=33.1**  **(MICS 2006)** | | **65.7**  **(MICS 2006)** | **64.5** | **65.1** | |  |
| Drop-out rate between DTP1 & DTP3 | Administrative Data | **7%** |  | |  |  |  | |  |
| Other\*  (WHO-UNICEF estimate 2012) | **7%** |  | |  |  |  | |  |
| Percent of districts with DTP3 coverage ≥80% | Administrative Data (EPI coverage 2012) | **58%** |  | |  |  |  | |  |
| Other\*  (WHO monitoring system. 2013 global summary) | **58%** |  | |  |  |  | |  |
| DTP3 coverage in the lowest wealth quintile is +/- X% points of the coverage in the highest wealth quintile | Administrative Data | **N/A** |  | |  |  |  | |  |
| Other  (MICS 2006) | **61%**  **(Urban: 79.5%)**  **(Rural: 53.2%)** | **94.6-40.3=54.3** | | **61.7** | **60.2** | **61** | |  |
| Fully immunised child coverage (%) | Administrative Data (EPI 2012, measles) | **71%** |  | |  |  |  | |  |
| Other\*  (MICS 2006) | **38%** | **72.5-17.8=54.7** | | **36.4** | **38.6** | **38** | |  |
| **Additional Health System Statistics** | | | | | | | | | |
| **Indicator** | | **Source** | | **Value** | | | | **Year** | |
| Under Five Mortality | | Administrative  Data (IGME, 2011 level and trend in child mortality report 2012 ) | | **77 (M: 87, F: 73)** | | | |  | |
| Other\*  (MICS 2006) | | **78 (M:81, F:75),**  **(Poorest:118, Richest:37)**  **(Rural:86, Urban:57)** | | | |  | |
| Total Expenditure on Health (THE) as percentage of GDP | | Administrative  Data (MOH statistics dept 2011-2012) | | **5.63%** | | | |  | |
| Other\*  (state source) | | **N/A** | | | |  | |
| Per capita expenditure on health | | Administrative  Data (NHA 2007) | | **57.41** | | | |  | |
| Other\*  (WHO estimate 2011) | | **152.2** | | | |  | |
| Total health sector budget for the year of application | | Administrative  Data (Government data 2013) | | **290,703,074** | | | |  | |
| Other\*  (state source) | |  | | | |  | |
| Percent of the health sector budget funded by the government from domestic sources | | Administrative  Data (Government data 2013) | | **80%** | | | |  | |
| Other\*  (state source) | |  | | | |  | |
| Budget of EPI programme for the year of application | | Administrative  (Actual Expenditure) | | **54,140,646** | | | |  | |
| Other\*  (CMYP projection 2013) | | **68,999,939** | | | |  | |
| Percent of sub-national level facilities with cold chain capacities fit for purpose (based on WHO definition “fit for purpose”) | | Administrative  Data (EPI data 2013) | | **90% ( based on that all currently functioning health facilities have functioning cold chain, the rest are: new health facilities and the need to replace out of date fridges)** | | | |  | |
| Other\*  (state source) | |  | | | |  | |
| Timeliness and completeness of facility and district (or equivalent) reporting | | Administrative  Data (EPI data 2012) | | **97% Completeness**  **24% Timeliness** | | | |  | |
| Other\*  (state source) | |  | | | |  | |
| **Please use the space below to provide:**   * **Explanation of any disparities between administrative statistics and ‘other’ statistics and details of any plans to improve data quality to address these disparities.** * **Further disaggregation of the Key Statistics Indicators (if available). This data will be used to illustrate equity differences by geographic location and urban/rural.** | | | | | | | | | |
| ***THREE PAGES MAXIMUM***  - The disparity between administrative and MICS 2006 regarding fully immunized child coverage is due to the following: administrative data is assuming that an infant would get measles vaccine after getting all other vaccines, and it is administrative data for the year 2012. While MICS result is based on a survey data done in 2006.  -Yemen is now undergoing the process of implementing the National Demographic Health Survey (NDHS). The field work for data collection will start in September 2013. The NDHS results will help updating most of the figures related to child health. | | | | | | | | | |

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| 2. **Description of the National Health Sector** |
| *This section will provide GAVI with the country context which will serve as background information during the review of the HSS proposal.*  *→ Please provide a concise overview of the national health sector, covering both the public and private sectors, including CSOs, at national, sub-national and community levels, with reference to NHP or other key documents.*  *→ Please include a copy of the National Health Strategy/Plan as Attachment 5. If the NHP is in draft format please provide details of the process and timeline for finalising it. If there is not an NHP, or if other documents are referenced in this section, please provide these other key relevant documents.*  *It is recommended that applicants refer to GAVI’s health system strengthening grant categories detailed in the Application Guidelines (Table 1, Under ‘Key Terms’). For each of the categories listed in the Guidelines (2.1-2.7) please provide a short commentary. In order to keep this section concise, please summarise the key elements in the context of the HSS support being asked for, and provide reference to the relevant section in the National Health Plan for further detail.* |
| ***TWO PAGES MAXIMUM***  Yemen is among the less developed countries that confronts many challenges in various areas. Geographically, Yemen is situated in the south-western corner of the Arabian Peninsula occupying an area of over half a million square kilometres. The natural topography of the country divides it into four major regions: costal, highlands, Tihama plateau and the eastern plateau in addition to number of islands in the Arab and Red seas.  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. Moreover, the young age group is a characteristic of the population pyramid where people under-15 years represent 46.3 % of the total population with a rapid annual growth rate of 3.02 %.  Administratively, the country is divided into 21 governorates (Hadramout governorate is divided administratively into 2 sub-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 MMR according to the last family health survey, 2003 was 366/100000 live births and the mortality for children under 5 102/1000 live births. As for the MICS 2006, under 5 mortality rate dropped to 78.2, and under 1 mortality rate was 68.5/1000. There are undergoing efforts to accelerate the interventions to reach MDGs 4&5 where an Acceleration Plan with high impact interventions was developed by MoPH&P in collaboration with development partners.  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. The private health sector has expanded greatly through the last 20 years, it is almost as equal as the public sector in size, however its interest is mainly focused on secondary and tertiary curative care and concentrated in the main towns and urban areas, clients are mostly those who can afford the costs. The 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, local authorities have the mandate of supervision on service provision locally. There is specific department at ministry and governorate levels for supervising services provided by the private sector, but this aspect needs to be further developed and coordinated.  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 mainly ) and some secondary health care services. During the last 10 years the involvement of NGOs in providing health services has grown up where some local NGOs like Yemen Family Care association (YFCA) , Charitable Society for Social Welfare (CSSW), Yeman and Alsaleh Foundation expanded its contribution to health services provision through mobile clinics and teams and also through their volunteers networks in coordination with MOPH&P at central and governorate levels, although further enhancement and consolidation of coordination is still needed.  The interest in introducing quality in the health system has increased lately; there is a movement to improve quality of PHC services provision at health units and health centres. With issuing the health Insurance law and by-laws in 2011, improving quality of health services at hospitals has become more pressing and the quality department at MOPH&P has been upgraded into a Directorate General.  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.  The number of health workers in public sector is 50,217, out of which 6,579 are medical doctors, 12,447 nurses and 2,479 medical assistants, Midwives 4,143 (Statistic dept 2011, MOPH&P). We still lack accurate figures about the health work force in the private sector and NGOs.  As in most developing countries, the health workforce is concentrated in the main governorates and cities where living conditions are better. Therefore other governorates are suffering from attrition of their health workers due to low or no incentives. In an attempt to tackle this challenge, MoPH&P is working now on developing the National Human Resources Strategy with support from the EC and WHO.  Current procurement system in the MoPH&P is according to the overall government procurement system ruled by the Tender and Auction law NO.(23) 2007 , and its by-laws issued by the Cabinet Decree No. (53) 2009. MOPH&P also relies in procurement on some international agencies such as WHO, UNICEF, UNFPA (e.g.: vaccines and cold chain through UNICEF and WHO, Contraceptives UNFPA, some items are procured through government procurement procedures and through International agencies based on source of funding, urgency of need and required specifications ). Currently there is a high committee at cabinet to review the Tender and Auction by-laws taking into consideration the special needs of specific sectors’ procurement requirements.  Concerning storage capacity especially for vaccines, it is sufficient as per EVM requirements (recently an EVM assessment has been done, attached). The supply of medical items specially vaccines is a mix of pull and push system according to level of health system (e.g. upon arrival into country to central stores is a pull system, from central level to governorates is a push, from GHOs stores to Districts and HFs is a pull system)  The national HMIS suffers from shortages in its material and technical capacities at all levels and thus it is unable to fulfil its tasks and provide decision makers with the needed reliable data. Accordingly, the planning and M&E functions of the MoPH&P and GHOs are affected negatively. Reporting from HFs to DHOs and GHOs is irregular and incomplete in many times. Nevertheless, the EPI reporting system is well functioning in terms of completeness and to a lesser extent in terms of timeliness at all levels. However, it is a standing alone system that needs to be integrated into the national system in order to ensure sustainability and effectiveness.  The EPI data quality is checked through supervision visits followed by feedback to the lower level and by reviewing data reported from governorates and districts, DQS is done periodically and organized by the MOPH&P central and governorate levels in cooperation with WHO. NIDs and SNIDs are followed by independent monitoring organized by the WHO. Lately in 2013, the ministry in cooperation with WHO and UNICEF have conducted an in-depth review of EPI and an EVM assessment.  As a result of insufficient coverage by health services in the peripheral areas (40% coverage gap) the approach to health service provision by reaching out with vaccination services to the unreached population in remote areas has started in 2005, which has significantly increased coverage of immunization by 28% penta3. The experience was further developed to implement 4 outreach rounds of integrated activities in selected districts (further explanation of the experience is described in lessons learned section). . Community Health Volunteers (CHVs) are one of the approaches in this regard, role and functions of CHVs will be integrated into the new human resources strategy under development.  For government stakeholders: planning, financing and implementation of health care services are done jointly by MOPH&P, Ministry of Finance and Ministry of Planning centrally. At governorates level, the governor with governorate health office, local councils, and finance office are the stakeholders involved. As for donor stakeholders: monthly donor coordination meetings are held, in addition to government-donor retreat and joint planning and review meetings. Also, regular HSCC meetings are conducted (TOR of HSCC is attached).  Public health law No. (4) 2009 is the main law governing responsibilities, rights and obligations of public health issues including immunization.  Voice of community is represented through local councils structures where community elected representatives are part of the governorate and district general assembly. They are part of the planning and budgeting, services and monitoring and evaluation committees at local level.  Health care financing is mainly decentralized according to the local authority law. However some public health programs such as EPI, Malaria control, TB control, HIV etc. Have a mixed funding modality where salaries of health workers and budget of health facilities are part of the local budget, while supervision and supply and training and campaign and outreach activities are centrally funded.  The following graph shows the flow of funds across the health system: |

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| 3. National Health Strategy and Joint Assessment of National Health Strategy (JANS) |
| *This section will be used to determine how immunisation is addressed in the national health plan, and what the key findings of an independent JANS assessment of the strategy were. The Independent Review Committee (IRC) will use the findings of a JANS assessment to gain an understanding of the policy and health sector context that will inform their assessment of the credibility and feasibility of the HSS proposal.*  *→ Please provide a reference to the relevant sections and pages in the NHP which outline immunisation policies, objectives, and activities.*  *→ If a Joint Assessment of the National Health Strategy (JANS) has been conducted, please provide the JANS report as an attachment.*  *→ Please provide a summary of how the government and partners have addressed the weaknesses and recommendations identified in the JANS or attach the country’s response.* |
| ***ONE PAGE MAXIMUM***  Yemen has a National Health Strategy (NHS) 2010-2025 that was developed in coordination with all development partners and in a bottom up approach. This NHS was structured based on the six building blocks of health systems. Under health service provision (page 34 of the English copy), the strategy illustrated the importance of integrating the national immunization programme and other vertical programmes within the national health system. To date Yemen has not conducted a JANS as the debate is still should we do a JANS or should we revise the strategy first, given the uprising challenges the health system is experiencing following the 2011crisis.  The strategy itself was not budgeted but its objectives are reflected in the country’s current 5 year development plan 2011-2015, which included the policy and strategy of EPI.  Moreover, and in response to the challenging situation, a two-year transitional plan 2012-2014 was developed. This plan was kept at a strategic level to provide flexibility in planning and implementation among different sectors. In June 2013, a joint MoPH&P/DP retreat was conducted to improve harmonization and alignment in implementation around this transitional plan.  The EPI cMYP will be detailed in another part of this application. |

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| 4. Monitoring and Evaluation Plan for the National Health Plan |
| *This section will provide background information on how the country organises M&E arrangements and whether this proposal is aligned and complementary to national M&E plans.*  *→ Please attach a copy of the M&E Plan for the national health plan.*  *→ Please provide a summary of how the National M&E Plan is implemented in practice. In your answer refer to relevant sections of the M&E Plan in the national health plan for further details.*  *→ Please provide a description of how development partners are involved in the M&E of the national health plan implementation and financing. Is there a Joint Annual Health Sector Review (JAR) and if so how and when are they are conducted? Please outline the extent of GAVI involvement in the JAR process.*  *→ Is the immunisation programme review linked to the Joint Annual Review (JAR)? Please state Yes/No.* |
| ***ONE PAGE MAXIMUM***  Monitoring and Evaluation Plan for the National Health Strategy    The health sector in Yemen still lacks a unified M&E framework. The priority health programmes are vertical and each uses its own M&E framework including EPI. Moreover, the GF and other major donors unintentionally contributed to this fragmentation through supporting the establishment of separate M&E mechanisms, using program specific staff and tools, which they are funding. Accordingly, data is collected and analysed by each programme individually. The results are used to inform reviews and planning processes related to each individual programme separately.  The Ministry has initiated a process of unifying M&E framework bringing in together the main primary health care programs by developing a joint framework for M&E since 2009, and identified 16 core indicators to be reported on periodically and annually, this framework and indicators were approved and disseminated to the GHOs, they are expected to report annually accordingly, the process needs further follow up and improvement. In addition, there is a joint annual planning and review session involving PHC sub-sector and GHOs to discuss and develop the annual plans. Integrated supervision tools for management and health service delivery levels have been developed and used; it needs further review and updating.  As for CSOs, it varies from one to another according to their-own governance structure and mechanisms. In principle, they are using the government indicators, however they are not shared with Ministry of Health and accordingly no sufficient information available  Furthermore, there are attempts at wider range from the Ministry of Public Health and Population reflected by establishing a general M&E unit.  There is no comprehensive Joint Annual Health Sector Review although it was planned in the National Health Strategy 2010-2025, the 2011 crisis is one the reasons. However, there are joint reviews on lower scale done bilaterally on programs level but not well documented.  There is annual analysis of EPI performance, after which annual plans are developed using the data reviewed and based on the cMYP. Furthermore, an external comprehensive review of the EPI programme and EVM just concluded during the period 6-26 July 2013. |

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| 5. Health System Bottlenecks to Achieving Immunisation Outcomes |
| *This section will be used to understand the main bottlenecks affecting the health system performance. The analysis here underpins the application, ensuring the proposed activities are designed to address the bottlenecks.*  *→ Please describe key health and immunisation system bottlenecks at national, sub-national and community levels preventing your country from improving immunisation outcomes. Consider bottlenecks to providing services to specific population groups, such as the under reached, marginalized or otherwise disadvantaged populations. The country is also asked to consider gender related barriers to accessing quality services.*  *In order to keep this section concise, please summarise the key elements in the context of the HSS support being asked for, providing a reference to the relevant section in the National Health Plan for further detail.*  *→* *Please refer to bottlenecks which impact on gender and equity-related access to immunisation.*  *→ Please reference the analytical work that led to identification of the bottlenecks.*  *→ Describe the bottlenecks identified in any new vaccine proposals submitted to GAVI, the National Health Plan, and any recent health sector assessments such as the Effective Vaccine Management (EVM) assessment or Post Introduction Evaluation (PIE).*  *→ Which of the above specified bottlenecks will be addressed by the current proposal? Which bottlenecks are addressed by other national or externally supported programmes?*  *In order to keep this section concise, please summarise the key bottlenecks and provide references to the relevant sections in existing bottleneck analyses. Please ensure the referenced analyses are provided as attachments.* |
| FOUR PAGES MAXIMUM  **General framework conditions affecting health sector:**  Based on 2011 data, Yemen has a population of 24.5 million scattered in approximately 136,000 settlements with continued high population growth of 3.02 % (population growing at over 0.8 million people per annum), this huge increase of population annually is a great challenge to the government to catch up with the enormously increasing needs of population in face of limited resources including those needed to offer basic health services to satisfy needs.  Most of population in Yemen inhabits the rural areas (70-75%). Physical access to health services, level of education, means of communication and transportation and wealth, all get less as remoteness and dispersal of population get more and more.  **Socio -political Bottlenecks:**  GOY faces major challenges to improve the health status of its population that goes beyond the mandate of the health sector: poverty, food insecurity, high illiteracy especially among females are major contributing factors to poor health (Country Cooperation Strategy for WHO and Yemen (CCS), 2009, P 16). The health system is further undermined by conflict and political instability affecting the health infrastructure and availability of quality services. Inadequate food, immunization converge below 90%, poor water and sanitation conditions and un-healthy behavior put the population at higher risk of morbidity and mortality from communicable diseases and malnutrition particularly among under 5 children (Yemen Health Priorities for the Transitional Phase – WHO, June 2012, P. 2).  Insecurity is negatively affecting functionality of some health facilities in some geographical areas where there were armed confrontations; it also negatively affects access of population to services and ability of reaching out with services to certain geographical areas.  The internal displacement of population because of armed conflict was a challenge to the health sector to secure services and prevent disease outbreaks, it started in 2008 and peaked during 2011, but eased down starting 2012 because of partial political stability. Currently, it is limited to few geographical areas but needs to be addressed where necessary.  The continuous flow of migrants and refugees getting into the country every day coming mainly from the horn of , Ethiopia and Eritrea, is a serious challenge to the health system some of them get settled in Yemen mainly gathering in certain areas in towns and refugee camps, and some are scattered in urban and rural areas where livelihood is available, while others travel across the country from the south to the north heading into the neighboring Gulf Countries, the new arrivals annually are about 100-110 thousands(Yemen Fact Sheet-May 2013, UNHCR, [www.unhcr.org](http://www.unhcr.org)). Immunization related risks has increased very much because of this influx of people into country, for example the high risk of importing poliomyelitis from the horn of Africa in 2013, measles outbreak in 2011-2012, and has made an additional burden on the EPI by targeting higher age group by vaccination among refugees, for example vaccinating adults with measles and polio vaccines.  There are, also, marginalized groups of population scattered in communities whom are not utilizing available services as much as other society groups do.  Nomad population, though limited in numbers, but scattered in the governorates of Marib, Abyan, Shabwa, Hadramout and Almahara, improving utilization of services by those groups is a challenge the health system has to be tackle innovatively.  **Health System Bottlenecks:**  The national health system in Yemen is facing multiple challenges hindering the process of health development to upgrade the already very low health conditions as suggested by indicators. The weak health system elements in particular the serious shortage of essential medicine for mothers and children, poorly functioning health information and referral systems, weak supervisory system affect both quality and scaling up of health services delivery (The National Health Acceleration Plan, 2013-2015, P. 8).  Accessibility to PHC services including EPI services is a major concern of the health system, as more than 35% of population has no access to fixed health services, distribution of health facilities across the country is not homogeneous leaving many of the remote areas’ population deprived of health services creating pockets of high susceptibility to disease outbreaks (MOPH&P annual report 2011, P. 22). On the other hand, not all health facilities are well functioning, local authorities are experiencing serious difficulties in equipping, recruiting and deploying staff, and securing operational budget to run health facilities newly constructed through the local resources. In addition, periodic reporting from DHOs and GHOs show that (3101) 81% of the facilities are providing EPI services because of several reasons: including cold chain availability, budget availability, and staff availability. Lately some health facilities become out of function because of the effects of the political crisis during 2011, which negatively influences the efforts to increase EPI coverage through fixed health services (EPI Annual  Coverage Report 2012, excel sheet).  Though of the improvement of EPI coverage since 2005, adopting the strategy of reaching out to remote communities with EPI and integrated PHC and RH services, this improvement has come to a stagnant level around 85-87% penta3 coverage during the period 2005-2010 (APR 2009-2010), that is because of reasons including those mentioned above. Regretfully, the political conflict and instability the country experienced during 2011 has resulted in some negative impacts on EPI achievements reflected by decline of the coverage from 87% 2010 to 81% 2011. Though the situation has eased down since 2012 but the EPI coverage didn’t recover significantly influenced by the general loosening of the government system where accountability and security are strongly compromised.  Within this situation, some negative rumors about vaccination have grown up among some groups within some districts and governorates influenced by the growing radical religious ideologies. It is still of limited scale, and needs to be addressed systematically.  There is a huge skewing of staff distribution across health facilities where 80% of staff is working is urban areas, while 80% of public health facilities are being in rural areas (the National Health Five Year Plan 2011-2015, P. 31, Arabic version). The CCS, also, shows an example of disparities among governorates (e.g. Aden, with population of 800,000 has 10.7% of the national health work force, but Taiz with a population of 2.4 Million has only 8.3%), training of health staff in most of the times is not based on demand or not on a well deliberated vision, the output of health work force training institutions and faculties of medicine, nursing and other health fields is not consistent with the ministry plans (CCS 2008-2013, WHO-Yemen, P.16). Staff working in health facilities is low paid, their health facilities are low budgeted, and some health facilities have no budget, not well equipped, and there is no reasonable incentive system to help motivating staff and deploying others to work in rural areas.  **In-equities:**  The gender gap in Yemen, although narrowing since 1999, is still among the widest in the world with Yemen rank at 117 among 177 countries in term of gender equality (Human Development Report 2006, UNDP), gender relations are shaped by diverse religious cultural, social and political traditions (CCS, P. 14), gender disparities are deeply rooted in cultural traditions, inhibiting women from equal access to basic services, job opportunities and civic participation (Country Program Document (CPD), UNICEF, 2012-2015). To help tackling this challenge, in addition to outreach activities, the MOPH&P has gone for developing and expanding integrated community based health services in which the community health volunteers (CHVs) are expected to play a major role in raising awareness, providing an integrated package of PHC services including RH services and nutrition related interventions. This experience is still at its first steps quantity and quality wise, challenges include expanding the network of CHVs across rural areas focusing on remote communities, assuring that CHVs get qualifying training completed as per the national CHV guidelines (3 modules) in face of the variable and partial interest of the DPs and vertical PHC programs in specific aspects of CHVs tasks, assuring continuous availability of supplies for CHVs, and retaining of CHVs in function, the poor people in remote areas, in particular, are the most to suffer because, in addition to the above barriers, of limitation of affordability to secure transportation and other costs in order to get health care. Adding to this, women find it more difficult to access services mainly because of the social norms that they need somebody to travel with them if they need to get health care, and they like to be seen by female health care providers, which are not available in many health facilities, neither in sufficient numbers nor in needed qualifications.  Under-five mortality rate shows a very wide disparity between the poorest and richest quintile being 120 among poorest 20% and less than 40 per 1,000 live births among the richest 20%. Similarly, the infant mortality rate drops from over 90 to around 40 per 1,000 live births for the poorest and richest 20% of the population, respectively, and most of the deaths could be averted by Immunization (Maternal and Child Health Inequalities in MENA Region, UNICEF, June – 2011, P. 7). Similarly, utilization of services are poorly utilized by the poor people compared to the rich people as explained by the figure below: Service use indicators by wealth quintiles   **Health Information system:**  Though the EPI has got a relatively good information system, the Health Management Information System (HMIS) of the ministry is weak, still suffering from fragmentation, severe shortage of material and technical capacity.  The CCS 2008-2013, P. 18, states that some of the bottlenecks in the HMIS are:   * No data base available to use as a basis for decision making. * Data collected in most of the various health facilities are not accurate and sending of statistical reports from the periphery to the centre is not regular or in time. * Lack of supervision and monitoring and * Lack of sufficient training.   The PHC programs are having their own information systems, which is tailored to their needs, data collected is not very sensitive to the needs of each level of health system, ending up in collecting a lot of un-needed data while indicators are difficult to extract from those data. Because of the multiple data collected to satisfy the individual needs of the multiple programs, the health workers at health units and health centers are required to use many registers and to prepare multiple monthly reports, which is an over-burden and a time consuming process. Data reported from the field is ending up at multiple programs’ inlets rather than into a single window at central level. Department of Statistics and Research at central level is not coordinating that process, and in many times is not updated by those programs receiving data from the field.  There is no comprehensive monitoring and evaluation system in place to measure health system plans achievements and to re-orient the health system national plan accordingly.  **surveillance system:**  The disease surveillance system in Yemen started for poliomyelitis as acute flaccid paralysis surveillance in 1998. Gradually more diseases were added to the list of communicable diseases under surveillance to become 31 diseases including all vaccine preventable diseases. In May 2013, MOPH&P, WHO, UNICEF and CDC-Atlanta conducted a joint review of the surveillance system, which concluded that the surveillance system is a strong one but, needs some strengthening and expansion particularly in the area of early detection of polio virus importation (Joint Review Mission Report, June 2013). Since the population covered by health facility services is about 64%, which means that 36% of population are not easily caught by the surveillance network, this indicates the critical need for developing a community based surveillance (CBS).    **Community participation:**  Weak community participation in the planning and delivery of immunization services, which has negative implication on sustainability of provision of immunization services, as well as weak community ownership.  Community awareness about health issues in general is low; it is in many cases built on rumours and misconceptions about health issues particularly preventive health interventions resulting into inappropriate health care seeking behaviour and low demand and utilization of preventive health care services mainly.  Bottle necks to be addressed by this proposal are:  - 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.  - Deficient performance of health care delivery system particularly expansion of EPI services into more health facilities, un-satisfactory skills of health care providers, and the de-motivation of staff. The weak collaboration/partnership between public and private health sectors in service delivery, particularly provision of EPI services.  - Weak and fragmented HMIS, particularly skills of analysing and reporting data, fragmentation of service reporting particularly PHC services, and the need to expand coverage of surveillance for vaccine preventable diseases.  - Low awareness and growing misconceptions about the importance of vaccination, weak community participation in raising awareness, planning and providing community based health services. |

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| 6. Lessons Learned and Past Experience | |
| *This description will highlight to GAVI how lesson-learning has been incorporated into the design of the activities.*  *It will provide the evidence base that demonstrates that the proposed activities will be effective, and that implementing them will achieve the desired intermediate results and immunisation outcomes.*  *→ Please use the table in the proposal form to summarise the evidence base and/or lessons learned related to each of the objectives in the proposal. Applicants are asked to provide examples specific to their country of relevant interventions that were successful.*  *→ In addition please provide examples illustrating the challenges to successful implementation. If no evidence base exists within the country of question, please note ‘not applicable’.*  *\*Where possible, please provide evidence of this learning by providing a reference or a web-link to a published document related to each example.*  The following lessons learnt are reflecting mainly our experience and observations throughout the last years of implementation funded by GAVI and other DPs, the End of Project Assessment is expected to start by the end of 2013, recommendations and lessons learnt will be integrated into the Annual Report: | |
| **Objective** | **Example(s) of lessons learned, highlighting both successes and challenges** |
| **Objective 1: Enhancing equitable access to immunization and integrated PHC services.** | **Integrated outreach:**  Establishing integrated outreach through the GAVI support has proven applicable though the difficulties faced on the start of the process because of the resistance of vertical program to work together. It had proven that it helps increasing uptake of EPI services and also helps making accessible the IMCI and RH services to the targeted population in remote areas improving equity in accessing services.  **This has been possible because of the following reasons:**  - Strong commitment and push from the senior leadership of the sub-sector PHC in the ministry including the deputy minister and the DGs of departments in the sector - The participatory, lengthy process of discussions and work to conclude agreement on integrating the outreach services.  - Starting gradually by involving some of the vertical programs but not all in the experience  - Including the concerned programs in the planning, implementation and supervision on the activity  - Observing capacity of districts in applying the outreach package, so the package of services can be extended or slim.  **Outcome:**  - The concept and experience has been taken up by the World Bank and reflected in the design of the Health and Population Project funded by the WB. UNICEF is supporting funding integrated outreach in certain districts, WHO is doing that to a lesser extent, both organizations support is subject to the availability of funds. Dutch Government supported in Dhamar has supported the conduction of integrated outreach rounds. - The outreach services are subject to further development, we are trying to integrate nutrition services in the package (to try diagnosis and referral or to add starting treatment during the outreach round), Malaria diagnosis and treatment in targeted districts, and to include Schistosomiasis treatment in targeted districts if applicable.  **Challenges:**  - Utilization of outreach services is very much influenced by availability of medicines. So, securing medicines is very crucial.  - Performance of outreach teams is affected by the level of cooperation among concerned programs at central and governorate level. So, it is very important to keep all involved.  **Vaccination coverage:**  Increase in EPI coverage through the fixed and outreach services has come to a certain level and became stagnant, we need to explore other approaches to further increase EPI coverage, such as expanding partnership with local and international CSOs ( e.g. providing EPI services and conducting campaigns in Al-Jawf governorate in coordination with ADRA and IOM). |
| **Objective 2:- Improving the integrated health information including surveillance, monitoring and evaluation systems and research centrally and at the health facilities in the targeted districts** | **Integrated supportive supervision:**  The integrated supervision is, also, established through the GAVI support, integrated supervision lists developed making it possible to have an overview of the health facility functions, which is very clearly superior to the vertical program specific supervision, but not completely rule out the specific technical supervision, which is still needed to provide a detailed picture of variable aspects of service provision to help programs identify and correct specific malfunctions. It did help in breaking barriers across programs.  The commitment of senior leadership and developing the list through programs interactions, preparing supervisors from programs and involving them in the supervision activities had helped making it to work.  **Challenges:**  - Making consensus on an integrated supervision list within the wide diversity of functions to be looked at (PHC, Curative care, etc.) is a challenge.  - Another challenge is the vertical programs technical needs.  - Changing the culture and approach of supervision from the police inspection attitude to the supportive comprehensive approach. |
| **Objective 3: Community empowerment and civil society participation in provision of immunization and essential health services including and not limited to community volunteers.** | **Community Health volunteers**  Community Health Volunteers (CHVs) role and tasks have been looked at comprehensively through the support of GAVI, an integrated national CHV package of training has been developed. It has been with the same approach as it is with the above experience. Building on that experience, JICA has supported the ministry in coordinating the participatory and lengthy process of developing the integrated national CHV guidelines, and supported improving training material practically to make it more practice oriented and easier to understand. Completing the 3rd training module is expected to be accomplished during 2013.  **Challenges:**  - Though training of many CHVs has been done, but completing 3 modules of training needs more comprehensive planning and resource mobilization.  - The variable interests of development partners in certain aspects of the CHV role is a challenge to completing the 3 module training  - Insufficient capacity of the ministry to coordinate DPs inputs and guide the process of expanding the experience is another challenge.  - securing supplies and retaining CHVs is a challenge. |
| ***TWO PAGES MAXIMUM*** | |

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| PART D - PROPOSAL DETAILS |
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| **For further instructions, please refer to the Guidelines for Completing the HSS Application** |
| 7. Objectives of the Proposal |
| *This section will be used to assess whether the proposed objectives are relevant, appropriate and aligned with the National Health Plan and cMYP, and contribute to improving immunisation outcomes. It will also ensure alignment with the bottleneck analysis above.*  *→ Please succinctly describe the immunisation and HSS objectives to be addressed in this proposal and explain how they relate to, and contribute to, reducing HSS and immunisation bottlenecks (identified in section C.5 above) and strengthening of the health system. Please describe how these objectives are aligned with those in the national health plan and cMYP.*  *The objectives need to be aligned to and numbered in the same way in the HSS M&E Framework (Attachment 3) and also in the detailed Budget, Gap Analysis and Workplan Template (Attachment 4).*  *For each objective, please describe:*   1. *Which immunisation outcomes will be improved by implementing the activities, and how will the activities contribute to their improvement? Please focus on the key activities related to each objective rather than every single activity. Please demonstrate this link in the next section on the results chain.* 2. *Whether and how the proposed objectives relate to the equity and gender related barriers to access as identified in the bottleneck analysis, and how the objectives will result in narrowing the equity gap in immunisation coverage and contribute to reaching the under reached, underserved and marginalised populations. Countries are requested to consider gender related and geographic barriers to access of immunisation and other health services.*   *→ Please list and describe all of the proposed activities in the Budget, Gap Analysis and Workplan Template. If GAVI funding is requested to go into pooled funds, please attach the Annual Work Plan and Budget for the pooled fund and related TORs.*  *This description will be used to assess if the proposed key activities will be sufficient to achieve the identified immunisation outcomes.* |
| TWO PAGES MAXIMUM  **Objective 1: Enhancing equitable access to immunization and integrated PHC services.**  This objective addresses the geographical and social barriers to utilization of EPI services and a basic integrated package of PHC services affecting people in remote areas because of geographical barriers and scarcity and un-affordability for communication means and cost of services, where most of the population are living and poverty level goes higher while services get lesser including availability and diversity of services. It, also assures that vaccination and integrated outreach services are targeting communities in special situations such as the disadvantaged, marginalized, and refugee communities, people living in areas with unstable security situation, and allows for use of interventions proved being successful in our situation as well as innovative approaches to access those targeted population. The integrated outreach teams include minimum a female staff out of three to four persons, which responds to needs of women increasing uptake of tetanus toxoid vaccine, ANC, family planning and counselling. The package of integrated outreach services targets maternal and child health, whom are the most vulnerable persons in family to disease. Addressing an important aspect of equity within the family. Reaching out with services to the people in remote areas within the catchment areas of the health facilities increases feeling of responsibility and knowledge of health facility staff about the population they are serving, and enhances link between them and population. It also, enhances efficiency of health service delivery system through complementarities established between fixed and outreach service delivery, and improving service delivery at health facility level. The objective contributes directly to increasing vaccination coverage of target children and mothers; providing integrated services is an integral part of the national 5 years plan 2011-2015(Health Services and Quality, chapter 4, page 82, Arabic version). In addition, this approach is building on the cumulative knowledge and experience of the Ministry during the last 8 years with outreach approaches, which helped in increasing penta3 coverage by 25-28% of vaccination targeted children, adding to that provision of IMCI, and RH services, which made the outreach services more efficient and more equitable being addressing population’s needs other than EPI services, which was funded by GAVI support, and at the same time has helped in increasing immunization services acceptance and uptake.  **Key activities are:**   * 1. **Conducting 4 outreach rounds of integrated and EPI services in targeted districts including groups and communities of special needs, and securing supplies and medicines needed.**   2. **Expanding provision of EPI services in new public health facilities and selected private health facilities.**   3. **Improving effectiveness of vaccine management at all levels including increasing cold chain capacity.**   4. **Training staff in health facilities in the provision of integrated PHC services.**   5. **Supportive integrated supervision on performance of health services including data quality assessment.**   6. **Motivating staff involved in EPI functions using objective performance based criteria.**   7. **Improving coordination and Program management at central and governorate levels (quarterly meetings, annual review and planning meetings, NITAG meetings).**   8. **Fund to motivate, GHOs, DHOs, private providers, SCOs to improve service provision and EPI coverage using innovative initiatives and modalities**   **Objective 2:- Improving the integrated health information including surveillance, monitoring and evaluation systems and research centrally and at the health facilities in the targeted districts**    This objective attempts to address the long lasting problem of poor performance of the HMIS in the country in order to serve the needs of the EPI programme in understanding and documenting the impact of EPI on morbidity and mortality. It will also aim at expanding the surveillance net in order to reach all districts targeted by the grant. This will be done through increasing the availability of resources (trained personnel, logistics, IT support and regulations and frameworks) needed for a strong surveillance and information systems as well as updating the sources of information (SARA EPI coverage survey).  The planned activities will contribute to achieving the strategic directions set by the government of Yemen in its NHS 2010-2025 (NHS, 2010-2025, page 69, English version) and the national 5 year health plan 2011-2015 (Health Information System and Research, chapter 4,page 82, Arabic version). In addition, it will complement all the efforts currently undergone by the information department in the MOPHP and at peripheral level in the governorates and districts that are either supported by the government or development partners.  It will initiate the efforts towards building an integrated electronic HMIS gradually in the GHOs and DHOs using whatever resources available and upgrading it at the different levels.  Through capacity building of health personnel working on surveillance, data collection and registration it is hoped that the performance of those health workers will improve and thus saving their time and efforts at the health facilities where they are lost among several registries and health indicators that has to be prepared in a regular manner. At the same time it will enable analyzing data and giving the needed feedback to the health facilities, DHOs and GHOs. Accordingly, the health workers will be able to better utilize their time and focus on health services including EPI services.  Operational studies and research are still weak areas in the health sector that needs development. Managing to conduct few studies in the area of EPI including equity, will provide valuable data on the magnitude and nature of unreached areas and some marginalized groups’ locations and therefore better planning EPI activities that would improve immunization outcomes and coverage.  **Key activities are:**   * 1. **Develop, revise and update the regulatory framework and data registers, records and forms.**   2. **Train health personnel centrally and in the targeted governorates and districts on data collection and information systems and on data analytical skills**   3. **Upgrade the surveillance and HMIS infrastructure in the MoPH&P and targeted Governorates and Districts including software tools.**   4. **Capacity building in Epidemiology, centrally and at the targeted governorates and districts.**   5. **Establish and expand surveillance sites thus strengthening the current surveillance net**   6. **Implement SARA survey at year 2 and year 5 of the grant for the HFs in the targeted districts (complementing SARA surveys conducted in the remaining districts from other sources).**   7. **Conduct at least 4 researches and KAP studies during the grant duration to better understand the needs of the unreached population and EPI related infrastructure issues**   8. **Establish a community based surveillance**   9. **Performance based incentives based on identified performance criteria for HMIS, Surveillance staff at central and governorate level**   **Objective 3: Community empowerment and civil society participation in provision of immunization and essential health services including and not limited to community volunteers.**  This objective is contributing to achieving the national 5year health plan 2011-2015 (Raising Community Awareness on Health and Population Issues, Chapter 4, Page 108, Arabic version), and meant to address the weak community awareness through health education and sensitization by trained Community Volunteers and ensure sensitization of key local authorities to create an enabling environment for health activities as well as strengthening the links between the health facility and the community. The role of CSOs will be to ensure the trainings of community volunteers on health education and monitor their regular activities. It will also be to ensure the follow up of the immunization status of the children and women of child bearing age and be a link between the community and the health facility.  The CSOs will also ensure Task shifting to community based interventions to address indirect cost barriers and ensure wide coverage of basic health services according to national guidelines and policies, providing integrated outreach by expansion of the provision of Immunization and Integrated PHC services out of health facilities at community level through delivery by CSOs / community midwives, unemployed trained health workers at community level, the MOPH&P in close cooperation with YFCA and CSOs network to coordinate the inputs of the CSOs. CSOs role will address two levels, raising awareness will be nationwide and service delivery will be targeting challenging areas not or insufficiently covered by public health services (conflict areas, nomadic, refugees, marginalized, displaced, potential returnees from neighbouring countries,) using innovative approaches (private health care providers, supporting un-employed midwives, training persons from nomadic and marginalized groups to provide basic health services with focus on EPI, and adopting sponsor child strategy in schools). Mass media will be used to address issues of raising awareness and mobilizing communities through the national health education centre.  **Key activities are:**  **3.1** **TOTs for targeted CSOs in Behaviour Change Communication (BCC).**  **3.2 Cascade Training on BCC (trainers, health workers including midwives) in targeted communities (poorest people, geographically excluded).**  **3.3 Advocacy on immunization targeting associations, community structures, religious leaders.**  **3.4 Strengthen positive household childcare practices through community participatory learning and action.**  **3.5 Provisions of basic health and EPI services in challenging areas not or insufficiently covered by public health services using innovative approaches.**   * 1. **Social mobilization activities on the integrated services package (mass and local media).** |

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| 8. Results Chain | | | | | | |
| *This description will detail to GAVI how the proposed activities will result in improved immunisation outcomes.*  *→ Please present a Results Chain using the template provided in the application form for each objective. This diagram should demonstrate how activities contribute to achieving outputs / intermediate results and how outputs/intermediate results contribute to achieving immunisation outcomes. The outputs / intermediate results should link directly to the HSS bottlenecks identified in Section 5 and should address or contribute to addressing the selected bottlenecks for the GAVI HSS proposal.*  *(Please only include the key 4-5 activities for each objective that are central to delivery of intermediate results and immunisation outcomes. It is not necessary to list all activities for each objective. The full list of activities should be completed in the workplan and budget (see Section 10)).*  *→ The Results Chain should be consistent with the HSS M&E Framework. For every output / intermediate result and immunisation outcome listed in the Results Chain there should be corresponding indicator(s) in the HSS M&E Framework to measure achievement.*  *→ Please note that a GAVI HSS proposal must include the six immunisation outcome indicators listed in the Guidelines Key Terms Section. Applicants are encouraged to include other immunisation outcome indicators as well which relate specifically to the part of the health system where funds will be used.*  *→ Each result and outcome listed in the results chain should have a corresponding indicator in the Monitoring and Evaluation Framework.* | | | | | | |
| ***Objective 1:* Enhancing equitable access to immunization and integrated PHC services.** | | | | | | |
|  | **Key Activities:**   * 1. **Conducting 4 outreach rounds of integrated and EPI services in targeted districts including groups and communities of special needs, and securing supplies and medicines needed.**   2. **Expanding provision of EPI services in new public health facilities and selected private health facilities.**   3. **Improving effectiveness of vaccine management at all levels including increasing cold chain capacity.**   4. **Training staff in health facilities in the provision of integrated PHC services.**   5. **Supportive integrated supervision on performance of health services including data quality assessment.**   6. **Motivating staff involved in EPI functions using objective performance based criteria.**   7. **Improving coordination and Program management at central and governorate levels (quarterly meetings, annual review and planning meetings, NITAG meetings)**   8. **Fund to motivate, GHOs, DHOs, private providers, CSOs to improve service provision and EPI coverage using innovative initiatives and modalities***.* |  | **Outputs / Intermediate Results:**  **-** % of penta1 coverage increased from 89% to 94%  - 95% of targeted districts conduct 4 rounds of outreach annually  ***-***90% of newly functioning public health facilities reporting on immunization services for the year of introducing the service.  **-** 75% of the selected private health facilities reporting on immunization services for the year of introducing the service.  - Number of female staff got integrated training increases by 50%  **-**  95% of targeted HFs have appropriate cold chain  **-** 90% of GHOs get regular feedback on the supervision visits |  | **Immunisation Outcomes:**   * Pentavalent3 coverage increased from 82% in 2012 to 90% in 2018. * Measles coverage increased from 71% in 2012 to 90% by the end of 2018. * % of districts that have at or above 80% Penta3 coverage increased from 58% to 90% * Penta3 coverage in the lowest wealth quintile is +/- X % points of the coverage in the highest wealth quintile reduced from 54% to 40% |  |
| ***Objective 2:* Improving the integrated health information including surveillance, monitoring and evaluation systems and research centrally and at the health facilities in the targeted districts** | | | | | |  |
|  | **Key Activities:**   * 1. Develop, revise and update the regulatory framework and data registers, records and forms.   2. Train health personnel centrally and in the targeted governorates and districts on data collection and information systems and on data analytical skills   3. Upgrade the surveillance and HMIS infrastructure in the MoPHP and targeted Governorates and Districts including software tools.   4. Build the epidemiological capacity centrally and at the targeted governorates and districts.   5. Establish and expand surveillance sites thus strengthening the current surveillance net.   6. Implement SARA survey at year 2 and year 5 of the grant for the HFs in the targeted districts (complementing SARA surveys conducted in the remaining districts from other sources).   7. Conduct at least 4 researches and KAP studies during the grant duration to better understand the needs of the unreached population and EPI related infrastructure issue   8. Establish a community based surveillance   9. Performance based incentives based on identified performance criteria for HMIS, Surveillance staff at central and governorate level |  | **Outputs / Intermediate Results:**  - 70% of the districts receive completed integrated reports from 80% of functioning HFs (EPI, RH, IMCI)  - 80% of GHOs integrated service reports received at central level are complete.  - Research results are discussed and integrated into the ministry's strategies and plans  - 80% of facilities in target districts got updated data (SARA) |  | **Immunisation Outcomes:**   * Results of research and assessments are providing evidence for the annual and strategic planning of EPI in 70% of districts. (This provides evidence to improve coverage). |  |
| ***Objective 3:* Community empowerment and civil society participation in provision of immunization and essential health services including and not limited to community volunteers.** | | | | | |  |
|  | **Key Activities:**  3.1 TOTs for targeted CSOs in Behaviour Change Communication (BCC).  3.2 Cascade Training on BCC (trainers, health workers including midwives) in targeted communities (poorest people, geographically excluded).  3.3 Advocacy on immunization targeting associations, community structures, religious leaders.  3.4 Strengthen positive household childcare practices through community participatory learning and action.   * 1. Provision of basic health and EPI services in challenging areas not or insufficiently covered by public health services using innovative approaches.   2. Social mobilization activities on the integrated services package (mass and local media) |  | **Outputs / Intermediate Results:**  - Number of CSOs conducting training on BCC in target governorates increased from 3 to 6.  - 50% of targeted communities has at least a community health volunteer.  - 50% of targeted schools have at least 50% of students receiving documentation for EPI, Hygiene, and nutrition.  - 60% of targeted females attending the awareness sessions in communities with CHVs.  - 50% of selected districts have 50% of health facilities conducting routine awareness activities (sessions, face to face, megaphone, etc.).  - 60 % of targeted schools have at least 2 teachers conducting quarterly health education in collaboration with the health staff for support. |  | **Immunisation Outcomes:**   * Pentavalent3 coverage increased from 82% in 2012 to 90% in 2018. * Community awareness on importance of immunization in communities of remote areas increased by 50%. |  |
| ***IMPACT: Please provide an impact statement and indicator(s)***   * *the impact of achievement by increasing coverage of targeted population by vaccination improves rates of mortality and morbidity of <5 children, and helps reducing inequity by focusing on inclusion of disadvantaged communities in the projects interventions:* * ***Indicators:***   *Under 5 mortality*  *Under 1 mortality* | | | | | | |
| ***ASSUMPTIONS:***   * *The political and security situation is relatively stable.* * *Economical situation not to severely deteriorate.* * *Country not to experience wide scale armed confrontations.* | | | | | | |
| ***THREE PAGES MAXIMUM*** | | | | | | |

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| **For further instructions, please refer to the Guidelines for Completing the HSS Application** |
| 9. Monitoring & Evaluation Framework |
| *This description will enable GAVI to assess how programme performance will be monitored and to ensure alignment with National M&E arrangements. The proposed M&E framework for the HSS grant should link to the proposed results chain. While the Results Chain provides the rationale for how the proposed activities will result in improved immunisation outcomes, this section provides details of how the monitoring and evaluation will be undertaken.*  *→ Please provide an HSS grant Monitoring & Evaluation Framework as Attachment 3 (please complete the GAVI template).*  *→ Please provide a description of how the monitoring and evaluation will be carried out for the grant, indicating how M&E is aligned with the national health plan results framework.*  *→ Which sources of data will be used?*  *→ How much budget will be allocated to M&E of this grant?*  *→ Please describe the M&E system strengthening activities to be funded through this proposal.*  *→ Please identify one or more immunisation outcomes for each objective. These will be used for PBF’s performance payment (see Figure 1 on page 7 of the Guidelines)*  *→ Please identify a number of intermediate results indicators related to each objective of the grant that shall be used for tracking the overall progress of the grant implementation (these will be used for PBF’s programmable section (see Figure 1 on page 7). These are the same intermediate results indicators that are included in the Monitoring & Evaluation Framework, and will be used to measure the outputs/intermediate results that are included in the results chain in Section D.8.*  *Please note that GAVI strongly recommends that each proposal includes an end of grant assessment in their M&E Framework.* |
| ***TWO PAGES MAXIMUM***  The M&E framework for HSS grant is attachment No.3  The MOPH&P counts on two main sources of data to monitor health system performance, these are: routine administrative data reporting collected by the programs, surveys including household and health facility surveys.  The administrative data are collected on monthly basis at health facility level, which include the services in the fixed sites and outreach services, then sent to the district level where all the reports are compiled and sent to the governorate and then to the central level. Completeness and timeliness of the reporting are monitored at all levels especially for EPI data. Reporting on other health services follows the same order and chronology. Those data collection tools are used for measuring achievements of indicators needed to be measured using administrative data. Starting the third year of implementation, the integrated reporting system is expected to commence adding a new dimension to the ministry efforts to enhance strengthening of integration and health system performance; those integrated data collection forms will be the source for data for measuring achievements of those indicators.  Integrating health facility service reporting is going to be tried for PHC services, lessons learnt will be utilized in expanding the experience to include more services if feasible. Integration Capacity building of staff at central and local levels in the fields of research, data analysis, data collection and surveillance are included, supported by installing a soft-ware for integrated reporting system. The improvement in capacity building and data collection tools is expected to improve data quality, analysis skills, which will help in making this proposal achievement measurement smoother and quicker.  Research and surveys will be implemented by health staff, where applicable, to improve their skills. It will be, also, the approach of measuring proposal achievements needed to be measured by surveys and research.  End of project assessment will be done by an independent body; design is to be participatory and oriented to pick up lessons learnt for further improving health sector policies and strategies; .  **Immunization outcome indicators:**  Indicators for measuring progress are:  **Objective 1:**   * **Pentavalent3 coverage increased from 82% in 2012 to 90% in 2018** * **Measles coverage increased from 71% in 2012 to 90% by the end of 2018**   The methodology of measuring indicators’ achievements will be by using routine data of the health system collected by the EPI producing the EPI annual coverage report. Those data will be verified by the annual WHO-UNICEFJRF.  **Objective 2:**   * **Results of research and assessments are providing evidence for the annual and strategic planning of EPI in 70% of districts**   The methodology will be by measuring inclusiveness of research recommendations into the EPI annual plans or updates of plans at district level following concluding research results, which will be circulated to GHOs and DHOs for use in planning and updating their plans. It will, also, be discussed in the annual review meetings for conducted with GHOs.  **Objective 3:**   * **Community awareness on importance of immunization increased in communities of remote areas by 50%.**   Methodology will be by conducting the KAP surveys, and reported according to timing of surveys conduction.  **Intermediate result indicators:**  the intermediate result indicators for tracking progress will be:  **Objective 1**,:   * **penta1 coverage increased from 89% to 94%**   The methodology will be using the routine administrative data reported by the governorates and compiled at central level (EPI). Verification source of data will be the annual JRF by WHO-UNICEF.  **Objective 2**:   * **80% of GHOs integrated service reports received at central level are complete.**   The methodology will be using the routine administrative data reported by the governorates and compiled at the central level by the statistics and information department at MOPH&P.  **Objective 3:**   * **50% of targeted communities have at least a community health volunteer.**   The methodology will be using the administrative data reported by the implementing CSOs, monitoring will start in the third year of implementation of the grant, because of the preparatory workshops and training will start in the second year of implementation. Monitoring will be on annual basis from 2016 on-ward.  The results of the annual monitoring of immunization outcome and intermediate result indicators will feed into and update annual plans including those of the grant.  Budget allocated specifically for M&E of this grant covers the costs of the following activities:  - End of project assessment (70,000 $)  - 4 KAP surveys on EPI perceptions, equity, etc. (70,000 $)  - EPI coverage survey by the end of the project (250,000 $)  - 2 SARA surveys (740,000 $)  **Total 1,130,000 $**  The baseline data, for impact indicators and fully immunized children, will be collected from the results of the ongoing NDHS. |
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| 10. The Proposal Development Process |
| *This section will give an overview of the process of proposal development, outlining contributions from key stakeholders.*  *→ Address all the items listed below. Indicate if any of these are not applicable and explain why:*   1. *The main entity which led the proposal development and coordination of inputs. It is possible to have multiple lead implementers, however the country must decide which department will lead the proposal development process.* 2. *The roles of HSCC and ICC.* 3. *Cooperation between EPI programme and the other departments of MOH involved in the proposal development.* 4. *Involvement of subnational level (provincial, district, etc.) entities.* 5. *The role of CSOs in the proposal development. Applicants must describe whether the HSCC/ICC worked with any CSO platforms/coalitions, or just with individual organisations. Please provide the names of the specific CSOs or of the CSO platforms involved.* 6. *The names and roles of other specific development partners/donors.* 7. *The role of the private sector, if applicable.* 8. *Description of technical assistance received during the proposal development. Include the source of technical assistance and a comment on the quality and usefulness of that technical assistance.* 9. *Description of the overall process of proposal development: duration, main steps of the proposal development, analytical work involved in the proposal development, links between the proposal development and national health sector planning/budgeting, links between the proposal development and JANS (if applicable).* 10. *Description of the most challenging elements during the proposal development and how they were resolved.* |
| ***TWO PAGES MAXIMUM***  MOPH&P has led the process through a joint committee headed by the Deputy minister for PHC and deputy minister for planning and membership of:  Family Health DG,  Health Policy Unit DG and member,  Planning DG,  EPI Director  EPI data manager  Director of child health department  DG of surveillance and diseases control.  Yemen family care association (YFCA)  WHO focal point for HSS  WHO data manager  UNICEF child health officer (attached the Minister decree).  The committee has started working since formation and met many times throughout the process of developing the proposal starting the meeting at the planning sub-sector facilities during th process of developing the objectives and main interventions of the proposal.  With getting into the detailed work of developing the proposal, the family health department has taken the lead in coordinating the process of developing the proposal done by all relevant departments and development partners stated in the ministerial decree, the relevant departments in both PHC and Planning sub-sectors including EPI, child health, nutrition, statistic sand information and health policy unit were involved throughout the process of preparation including planning activities, cost calculation, resources collection, and budget calculation for activities..  The team has worked on different levels, working as sub-groups on specific parts of the proposal according to profession and discussing and approving the work of the sub-groups in common meetings of the team.  Some members of the committee from MOPH&P, WHO, and UNICEF has participated in the “Applications’ peer review workshop” held in Cairo June 2013.  Governorate health offices were contacted to complete data and missing information, 4 GHO-DGs were invited to attend the HSCC to discuss and approve the proposal.  WHO and UNICEF were part of the committee continuously working with the ministry team members. In addition to that, colleagues from WHO and UNICEF continued to provide technical support throughout the process of developing the proposal.  On analysing the gaps and complementarity, relevant DPs were contacted by email and their responses were integrated into the application form.  Civil society was represented by the YFCA, which is a member of the committee whom was actively participating in the process of proposal development.  The committee has got in continuous meeting status for the last 4 weeks, inviting programs, communicating with DPs and collecting and organizing data and information.  Relevant partners had got the opportunity to review and comment on the proposal. The draft was circulated to all health partners and comments were received during the HSCC committee meeting, most of the reviews and comments were through emails  The meeting to discuss and approve the proposal had been made 2013 an extended meeting involving the HSCC members, NITAG members, 4 GHO-DGs, and YFCA. Meeting was held in the 4th of September  WHO office was contacted several times during the process of proposal preparation. Colleagues there were very cooperative and provided advice and feedback on proposal material produced by time. |

# PART E – BUDGET, GAP ANALYSIS AND WORKPLAN

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| 11. Detailed Budget and Work plan Narrative |
| *This description will be used to assess if the proposed budget shows sufficient justification for the proposed activities and activity costs within the HSS grant.*  *→ Please provide a detailed budget and workplan as Attachment 4 to this proposal. Please refer to the Guidelines for the list of items required from the budget and workplan. It is highly recommended that applicants use the GAVI HSS Budget, Gap Analysis and Workplan template as Attachment 4. However, countries can also provide this information in the format of an existing national Annual Operational Plan or equivalent document.*  *→* *Please include additional information on the assumptions within the budget and justification of unit costs to demonstrate that they are reasonable and supported by in-country planning. These assumptions and unit cost justifications may be inserted here or attached as separate documentation.* |
| ***TWO PAGES MAXIMUM***  The funds for implementation of all activities will be disbursed by the integrated management unit to the implementing partners based on the activities costs to the bank account of the implementing partner including the CSOs and UN agencies based on the financial management mechanisms.  Explanations regarding the activities with high unit costs:  Printing: the printing materials including (training materials for Physicians, Health workers and Volunteers/ registries and recording forms for outreach rounds/ health promotion materials used during the outreach activities) this materials are needed for all Health Facilities in the targeted 114 Districts and for the whole period of the proposal (5 Years), so the cost is calculated to cover the minimal appropriate requirement.  Furnishing is for the EPI theatre hall which accommodates about 150 persons, which includes furnishing and equipping the hall with audio-visuals and training equipment. This hall has never been furnished or equipped since the construction of the EPI building.  SARA cost is an estimate based on the costs spent by WHO office in 8% of health facilities in 2013.  Expensive Activities: the outreach rounds are conducted in all targeted 114 districts through mobile health teams, each team consists of 4 health workers + 1 community health volunteer (4+1 model), this team work for 5 days in average in different targeted areas based on the micro-plan developed during the planning-workshops, each team is equipped with the medicines needed for children and women in child peering age, the outreach Team has a rented car for the working 5 days. In addition to that there are supervision from different levels (each 4 - 5 teams have one Supervisor from the district and each district has 3 Supervisors from the District health office, the supervision includes supervision from the Governorate and Central supervision. Including the cost are the transportation of the medicines and equipments to the targeted districts and the cost of the accountants and operational cost of the technical outreach teams from the different health departments.  Cost of Workshops/Training: the cost is dependent on the type of the workshop and training. Most workshops are of short duration 2-3 days with 30 - 40 participants in each, in addition to the facilitators and assistants and refreshment and stationary.  Training Courses: the cost is based on the Participants number and number of days of training, the cost of the Stationary and cost of refreshment and lunch (the working hours 8 AM to 4 PM daily for 16 days the duration of one training course) the cost include the per diem for the Trainers for the 16 days. In each training course participants are 24 Health Workers or Community Health Volunteers (CHVs), all training courses are conducted in the training facilities at the capital of the Governorate for the whole of the course.  So the cost for conduction of the workshops and training courses are different.  Ministry of Public Health and Population has an agreed criteria regarding the cost each activities, which are used by different health partners working in the same area e.g. the Health and Population Project (HPP) supported by word Bank  The activities will be under the three main objectives which are:  1)**Equitable access to immunization and integrated PHC services**. 2) **Enhancing the M&E supportive systems with particular focus on HMIS, surveillance, and research. 3) Community empowerment through civil society participation in provision of immunization and essential health services including and not limited to community volunteers.**  All the planned activities aimed at increasing the immunization coverage either in direct way or indirect way. In addition, all health services will be improved.  Some of the activities will be implemented nationwide and some others will be implemented in 9 governorates (114 districts) mainly the integrated outreach activities, since these activities in the remaining governorates will be supported with the same strategy through the other partners including Government, WB, UNICEF and WHO.  **Under the objective 1:**  The main activities which will increase the coverage in the remote areas and hard to reach areas are the integrated outreach activities in 9 governorates in 4 rounds every year, criteria for rates in the budget calculation are based on the same criteria agreed upon with other partners: WB, WHO, (WB criteria for funding outreach activities are attached) .  Development/updating the plans and micro-planning at the health facility level for the integrated activities will be done once every year. TOT on the planning for governorate and district staff will be done in the 1st year of the proposal. Training of health workers on the integrated health services will be carried out every year, the costs of training and meetings are calculated based on the rates agreed upon between the ministry and partners.  Medicines and medical supplies for the mobile teams will be secured for the all 4 rounds of the outreach activities, medicines and medical supplies will be through the UN agencies (WHO, UNICEF).  EPI specific activities will be also carried out like: Mid level Management (MLM) course for governorate and district staff, Effective Vaccine management for governorate, district and HF level, and EPI refreshing training. Special assessment will be also carried out like the Vaccine management assessment in 2014 and Data Quality Self Assessment (DQS) every year.  The fund will be used to partially secure the cold chain equipments since there are some other partners will cover the rest of the cost like WB, UNICEF and WHO. Procurement of cold chain will be done through the UN agencies (UNICEF, WHO).  The supportive supervision will be implemented in an integrated manner at all levels using a unified integrated supervisory check list.  Motivation of the EPI staff is also considered based on their performance. Specific criteria and indicators are already developed to measure the performance, those criteria and rates used in the previous GAVI grant will be applied in this grant.  Refugee, marginalized and IDPs communities are high risk groups; therefore they will be targeted by supplementary activities through mobile teams providing integrated PHC services to contribute to attaining equitability (using outreach standard rates).  **Under Objective2:**  The activities aim at improving the integrated HMIS and the monitoring and evaluation.  This will include training on data collection, reporting and analysis at different level. Software will be procured for this purpose at central and governorate level. Forms and registries will be also printed and distributed; this will result in developing integrated monthly reports. Printing material and software procurement will be done according to financial management procedures listed in the Financial Manual used for the previous GAVI grant (attached).  Surveillance system will, also, be improved through carrying out training for staff at all levels on disease surveillance. Planning and review meeting for governorate and district level will be implemented. Outbreak/disease field investigation will be supported.  Two SARAs assessment will be also carried out in 2015 and 2018 for all health facilities in the 9 targeted governorates, cost estimate is based on the experience of SARA conducted in 2013 funded by WHO.  **Under Obejctive 3:**  The planned activities under this objective aimed at empowering the CSOs to assist in reaching to the difficult and hard to reach areas. This will include training of CSO staff on integrated health services and communication. School teachers and HWs of the CSO will be trained on conducting positive household visit to increase the awareness of communities in the targeted areas.  Outreach activities will be implemented through the CSOs in the specific targeted areas which will assist in increasing the immunization coverage in these hard to reach areas.  Social mobilization activities will be also implemented in these areas.  Community health volunteers will be trained on integrated health services according to the national guidelines including their role in increasing the awareness of the community. |

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| 12. Gap Analysis & Complementarity |
| *This description will ensure GAVI is aware of support provided by other donors, thereby avoiding overlap or duplication, and highlighting the value-added of the requested GAVI support.*  *→ Please complete a gap analysis that is related to each of the GAVI HSS proposal objectives. The gap analysis should use information as available in National Health Sector Strategy/Plan, cMYP, or other gap analysis conducted, to show the total resource requirements for health systems strengthening related to each of the proposal objectives. Applicants are encouraged to use the GAVI HSS Budget, Gap Analysis and Workplan Template but can chose an existing country template.*  *→ For each of the objectives, applicants should list different resources for HSS financing already in place that contribute to the proposal objective, including government and external donor contributions, the project name if applicable (or indicate budget support), duration of support, funding amount provided (in US$), and geographic location covered by the support. The guidelines provide more detail on the key required elements of the gap analysis.*  *→ In the box below, please provide a narrative description of other efforts by the Government or development partners that focus on the bottlenecks that are addressed by the proposal objectives, including the timeframe and the geographic location of this support, thereby highlighting the value-added of GAVI support and how the current proposal complements those efforts.*  GAVI encourages the use of data from existing gap analyses, rather than undertaking a new gap analysis. |
| ***TWO PAGES MAXIMUM***  The bottleneck of poor accessibility and quality of services is addressed under objective 1 which was developed to complement all the on-going efforts by the government and development partners. The selected districts for GAVI support are all the remaining districts partially covered by the limited resources of government and some DPs, in general this support is creating a gap in service provision among districts, and those selected districts for GAVI support are among the most needy and most deprived ones. A joint exercise was done where all the governorates and districts were mapped by supporting agencies and the team identified together those districts that need GAVI support in order to achieve nation-wide coverage by integrated and EPI health services. The following table shows the mapping of districts regarding vaccination coverage, districts with non-vaccinated infants≥ 500, current and potential sources of support for integrated outreach activities:   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Governorate** | **No. districts** | **Districts with ≥ penta3 + ≥ 500 unvaccinated children** | **Districts included in last GAVI support** | **Current/ future support + Government** | **Remarks** | | Ibb | 20 | 8 | 8 | WB |  | | Abyan | 11 | 4 | 2 | GAVI |  | | Sanaa Town | 10 | 2 | 1 | - | Urban, innovative : refugees and marginalized | | Al-Baidha | 20 | 0 | 0 | GAVI | Security instability, to adopt special approach | | Al-jawf | 12 | 0 | 0 | GAVI | Innovative: CSOs (ADRA, etc.) | | Hodieda | 26 | 3 | 7 | WB |  | | Al-Dhale’ | 9 | 1 | 3 | WB |  | | Al-Mahwit | 9 | 0 | 4 | GAVI |  | | Al-Mahara | 9 | 0 | 0 | - | Innovative : tailored local approach to increase EPI coverage | | Taiz | 23 | 10 | 5 | UNICEF |  | | Hajja | 31 | 15 | 5 | UNICEF |  | | Hadramout-Mukalla | 14 | 2 | 3 | GAVI | Innovative : tailored local approach to increase EPI coverage | | Hadramout-Syeoun | 16 | 0 | 3 | GAVI | Innovative : tailored local approach to increase EPI coverage | | Dhamar | 12 | 9 | 7 | GAVI |  | | Shabwa | 17 | 0 | 1 | GAVI |  | | Saada | 15 | 2 | 2 | UNICEF |  | | Sana’a | 16 | 4 | 4 | WB |  | | Raima | 6 | 3 | 0 | WB |  | | Aden | 8 | 2 | 0 | - | Urban, innovative : refugees and marginalized | | Amran | 20 | 4 | 4 | UNICEF |  | | Lahj | 15 | 3 | 3 | UNICEF |  | | Mareb | 14 | 0 | 2 | GAVI |  | | **Total** | 333 | 72 | 64 |  |  |  |  |  |  | | --- | --- | --- | | **Integrated Outreach Support** | **Time** | **No. Districts** | | UNICEF | 2014-2015 | 104 | | WB | 2011-2017 | 69 | | WB | 2015-2017 | 6 | | GAVI | 2014-2018 | 114 | | **Total** | | 293 |   MOPHP is addressing the gap of poor accessibility for women by adopting the provision of RH services within the package of the integrated outreach and making one of the outreach team members a female staff. In addition the CHVs will play an important role in that aspect being females and resident in communities and their package of tasks includes RH services and related awareness raising issues. Other development partners are also working on this gap: e.g. UNFPA is focusing on supporting RH services and provision of family planning commodities, GIZ supporting fixed RH services, and Community based RH services, KFW is supporting social marketing of contraceptives and voucher scheme for maternal and RH services, USAID is supporting basic qualifying training of CMWs and provision of services for females through the mobile teams. WB  GAVI proposal is complementing those activities and addressing areas where there is not sufficient support, particularly including female staff in the outreach teams, training and supporting CHVs and female staff at health facilities.  In the area of human resource development, identified as one of the major bottlenecks in the health system, the MOPHP/HR department developed a database that was supported by WHO to capture all the health workers in the country by name, area, speciality and if employed or not. This was followed by drafting a situation report of HR in the country and EC are now complementing this by providing a long term expert to finalize the strategy, develop the plan and initiate implementation efforts. This will lead to understanding the HR needs for Yemen by area and by field of service and thus increasing and improving quality of health services, including EPI, in the deprived areas. As for this proposal, the focus was on capacity building of staff in the areas of integrated services (obj.1) and information and surveillance (obj.2). It also targets developing the capacities of health volunteers (obj. 3).  The MOPH&P is committed to the surveillance program with full time staff and an operational annual budget that is used for central and governorate operations but not sufficient enough to meet the needs. Currently, WHO is the main supporting partner focusing on polio and measles surveillance. CDC Atlanta is supporting in establishing the Field Epidemiology 2 years Training Program. NAMRU 3 – Cairo provide support to the surveillance program on ad hoc basis. GAVI support is needed in expanding the current surveillance system + establishing Community Based Surveillance by training CHVs on surveillance using special guidelines for them and applying the lay case definition for few diseases of priority for surveillance. These CHVs will be connected to the surveillance net work through the nearest health facility.  In order to address the gap of poor performance of the health information system, the MOPHP is supporting the health information sector centrally and in the governorates by strengthening its staffing and infrastructure. Population-based surveys are still the main source of the HMIS in Yemen. The DHS is now being implemented and preliminary results are expected first half of 2014. The current DHS is supported by government, and DPs including USAID, WB, UNICEF, DFID, UNFPA, WHO, the Netherlands Embassy, GIZ.  In 2006 the MOPHP developed, with the support of several development partners, a database on health facility services and capacities through implementing a nation-wide SARA survey. The aim now is to update this database and this started already in 126 HFs from WHO support, mainly in the post-crises districts. The joint EC/WHO project, for which the road map is currently under development, is going to conduct SARA in number of districts (number and area not yet decided). Under objective 2 in GAVI proposal, a SARA survey is planned in all the districts covered by GAVI support. The HSCC will ensure that there will not be any overlapping between the EC/WHO project and GAVI but rather they will complement each other in terms of areas in order to have a nation-wide updated database.  M&E is still a major gap in the health system of Yemen. The fragmentation in reporting and supervision is well recognized by MOPHP for which the M&E unit was established under the minister’s office. However, this step still needs further support from all partners. Under the EC/WHO project, technical assistance will be provided to support the M&E unit in terms of identifying its TORs and capacities needed. The TA will also help in identifying the core indictors that the government should be focusing on to monitor the progress of its health system.  In the area of community participation and involvement, MOPH&P is working with DPs to expand the CHVs network mainly UNICEF, WB, GIZ and a number of international and national NGOs. MOPH&P is trying to coordinate those efforts through the Technical Cooperation Department and the relevant programs. Other initiatives that aim at strengthening community participation includes the Basic Developments’ Needs (BDN) project facilitated by WHO worked closely with over 25 communities supporting income generating projects and social determinants of health related interventions (access to clean water, sanitation, etc.), SFD is supporting implementation of community led sanitation systems initiative. GAVI support in objective3 is needed to help expanding the CHVs network in areas not covered by other partners, using innovative approaches to increase EPI coverage through community members involvement including community leaders, school children and community members in communities with special needs, |

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| 13. Sustainability |
| *This description will enable GAVI to assess whether issues of sustainability have been adequately addressed.*  *→ Please describe how the government is going to ensure sustainability of the results achieved by the GAVI grant after its completion.* *This should encompass sustainability of financing for immunisation services and health system strengthening, as well as programmatic sustainability of results.*  *→ If there are other recurrent costs included in this proposal please describe how the country will cover these costs after the funding finishes.* |
| ***TWO PAGES MAXIMUM***  In general, the current annual government budget allocated for the health sector is low, and there were no significant increases during the last three years, particularly due to the overall political crisis Yemen was suffering from since 2011 and its economic implications, the MDGs gap still wide.  However, there are clear evidences reflecting Government commitment toward health in general and immunization in particular, including:   * MoF allocated in 2013 budget, 1.7 billion YR (equivalent to around 8 million USD) in the local authority budget as an additional budget for public health facilities all over the country. * Despite the competing health needs specially those newly emerged as a result of the crisis, immunization budget was not affected, and the government was able to fulfil all its commitment toward the cost of routine vaccines and its share for the newly introduced vaccines funded by GAVI, even though MoPHP introduced Rota virus vaccine in 2011 and kept its higher share in the cost of the newly introduced vaccines.   Guidelines, implementation manuals and integrated training modules developed under the last GAVI HSS grant have been adopted nationally, e.g. the integrated training modules implemented in around 80% of districts funded by domestic and donor funds including SFD,UNICEF, WHO and Save the Children organization, the Netherlands Government, the European Commission (EC), World Bank, and International Medical Corps (IMC).  The sustainability of the results achieved by the GAVI grant after its completion has been taken into consideration during the development of this proposal, where the proposed activities are focusing on building and consolidating already existing national system and programs as outreach program, CHVs and HMIS, many of the proposed activities are building on past experiences, success stories and lessons learnt from the implementation of the activities funded by GAVI under the previous HSS grant. In addition, the national human resources capacity was built up throughout the period of previous support and became sufficient to plan, train and supervise activities related to the interventions implemented in this proposal. This capacity is retained into the health system on all levels.  The proposed activities are not solely funded by GAVI, but incorporated under different domestic and external sources of funding, also designed in a feeding in chain of activities and results model, for example provision of integrated package of basic health services including immunization through outreach program was initiated in 2008 under the last GAVI – HSS grant in 64 districts, few months later on, the approach introduced in another 5 districts in Dhamar governorate under the Government of Netherlands support, shortly another set of districts joined under UNICEF support and is increasing. 72 districts, including 22 districts from the 64 under GAVI support, are implementing a further more developed version under the HPP project funded by the WB.  Since the beginning of introducing integrated outreach in 2008, the government is continuing to fund immunization outreach activities in the remaining districts from the approved budget line allocated by MoF for MoPHP central budget to fund those activities. At local level, some governorates (e.g. lahj) secured additional funds for extra rounds of outreach from their local budget.  Government share is still a significant source of funding for many interventions of the proposed activities, e.g. GAVI grant will not fund salaries of the health staff, construction, and maintenance of health facilities, as such interventions funding will be kept mainly under the responsibility of the government.  Based on the experience of governorates, which succeeded in securing some domestic funds in their local budget (lahj), The MoPHP started a dialogue with MoF to allocate additional funds within the local authority budget of governorates to cover recurrent costs included in this proposal when GAVI grant comes to an end. |

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| PART F – IMPLEMENTATION ARRANGEMENTS AND RISK MITIGATION |

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| **For further instructions, please refer to the Guidelines for Completing the HSS Application** |
| 14. Implementation Arrangements |
| *This section will be used to determine if the necessary arrangements and responsibilities for management, coordination, and technical assistance inputs of the implementing parties have been put in place to ensure that programme activities will be implemented.*  *Please describe:*  *→ How the grant implementation will be managed. Identify key implementing entities and their responsibilities with regard to specific grant activities.*  *→ Mechanisms which will ensure coordination among the implementing entities.*  *→ Financial resources from the grant proceeds that will be allocated to grant management and implementation.*  *→ The role of development partners in supporting the country in grant implementation.* |
| ***TWO PAGES MAXIMUM***  The lead implementing body is Ministry of Public Health and Population; it will follow the same arrangements as for the previous GAVI fund, where the fund is deposited in the same bank account which has been open for HSS and ISS funds since 2008 and certified by UNICEF. The vast majority of activities will be implemented by departments of the PHC sector, which are at the same time the counterparts of the main development partners supporting and funding such interventions and similar activities including WB, UNICEF and WHO to assure smoother coordination and complementarities. In addition, the previous GAVI fund administration experience was developed and managed under this sector through the Administration Unit. Based on GAVI - TAP, the financial management of the fund and the bank account (FMA) had been assessed by GAVI in September 2010, based on the results risk rating of financial management system at that time was scored between low and moderate reflecting good accountability according to the TAP scoring system. Recommendations of the FMA were included in the Aide Memoire and implemented accordingly (FMA report 2010, Aide Memoire).  All of those are reasons to assign responsibility of administrating the fund to the PHC sector.  Management of GAVI HSS support:   |  |  | | --- | --- | | **Management mechanism** | **Description** | | Name of lead individual / unit responsible for managing GAVI HSS implementation/M&E etc. | The GAVI HSS support will be managed through existing structures. The PHC Sector, Integrated Management Unit (IMU) will be the lead unit responsible for administering the fund. Main implementing bodies are the relevant directorates and programs from the PHC, Planning and Population sectors in the ministry, whom have the mandate to implement those activities: particularly Family Health-GD, EPI, Child Health, Nutrition, RH-GD, Surveillance and Disease Control-GD, the Health Policy Unit, statistics and information-GD and the Planning-GD. The civil society organizations are also part of the implementation bodies, which will be represented by the YFCA, WHO and UNICEF | | Role of HSCC (or equivalent) in implementation of GAVI HSS and M&E | HSCC will have the role of financial and technical oversight, in addition to coordination among all HSS initiatives, and providing support and advice. The HSCC will approve the annual work plans. | | Mechanism for coordinating GAVI HSS with other system activities and programs | Sharing of reports and conducting of regular meetings with all major donors and national stakeholders related to HSS and to vertical programs. Through the HSCC, the different HSS interventions will be coordinated. The program will use the tools and methodologies developed by the previous HSS Funded by GAVI and develop it, in order to build on what now exists. |   Roles and responsibilities of key partners (HSCC members and others)   |  |  |  |  | | --- | --- | --- | --- | | **Title / Post** | **Organisation** | **HSCC member yes/no** | **Roles and responsibilities of this partner in the GAVI HSS implementation** | | Minister | MoPHP | Yes | As Chairperson of the HSCC, represents the GAVI HSS program to all stakeholders, and takes lead role in technical and financial oversight, and in guidance of the program. | | Deputy Minister, PHC Sector | MoPHP | Yes | Vice Chairperson of the HSCC, and assists in the duties of the Chairperson. Directly oversees the IMU, the lead unit responsible for implementation of GAVI support. | | Director, Health Policy Unit | MoPHP | Yes | Supervises and implements all activities related to policy. Assures harmonization with other stakeholders. | | Director, Planning Department | MoPHP | Yes | Supervises implementation of actions relevant to planning. Coordinates at the executive level between the PHC and other sectors, and compiles reports for this purpose. | | Directors of PHC programs e.g. IMCI, nutrition, public health, reproductive health and EPI | MoPHP | Yes | Work as a team for preparation of joint plans, establishing supervision and monitoring systems, providing technical input for developing tools for training modules and guidelines for implementation of programs. | | Representative | MoF | Yes | Member of working group dealing with cost efficiency and effectiveness. Participates in meetings, advocates for financial resources, follows up on implementation. | | Advisor | WHO | Yes | Provides technical assistance and inputs, and is signatory to project reports, it will also be involved in Procurement. | | Program manager | UNICEF | Yes | Procurement agency. Also, technical inputs, coordination of activities, exchange of experiences. | | Representatives | Other donor agencies – such as World Bank, EC, USAID, JICA, others |  | Technical inputs, coordination of activities, exchange of experiences. | | Representative | Ministry of Information | Yes | Advocacy and promotion of GAVI support. | | Representative | Ministry of Planning and International Cooperation | Yes | Identifies gaps in funding, attracts and mobilizes local and international resources for expansion. | | NGO representatives | YFCA, SOUL | Yes | Implement activities according to plan. Participates in meetings, provides inputs and feedback on experiences. | | Representative | Higher Council for Motherhood and Childhood | Yes | Responsible for multi-sectoral collaboration among ministries and NGOs. | | DG and other officials | Governorate Health Offices | No | Responsible for direct supervision of public health programs at governorate level, approves district plans, financial authority for disbursement of funds, participates in supervision and monitoring of program activities in their governorates and districts, compiles reports and sends to higher levels, assuring completeness and timeliness. | |

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| 15. Involvement of CSOs |
| *This description will be used to assess the involvement of CSOs in implementation of the proposed activities. CSOs can receive GAVI funding through GAVI HSS grants going to the MoH and then transferred to the CSO[[2]](#footnote-3).*  *→ Please describe how CSOs will be involved in the implementation of the grant activities, indicating the approximate budget allocated to CSOs.*  *→ Please ensure that any CSO implementation details are reflected within the detailed budget and workplan.* |
| ***TWO PAGES MAXIMUM***  CSOs have played an important role to date in the advocacy, prevention and control of NCDs at both country and global level. They help to mobilize public and political awareness, shape policy response, and also support or deliver prevention and treatment programs, often filling gaps between services provided by the state and private sector. A key influence on CSO involvement in service provision is the relationship with government. CSOs need to ensure that they are able to maintain their own distinctive contribution to development and not merely become contracting agents of the state.  The important role of civil society organizations which have worked on the record in various ways and contributed to help them, including customs exemptions, tax , overcome the difficulties, providing facilities, and mitigation of routine procedures for the establishment as organizations, which are giving it enough space to work and move an active partner and important, especially after the democratic transition and the adoption of multi-party politics in the late eighties of the last century where formed several political parties in Yemen - that the party is a non-formal systems of governance democracy because of its ability to framing and recruitment and representation and control - (17), and parallel with knead been adopted many cultural associations, social and sports paved the way to the growth and development of associative movement in Yemen, which contributed to the development of model informally represented in civil society, which occupied and still occupies an important position not on the political scene in Yemen, but also exceeded its role in other levels, especially social, cultural, and development.  Yemen family care association (YFCA) is a non-government voluntary and non-profit organization. Established in 1976, YFCA has been catering for Yemeni families in Sana’a and governorates. YFCA provide its services in its specialized hospital in Sana’a in addition to six fixed reproductive health centers in Sana’a, Aden, Hadramout, Hodaiddah, Ibb and Hajjah. YFCA have expanded its programs to governorates of Saa’da, Lahj, Abyan and Amran through its emergency services. And one of active NGOs in Yemen, which will cooperate to implement the activities through their mobile clinic and the community health worker and government community volunteer network.  The main SCO involved in implementation of the proposal is the YFCA; some of the activities in the field will include other CSOs working in the field of health, and through building the capacity of other local CSOs in areas where such organizations are available and providing health services difficult to be provided by the health sector. Coordination of implementing such activities will be done through the coordination mechanisms between MOPH&P, YFCA and the CSO network which is a civil society network established to facilitate coordination among CSOs in the country. |

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| 16. Technical Assistance |
| *This description will outline to GAVI how technical assistance will support implementation of the proposed activities.*  *→ Please describe technical assistance (consultancy services) included in the grant activities. Please describe how this technical assistance will improve the way health systems and immunisation programme function.*  *→ Please outline how technical assistance will improve institutional capacities of government agencies and CSOs and contribute to sustainability.* |
| ***ONE PAGE MAXIMUM***  Most of the activities depend on the national capacities, based on lessons learnt and previous experiences, a limited number of activities need technical assistance which will be provided from/through other DPs working in the same areas mainly WHO, UNICEF, WB.  Implementation is done mainly by the government staff supported by the technical assistance of DPs.  The proposal includes allocating significant amount of money in training and upgrading skills of staff, which help improving capacity of staff at governorate and district levels as well as local CSOs, to provide high quality services.  Technical support to conduction of surveys and studies will be by utilizing the local expertise where possible and through the WHO and UNICEF long term experts available in country office. Technical support to develop the integrated HMIS system will be provided by the EU. |

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| Risks and Mitigation Measures | | | | |
| *This information reflects the risk of a country not being able to implement the proposed activities within this grant proposal and/or spend the funds as approved by GAVI. It is expected that the Lead Implementer will be responsible for assessing and ensuring that risk mitigation measures are actually implemented.*  *→ If the country has existing health sector risk analysis please attach these assessments and provide here a brief reference to the relevant sections.*  *→ If the country does not have existing health sector risk analysis, please complete the table below for each of the proposed objectives. Please refer to the Guidelines for Completing the HSS Application for a description of the various types of risk. If the risk is categorised as ‘high’, please provide an explanation as to why it is ‘high’.* | | | | |
| **Description of risk** | ***PROBABILITY***  ***(high, medium, low)*** | ***IMPACT***  ***(high, medium, low)*** | ***Mitigation Measures*** | |
| ***Objectives 1, 2, 3:*** | | | | |
| *Fiduciary Risks:*   1. Potential risks might arise because of slowly improving political and security stability 2. The GoY may not be able to sustain the expected results of the project after its completion, due to lack of financial resources. 3. It may be difficult to manage expenditures spent at decentralized level during the implementation of outreach service in some districts. | ***Low*** | ***Low*** | | 1. To stem the unrest, GOY is working in close coordination with DPs to accelerate and diversify economic growth (eg. Riyadh, London and New York conferences for Yemen friends, as well as good governance to improve both the resources and opportunities available overall, and to improve the performance of the GoY. 2. National dialogue is going on to shape the future of Yemen 3. The political and financial issue can be improved during the next years if the donor countries fulfil their obligations towards Yemen 4. In regions/Conditions where political and security unrest is dominating , other channels to manage funds and implement activities will be used, mainly local/international CSOs and UN agencies where possible. 5. Planning well for the outreach services will ensure proper control over disbursement. Before the implementation of each round, the plans will be reviewed and verify their compliance to the national and district level planning guidelines for mobile outreach rounds. The plan’s proposed budget will be also reviewed to verify compliance to the financial guidelines. 6. The planning and controls will be done in an organized manner based on documented procedures. 7. Flow of funds will be managed by the MOPH&P through the use of bank transfers from the grant’s Account. 8. Funds will be disbursed to the bank account at the Governorate level according to the planned activities and time frame of implementation. |
| *Institutional Risks:*   1. Weakness in capacity of implementation particularly at low level 2. Diversity of activities and implementers in lead at different levels, and multiplicity of sources of funding | ***Low-Medium*** | ***Low*** | | 1. The ministry is working on coordination with stakeholders and DPs to improve coordination 2. Sharing information among stakeholders 3. The past experience of the ministry in implementing similar activities and lessons learnt is will help in better understanding and implementation |
| *Operational Risks:*   1. In some districts there is insufficiency of human resources especially female staff 2. The procurement of drugs may be delayed and could affect the timely implementation of outreach. Also drugs might not comply with acceptable quality standards. 3. It may be difficult to reach marginalized groups or areas with unfavourable security situation, the geography, and scattered population distribution in Yemen compound the challenge. 4. Quality of data reported from the field and introducing integrated reporting system | ***Medium*** | ***Low*** | | 1. Training with particular focus on weak infrastructure districts and female staff is a main intervention in this proposal and other donor related interventions. 2. Drugs will be procured by the UN organization to ensure its timely procurement and that it meets the WHO quality standards. 3. The outreach services will support planned rounds using mobile teams that comprise local personnel from these communities that would enhance the opportunities to reach these groups especially in high-security areas. 4. The data collected is using the official national data forms used by the health system, data are checked at governorate and central level for consistency, completeness and accuracy, supervision visits are cross checking and feedback will be given. Integrated reporting system will be introduced gradually and assessed according to implementation outcomes. |
| ***Overall Risk Rating for Objective 1*** | ***Low-Medium*** | ***Low*** | |  |
| ***TWO PAGES MAXIMUM***  **Please note that the above risk and mitigation measures are built on experience of implementation of previous GAVI grant. In addition, GAVI had done an independent Financial Management Assessment in Sept. 2010, which results were positive regarding financial risks. While the following risk and mitigation measures were done by the WB during planning for the HPP 2009, and before implementation, it means that our analysis is based on practice result and the WB analysis was based on expected and potential risks.**  **For reference to the WB analysis of risks including Fiduciary and Social aspects was done in 2009, see the HPP Project Assessment Document (PAD on a proposed grant in the amount of SDR 23 Million (US$35 Million equivalent) to the Republic of Yemen for a Health and Population Project, WB – December 2010, P. 27-28):** | | | | |

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| 18. Financial Management and Procurement Arrangements | | |
| *In this section applicants are requested to describe:*  *→ a) The proposed financial management mechanism for this proposal*  *→b) Financial Management Arrangements Data Sheet: The proposed processes and systems for ensuring effective financial management of this proposal, including the organisation and capacity of the finance department and the proposed arrangements for oversight, planning and budgeting, budget execution (incl. treasury management and funds flow), procurement, accounting and financial reporting ( incl. fixed asset management), internal control and internal audit, and external audit. CSOs can receive GAVI funding through two channels: (i) funding from GAVI to MOH and then transferred to CSO, or (ii) direct from GAVI to CSO. Please refer to Annex 4 of the Guidelines for further details*  *→ c) The main constraints in the (health sector’s) financial management system. Does the country plan to address these constraints/ issues? If so, please describe the Technical Assistance (TA) needs in order to fulfil the above functions.*  *4 pages (more pages necessary if more than one lead implementer)* | | |
| *Question (a): applicants should indicate whether an existing financial management mechanism or modality will be employed (pooled funding, joint financing arrangements or other), or if a new approach is proposed. If an agency-specific financial arrangement will be used, specify which one. A rationale for this choice should be provided.* | | The financial management/modality to implement the proposal will use the same mechanisms as has been followed to implement the previous GAVI support including improvement measures recommended by the results of the independent financial management assessment done by GAVI in 2010. MOPH&P will be the lead implementing body. |
| **Question (b):****Financial Management Arrangements Data Sheet** | | |
| **Any recipient organization/country proposed to receive direct funding from GAVI must complete this Data Sheet (for example, MOH and/or CSO receiving direct funding).** | | |
| 1. Name and contact information of Focal Point at the Finance Department of the recipient organization | DG-Finance Department  Mr Abdulkarim Al-wali  +967 777 354 134 | |
| 1. Does the recipient organization have experience with GAVI, World Bank, WHO, UNICEF, GFATM or other Development Partners (e.g. receipt of previous grants)? | YES | |
| 1. **If YES**  * Please state the name of the grant, years and grant amount. * **For completed or closed Grants of GAVI and other Development Partners:** Please provide a brief description of the main conclusions with regard to use of funds in terms of financial management performance. * **For on-going Grants of GAVI and other Development Partners:** Please provide a brief description of any financial management (FM) and procurement implementation issues (e.g. ineligible expenditures, mis-procurement, misuses of funds, overdue / delayed audit reports, and qualified audit opinion). | **GAVI: HSS program**, 2007-2013, 6,500,000$  The last year of activities implementation  WB: HPP project, 2011-2017, 35,000,000$  No financial management or procurement implementation issues.  **WHO:** continuous cooperation including technical and financial support within the framework of the CCS.  **UNICEF:** continuous cooperation including technical and financial support according to the agreed plans. Occasionally the electronic finance system is closed because of not clearing advances in time. | |
| **Oversight, Planning and Budgeting** | | |
| 1. Which body will be responsible for the in-country oversight of the programme? Please briefly describe membership, meeting frequency as well as decision making process. | The HSCC, chaired by minister of public health and population, membership includes deputy minsters for PHC, Planning, and population from MOPH&P. Deputy ministers of Education, Information, endowment, youth and sport, Local Administration, the high council of motherhood and child hood. DGs and directors of relevant Depts. CSOs are represented and development partners including WHO, UNICEF, USAID, EC, GIZ,  It meets 3 times annually in average; decisions are based on voting process following discussions of issues and data provided to the committee. | |
| 1. Who will be responsible for the annual planning and budgeting in relation to GAVI HSS? | The relevant implementing bodies described in the management arrangement table will meet annually to review achievements and plan identifying budget needed for implementation before submitting that to the HSCC discussion and approval, they are:  Family Health-GD, EPI, Child Health, Nutrition, RH-GD, Surveillance and Disease Control-GD, the Health Policy Unit, statistics and information-GD and the Planning-GD. The civil society organizations, which will be represented by the YFCA, and DPs: WHO and UNICEF. | |
| 1. What is the planning & budgeting process and who has the responsibility to approve GAVI HSS annual work plan and budget? | The proposal budget and work plan is the guiding reference to the process, implementing bodies meet annually to revise the plan based on updates of implementation at all levels and adjust plan accordingly, plan will be reviewed technically and financially by the IMU, then submitted to the HSCC for approval | |
| 1. Will the GAVI HSS programme be reflected in the budget of the Ministry of Health submitted every year to the Parliament for approval? | YES  within the annual MOPH&P plan submitted to the cabinet then to the parliament for approval | |
| **Budget Execution (incl. treasury management and funds flow)** | | |
| 1. What is the suggested banking arrangement? (i.e. account currency, funds flow to programme) Please list the titles of authorised signatories for payment release and funds replenishment request. | The already existing bank account is going to be used, it is in Dollars, which is already approved by HSCC and certified by UNICEF. Funds transferred from GAVI are deposited into this account. Authorized Signatories are Deputy Minister for PHC, DG Finance at MOPH&P representing MoF, and DG-Family Health. | |
| 1. Will GAVI HSS funds be transferred to a bank account opened at the Central Bank or at a commercial bank in the name of the Ministry of Health or the Implementing Entity? | The account is opened in a cooperative/commercial (Cooperative and Agricultural Credit Bank), which has branches in all governorates; the account is in the name of Inter-agency Coordinating Committee for immunization (ICC). | |
| 1. Would this bank account hold only GAVI funds or also funds from other sources (government and/or donors- “pooled account”)? | It is a pooled account including GAVI funds and other funds. | |
| 1. Within the HSS programme, are funds planned to be transferred from central to decentralized levels (provinces, districts etc.)? **If YES**, please describe how fund transfers will be executed and controlled. | YES  Funds are disbursed to the bank account of each GHO. They will be transferred in instalments, based on work plans that specify agreed activities to be carried out within the governorate, using the current system of advances used by the Ministry for government/donor funds. Governorates, where possible, will use the same mechanisms for dispersing funds to districts. All transfers of funds will be signed by the authorized persons at the intended specified level. Forms are bi-lingual. There is supervision on implementation of activities from the local and central levels, funds disbursed are subject to the internal control mechanisms at central and local levels, there is annual external audit by COCA, and another external audit done annually by an auditor who is linked to an international audit firm. | |
| **Procurement** | | |
| 1. What procurement system will be used for the GAVI HSS Programme? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other Development Partners’ procurement procedures) | The HSS program current FM is the reference for procurement procedures, it is already approved by HSCC and GAVI, it is based on the MOPH&P procurement regulations. It, also, allows for procuring through WHO and UNICEF according to their procurement regulations. | |
| 1. Are all or certain items planned to be procured through the systems of GAVI’s in-country partners (UNICEF, WHO)? | Yes  It also allows for procuring through WHO and UNICEF according to their procurement regulations especially for medicines, medical equipment, in order to ensure good quality and low cost. This will also ensure efficiency, as procurements mechanisms for purchase through these two sources. | |
| 1. What is the staffing arrangement of the organization in procurement? | It is the mandate of the Procurement and storage department headed by a director of the directorate whom represents the ministry of finance; it is under the supervision of the DG-Finance at MOPH&P whom also represents the MoF also. | |
| 1. Are there procedures in place for physical inspection and quality control of goods, works, or services delivered? | YES  There are several committees for specifications, bidding offer envelopes opening, analysis, decision, evaluation of goods received. Each of them is working at a certain stage of the procurement process according the national procurement guidelines | |
| 1. Is there a functioning complaint mechanism? Please provide a brief description. | YES  According to the Bidding law and by-laws, this goes in line with the international practice. This law and by-laws were revised and updated in 2007 and 2009 consequently; the process of revision was supported technically by the WB. | |
| 1. Are efficient contractual dispute resolution procedures in place? Please provide a brief description. | YES  It is according to the above mentioned laws and bylaws, starting by negotiations between contractual parties, then independent arbitration, followed by going to the court. Timing for those steps is described in the bylaws. Also, the high authority for control of bidding is a channel for control of biddings and investigating complaints. | |
| **Accounting and financial reporting (incl. fixed asset management)** | | |
| 1. What is the staffing arrangement of the organization in accounting, and reporting? | IMU, A financial officer, a Secretary, 2 support staff.  The MOPH&P finance- GD with its departments of accounting and procurement.  Reports are submitted to the HSCC in each meeting. APR is done annually.  The MOPH&P financial reporting is included in the annual financial report submitted to the cabinet, and the parliament. | |
| 1. What accounting system is used or will be used for the GAVI HSS Programme? (i.e. Is it a specific accounting software or a manual accounting system?) | It is basically an excel accounting software, there is an additional manual part covering the bank book account and assets control | |
| 1. How often does the implementing entity produce interim financial reports and to whom are those submitted? | A report for each HSCC meeting (3 per year), annual as part of the APR to GAVI, Annually to the finance department at MOPH&P to be included in the ministry annual financial report submitted to the cabinet. | |
| **Internal control and internal audit** | | |
| 1. Does the recipient organization have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures? | YES  There is Financial Manual approved by HSCC, GAVI and certified by UNICEF for the GAVI support.  The MOPH&P internal control system and financial management procedures are following the national financial and procurement and storage laws and by-laws. | |
| 1. Does an internal audit department exist within recipient organization? If yes, please describe how the internal audit will be involved in relation to GAVI HSS. | YES  (It is basically done through the GD of Finance and its departments of accounting and procurement, whom are representing MoF. in addition, there is the GD of Internal Control assuming its task in internal auditing, which was established by law. | |
| 1. Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations? | It is done through the overview and supervision of the HSCC | |
| **External audit** | | |
| 1. Are the annual financial statements planned to be audited by a private external audit firm or a Government audit institution (e.g. Auditor General)?[[3]](#footnote-4) | YES  It is audited by an private external independent auditor according to the requirements of GAVI | |
| 1. Who is responsible for the implementation of audit recommendations? | The IMU, implementing departments under the supervision and follow up of the HSCC. | |
| ***THREE PAGES MAXIMUM*** | | |
| *Question (c): Please indicate the main constraints in the (health sector’s) financial management system. Does the country plan to address these constraints/ issues? If so, please describe the Technical Assistance (TA) needs in order to fulfil the above functions* | | |
| ***HALF PAGE MAXIMUM*** | | |

# SUMMARY OF A COMPLETE APPLICATION

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| **HSS Proposal Forms and Mandatory GAVI attachments**  *→ Please place an ‘X’ in the box when the attachment is included* | | |
| *No.* | *Attachment* | ***X*** |
|  | HSS Proposal Form |  |
|  | Signature Sheet for Ministry of Health, Ministry of Finance and Health Sector Coordinating Committee (HSCC) members |  |
|  | HSS Monitoring & Evaluation Framework |  |
|  | Detailed work plan and detailed budget |  |

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| **Existing National Documents - Mandatory Attachments**  Where possible, please attach approved national documents rather than drafts. For a highly decentralised country, provide relevant state/provincial level plan as well as any relevant national level documents.  *→ Please place an ‘X’ in the box when the attachment is included* | | |
| *No.* | *Attachment* | ***X*** |
|  | National health strategy, plan or national health policy, or other documents attached to the proposal, which highlight strategic HSS interventions |  |
|  | National M&E Plan (for the health sector/strategy) |  |
|  | National Immunisation Plan |  |
|  | Country cMYP |  |
|  | Vaccine assessments (EVM, PIE, EPI reviews), if available |  |
|  | Terms of Reference of Health Sector Coordinating Committee (HSCC) |  |

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| --- | --- | --- |
| **Existing National Documents - Additional Attachments**  Where possible, please attach approved national documents rather than drafts. For a highly decentralised country, provide relevant state/provincial level plan as well as any relevant national level documents.  *→ Please place an ‘X’ in the box when the attachment is included* | | |
| *No.* | *Attachment* | ***X*** |
|  | Joint Assessment of National Health Strategy (if available) |  |
|  | Response to Joint Assessment of National Health Strategy (if available) |  |
|  | If funds transfers are to go directly to a CSO or CSO Network, please provide the 3 most recent years of published financial statements of the lead CSO, audited by a qualified independent external auditor |  |
| … |  |  |

**Applicants are strongly encouraged to carefully read the instructions provided within the relevant sections of the guidelines before completing the application form.**

1. For a definition of ‘systems readiness’ see: <http://www.who.int/healthinfo/systems/sara_indicators_questionnaire/en/> [↑](#footnote-ref-2)
2. In special circumstances grant funds can go directly from GAVI to a CSO, please refer to the Application Guidelines for further information. [↑](#footnote-ref-3)
3. If the annual external audit is planned to be performed by a private external auditor, please include an appropriate audit fee within the detailed budget. [↑](#footnote-ref-4)