**Response to the requested clarifications by the IRC on:**

**HSS proposal submitted by Yemen**

**February 2014**

* Please include intermediate results for the M&E Framework

It has been integrated into the M&E framework (updated framework attached)

* Please provide some lessons learnt on HSS implementation

The lessons learnt and listed in section(6) are based on previous GAVI HSS grant implementation, learnt through the process of implementation and feedback from governorate and district levels, they are listed against the objectives of the new proposal. In addition to those objective specific lessons, there are general learning lessons including the following:

* Clear technical and geographical mapping of interventions by the stakeholders is important for better coordination and harmonization, minimizing overlapping, and addressing the gaps.
* Investing in integrated training at different levels resulted in improving capacity of staff to overcome limitations of resources especially at peripheral level to provide multi disciplinary services.
* Institutionalization of integrated outreach services was a major remedy strategy to overcome the low coverage by EPI services as well as other services in a country with a highly scattered population over more than 130,000 settlements.
* The approach of implementing GAVI HSS grant has gone diagonally benefitting from the strengths of some strong vertical programs such as EPI (human resources and infrastructure), IMCI (training approach) to a more horizontal integration at service delivery level.
* Please clarify how the quality of activities for intermediate outcomes in objective 3 will be monitored (e.g. quality of awareness sessions in communities with CHVs to females; quality of teacher-led health education programmes).

Training of trainers is done according to an already prepared training material, they are trained by qualified trainers whom are known to the ministry, and training at lower level is supervised from the higher level, UNICEF will be supporting technically in the process of training. Impact will be measured through the 2 KAP studies planned in the proposal.

* Please clarify why such moderate increases over the 5 year HSS period were assumed for objective 3: (% targeted communities having a CHV – 50% by 2018; % of targeted schools that have >50% of students receiving documentation for EPI, Hygiene, and nutrition – estimated at 50% by 2018).

Based on the experience and lessons learnt from CHV program implementation by the ministry, WHO, and UNICEF the achievements were less than expected. That is because of the multiple interventions needed for implementation, capacity of implementing agencies as indicated in the proposal is still not very well developed, and it is a learning by doing partnership exercise between the Ministry of Health and the Civil Society Organizations.

* Please justify the performance based incentives for staff involved in EPI activities which have been costed at US$916,000

The proposed incentives are targeting multiple categories of staff involved in EPI, surveillance, and management information system at district, governorate, and central levels, based on performance criteria, which will be distributed to the targeted staff, justification of payment will be done according to scoring results of those criteria done at governorate and central levels by the relevant management lines, and cross check of justifications will be done randomly and whenever a need shows up. This approach of motivation is also considered based on the experience with previous GAVI grant. In general the proposed budget for incentives has been kept at lower level about 5% of budget for planned activities.

* Please explain who will do the training and how it will be undertaken and evaluated.
* Throughout the last 2 decades the ministry has developed the capacity of national staff in cooperation with WHO and UNICEF mainly, most of the training activities will be done by those national trainers according to area of expertise from different levels of health system.
* WHO and UNICEF will be technical resources and back stopping for the process of training.
* Training activities particularly related to raising awareness will be technically supported/done by trainers provided by UNICEF.
* Regarding HMIS, EU is going to provide technical support for integrating the HMIS.
* The training evaluation is included into the training package such as (pre and post tests, evaluation sheets)
* Evaluating the Impact of training is reflected into the supportive supervision reporting from different levels about the performance of trainees at service delivery level

Trainers are available at central, governorate, and district levels according to the implementation needs. There will be training of new trainers, where needed at governorate and district levels to meet the requirements of getting into new districts. In general, training of trainers at governorate level will be done by trainers available at central level and selected good trainers at governorate level, training at district level is done by governorate trainers and district trainers with supervision form the central level to control quality of training.

* Please confirm if there will be monitoring will be done to examine changes in the percentage of women accessing health services over the HSS period.

There is documentation of utilization of outreach activities; CHVs activities including women utilized RH, vaccination, and raising awareness sessions, those data are reported to the higher level where monitoring of data can be concluded. In addition, review of random sample of registers’ data at service delivery level will be done. Rate of women access to health services will be evaluated through random sample health facility based survey supported by WHO. Currently, the ministry is conducting an DHS, which will provide a baseline data, and the EPI coverage survey planned by the end of the of this phase supported by GAVI will show the change in utilization of EPI services according to gender.

* Yemen has indicated problems of power failures. Please clarify why the country is considering purchasing compression electric refrigerators rather than solar refrigerators.

The requested refrigerators are electrical/gas, gas is subsidized by the government and available almost all over the country because it is a main source of fire for cooking at houses, and it is the main alternative power supply used by health facilities to overcome power failure. Governmental operational budget covers health facilities and includes costs of gas supply. On the other hand, routine maintenance of solar units at health facilities is not done according to instructions and replenishing out of order batteries is relatively costly. However, in some remote areas the ministry is providing and will provide solar units through the support of WHO and UNICEF.