Joint Appraisal report 2017

The italic text in this document serves as guidance, it can be deleted when preparing the Joint Appraisal report.

Country	Yemen
Full Joint Appraisal or Joint Appraisal update	Full Joint Appraisal
Date and location of Joint Appraisal meeting	Beirut, Lebanon, 15th -18th May 2017
Participants / affiliation[1]	MoPHP&P, Yemen, UNICEF (YCO, MENARO), WHO (YCO, EMRO, HQ), GAVI Secretariat
Reporting period	2016
Fiscal period[2]	January – December
Comprehensive Multi Year Plan (cMYP) duration	2016-2020

1. SUMMARY OF RENEWAL AND EXTENSION REQUESTS

As part of the ongoing grant cycle, Gavi reviews and renews its support to the country annually (referred to as "renewal"). If a country's new and underused vaccine support (NVS) is coming to an end and the country is still eligible for Gavi support, it may submit a request to extend the support (referred to as "extension").

Below tables 1.1 to 1.4 will be pre-populated by the Gavi Secretariat based on the country information submitted through the Country Portal on 15 May and four weeks before the Joint Appraisal meeting. If there are any changes to be made, these changes should be discussed during the Joint Appraisal and flagged in the Joint Appraisal report.

1.1. New and Underused Vaccines Support (NVS) renewal request(s)

Type of support (routine or campaign)	Vaccine	End year of support	Year of requested support	Target (population to be vaccinated)	Indicative amount to be paid by country	Indicative amount to be paid by Gavi
NVS -Pentavalent in existing presentation	*Extension*	2018	2018	890,000	US$ 438,500	US$ 2,933,500
NVS – *PCV in existing presentation*	*Extension*	2018	2018	890,000	US$1,308,000	US$ 8,684,000
NVS – R*otavirus in existing presentation*	*Extension*	2018	2018	890,000	US$ 536,500	US$ 3,278,000
NVS – IPV *in existing presentation*	*Extension*	2018	2018	tbc	N/A	tbc

1.2. New and Underused Vaccines Support (NVS) extension request(s)

[1] If taking too much space, the list of participants may also be provided as an annex.

[2] If the country reporting period deviates from the fiscal period, please provide a short explanation.

If 2017 is the last year of an approved multiyear support for a certain vaccine and the country wishes to extend Gavi support, please do so by requesting an extension of the vaccine support. The extension can be requested maximum for the duration of the Comprehensive Multi-Year Plan (cMYP), which must be submitted to Gavi.

Type of Support	Vaccine	Starting year	Ending year
Vaccine	IPV	2015	2018

1.3. Health System Strengthening (HSS) renewal request

Gavi commits to Health System Strengthening grants up to a five year period, with the first tranche approved with the approval of the proposal. In subsequent years, the country should submit a renewal request for the approval of the following HSS funding tranche.

*Below table summarises key information concerning the amount requested for the next year. Please note that funds previously requested and approved may be pending disbursement and do **not** require further approval.*

Total amount of HSS grant	US$ 17,639,234
Duration of HSS grant (from…to…)	2014-2018 (GAVI HSS2)
Year / period for which the HSS renewal (next tranche) is requested	NA
Amount of HSS renewal request (next tranche)	US$ 0

2018 programme year has been approved by HLRP in Nov 2017 for utilization and disbursement in 2017 depending on country needs and absorption capacity in response to the emergency situation.

Recipient	2014 - Yr1	2015 - Yr2	2016 - Yr3	2017 - Yr4	2018 - Yr5	Total
MoPHP	4,200,000					
WHO		1,639,641	1,747,194	1,331,080	tbc	
UNICEF		1,720,359	1,612,764	2,028,274	tbc	
	4,200,000	**3,360,000**	**3,359,958**	**3,359,354**	**3,359,922**	**17,639,234**

1.4. Cold Chain Equipment Optimization Platform (CCEOP) renewal request

Similar to the Gavi HSS support, the Cold Chain Equipment Optimisation Platform provides phased support for a maximum duration of five years, which is subject to an annual renewal decision.

Below table summarises key information concerning the amount requested for the next year.

Yemen is planning to submit a request for support in September IRC and the country is requesting that Gavi considers to allow for a joint investment of 20% country resources instead of 50% according to the policy.Yemen Country participated in the CCEOP workshop which was held in Benin and all the Cold Chain data which was collected during CCA exercise in March and April 2017 shifted to WHO provided Cold Chain Inventory and Gap Analysis tool. Work in progress on Application which will be submitted in September 2017.

Total amount of CCEOP grant	US$	
Duration of CCEOP grant (from…to…)	2016-2021	
Year / period for which the CCEOP renewal (next tranche) is requested	2018	
Amount of Gavi CCEOP renewal request	US$	
Country joint investment	**Country resources**	US$ 20%
	Partner resources	US$ 80%
	Gavi HSS resources[3]	US$ (Govt./country share will be paid through GAVI HSS)

The CCEOP joint investment contribution, is set at 50% for Yemen per Gavi policy, and it was requested during the Joint Appraisal that Gavi should allow for flexibility for Yemen to contribute with 20% for the joint investment. The joint investment will be taken out from the future HSS grant allocation. There are critical cold chain needs that needs urgent attention.

1.5. Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future[4]

Indicative interest to introduce new vaccines or request HSS support from Gavi	Programme	Expected application year	Expected introduction year
	GAVI HSS 3	2017	2018

Yemen requested for the application for new HSS grant. It was decided that Yemen Country team will submit the concept note for the GAVI HSS 3 and they will start working on the development of proposal. All stakeholders agreed to hold meeting in Sep/Oct 2017 to discuss the GAVI HSS 3 proposal. GAVIs shift to the country engagement framework which includes dialogues at the country level is not entirely feasible in Yemen and hence the process and approach will require to be adapted and made flexible in the Yemen context. With reference to the emergency and fragility policy approved by the Gavi Board in June 2017 flexibilities for Yemen considering both flexibility and fragility can be applied. Standard required documents may not be available for Yemen (eg CES) due to access issues and support will need to continue to be channeled through partners. HSS3 proposal will be developed taking into consideration other support such as the WB and the Yemen Humanitarian Response Plan. A workshop to define these activities and objectives will be held in October 2017 with Government and partner apraticipation.

Background

*Gavi's support to a country's immunisation programme(s) is subject to an **annual performance assessment**. The Joint Appraisal is a key element of this performance review. It is an annual, country-led, multi-stakeholder review of the implementation progress and performance of Gavi's support to the country, and its contribution to improved immunisation outcomes.*

*To inform the Joint Appraisal discussion, the country is expected to post all reporting document on the Gavi Country portal not later than **four weeks ahead of the Joint Appraisal meeting**.*

*This includes reporting against **key requirements**:*

[3] This amount must be included either in an earlier HSS approval or else in the current HSS renewal request in section 1.4 above.

[4] Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.

- *Update of the grant performance framework (GPF) for indicators which are due*
- *Periodic financial reports, annual financial statements and audit reports (for all types of direct financial support received, with specific submission deadlines depending on a country's fiscal year)*
- *End of year stock reporting (which is compulsory to be submitted by 15 May of each year to calculate future vaccine requirements)*

Other critical information to be posted on the Country Portal four weeks prior to the Joint Appraisal include:

- *Immunisation financing and expenditure information*
- *Data quality information (including annual desk review and progress report on the implementation of immunisation data quality improvement plans)*
- *Annual progress update on the Effective Vaccine Management (EVM) improvement plan*
- *Campaign reports (if applicable)*
- *HPV specific reporting (if applicable)*
- *HSS end of grant evaluation (if applicable)*
- *Post Introduction Evaluation (PIE) reports (if applicable)*
- *Expanded Programme on Immunization (EPI) reviews (if applicable)*
- *Gavi and/or polio transition plans or asset mapping information (if applicable)*

Other information that will inform the Joint Appraisal discussion include:

- *Report by WHO and UNICEF on their technical assistance milestones funded through the Partners' Engagement Framework that should be updated four weeks in advance of the Joint Appraisal*
- *Analysis on coverage and equity and other relevant programme aspects, as informed by the Joint Appraisal Analysis Guidance (if available)*
- *Full Country Evaluation report (if applicable)*
- *Other evaluation of Gavi programmes*

***Note: Failure to submit the relevant information described above on the country portal four weeks ahead of the Joint Appraisal meeting (except for the vaccine renewal request, which is to be submitted by 15 May) may impact the decision by Gavi to conduct the Joint Appraisal meeting and renew its support**.*

2. CHANGES IN COUNTRY CONTEXT SINCE LAST JOINT APPRAISAL

Comment on changes which occurred since the previous joint appraisal, if any, to key contextual factors that directly affect the performance of the immunisation system and Gavi grants (such as natural disaster, political instability, displaced populations, inaccessible regions, etc., or macroeconomic trends or disease outbreaks).

Please indicate if the country has been formally identified by Gavi as fragile and specify if flexibilities in grant management are being requested.[5]

External factors

Since 2015, the government in Sanaa has been led by the Houthis. This situation had numerous serious internal and international repercussions which has led to a conflict involving interventions from several countries. Since 2015, the conflict has intensified and is affecting now 20 of the 23 governorates. The conflict's consequences and the existence of an in situ government in Sana'a versus an elected government in the south have led to a need for humanitarian action and increased coordination in the health area.

The conflict has created a humanitarian crisis with almost 80% of the population requiring assistance to meet their basic needs for food, water, healthcare, shelter and other basic supplies.

According to UN agencies, by November 2016, health facilities reported nearly 7,070 people killed and more than 36,818 injured. About half of the Republic of Yemen's population of about 29.7 million lives in areas directly affected by the conflict. Over 3.5 million Yemenis have been internally displaced (IDPs).

Yemen is a food-deficient country that produces only 10 percent of its cereal requirements and relies heavily on imports and food assistance. The country's low food self-sufficiency has been worsened by the conflict, which has disrupted economic activities, led to the suspension of safety net programmes and the implementation of import restrictions.

Incomes in Yemen have fallen dramatically and many public sector workers have gone for months without being paid. As a result, 80 percent of Yemenis are now in debt, and more than half of all households have had to buy food on credit. Many households – 60 percent – have resorted to negative coping mechanisms such as reducing their food portions or skipping meals altogether.

The preliminary results of the Emergency Food Security and Nutrition Assessment (EFSNA 2017) show that food security and nutrition conditions are deteriorating rapidly due to the ongoing conflict. The number of food insecure people is now estimated at 17.1 million people – an increase of 3 million in seven months. Of this figure, 7.3 million are considered severely food insecure and in need of emergency food assistance. The Yemen Nutrition cluster estimated in November 2016 that 1.9 million children under five are acutely malnourished with 360,000 with severe acute malnutrition. 900,000 pregnant or lactating women are also malnourished.

The health system is dramatically affected by the conflict with 15.2 million people lacking access to basic healthcare. At least 51% health facilities are not functional due to insecurity and shortages of fuel and medicines (to be compared to 25% in 2015). More than 412 health facilities have directly affected due to direct damage, attacks and in some instance commandeering by armed groups.

As a consequence of the conflict, access to health facilities has been limited. In addition to trauma care, hospitals are running out of all essential and curative medicines. The scarcity of fuel threatens the cold chain of perishable medicines.

Yemen is facing the "world's worst cholera outbreak" according to the UN agencies. The first wave was started in 05th Oct 2016 till Feb .2017 and the second wave was started in 27th April 2017. The number of suspected cholera cases are 474,155 cases and 1,953 deaths till Aug 7, 2017.

Gavi has stated the availability of the OCV stockpile since 2016 when the number of confirmed cases was relatively low. This was followed by a series of teleconferences with Government and stakeholders including WHO HQ. At the time of the JA, a WHO team was in Yemen for a cholera assessment to provide recommendations including for the decision to undertake a large scale OCV campaign. The outcome of this assessment however was not to carry out the campaign.

[5]For further information refer to http://www.gavi.org/about/governance/gavi-board/minutes/2016/7-dec/minutes/08a---fragile-settings,-emergencies-and-displaced-people/

Financial and Human Resource issues

Since September 2016, the government is unable to pay most of the needed drugs and commodities, the health facilities operational costs including electricity bills, communication and other utilities of Health facilities.

Since October 2016, the Government isalso unable to pay its staff salaries.

The currency has been devalued by around 75% last year. The limited availability of circulating bills has added a challenge for the banking transactions.

Despite the situation, UN agencies have been able to deploy some staff in the country allowing technical assistance to be provided to the MoPHP, assisting in planning, implementation and monitoring of the critical activities.

Health facilities (REFERENCE, HeRAMs)

Out of total 3,507 health facilities; 1,579 (55%) were reported to be fully functional and accessible, 1,343 (38%) were partially functional and 504 (17%) not functional. (HeRAMs Yemen 2016). The closure is also linked to staff availability, staff displacement, lack of electricity or other sources to run the cold chain equipment, managerial issues, unavailability of funds to run the HFs, unavailability of logistics etc.

In addition, populations are facing mobility issues due to high fuel prices, non-payment of salaries leading to decrease in purchasing power limiting their access to functional health facilities.

Planning

As in previous years, the Primary Health Care sector at the Ministry of Health leads the planning and implementation process.

The process for development of cMYP 2016-2020 was initiated in 2016. The initial draft prepared in consultation with MoPHP and partners is available and requires finalization and formal approval by MoPHP. The draft cMYP has been submitted officially as a prerequisite for GAVI MR application in May 2017.

Donors

The GoY requested and received a waiver for payment of 2015 co-financing requirements. For future co-financing requirements, a similar waiver will be requested for 2016. It is anticipated that those requirements may be supported through the two year World Bank support starting (2017-2018).

GAVI is the main financer of EPI programme with around 65% of the total expenditure (compared to 53% in 2015). The UNICEF support financing the routine vaccines 2015, 2016 and 2017.

For 2017, WB agreed to channel their support through WHO and UNICEF a new tranche of payment started in April 2017.

Immunization related updates will be detailed in Section 3 ‘Performance of the immunization system in the reporting period’.

Vaccine Management

All the vaccines in use by EPI are procured through UNICEF including those supported by Gavi. Vaccine and injection supply levels are managed through the Vaccination Supplies Stock Management (VSSM) software are generally monitored on a weekly basis at the central level, and governorates on a monthly basis.

Challenges:

- There were two initial incidents of refusal in the clearance of vaccines due to issues at the airport. In last quarter of 2016 two consignments sent from Djibouti stocks were not allowed entry by the customs authorities at Sanaa airport. The return of the two consignments costed significantly to both UNICEF and Gavi and also brought the country to the risk of a stock out. This was resolved through extensive efforts all partners and the active role of the MOPHP. While this is currently not an issue however the potential of such risks remain under the situation in Yemen.
- Though it is understood that that there are two distinct authorities working in the country (South & North). The main vaccine stores are in the North of the country where most vaccine deliveries are

made. It is critical that in the changing scenario developing enhanced storage facilities in the South is also considered. Most of the cold chain currently in use (refrigerators) operate with kerosene. Due to non-availability and high escalation of fuel prices extensive support is being by UNICEF (Gavi resources. UNICEF is planning to expand its support to provide gas to 1308 priority EPI centers in the next few months.

- As with all MOPHP staff, those involved in vaccine management have not received their salaries since October 2016. Government is unable to provide funding for operational costs, including salaries since 2014.
- The Government of Yemen funded vaccine needs till 2014 but since then has been variable in its commitment eventually leading to a request for waiver on Gavi co-financing since 2015. Currently all non Gavi vaccines are provided by UNICEF which in the past had been funded by the Government. It is planned that UNICEF will meet co-financing obligations on behalf of the Government of Yemen through the WB supported project
- Vaccines supply from central stores to Governorates and below incurs substantial transport cost which is currently being borne by UNICEF through Gavi funds and is contributing to an increase in the overall service delivery and operational costs.

As way forward the capacities of EPI need to be strengthened in the area of vaccine management. In addition to the training on vaccine management, the following positions were discussed and are being proposed to be covered by the HSS2 last tranche Gavi support:

- General vaccine and cold chain manager - officer
- Store keeper
- Assistant store keeping
- Vaccine store and supply manager
- Store accountant
- Cold chain maintenance

It was also decided that UNICEF & WHO will coordinate with MoPHP to make list of the EPI staff who working at the central, Governorate/district level and who are eligible to be given incentives. However these incentives will be given only in current scenario to compensate them as the staff has not been receiving the salaries. Once the security/economic situation became normalize then these incentives will not give to EPI staff.

Currently GAVI supported staff is working through UNICEF support in GHO offices of Sa'ada, Taiz, Aden, Sana and Hodeaida. To strengthen the coordination between central level and the staff working in the Governorates it was decided to identify the focal point at central level who will coordinate with GAVI supported staff at Governorate level.

In case of limitation of available resources the MoPHP in consultation with partners will prioritise the positions required.

3. PERFORMANCE OF THE IMMUNISATION SYSTEM IN THE REPORTING PERIOD

This section should provide a succinct analysis of the performance of the immunisation system, including a thorough analysis immunisation coverage and equity, as well as a review of key drivers of poor coverage. It should focus on the evolution/trends observed over the past two to three years and particularly changes since the last Joint Appraisal took place.

Information in this section will substantially draw from the recommended analysis on coverage and equity and other relevant programme aspects which can be found in the Joint Appraisal Analysis Guidance (http://www.gavi.org/library/gavi-documents/guidelines-and-forms/joint-appraisal-analysis-guidance/).

3.1. Coverage and equity of immunisation

Please provide an analysis of the situation related to coverage and equity of immunisation in the country.

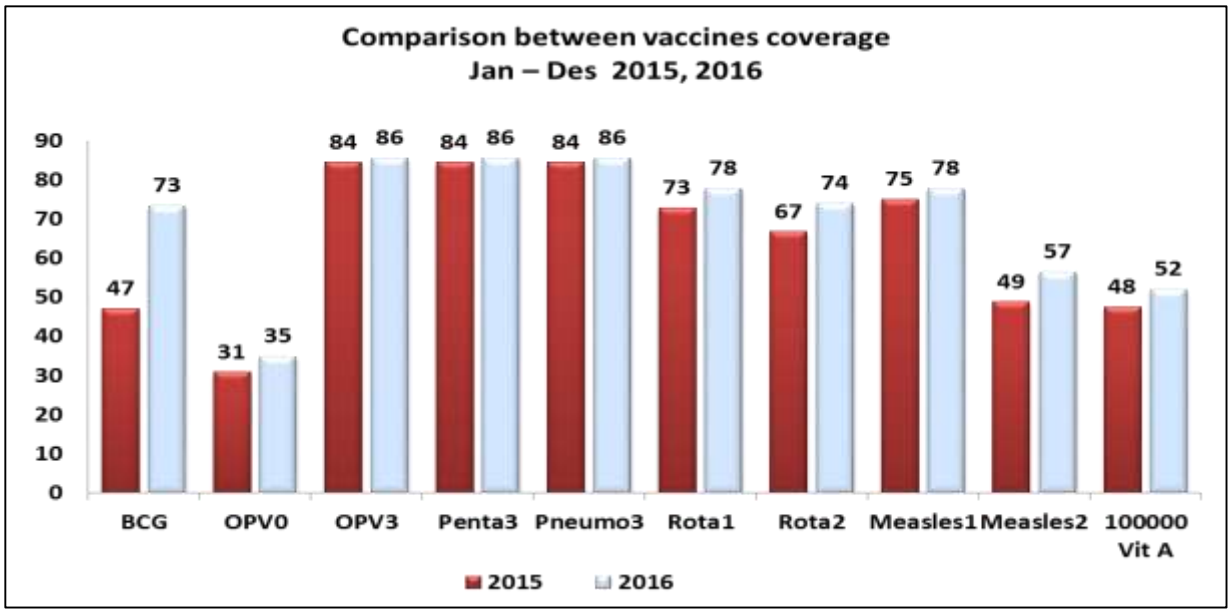
*Provide a summary of the difference in **coverage across various geographical areas, populations and communities** and the evolution over the past years. Relevant information includes: overview of*

districts/communities which have the lowest coverage rates and/ or the highest number of under-vaccinated children, number of VPD cases observed in various regions/ districts etc.

Countries are strongly encouraged to include heat maps or similar to show immunisation coverage trends over time. Examples of such analysis are available in the Joint Appraisal Analysis Guidance (available via http://www.gavi.org/library/gavi-documents/guidelines-and-forms/joint-appraisal-analysis-guidance/)

The year 2016 has been a challenging year for the routine EPI. However, despite many difficulties, a number of EPI centers remained operational as well as the Governorate and District vaccine stores. The vaccine supply to the country was maintained despite enormous challenges presented due to access and security issues, thanks to the UNICEF supply division and Yemen Country Office,whose role was paramount in this regard including the cooperation from WHO and national programme team. No vaccine stock outs were reported in 2016 at any level.

2016 JRF data indicate a more than double the reported cases of NNT, and a many fold increase in those of pertussis. This further necessitates the need to enhance coverage and equity through concerted routine and outreach immunization activities. The increase in neonatal tetanus cases also requires a focus on TT/Td vaccination,and in as much as possible on clean delivery practices challenged in the present country circumstances.



BCG administrative coverage improved from 47% (2015) to 73% in 2016, Penta 3 coverage improved from 84% (2015) to 86% in 2016, MR coverage improved from 75% (2015) to 78% in 2016. In 2015 the BCG coverage was low and one of the main reason was global shortage of vaccine. However, as can be seen from the graph below, admin data shows that rota has lower coverage than the other vaccines. This can in part be explained by restrictions on age group for vaccination to 3 month for the 1. dose and below 8 months for Dose 2 and the fact that some children will not meet the age group criteria when majority of outreach activities were conducted in the last 2 quarters of the year in both 2015 and 2016.

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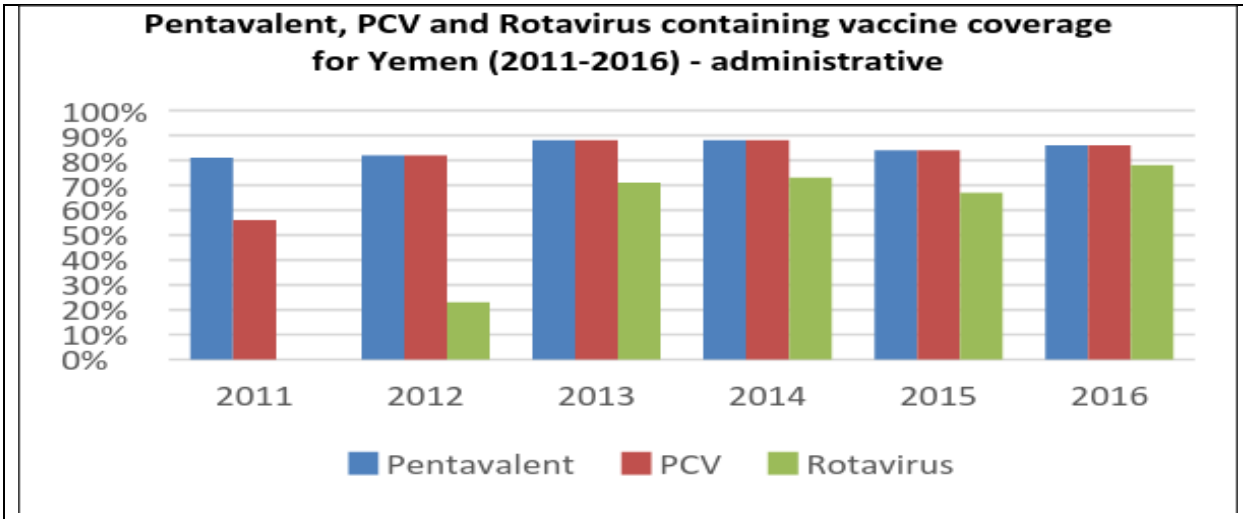
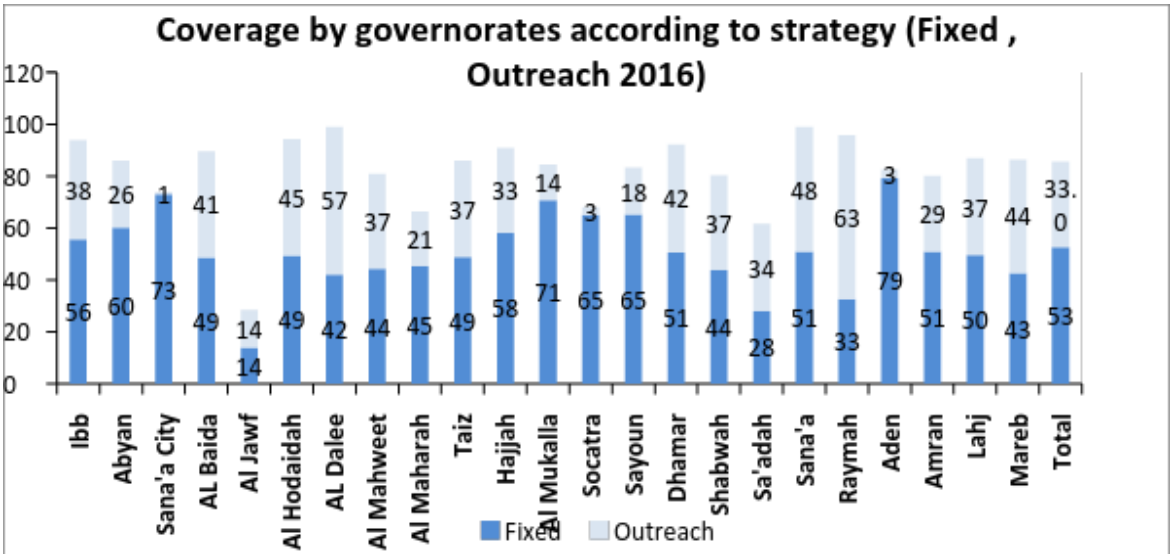
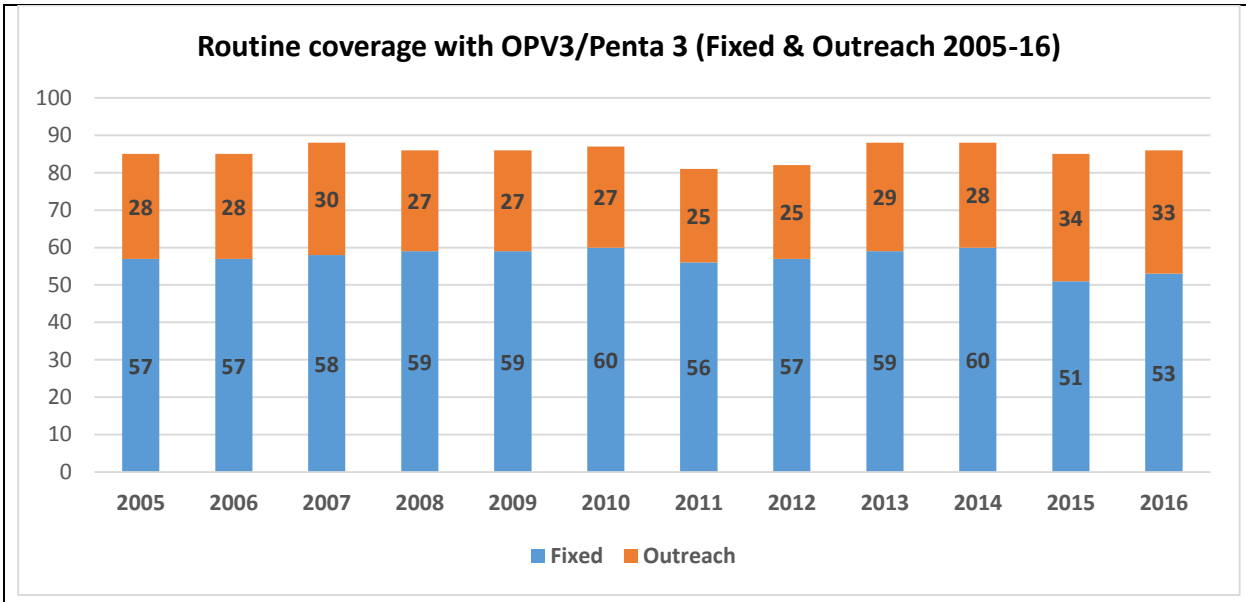


High risk districts regarding TT coverage were identified and funding proposals submitted to UNICEF HQ, US $1.2 Million were provided to Yemen to conduct 2 rounds of MNNT campaign in 46 high risk districts.

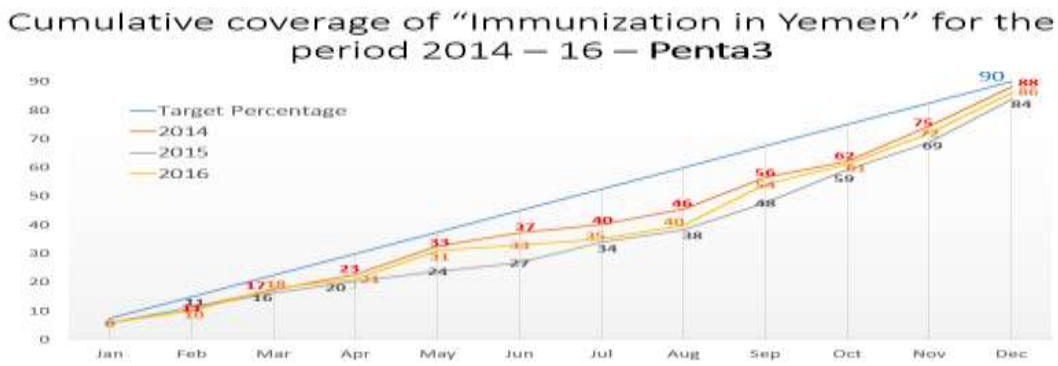
5 Integrated Outreach Rounds (IOR) conducted in country in 2016, four of these in the later half of the year. Through integrated Outreach rounds 34% and 33% in 2015 and 2016, consecutively, of the target children under 1 year old were vaccinated. IORs conducted in all targeted 307 districts of Yemen. IOR is used as strategy to reach to eligible and defaulter children in high risk population in hard to reach and security compromised areas. Measles mop up campaigns conducted in targeted areas, however there are certain areas in Yemen from where Measles outbreak reported e.g Amran, Sa'ada, Seyon, Al-Mahraetc.

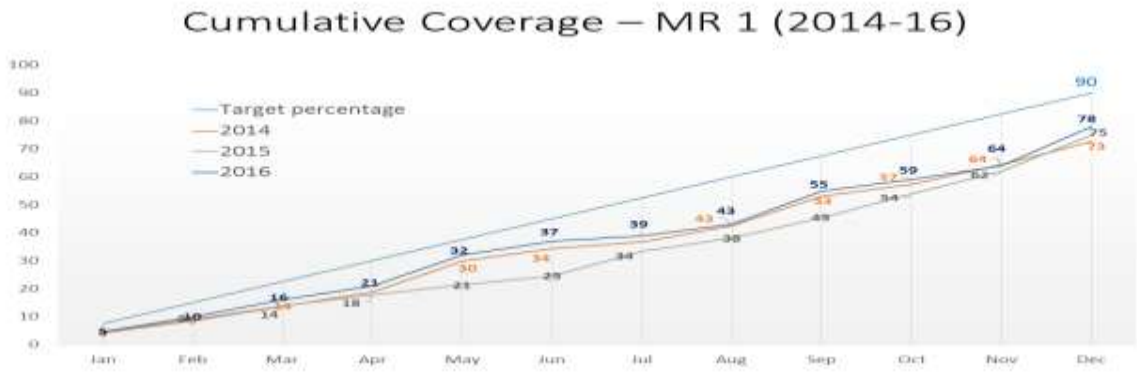


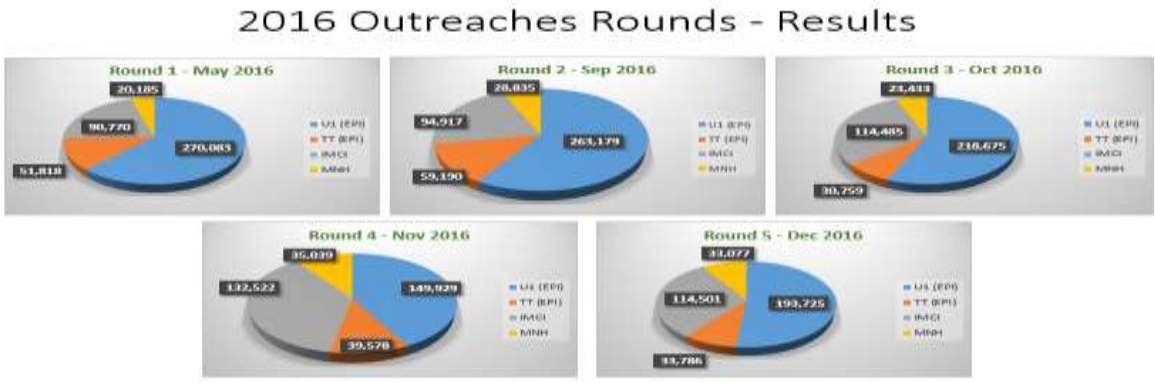
Since 2003 hard to reach communities have been reached with immunisation services through outreach and integrated outreach, however the reliance on IOR has been even more critical since the start of the conflict. Although the IOR on national account for around 34% of the achieved coverage, this varies between governorates. These activities include all routine vaccines used by the programme.



Under the GAVI TCA support consultant deployed in target Governorates, including Cold chain and vaccine management consultant in Sa'ada, Aden and Taiz, Governorate Operational consultant in Sa'ada, Aden and Taiz, C4D consultant in Sa'ada, Aden and Taiz and C4D consultant in Sana'a and Hodeida. Two posts including Cold chain and vaccine management consultant and C4D consultant identified to central level, however the recruitment is in progress. Cold Chain Equipment Optimization platform (CCEOP) activity started in 2016. Consultant for the activity was hired by UNICEF MENARO and NYHQ who started the activity in Oct 2016. In initial phase she completed the assessment in central cold room and target health facilities in Hodeida and Sana'a Governorate and trained the master trainers regarding training of the assessors. Due to contractual issues the consultant came after break of 5 months in meantime teams of assessors were trained and they have start the data collection. Data regarding cold chain has been collected from 90% of the Health facilities and data entry is also in progress. This will be followed by development of CCEOP proposal by consultant.







Equity analysis:

Equity analysis done in light of surveys and SIAs data. As per Yemen National Health and Demographic Health Survey 2013, Children in urban areas are more likely than rural children to be fully vaccinated (59% compared with 37%), Children in the highest wealth quintile are more likely to be fully vaccinated than those in the lowest (62 % and 24 % respectively). Analysis has been considered during planning for operational and communication activities. Strategies have been developed to reach to children and CBAW with in high risk groups including IDPs, MoPHPammashen, Refugees, Migrantsetc with vaccination services in hard to reach and security compromised areas.

3.2. Key drivers of low coverage/ equity

*Please highlight key drivers of the low levels of coverage and equity highlighted in the section above. For those districts/communities identified as lower performing, explain the **key barriers** to improving coverage.*

- ***Health Work Force****: availability and distribution of health work force.*
- ***Supply chain****: key insights from latest EVMs and implementation of the EVM improvement plan.*
- ***Demand generation / demand for vaccination****:key insights related to demand for immunisation services, immunisation schedules, etc.*
- ***Gender-related barriers***[6]*:any specific issues related to access by women to the health system.*
- ***Leadership, management and coordination****: Leveraging the outcomes of the Programme Capacity Assessment and/or other assessment, please describe the key bottlenecks associated with management of the immunisation programme; this includes the performance of the national/ regional EPI teams (e.g. challenges related to structure, staffing and capabilities), management and supervision of immunisation services, or broader sectoral governance issues.*
- ***Other critical aspects****: any other aspect identified, for example based on the cMYP, EPI review, PIE, EVM or other country plans, or key findings from available independent evaluations reports*[7]*.*

- Health work force availability. In August 2016, the Ministry of Public Health and Population (MoPHP) in Sana'a announced it could no longer cover operational costs for health services, as a result health services provided by public institutions are collapsing while needs are surging. Absenteeism among key staff is reportedly rising as employees seek alternatives to provide for their families.
- By October 2016, only 45 per cent of health facilities in 16 out 23 governorates surveyed were fully functional bringing additional difficulties in accessing healthcare.
- Parties to the conflict routinely impose restrictions on movements of people, goods and humanitarian assistance.
- Change in vaccine distribution channels has led to delays in vaccine availability and high costs.
- Capacity to reaching vulnerable populations ie IDPs, hard to reach population. Since March 2015, more than 3.5 million people have been displaced within Yemen, including 2 million who remained displaced as of January 2017. About half of the current internally displaced persons (IDPs) are sheltering in Hajjah, Taizz and Sana'a. Roughly 73 per cent are living with host families, or in rented accommodation, straining already scarce resources and 20 per cent are living in collective centers or spontaneous settlements. Majority of IDP are women and children.
- Challenges to distribute vaccines to the districts related to financial resources availability, lack of cold chain vehicles, limited fuel and poor staff motivation.
- Vaccine hesitancy in some areas following the spread of rumors through social media.
- More than 80% of birth deliveries take place at home.
- Towards the end of 2016, vaccines that arrived to the Sana'a airport, were not accepted and returned to Djibouti, this happened twice before obtaining clearance, and with the presence of high level officials at the airport to collect the shipment of vaccines. UNICEF has since then required signed commitment from the minister as an additional step prior to sending the vaccines to the country and due to this additional step there are delays in vaccine shipment. UNICEF requested MoPHP to revert back to previous shipment procedures to avoid any delaysMoPHP agreed to give blanket approval for all vaccine shipments for 1 year on the basis of immunization forecast.

3.3. Data

*Provide a succinct review of key challenges related to the availability, quality and use **of immunisation data**. This section should at least cover insights on coverage data (target populations, number of children vaccinated) and could also cover topics such as vaccine supply chain data, VPD surveillance data, AEFI data.*

[6] Gender-related barriers are obstacles (for access and use of health services) that are related to social and cultural norms about men's and women's roles. Women tend to be the primary caretakers of children, but sometimes lack the decision-making power and resources to access or use available health services.

[7] If applicable, such as Full Country Evaluations (relevant for Bangladesh, Mozambique, Uganda and Zambia) and Technical Assistance evaluations (conducted for Gavi Partners' Engagement Framework tier 1 and tier 2 priority countries).

Please take the following aspects into account:

- ***Compliance** with Gavi's data quality and survey requirements (the requirements are detailed in the general application guidelines available on www.gavi.org/support/process/apply/. If you are not compliant, explain why.*
- *Highlight key **challenges** pertaining to data availability, quality and use, referring to results from most recent annual desk review, any recent assessments and implementation of immunisation data quality improvement plan. For example, are you aware of key limitations / weaknesses related to the quality of the data and data analyses you have used to inform this Joint Appraisal.*
- *Main **efforts / innovations / good practices** focused on improving data system strengthening and addressing key issues.*

Country has not being able to conduct the recommended Gavi requirements on data quality and surveys. A new DQS is planned to be conducted in august 2017 along with the annual desk review.

Both exercises will lead to the development of a data quality improvement plan. Two WHO staff participated in the EMR Sub-regional WS on data Quality, held in Islamabad Pakistan in Nov 2016. UNICEF MENARO is planning a regional data quality workshop in the third quarter this year to strengthen sub-national capacity in linking health care workers with communities and improving microplanning with an equity focus.

Coverage survey highlighted in HSS plan however the activity not conducted due to various reasons, first and foremost is the unavailability of sufficient funds and another key reason was the ongoing volatile security situation which may didn't permit to conduct smooth activity.

Last DHS was conducted in 2013 and report was issued in 2015 however there are no plans in near future to conduct another DHS. Due to access issues a quality survey cannot be held at this stage and has not been prioritized.

It was discussed during the JA that in the current conflict context, an EPI coverage survey will not be feasible.

The major challenges around the data collection and management relate to the cross cutting issue of staff not being paid and the availability of IT tools to streamline the recording of data. Most of the data collection is paper based at district level, then it get send by email or fax to the Governorates who then send it to the two data officers at central level to manually input it into the web based platform developed by WHO. This data is only collected through surveys – the last one took place in 2013. Additional challenges related to electricity, human resources capacity and internet access remain.

Given the challenges facing the lack of financing for operational costs and the implications in the data management system, it was identified an urgent need to provide incentives to the key staff involved in delivery of immunization and in the management of the EPI programme. A comprehensive plan encompassing all requirements with reasonable remuneration will be developed by WHO and UNICEF in collaboration with the MoPHP.

Support is required for additional incentives at Governorate level – overall perceived need by the group is one data manager by governorate and 2 at central level for a total of 25 people.

MoPHP acknowledges the support provided by PEF TCA to the management of data, however, the allocated staff has been partially pulled away for the cholera response and other emergency work. Additional needs for training at district level and the development of a data validation system remains necessary.

Training at capacity level on data management. An external validation and assessment of the quality of data is necessary.

3.4. Role and engagement of different stakeholders in the immunisation system

Please provide relevant information on the role and engagement of the various stakeholders:

- ***National Coordination Forum** (ICC, HSCC or equivalent): the extent the forum meets the Gavi requirements (please refer to http://www.gavi.org/support/coordination/ for the requirements).*
- ***Civil society**: the role and engagement of civil society in the immunisation system in the past year (service delivery, demand generation etc.).*

- ***Other donors****: the role and investments of other bilateral and multilateral donor in the immunisation system. Please include information on possible reductions in non-Gavi donor support that influence the overall system capacity (e.g. reductions in GPEI funding).*
- ***Private sector****: public-private sector collaboration, indicating possible vaccine supply between Government and private sector and the percentage of children receiving immunisation through the private sector.*
- ***Cross-sectoral collaboration****: e.g. collaboration between health and education programmes.*

Yemen Humanitarian Response Plan (YHRP)

- The YHRP aims at meeting the acute needs of 10.3 million people in all governorates where access and operational capacity permits and addressing moderate needs in areas where the population is at risk of slipping into acute need. The total resource requirement for 2017 is $2.1 billion.
- The YHRP covers 120 organisations working across Yemen, with 9-46 organisation operating in each governorate, a total of 287 projects (41 by UN, 93 by INGO, 24 by Gulf, 129 by National NGOs). In 2017, the Yemen Humanitarian Coordination Team will strengthen integrated approaches to key issues that cut across the response.

Yemen Health Cluster

- As of December 2016, 33 active partners were coordinating with the Health Cluster, an increase of more than one third since the 2016 YHRP. These partners provide a wide range of accessibility nationwide.
- 2017 Health Cluster response plan targets 10.4 million people in 2017, including the 8.8 million people identified as facing acute health needs. 2017 Health Cluster plan prioritizes activities to address immediate and long-lasting repercussions of the crisis. This will include supporting health facilities in order to keep them operational following damage or due to other challenges, as well as supporting provision of essential, life-saving primary health care (PHC) and maintaining pipelines for medicines and supplies.
- The Health response under the YHRP has the following objectives: 1. Provide integrated primary, secondary and referral health services, surveillance and response, and medical supplies in priority districts; 2. Strengthen reproductive, maternal, newborn, child and adolescent health (RMNCAH) interventions, including violence against women; 3. Support community-based health initiatives and sustain the main pillars and infrastructure of the health system; 4. Strengthen health sector coordination and health information systems.

World Bank Emergency Health and Nutrition Project (EHNP)

- Final agreements were signed first quarter of 2017, the World Bank funding is expected to go a long way towards bridging the gaps between immediate relief, support for essential services that complement relief efforts, maintaining functional institutions and promoting future recovery. The UN-World Bank partnership aims to complement activities within the Yemen Humanitarian Response Plan, focusing on the humanitarian-development nexus and taking a resilience-based approach that will promote early recovery.
- The EHNP is a $200 million grant (for implementation through UNICEF and WHO, working with relevant partners) to support the local health system in delivering emergency and essential health and nutrition services for an estimated 7 million Yemenis, largely within the scope of the YHRP. The duration of the implementation of the EHNP is January 2017 to December 2019, with $60 million for 2017, $110 million in 2018 and $30 million for 2019. Of the 124 million allocated to UNICEF US$46 million is for health and US$53 million is for nutrition.
- The project will finance health and nutrition services as well as help maintain the capacity of the existing health system, i.e. public HFs and community level engagement. In addition, the EHNP will cover support for procurement of traditional vaccines and essential medicines, co-financing of Gavi vaccines and for immunisation through integrated outreach rounds from 2018 onwards. Considering that Gavi HSS2 is being implemented by UNICEF/WHO as is the WB grant, it will be critical to ensure that this support is complementary,

ICC and HSCC:

Traditionally Yemen has had functional and effective Health System Strengthening Coordination Committee (HSSCC) and EPI task force. Despite the crisis and coordination challenges the Government reports that three meetings of HSSCC and 10 meetings of EPI task force were held in 2016.Understandabaly the attendance and the quality of the meetings is challenged at times. HSSCC is chaired by Acting health Minister/Deputy Minister and all key and policy level decisions are discussed and endorsed by this high level committee. Various matters e.g Introduction of new vaccines, performance of activities are discussed and their performance assessed in these committees.. The Government considers the EPI task force is being effective in Yemen. In the ongoing challenging situation EPI task force has played very important role in planning and monitoring of EPI activities. EPI task force is chaired by Deputy Health Minister.

CSOs

- NGOs are involved in immunisation, mainly in communication activities. The UNICEF C4D officers at central and governorate level (PEF TCA supported positions) are liaising with NGOs. UNICEF field offices have used funds to support activities through CSOs/NGOs. The activities are conducted regarding EPI communication especially in immunisation week. Focus is mainly in districts with refusal problem.

4. PERFORMANCE OF GAVI GRANTS IN THE REPORTING PERIOD

4.1. Programmatic performance

*Provide a succinct analysis of the performance of Gavi grants for the reporting period. Describe **how Gavi support is contributing to advancing the performance of the overall immunisation programme** and health sector strategies (with a particular focus on those districts/communities with lower coverage), and how the barriers identified in section 3 above are being addressed, stating -as relevant- **good practices and innovations.***

This analysis should cover all Gavi support received, including NVS, HSS and CCEOP. This section must address the following:

- ***Achievements against agreed targets**, as specified in the grant performance framework (GPF), and other grant-related activity plans. If applicable, reasons why targets as specified in the GPF have not been achieved, identifying areas of underperformance, bottlenecks and risks.*
- ***Overall implementation progress** of Gavi grants including **NVS**, **HSS** (incl. performance based funding **PBF**) and **CCEOP**.*
- *Past performance for measles and rubella (immunisation coverage analysis and rubella surveillance, performance[8]) and progress against the country's **measles-rubella 5 year plan**.*

*Please mention any other **relevant initiativenot supported by Gavi** that addresses the key drivers of low coverage (described in section 3).*

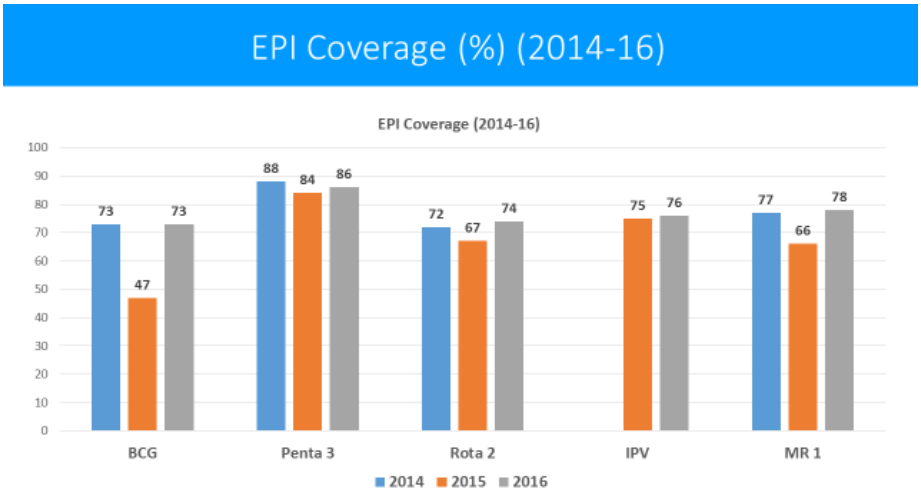
1. Through integrated Outreach rounds 30-35% of target children under 1 years were vaccinated. OR & IORs conducted in all 307 districts of Yemen. IOR is used as strategy to reach to eligible and defaulter children in high risk population and in hard to reach and security compromised areas.
2. In 2016 through IORs the number of beneficiaries/vaccine doses give are as follows;
    a). Total number of 1,095,591 doses of vaccines given to children U1 years
    b). Total number of 215,131 doses of TT given to pregnant and WCBA
    c). Total number of U 5 managed and treated were 547,195 (IMC)
    d). Reproductive health services were given to 140,569

[8] Please include analysis of MCV1 and MCV2 routine immunisation and MCV campaign coverage at national and sub-national levels (admin and survey data), information on case distribution by age, geography, vaccination history, etc. for measles and rubella (including CRS), including outbreaks, at national and sub-national level.

3. District micro planning exercise conducted all 21 Governorates and for the remaining governorates it is ongoing. High risk population including migrants, refugees, IDP included in microplans.
4. Vaccine supply to the country remain continues and role of UNICEF supply division and Yemen Country Office is highly appreciated in this regard. No vaccine stock outs reported in 2016 at any level. However, there are additional requirements for importing vaccines in the terms of obtaining an official letter for every consignee.
5. BCG coverage improved from 47% (2015) to 73% in 2016, Penta 3 coverage improved from 84% (2015) to 86% in 2016, MR coverage improved from 75% (2015) to 78% in 2016. Despite many challenges the EPI targets were almost achieved because of operationalization of closed EPI centers, focus on vaccination through fixed centers, conduction of Integrated Outreach Rounds in tier 2 and 3 areas and vaccination of children in high risk and hard to reach areas through mobile teams. Integrated Outreach Rounds and Mobile teams played critical role in reaching to children from high risk groups in hard to reach and security compromised areas and in areas without access to health services..
6.High risk districts regarding TT coverage were identified and proposals submitted to funding to UNICEF HQ, US $1.2 Million provided to Yemen to conduct 2 rounds of MNNT campaign in 46 high risk districts.1st round of TT campaign conducted in April/May 2017 in 46 high risk districts in 8 Governorates (Al Baida, Socotra, Ibb, Al-Mahra, Hajjah, Dhamar, Sana'a Governoarate and Lahj). 36,774 Pregnant women and 323,140 WCBA (Women with Child Bearing Age) vaccinated in TT campaign. 2nd Round of TT campaign will be conducted in Oct 2017.

Indicator	Target	Achievement[9]
Penta3 Coverage	88%	86%
PCV3 Coverage	88%	86%
Rotavirus containing vaccine Coverage	88%	78%
IPV Coverage	88%	76%
MCV1 Coverage	86%	78%
% of districts with Penta3 coverage greater than 80%	86%	64%

7.Five rounds were conducted in country due to the delay in the agreement with the both agencies, delay in flow funds and snd drug supply. This has been the case for 2015 and may also happen in 2017



8.Measles mop up campaigns conducted in targeted governorates in 46 districts however there are certain areas in Yemen from where Measles outbreak were reported e.gAmran, Sa'ada, Seon, Al-Mahra etc.
9. Under the GAVI TCA support consultant deployed in target Governorates including Cold chain and vaccine management consultant in Sa'ada, Aden and Taiz, Governorate Operational consultant in Sa'ada, Aden and Taiz, C4D consultant in Sa'ada, Aden and Taiz and C4D consultant in Sana'a and Hodeiada. Two posts including Cold chain and vaccine management consultant and C4D consultant

[9]Administrative coverage

given to central level however the recruitment is in progress.
10.Cold Chain Equipment Optimization platform (CCEOP) application preparation activity started in 2016. Consultant for the activity was hired by UNICEF MEANRO and NYHQ who started the activity in Oct 2016. In initial phase she completed the assessment in central cold room and target health facilities in Hodeida and Sana'a Governorate and trained the master trainers regarding training of the assessors. Due to contractual issues the consultant came after break of 5 months in meantime teams of assessors were trained and they have start the data collection. Data regarding cold chain has been collected from 90% of the Health facilities and data entry is also in progress. This will be followed by development of CCEOP proposal by consultant.
11.Governorate EPI review was held in July in 2016 in Hajja (12 governorates) and in Ibb for the remaining 11. Central EPI review meeting held in Dec 2016.
12.NIDs conducted in Jan and April 2016. In Jan MR mop up conducted in 64 HRDs. (to be expanded). A national polio campaign were planned for august 2016 are not conducted.
13.Switch from tOPV to bOPV conducted successfully in April 2016.

4.2. Financial management performance (for all cash grants, such as HSS, vaccine introduction grants, campaign operational cost grants, transition grants, etc.)

Provide a succinct review of the performance in terms of financial management of Gavi's cash grants. This should take the following aspects into account:

- *Financial **absorption** and utilisation rates[10];*
- ***Compliance** with financial reporting and audit requirements;*
- *Major issues arising from cash programme **audits** or programme capacity assessments;*
- *Financial management **systems**[11].*

YEMEN - TOTAL COMMITMENTS - Inception to March 31, 2017

						Cash Balance		
	Recipient	Commited	Approved	Disbursed	Status	Cut off date	Source of Info	Amount US$
HSS1	MOPHP	6,335,000	6,335,000	6,335,000		31/12/2016	Financial statement	92,159
HSS2	HSS2	17,639,234						
	WHO		4,664,203	3,333,123		31/12/2016	Financial statement	591,728
	UNICEF		5,415,109	3,386,835		16/03/2017	email	7,675
	MOPHP		4,200,000	4,200,000		31/12/2016	Financial statement	223,803
INS		1,194,757	1,194,757	1,194,757	Closed			
ISS		5,049,500	5,049,500	5,049,500		31/12/2016	Financial statement	473,054
MR - Operational cos	MOPHP	7,533,500	7,533,500	7,533,500		31/12/2016	Financial statement	223,737
VIG Measles-Rubella	MOPHP	767,500	767,500	767,500				
VIG Penta	MOPHP	200,000	200,000	200,000	Closed			
VIG Pneumo	MOPHP	257,000	257,000	257,000	Closed			
VIG Rota	MOPHP	270,500	270,500	270,500	Closed			
VIG IPV	MOPHP	614,000	614,000	614,000		31/12/2016	Financial statement	132,158
		39,860,991	**36,501,069**	**33,141,715**				**1,744,314**

Funds available with MOPHP	1,144,911
Funds available with WHO	591,728
Funds available with UNICEF	7,675

Compliance:

- Financial statements have been received from WHO and MoPHP as of Dec 2016. UNICEF has provided the cash balances and financial report will be provided by HQ offices in June 2017 as stated in the Grant Agreement.
- MoPHP bank statements to support the cash balance reported are expected to be provided by

[10] If in your country substantial amounts of Gavi funds are managed by partners (i.e. UNICEF and WHO), it is recommended to also review the fund utilisation by these agencies.
[11] In case any modifications have been made or are planned to the financial management arrangements please indicate them in this section.

26 May.

- Audit for 2016 is currently ongoing and the report will be available at the end of June 2017.
- There are remaining balances of cash grants of approximately US$1.1 million with MoPHP. The use of these balances has been under discussion since 2015 and the Ministry is insisting to use the funds for the procurement of locally produced essential medicines for use in integrated outreach activities and operational costs. Gavi has conveyed to the Government that any procurement using Gavi funds needs to be done adhering to UNICEF procurement rules. is to submit a detailed proposal to use remaining funds with them to procure essential medicines.

Absorption:

- UNICEF funds for programme year 2015-2016 have been almost fully utilized. 2017 Funds have been disbursed in May 2017.
- 2018 workplan and budget is to be submitted by 1st of June.
- WHO has requested a no-cost extension for the utilization of the programme year 2015 funds disbursed in July 2016 until Dec 2017. Funds for 2016 funds have been disbursed in Feb 2017. Delays in the processing and clearance of grant agreement have delayed the disbursement of funds. The most critical impact of this fund flow has been delays in implementation of integrated outreach activities which as a result are concentrated towards the second half of the year for the third time in a row.

4.3. Sustainability and (if applicable) transition planning

Provide a brief overview of key aspects and actions concerning the sustainability of Gavi support to your country. Please specify the following:

- *Financing of the immunisation programme, including **co-financing** requirement: fulfilment of co-financing commitment.*
- ***Gavi transition planning**: if your country is transitioning out of Gavi support, specify whether the country has a transition plan in place. If no transition plan exists, please describe plans to develop one and other actions to prepare for transition.*
- *If a transition plan is in place, please provide information on the following:*
  - *Implementation progress of planned activities;*
  - *Implementation bottlenecks and corrective actions;*
  - *Adherence to deadlines: are activities on time or delayed and, if delayed, the revised expected timeline for completion;*
  - *Transition grant: specify and explain any significant changes proposed to activities funded by Gavi through the transition grant (e.g., dropping an activity, adding a new activity or changing the content/budget of an activity);*
  - *Submit a consolidated revised version of the transition plan.*
- ***Polio transition planning**: If your country is transitioning out of immunisation programme support from other major sources, such as the Global Polio Eradication Initiative, specify whether the country has a transition plan in place. If such a transition plan exists, please briefly describe it. If no transition plan exists, please describe plans to develop one and other actions to prepare for polio transition.*

Being one of the poorest countries in the region, Yemen has continually relied on external funding however the ongoing crises have exacerbated the reliance. Experience from 2015 and 2016, has shown continued commitment of the national health authority along with partners for maintaining the implementation of the public health programmes, despite availability and access to services due to security challenges that currently. The lack of domestic resources and shortage of human resources and other health system issues has major implications on sustainability of current health programmes in general and specifically EPI activities.

The MoPHP has been receiving funds directly from GAVI since 2008, initially through HSS1 and then HSS2 till 2014. Due to crisis in march 2015 the GAVI like other donors decided to channelized the funds

through UNICEF and WHO to ensure the continue support to EPI programme and other health programmes. The government of Yemen was paying for traditional vaccines and its co-financing share of the cost of the GAVI vaccines on timely manner as scheduled with GAVI, but has become unable to fulfill this commitment after crisis in 2015 which became deteriorated in 2016. MoPHP requested GAVI to give them waiver for 2015, 2016 and 2017 and they also requested UNICEF for pay for the traditional vaccine and also pay their share for GAVI vaccines under co-financing agreement. UNICEF has been supporting MoPHP since 2015 regarding procurement of traditional vaccines and GAVI share under co-financing.

According to reports most of the Health facilities and EPI centers have been non –functional or partially functional due to various reasons including damage to Health facilities, demotivation of staff due to not receiving the salaries since more than 08 mths, security reasons etc. There is urgent need to boost the moral of health staff to make the health facilities functional by providing them incentives and other supplies.

In view of the current resources constraints, dependency on the external resources and to ensure equal access to essential services to maximize efficiency as a principle, the national health authority along with technical support from WHO and in collaboration with UNICEF working on the development of the minimum service package as per current national priority, to guide the delivery of health services by the level of care. Hence, this needs to be taken into account, along with the lessons learnt from the pilot projects to guide the partners' support, including that of GAVI's.

To ensure the sustainability and improving the health services in general and EPI specifically in current scenario and within the available resources following actions need to be taken;

1. Empowering the districts/governorates to take immediate decisions/steps to improve routine EPI
2. The Routine EPI coverage at the district level need to be improved through functionalization of EPI centers through making the cold chain equipment functional, updating the microplans, training of staff, effective vaccine management and ensuring access to children and PL/WCBA.
3. There are needs to ensure timely implementation of quality Integrated Outreach Rounds with introducing such strategies which are more cost effective and access to all children irrespective of sex, educational level etc.
4. Improve the quality of health services through timely provision of commodities, supplies and capacity of HRs involved in the activities and timely transfer of funds.
5. Improvement in reporting of data from field level to the central level and partners especially the IMCI, RH and Nutrition.
6. Focus on communication activities especially in areas where there is lack of awareness and high number of refusals and rumors.

Polio Status

The last lab-confirmed case of wild polio virus (WPV) in Yemen occurred in 2006, at the tail end of an outbreak that started in 2005 from cases imported from Africa, resulting in 478 cases of paralysis among children – one-third of the global polio burden in 2005. The country was declared polio-free in 2009. Since then, there have been three outbreaks of vaccine-derived polio virus (VDPV) in 2011 and 2013, but few VDPV cases after 2013, which has been attributed to improvements in AFP/polio surveillance and to a series of high-quality, large-scale vaccination campaigns conducted from 2011 to 2014 in response to the VDPV outbreaks.[12]

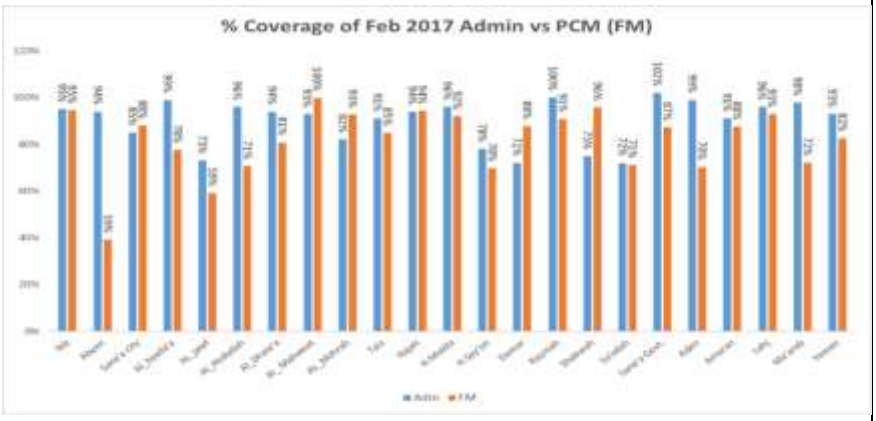
To maintain its polio-free status and upon recommendation of the regional polio technical advisory group, the county has continued to conduct national polio vaccination campaigns (NIDs) since the conflict began. These include two rounds both in 2015 (in August and November) and in 2016 (January and April), each reaching 4.5 to 4.8 million children under the age of five, out of a target of approximately 5.1 million (88-94%)[13] and another round in 2017 (see below). The original plan was to conduct four rounds in 2016, but two were postponed due to insecurity.

[12]One case was found in Aden in 2016, according to the UNICEF country office.

[13] Presentation on Routine Immunization Activities given at the 2017 Joint Appraisal meeting, May 15-17, 2017, Beirut.

Yemen also introduced IPV in the routine programme in November 2015 and made the switch from the trivalent to the bivalent OPV in April 2016.

Is the country considered at high risk of polio transmission?



A recent analysis conducted by EMRO found the country to be at "medium-high" risk of WPV importation and spread or the emergence of VDPV.[14] This assessment was based on the potential pool of susceptible children resulting from low (<80%) vaccination coverage rates in previous campaigns in several areas (with a population of ≈400,000 children), the lack of recent polio campaigns in two districts, and a decline in the routine programme since the conflict began. Population movement, including a large IDP population and immigration from high-risk countries, was another factor. The assessment also found a low to medium risk of undetected or delayed detection of polio cases due to the fact that 41% of districts did not meet the targets for two key surveillance indicators (a non-polio AFP rate of >2 per 100,000 children under 15 and a stool adequacy rate of >80%) – with 27% of districts meeting neither target. According to official government data, the country as a whole meets both indicators – with a non-polio AFP rate of 5.3 per 100,000 and a stool adequacy rate of 91%. The country's capacity to respond rapidly to an outbreak was judged as medium-high.

What needs to be done to keep Yemen polio free?

To prevent the reemergence of polio in this conflict-ridden country, Yemen, with WHO, UNICEF and World Bank assistance, conducted another national OPV campaign in February 2017, reaching 4.8 million children under five years of age, for an estimated coverage of 93%, according to an independent monitoring report.[15] The campaign made special efforts to target IDPs and refugees, and engaged health workers, volunteers, religious leaders and local council officials in mobilizing their communities. A survey found relatively high population awareness of the campaign – 79% -- due to a wide-ranging communications campaign that included SMS messages, radio and TV announcements, and social mobilization through mosques, schools and community health workers. The three-day, door-to-door campaign – involving an estimated 40,000 vaccinators – reached children in areas where the violence has intensified, such as Sa'ada governorate, and has cut off access to health services.[16]

A key factor in the successful implementation of this and other recent SIAs since the conflict began has been the establishment by the EPI Task Force of an EPI emergency operations room within the MoPHP in Sana'a, and parallel structures in the governorates. The central emergency operations room, which includes a central hotline, allows daily coordination and communications with the governorates to make sure that they and the districts receive vaccines, IEC materials and other supplies during the campaigns, and that any bottlenecks are resolved quickly. In Operation room there are 15 staff during Integrated Outreach Rounds and 11 staff during Polio campaigns.

A second OPV round is scheduled for July/August in 2017. Additional SIAs are not at present being

[14] "Poliovirus risk analysis for conflict-affected polio-free countries", EMRO, December 2016 presentation, found at: http://polioeradication.org/wp-content/uploads/2017/04/Risk-Assessment_Specific_EMR_Countries_2017.pdf.

[15] Presentation on Routine Immunization Activities given at the 2017 Joint Appraisal meeting, May 15-17, 2017, Beirut.

[16] WHO press releases (complete citation).

planned and instead the focus will be on improving polio vaccination coverage through integrated outreach rounds, mobile teams, and at fixed facilities. Maintaining AFP/polio surveillance and improving it in low-performing areas will also be critical to preventing polio from re-emerging in the country.

4.4. Technical Assistance (TA)

Briefly summarise key insights generated during the appraisal of Gavi supported Targeted Country Assistance (TCA) activities and milestones.[17] Specify whether amendments to the currently planned and ongoing Technical Assistance activities and milestones are envisaged (short term). If changes are envisaged please provide a justification.

Note: New Technical Assistance requirements for the next calendar year should be indicated in section 6 rather than this section.

GAVI PEF TCA through UNICEF (2017)

Under the GAVI TCA support, several consultants were deployed in several Governorates to provide technical assistance on cold chain equipment and vaccine management, C4D and governance and management.

A cold chain and vaccine management consultant and a governorate operational consultant supported Sa'ada, Aden and Taiz. C4D consultant supported Sa'ada, Aden, Taiz, Sana'a and Hodeiada governorates.

Two posts including a cold chain and vaccine management consultant and a C4D consultant are to be provided to the central level EPI programme, recruitments are undergoing.

S.No	Position	Level	Implementation Status
1	C4D Consultant	GHO Hodieada	Recruited
2	C4D Consultant	GHO Aden	Recruited
3	C4D Consultant	GHO Sana'a	Recruited
4	C4D Consultant	GHO Sa'ada	Recruited
5	C4D Consultant	GHO Taiz/Ibb	Recruited
6	Cold Chain & Vaccine Management Consultant	GHO Sa'ada	Recruited
7	Cold Chain & Vaccine Management Consultant	GHO Taiz/Ibb	Recruited
8	Cold Chain & Vaccine Management Consultant	GHO Aden	Recruited
9	Governorate Operational Consultant	GHO Sa'ada	Recruited
10	Governorate Operational Consultant	GHO Taiz/Ibb	Recruited
11	Governorate Operational Consultant	GHO Aden	Recruited
12	C4D Consultant	Central Level, MoPHPP	Recruitment in Process
13	Cold Chain & Vaccine Management Consultant	Central level, MoPHPP	Recruitment in Process
14	Immunization Specialist	UNICEF, Yemen Country Office	Recruited
15	Immunization Officer	UNICEF, Yemen	Recruited

[17] A summary of Technical Assistance approved under Gavi's Partner Engagement Framework (PEF) for the year under review and reporting status can be accessed via the PEF portal by registered users, or by contacting the Gavi Secretariat.

		Country Office	

Participants from MoPHP appreciated the support of GAVI and UNICEF regarding provision of HR support and filing critical gaps regarding HR however they recommended that there is need to strengthen linkages and coordination between staff working at the Governorate level and EPI staff at MoPHP at central level. There were recommendations to identify the focal point at EPI-MoPHP who will be look after the GAVI HR support at Governorate level.

Three UNICEF positions under the GAVI TCA support 2017 have been approved and the recruitment is in process.

Gavi PEF TCA (2017) through WHO

Under Gavi PEF TCA (2017) following positions were supported by Gavi

- International P4 for Immunization and Surveillance - 1
- National (NOC) Immunization and Surveillance -1
- National (NOB) for Data – 1

The NOC and NOB positions are filled, but the International Position P4 for Immunization and Surveillance was not filled. However WHO used partially the funds for P4 to support partially the P5 position of Deputy WR who also works as overall coordinator of Gavi support in the country.

For Gavi PEF TCA (2018) through WHO and remaining part of 2017

Considering that a P4 position for EPI supported by CDC is under process of recruitment, it is proposed that, Instead of international P4 for immunization and surveillance under the Gavi PEF TCA, the following additional staff for immunization is recruited :

- NOB for Immunization at Sub national level – 2
- G5 – Administration and Finance – 1 (National level)
- G-5- Programme Assistant -1 (National level)

It is further proposed that 50% of salary of P5 position of Deputy WR is paid as overall coordinator of Gavi support.

HSS3 Application Development

TA required for development of HSS3 support. This requires to be mobilized as soon as possible and if funding is needed, re-allocation of 2018 tranche may be considered. In addition Regional and country office contribution is expected.

MoPHP expressed needs to strengthen the coordination\supervision between central EPI and consultants at governorate level. This could be achieved by recruiting a focal point at central EPI level to be GAVI TCA focal point and by developing ToRs for sharing monitoring reports between governorates and central EPI

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Provide the status of the prioritised strategic actions identified in the previous Joint Appraisal[18] and any additional significant IRC or HLRP recommendations (if applicable).

[18] Refer to the section "Prioritised Country Needs" in last year's Joint Appraisal report

Prioritised actions from previous Joint Appraisal	Current status
1. Regular review meetings (analytical desk review bi-annually at National; quarterly at Governorate and monthly at district level)	● End of year EPI review for national level was held in December 2016. ● Governorate level meeting for 12 governorates was held in Hajja in 2016 (funded by EMPHNET) ● Governorate level meeting for 11 governorates was held in Ibb in 2016 (funded by EMPHNET) ● District level meetings could not be held in 2016 because of both funding and access issues
2. Microplanning to be updated on an annual basis in general and in districts where there are significant changes to be updated bi-annually.	● With support from UNICEF, workshops were conducted in 21 Governorates (among 23) to update micro-plans. Participants were from EPI, Nutrition, IMCI, RH and the workshops were facilitated by national level EPI. ● For the remaining 6 governorates, the delay is related to the competing priorities and the difficulty to transfer money to the governorate.
3. Undertaking quality and timely Integrated Outreach Activities	● In 2016, five Integrated Outreach Rounds were conducted in all governorates (with exception of Al Jouf where 4 rounds were conducted). Those rounds were mainly supported by GAVI and WB through UNICEF and WHO.
4. Inventory/Assessment of cold chain equipment and development of replacement plan of cold chain equipment towards developing CCEOP application.	● Assessment of the CCE: data regarding cold chain has been collected from 90% of the Health facilities with UNICEF support in March 2017. This will be followed by development of CCEOP proposal by a technical consultant.
5. Comprehensive EPI review and EVMA (subject to security situation) and review of integrated outreach rounds.	● Not conducted due to the security situation (difficulties to get the external reviewers to access the country). ● EVM was not conducted because of security issues. ● Capacity building exercise to be implemented before the EVM (2018).
6.Update communication plan and implementation of the key defined activities.	● Communication strategy developed and endorsed by MoPHP and PM office. ● Communication plans updated (and endorsed by MoPHP).
7.Support operational cost (at the governorate and district)	● Using GAVI funds, UNICEF provided fuel to the central cold room and all governorates and district cold rooms (107,000 Litres per quarter). ● WHO provided fuel to selected hospitals. ● To note that because of the government financial situation, no additional support is

	provided by the government for operational costs.
8. A. Gas for cold chain, transportation of vaccines B. Supervision	● UNICEF has been providing support for transportation of vaccines from central cold room to Governorate cold rooms and from Governorates to districts. ● UNICEF and WHO supported monitoring and supervision at central, governorate and district level.
Additional significant IRC / HLRP recommendations (if applicable)	**Current status**

If findings have not been addressed and/or related actions have not taken place, provide a brief explanation and clarify whether this is being priorities in the new action plan (section 6 below).

6. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND TECHNICAL ASSISTANCE NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

*Briefly outline the **key activities to be implemented next year** with Gavi grant support.*

*In the context of these planned activities and based on the analysis provided in the above sections, describe the five **highest priority findings and actions to be undertaken to enhance the impact of Gavi support**, indicating timelines and Technical Assistance needs.*

Please indicate if any modifications to Gavi support are being requested, such as:

- *Changes to country targets as established earlier, either from the agreed Grant Performance Framework (GPF) or as part of the NVS renewal request submitted by 15 May;*
- *Plans to change any vaccine presentation or type;*
- *Plans to use available flexibilities to reallocate budgeted funds to focus on identified priority areas.*

Note: When specifying Technical Assistance needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning, which will be informed by the needs indicated here.

Overview of key activities planned for the next year:

Key finding 1	**Difficult to access to certain pockets *(Hard to reach and Security Compromised areas etc)* for vaccinationto enhance immunization coverage. Some population are not fully reached (e.g. IDPs); inequity persists. There is a need to identify and localize unreached children, analyse bottlenecks, review strategies used and propose improvements and possibly new strategies.**
Agreed country actions	● Situation analysis regarding non/under vaccinated children o IDPs coverage and access to immunization services (tracking population,

		coverage survey) o Equity\bottle-necks analysis (following UNICEF workshop July 2017) ● Assessments of immunization strategies in regards of capacity to reach the unreached children (outreach, outreach plus, fixed and mobile) ● Explore possible other immunization strategies to reach under/non vaccinated children ● Review integrated approach (modalities, achievements, mapping, use of the outreach activities to strengthen the referral health facilities)
	Associated timeline	2018
	Technical assistance needs	Discussion will be done with MoPHP and necessary technical assistance needed will be reflected in TCA
	Key finding 2	**The EPI programme is facing huge human resource issues including lack of technical knowledge and capacities, low motivation, staff not receiving their salaries and insufficient staffing**
	Agreed country actions	HR all levels governorates, districts including CHVs/CHW ● Technical capacities, training: MLM, vaccine management cold chain, CHVs/CHWs refresher. ● Development of EPI modules (for various targets, using competency based approach), e.g. Training of Community Health workers (CHWs)/ volunteers (CHVs)
	Associated timeline	2018
	Technical assistance needs	
	Key finding 3	**Following the conflict and possibly rumour based vaccine side effects population trust in government and vaccines have decreased in some specific areas and populations**
	Agreed country actions	● Development and implementation of a plan to combat Vaccines Hesitancy ● Updated communication/risk management plans ● Communities and C4D Activities
	Associated timeline	2018
	Technical assistance needs	
	Key finding 4	**Cold chain equipment and vaccine management system are outdated putting the vaccines at risk**
	Agreed country actions	● EVM and CCEOP implementation
	Associated timeline	2018-2019
	Technical assistance needs	

Key finding 5	**MoPHP need technical assistance to prepare the HSS application and to ensure coordination at the MoPHP for all GAVI grant management (planning officer)**
Agreed country actions	● Preparation of GAVI HSS application in the context of the new approach ● Ensure management and monitoring and evaluation for all Gavi grants
Associated timeline	2018-2019
Technical assistance needs	
Key finding 6	**Immunization programme needs improved planning of activities, monitoring and evaluation and reporting at all levels (national, governorates and districts)**
Agreed country actions	● Updating Microplans at governorates level ● cMYP updated including measles 5 years plan
Associated timeline	2018
Technical assistance needs	Consultants will be hired to undertake the task of development of 5 years MR plan and cMYP

7. JOINT APPRAISAL PROCESS, ENDORSEMENT BY THE NATIONAL COORDINATION FORUM (ICC, HSCC OR EQUIVALENT) AND ADDITIONAL COMMENTS

Briefly describe how the Joint Appraisal was reviewed, discussed and endorsed by the relevant national Coordination Forum (ICC, HSCC or equivalent), including key discussion points, attendees, key recommendations and decisions, and whether the quorum was met. Alternatively, share the meeting minutes outlining these points.

If applicable, provide any additional comments from the Ministry of Health, Gavi Alliance partners, or other stakeholders.

Actions	Deadline	Comments	Focal Point
JA report finalization	01-Jun	* Gavi to review the draft report and share with JA participants (19 May) * JA participants to provide input by (26 May) * Gavi to share final JA report (1 June)	
HSS2 - 2018 Budget finalization	01-Jun	* Provide budget assumptions and breakdowns per activity line and justification on reallocation of funds using Gavi template * Gavi to review and approve	MoPHPP: Dr Ali J. WHO: Dr AbdulNasser UNICEF: Dr Bilal
CMYP finalization	01-Sep		WHO: Dr Akjemal

PEF TCA 2018	30-Sep	* Gavi to share form and updated guidance (26 May) * In country partners to finalize the costing of TA needs in GAVI form (30 Sept) * TC or workshop with RO and HQ offices for validation (tbc)	MoPHPP: Dr Ali J. WHO: Dr AbdulNasser UNICEF: Dr Bilal
MR campaign Application	21-May	* MoPHP to provide answer to the clarifications requested	MoPHPP: Abdul H. WHO: Dr AbdulNasser Dr Irtaza UNICEF: MoPHPammad Ibrahim / Dr Bilal
New HSS Grant	30-Jun	* MoPHP definition of priorities * Planning workshop September * Proposal preparation	WHO: Dr Akjemal
Integrated Outreach		*Review of the integrated outreach approach	
MoPHP Balances		* Approval of reallocation and updated workplan and budget for utilization of funds left with the MoPHP	
HSS2 End of grant evaluation		* Plan for end of grant evaluation HSS2	
HSS 3 Workshop		*Concept note including plan and budget for next HSS grant will be prepared and shared	

8. ANNEX

Compliance with Gavi reporting requirements

Please confirm the status of reporting to Gavi, indicating whether the following reports have been uploaded onto the Country Portal.

It is important to note that delayed reporting may impact the decision by Gavi to renew its support.

	Yes	No	Not applicable
Grant Performance Framework (GPF) reporting against all due indicators	X		
Financial Reports			
Periodic financial reports		X	
Annual financial statement	X		
Annual financial audit report		X	Due in June 2017

End of year stock level report	X		
Campaign reports			X
Immunisation financing and expenditure information		X	
Data quality and survey reporting			
Annual desk review		X	Will take place in Sept 2017
Data quality improvement plan (DQIP)		X	DQS will take place in Sept 2017 and will lead to the development of the DQIP
If yes to DQIP, reporting on progress against it			
In-depth data assessment (conducted in the last five years)	X		
Nationally representative coverage survey (conducted in the last five years)	X		
Annual progress update on the Effective Vaccine Management (EVM) improvement plan		X	Tbc?
Post Introduction Evaluation (PIE)			X
Measles-rubella 5 year plan		X	This will be added to the Cmyp update in 2018
Operational plan for the immunisation program			?
HSS end of grant evaluation report		X	End of grant evaluation has been budgeted and is planned to take place in 2018
HPV specific reports			X
Transition Plan			X

In case any of the required reporting documents is not available at the time of the Joint Appraisal, provide information when the missing document/information will be provided.
