Application Form for Gavi NVS support

Submitted by

The Government of

Yemen

Date of submission: **3 May 2017**

Deadline for submission:

i. **3 May 2017**
ii. 3 May 2017
iii. 1 September 2017

Select Start and End Year of your Comprehensive Multi-Year Plan (cMYP)

Start Year	2016	End Year	2020

Form revised in 2016

(To be used with Guidelines of December 2016)

Note: Please ensure that the application has been received by Gavi on or before the day of the deadline.

Gavi
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

The applicant country ("Country") confirms that all funding provided by the Gavi will be used and applied for the sole purpose of fulfilling the programme(s) described in the Country's application. Any significant change from the approved programme(s) must be reviewed and approved in advance by the Gavi. All funding decisions for the application are made at the discretion of the Gavi Board and are subject to IRC processes and the availability of funds.

AMENDMENT TO THE APPLICATION

The Country will notify the Gavi in its Annual Progress Report if it wishes to propose any change to the programme(s) description in its application.The Gavi will document any change approved by the Gavi, and the Country's application will be amended.

RETURN OF FUNDS

The Country agrees to reimburse to the Gavi all funding amounts that are not used for the programme(s) described in its application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the Gavi, within sixty (60) days after the Country receives the Gavi's request for a reimbursement and be paid to the account or accounts as directed by the Gavi.

SUSPENSION/ TERMINATION

The Gavi may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in the Country's application, or any Gavi-approved amendment to the application. The Gavi retains the right to terminate its support to the Country for the programmes described in its application if a misuse of Gavi funds is confirmed.

ANTICORRUPTION

The Country confirms that funds provided by the Gavi shall not be offered by the Country to any third person, nor will the Country seek in connection with its application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the Gavi, as requested. The Gavi reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how Gavi funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of Gavi funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the Gavi in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the Country confirm that its application, and Annual Progress Report, are accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programmes described in its application, as amended, if applicable, in the APR.

CONFIRMATION OF COMPLIANCE WITH THE Gavi TRANSPARENCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the Gavi Transparency and Accountability Policy (TAP) and complies with the requirements therein.

USE OF COMMERCIAL BANK ACCOUNTS

The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage Gavi cash-based support. The Country confirms that it will take all responsibility for replenishing Gavi cash support lost due to bank insolvency, fraud or any other unforeseen event.

ARBITRATION

Any dispute between the Country and the Gavi arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the Gavi or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland

. The languages of the arbitration will be English or French.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the Gavi. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The Gavi and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The Gavi will not be liable to the country for any claim or loss relating to the programmes described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in its application.

1. Type of Support requested

Please specify for which type of Gavi support you would like to apply to.

Type of Support	Vaccine	Start Year	End Year	Preferred second presentation[1]
NVS follow-up campaign	MR, 10 dose(s) per vial, LYOPHILISED	2018	2018	Not applicable

[1] Gavi may not be in a position to accommodate all countries first product preferences, and in such cases, Gavi will contact the country and partners to explore alternative options. A country will not be obliged to accept its second or third preference, however Gavi will engage with the country to fully explore a variety of factors (such as implications on introduction timing, cold chain capacity, disease burden, etc.) which may have an implication for the most suitable selection of vaccine.

If applying for any type of measles and/or MR support, summarise in the text box below the indicative major measles and rubella activities planned for the next 5 years (e.g. MCV2 introduction, measles or MR follow-up campaign, etc.).

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3. Executive Summary

Please provide a summary of your country's proposal, including the following the information:

- For each specific request, NVS routine support or NVS campaign :
  - The duration of support
  - The total amount of funds requested
  - Details of the vaccine(s), if applicable, including the reason for the choice of presentation
  - Projected month and year of introduction of the vaccine (including for campaigns and routine)

- Relevant baseline data, including:
  - DTP3 and Measles coverage data (as reported on the WHO/UNICEF Joint Reporting Form)
  - Target population from Risk Assessments from Yellow Fever and Meningitis A
  - Birth cohort, targets and immunisation coverage by vaccines

- Country preparedness
  - Summary of planned activities to prepare for vaccine launch, including EVM assessments, progress on EVM improvement plans, communication plans, etc.
  - Summary of EVM assessment and progress on EVM improvement plan

- The role of the Coordination Forum (ICC/HSCC or equivalent) and stakeholders' participation (e.g. government, key donors, partners, key implementers, CSOs) in developing this proposal

- Follow up campaign

  Globally, measles mortality has decreased remarkably, but efforts for measles and rubella control have also shown challenges. While the routine measles first dose (MCV1) coverage has increased globally from 73% in 2000 to 83% in 2009, this coverage has stalled and remained at 77-78% since 2010 in Gavi 73 countries. Other challenges include financial and programmatic sustainability for countries, determination of the target age group and ensuring high quality of campaigns. There are also concerns around campaigns being costly, detracting resources away from routine immunisation activities and possibly creating perverse monetary incentives. Measles activities are also being planned in isolation from other immunisation interventions with inadequate planning, budgeting and implementation processes.
  A comprehensive approach is essential to bringing about lasting reductions in measles and rubella morbidity and mortality. Uniformly high and timely routine immunisation coverage in every country, every year is the cornerstone for achieving continuously high levels of population immunity.
  In this regard, Gavi's Board in December 2015 endorsed Gavi's new measles and rubella strategy, whose aim is to provide a single coherent approach to measles and rubella, primarily at increasing routine immunisation coverage, putting a strong focus on measles-rubella control. Routine immunisation will be complemented, as needed, by higher-quality, better-planned, more targeted and independently monitored campaigns.
  The strategy supports a more comprehensive approach to measles and rubella, over a longer time period. Rather than offering support to campaigns and routine immunisation as separately planned, budgeted and implemented activities, Gavi is supporting countries to plan and deliver a coherent, integrated set of measles and rubella disease control activities. Countries will now be required to self-finance the first dose of measles vaccine in their national immunisation programme, and have a long term budgeted plan for measles and rubella activities, to ensure financial and programmatic sustainability.
  Preventive vaccination campaigns and the introduction of new vaccines such as MR vaccine can be used as strategic opportunities to improve routine immunisation, for example by supporting microplanning to identify underserved populations. These opportunities need to be aligned with countries' expressed needs and priorities for routine immunisation to ensure that they address recognised gaps or problems. It is therefore recommended that as countries develop their applications for measles and rubella support, they coordinate and align such requests with their applications for HSS support. Joint Appraisals and reviews of support should be used to ensure such linkages. This will help harmonise measles and rubella and HSS inputs, avoid possible redundancies and help maximise the effect of measles and rubella activities on strengthening the overall immunisation programme.

Gavi will support periodic measles follow-up campaigns at national or subnational levels, for Gavi-eligible countries which have not yet introduced MR, with a focus on children up to 5 years of age; noting that the timing, target age range, and geographical scope should be based on epidemiological data, and modelling wherever possible.
For Gavi-eligible countries which have introduced MR, support is available for periodic MR follow-up campaigns, again noting that the timing, target age range, and geographical scope should be based on epidemiological data, and modelling if available.

Measles vaccine was introduced in routine immunization at 9 months of age in 1964.

The second dose of measles vaccine was introduced at 18 months of age in 2003.

MR vaccine was introduced at 9 and 18 months of age to replace the single antigen measles vaccine in early 2015 following the MR catchup campaign in November 2014.

In Nov 2014 EPI- MoPHP introduced MR vaccine in Yemen and to boost the MR coverage it was decided to do MR campaign in Yemen. Nationwide campaign was conducted and 11,368,968 million children (93%) (9mths -15 yrs) were vaccinated against target 12,210,081 million. To sustain the high coverage which was achieved through nationwide round there was need to do strengthen the Immunization through fixed EPI centres and Integrated Outreach rounds however the beginning in March 2015 of the armed conflict as well as its ramifications on security, political situation, trade, livelihoods, basic service delivery have had direct and indirect impact on all spheres of life. The war has involved most of the governorates (esp Aden, Taiz, Sa'ada, Abyan, Lahj, Al-Dhale, Marib, Amran, Sana'a, Ibb, Al-Jawf, Hajja, Al Baida and Hodeida) and led to destruction of both public and private infrastructures; and caused the suspension of most of economic and investment activities. Beside other implications vaccination through fixed site and outreach sessions reduced significantly with Penta 3 and Measles 1 coverage in May/June 2015 being 15 to 25% below the coverage at the same time in 2014 and there were significant delays in starting Integrated outreach and immunization campaigns which were initially scheduled for April & May 2015 but could not be started till July & August, respectively. Measles coverage was tremendously reduced in 1st quarter of 2015. Measles cases were reported from various areas mainly from Sa'ada, Aden, Aljwaf, Lahj, Amran, Abyan Governorates.

The EPI- MoPHP in collaboration of UNICEF and WHO done the detail risk assessment exercise and identify the high, medium and low risk districts. It was decided that MR campaign will be conducted in two rounds, first High risk districts will be covered followed by Medium risk. Following the conflict, in August 2015 1st phase of MR mop-up round was conducted in 62 high risk districts targeting approx. 1.8 million children 6 months to 15 years of age with 1.59 million (88%) vaccinated and 2nd phase of MR mop up round was conducted in January 2016 targeting 2.63 million children from 6mths-15 yrs in 64 high-risk districts with 2.42 (92%) million vaccinated and because of the two mop up campaign number of reported cases and outbreaks were greatly reduced.

Although in 2016 Measles and Rubella cases have been reduced as compared to 2015 but still measles cases numbers are remain high. By December 2016, the total suspected cases reached 3417, 56 of which were classified as rubella and 144 were classified as measles. Measles cases were distributed in almost all governorates, 6 measles outbreaks were declared in 6 governorates (Shabwa, Aden, H.Sayeun, Amran, Saadah and Al -Maharah) resulting in 5 deaths due to measles. An increase in Rubella cases in older age groups (above age of 10 years), and to a lesser extent for measles was noticed especially in Al -Maharah outbreak where the majority of cases were above 20 years of age. As a result of the ongoing war that started at the beginning of 2015, several reporting sites were closed, more areas are considered hard to reach due to insecurity reasons or destruction of roads infrastructure, and this in turn increased the risk of having unreported cases and the occurrence of measles outbreaks. This is also associated with limited measles and rubella lab kits in the national lab, leaving more than 2000 cases pending, hence, more cases of both measles and rubella are still to be confirmed. Another key challenge to measles vaccination is lack of awareness about Measles, rumours about vaccination and refusals by families in some areas.

The vaccination profile of all suspected measles cases in 2016 showed that 40% were zero dose, 11% received one dose and 46% received 2 doses. 22% of the cases are under 1 yr, 24% cases are from 1-5 yrs, 34% cases are from 5-10 yrs, 6% are from 10-15 yrs, 1 % from 15-20 yrs and 3% from above 20 yrs. In addition, suspected Rubella cases in 2016 shwed 17% of the cases are above10 years. Keeping in view the current status of outbreaks and morbidity and mortality due to Measles cases MoPHP decided to do nationwide follow-up campaign targeting children from 6months - 15 years of age.

Justifications for targeting the age group of 6months to 15 years for the follow up campaign can be summarized as follows;

1. High prevalence of malnutrition among infants.
2. the relative low routine MR coverage (75%) in 2015, and recent introduction of the vaccine in 2014, which increases the epidemiological risk by shifting age of Rubella infection to a higher age group.
3. Current surveillance data revealed that there are confirmed Rubella cases (17%) and measles cases (11%) above 10 years.
4. 3.3 million people are IDPs and mostly they moved from security compromised areas to populated areas and living in host communities so there is high risk of outbreak (High epidemiological risk)
5. Continued unstability of security situation, wide spread and non-fixed armed confrontation lines, which further compromises access to health services.

MoPHP will be submitting the proposal to GAVI to get the funds for the vaccines, operational and communication cost of campaign. Nationwide campaign will be conducted in March 2018. Keeping in view the age groups of the reported cases campaign will be conducted form 6mths-15 yrs. Campaign will be conducted for 6 days. Vitamin A will be given along with Measles vaccines. Although campaign will be nationwide but there will be more focus on security compromised and high risk areas like Aden, Taiz, Sa'ada, Abyan, Lahj, Al-Dhale, Marib, Amran, Sana'a, Ibb, Al-Jawf, Hajja and Hodeida and especially those governorates where cases have repeatedly reported i-e Shabwa, Aden, H.Sayeun, Amran, Saadah and Al – Maharah. Planning meeting will organized at central and governorate level. Social mobilization and communication plan will be developed for creating awareness about the Measles campaign and all stake holders will be involved before and during the campaign to increase the acceptance and coverage during campaign. Micro plans will be developed for the operational activities. In security compromised areas meetings will be held with groups, influential to ensure access to inaccessible and semi inaccessible areas. Campaign will be conducted for 6 days through outreach points. The campaign activities will be supervised and monitored at each level. Campaign activities will be evaluated after the round.

Through this campaign major gaps regarding Measles coverage will be filled especially high risk districts/governorates and resultantly will help in Measles elimination.

4. Signatures

4.1. Signatures of the Government and National Coordinating Bodies

4.1.1. Government and the Inter-Agency Coordinating Committee for Immunisation

The Government of Yemen would like to expand the existing partnership with the Gavi for the improvement of the infants routine immunisation programme of the country, and specifically hereby requests Gavi support for:

MR, 10 dose(s) per vial, LYOPHILISED follow up campaign

The Government of Yemen commits itself to developing national immunisation services on a sustainable basis in accordance with the Comprehensive Multi-Year Plan presented with this document. The Government requests that the Gavi and its partners contribute financial and technical assistance to support immunisation of children as outlined in this application.

Table(s) **8.2.2** in the NVS follow-up campaign of this application shows the amount of support in either supply or cash that is required from the Gavi.Table(s) **8.2.3** of this application shows the Government financial commitment for the procurement of this new vaccine (NVS support only).

Following the regulations of the internal budgeting and financing cycles the Government will annually release its portion of the co-financing funds in the month of **Not Selected**.

The payment for the first year of co-financed support will be around **January 2018** for MR, 10 dose(s) per vial, LYOPHILISED.

Please note that this application will not be reviewed or recommended for approval by the Independent Review Committee (IRC) without the signatures of both the Minister of Health and Minister of Finance or their delegated authority. These signatures are attached as DOCUMENT NUMBER : 1 and 2 in Section 10. Attachments.

Minister of Health (or delegated authority)		Minister of Finance (or delegated authority)	
Name	Dr. Abdulsalam Al Madani, Deputy MoH for PHC	**Name**	Mr. Mohammed AlJunaid, DG of Finance

Date		Date	
Signature		Signature	

This report has been compiled by (these persons may be contacted in case the Gavi Secretariat has queries on this document):

Full name	Position	Telephone	Email
Dr Ali Jahhaf	DG-Family Health	+967 773 612 558	aljahhaf@yahoo.com

4.1.2. National Coordination Forum (Interagency Coordinating Committees (ICCs), Health Sector Coordinating Committees (HSCCs), and other equivalent bodies)

To be eligible for support, Gavi asks countries to ensure a *basic* functionality of their Coordination Forum (ICC/HSCC or equivalent body). Countries can demonstrate this by adhering to the requirements listed in section 5.2 of the General Guidelines. The information in this section and a set of documents submitted along with this application will help the Independent Review Committee (IRC) to assess adherence.

Profile of the Coordination Forum

Name of the Forum	HSCC
Organisational structure (e.g., sub-committee, stand-alone)	a committee with steering functions to oversee implementation and achievements of the support

The Terms of Reference for the Coordination Forum is attached as DOCUMENT NUMBER : 4. The Terms of Reference should include all sections outlined in Section 5.2 of the General Guidelines..

Please describe the role of the Coordination Forum and stakeholders' participation (e.g. government, key donors, partners, key implementers, CSOs) in developing this proposal:

- Approving all action plans submitted by MoPH&P;
- Supervising implementation of the various activities;
- Advocating for political commitments and financial support;
- Incorporating health issues within the national development plans;
- Putting health issues high on the political agenda;
- Fund raising in support of health initiatives;
- Involving local communities in health interventions;
- Mobilizing resources for the health system;
- Social mobilization and communication related to behaviour change initiatives;
- Supporting the MOPH&P in applying community based initiatives.
- To mobilize and coordinate support from government, partner agencies and others to strengthen EPI
- To develop a national policy framework for vaccines and immunization and approve addition of new vaccines and technologies to EPI as and when feasible.
- To advocate for increasing commitment to immunization at all levels.
- To advise on national strategic and financial planning.
- To ensure co-ordination among partners and government in planning and implementation of EPI
- To assess the EPI program activities
- To develop and monitor EPI communication and social mobilization plan
- To provide MoPH&P with EPI related technical advices

4.1.3. Signature Table for the Coordination Forum (ICC/HSCC or equivalent body)

We the members of the ICC, HSCC, or equivalent committee *[1]* met on the **17/01/2017** to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes from the meeting endorsing the proposal and of the meetings of the past 12 months are attached as Document number 5. The signatures endorsing the proposal are attached as Document number 7 (please use the list for signatures in the section below).

Function	Title / Organisation	Name	Please sign below to indicate the	Please sign below to indicate the

			attendance at the meeting where the proposal was endorsed	endorsement of the minutes where the proposal was discussed
Chair	Deputy minister of PHC	Dr. Abdulsalam Al Madani		
Secretary	DG Family Health , MOPH&P	Dr Ali Jahhaf		
Members	Dr. Nashuan Al-atab	Acting deputy minister of planning sector MOPHP		
	Mr. Ahmed Al Oshari	Assistance of Deputy Minister of Youth		
	Dr. Abdullah Al Ahmadi	Deputy Minister of Education		
	Mr. Naser AL Harbi	Deputy Minister of FInance		
	Mr. Ahmed Al Hatami	Deputy Minister of Information		
	Mr. Ameen Al-Arahabi	Deputy Minister of Local Administration		
	Dr. Nagibal Al-shawafi	Deputy minister of population sector		
	Mr. Hussain Al-Hadar	Deputy Minister of Religious Affairs		
	Mr. Mohammed Al Jounaid	DG of finance		
	Mr. Abdulssalam Sallam	DG of Health Education information and population center		
	Dr. Fadhl Al Akua	DG of Health Policy Unit		
	Mr. Nabeel Ali Thabet	DG of planning		
	Dr. Abdulhakim Al Kohlani	DG of surveillance		
	Mr. Nabeel Al Amari	DG of Yemen Family Care Association		
	Dr.Ghada AL Haboob	EPI Manager		
	Mr. Saleh Al-Badani	GIZ		
	Lamia Majed Awasah	Health Program co. in the supreme Council for Motherhood and childhood		
	Dr. Bilal Ahmed	Immunization Specialist, UNICEF		
	Dr. Arwa Aldram	SOUL		
	Dr.Mohammed Ibrahim	UNCEF		
	Dr. Faouzia Shafeeq	UNICEF		
	Mr. Motahar Al Absi	Vice Minister of Planning & International Cooperation		
	Dr. Abdulnasser AlRubai	WHO immunization officer		

By submitting the proposal we confirm that the quorum has been met. **Yes**

The minutes from the meeting endorsing the proposal and of the meetings of the past 12 months are attached are attached as DOCUMENT NUMBER : 6.

4.2. National Immunization Technical Advisory Group (NITAG)

Has a NITAG been established in the country ? **Not selected**

In the absence of a NITAG, countries should clarify the role and functioning of the advisory group and describe plans to establish a NITAG. This document is attached as **(Document Number: 8)**

5. Immunisation Programme Data

5.1 Background information

Please complete the table below, using the most recent data from available sources. Please identify the source of the data, and the date and attach the source document, where possible. The following documents should be referred to and/or attached:

- Comprehensive Multi-Year Plan for Immunisation (cMYP) (or equivalent plan). Please attach as DOCUMENT NUMBER 9.
- If applying for measles or measles rubella support, please check that the current cMYP includes all the information described in Annex 2 of the Measles and Rubella 2017 Application Guidelines. If this information is not included in the cMYP, please submit a cMYP addendum that covers the missing information and attach it as document number 40.
- New Vaccine Introduction Plan(s) / Plan of Action. Please attach as DOCUMENT NUMBER 12.
- New Vaccine Introduction Checklist, Activity List and Timeline. Please attach as DOCUMENT NUMBER 12.
- Effective Vaccine Management (EVM) assessment. Please attach as DOCUMENT NUMBER 20.
- Two most recent annual WHO/UNICEF Joint Reporting Forms (JRF) on Vaccine Preventable Diseases.
- Health Sector Strategy documents, budgetary documents, and other reports, surveys etc, as appropriate.
- In the case of Yellow Fever and Meningitis A mass preventive campaigns, the relevant risk assessments. Please attach as DOCUMENT NUMBER 24 and DOCUMENT NUMBER 25.

Please use the most recent data available and specify the source and date.

	Figure	Year	Source
Total population	29,483,174	2017	Projections based of 2004 Census, Central Statistics Organization (CSO)
Birth cohort	1,054,135	2017	The final results of the 2004 Census, Central Statistic Office (CSO) & Statistic Dept. EPI
Infant mortality rate (per 1000)	43	2013	DHS
Surviving infants*[1]*	982,510	2017	The final results of the 2004 Census, Central Statistic Office (CSO) & Statistic Dept. EPI
GNI per capita (US$)	900	2011	World Bank, World Deveopment Indicators Database, 2008
Total Health Expenditure (THE) as a percentage of GDP	5	2011	National Health Account report 2007, MoPH&P
General government expenditure on health (GGHE) as % of General government expenditure	4	2011	National Health Account report 2007, MoPH&P

[1] Surviving infants = Infants surviving the first 12 months of life

5.1.1 Lessons learned

Follow up Support

If campaigns with Measles, MR vaccines have already been conducted in your country, please give details of the lessons learned, specifically for: storage capacity, protection from additional freezing, staff training, cold chain, logistics, coverage, wastage rate, etc., and suggest action points to address them in future campaigns. If this information is already included in Plan Of Action, please reference the document and in which section/page this information can be found.

Lessons Learned	Action Points
- Implementing the campaign nationwide helps in assuring equity so that all targeted population all over the country get the same chance to be protected.	- campaign to be done in one phase all over the country
- Considering the special situation at level of governorates and	- detailed micro-planning of the campaign in consultation with the

districts during planning and allowing flexibility for those levels during implementations helps in achieving good coverage percentage.	governorates, early before time of conduction of the campaign.
- Working for all targeted population all over the country regardless of political differences and status quo at local levels, helps keeping health system integrity and ability to conduct activities all over the country.	- high risk areas special situation to be considered in the micro-planning
- Assessing cold chain capacity is crucial for smooth implementation of the campaign, further actions are to be done in this regard.	- integrating results of assessing cold chain capacity into the budget plan of the campaign.

5.1.2 Health planning and budgeting

Please provide information on the planning and budgeting cycle in your country

- With regard to the Health Sector, the relevant guiding reference is the « Fourth Five Year Plan for Health Development and Poverty Reduction (2011 – 2015) ».

- The last 5 year plan of the govenment of Yemen was for the period 2011-2015. Because of the start of the war on Yemen in March 2015 the country has got into a total seige, a severe damage to the infrastructure, multiple areas of confrontation lines, economical collapse, fragmented government, and got into an emergency situation. so, a new 5 years plan is not developed till now.

Please indicate the name and date of the relevant planning document for health

With regard to EPI, the relevant guiding reference is the Comprehensive Multi Year Plan (cMYP) for the period 2016 – 2020

Is the cMYP (or updated Multi-Year Plan) aligned with the proposal document (timing, content, etc.)

Yes, It is aligned and the planning process for both was simultaneously developed and they fed each other.

Please indicate the national planning budgeting cycle for health

2011-2015

Please indicate the national planning cycle for immunisation

2016-2020

5.1.3 Coverage and equity

Please describe any health systems bottlenecks or barriers to access, utilisation and delivery of immunisation services at district level (or equivalent), for example geographic, socio-economic and/or gender-related barriers. Please indicated if there are specific populations of concern. If available, please provide subnational coverage and equity data highlighting geographic, socio-economic, gender-related, or other barriers and any other relevant categories of vulnerable or high-risk populations.

According to UN agencies, by November 2016, health facilities reported nearly 7,070 people killed and more than 36,818 injured. 14 million, which is about half of the Republic of Yemen's population, lives in areas directly affected by the conflict. Over 3 million Yemenis have been forcibly internally displaced (IDPs). Severe food insecurity affects 14 million people, and an estimated 3.3 million are malnourished, including 1.4 million children, of whom 462,000 are suffering from acute malnutrition. Basic services across the country are on the verge of collapse. Chronic drug shortages and conflict-related destruction constrain access to health care services for around 14 million Yemenis, including 8.3 million children. More than 900 (22%) of the EPI centres have been closed and 87 (26%) of the district vaccine stores became closed after the crisis. EPI centres across the country were closed due to staff demotivation, no electricity or other sources to run the cold chain equipments, managerial issues, unavailability of funds to run the HFs, unavailability of logistics etc and these are the main challenges which has affected the coverage through EPI centres. In areas of active war or

inaccessible areas there are problems of access and challenges to ensure that supplies (Cold chain equipments, Vaccines, devices, Fuel etc) reach to EPI centres/HFs and these are the areas which become the source of outbreaks in the security compromised areas. Due to closure of health facilities the community especially female have access issues and even for other community members including children and males due to mobility issues to high fuel prices and considerably decrease in purchasing power access to health facilities to seek health services has been decreased. The problem is very high in some governorates which are badly affected by ongoing security crisis i-e Aden, Taiz, Sa'ada, Abyan, Lahj, Al-Dhale, Marib, Amran, Sana'a, Al Baida, Al-Jawf, Hajja and Hodeida.

Even before crisis the access to health services especially in rural areas where more than 80% of the population has been living have access issues. This is clear difference between vaccination coverage in rural and urban areas as well in educated and uneducated parents and poor and rich community. According to the Yemen National Health & Demographic Health Survey (2013) the Measles coverage was 63%. Measles vaccination of children of Uneducated mothers was 58% while the vaccination in higher educated mother was 85%. The Measles vaccination coverage in lowest quintile was 52% and in highest quintile the coverage was 77%.

To ensure access to the children and community especially in security compromised areas micro plans have been regularly revised. In dec 2016 microplanning exercise has been done in 12 Governorates and in remaining it will be done in first quarter of 2017. In these micro plans all the children including those who are living in security compromised areas, IDPs, refuges, from marginalized communities have been identified and plans are developed to reach to these children.

For Measles campaigns all the children will be accessed. Comprehensive social mobilization and communication plan will be developed in which all stake holders at district, governorate and central level will be involved. Community sessions will be conducted through CHVs, awareness seminars/sessions will be conducted in schools and influential will be involved especially in security compromised areas. To easy access and keeping in view the social cultural issues females health workers will be involved in each team. On the basis of micro plans outreach points will be identified which are acceptable to community members.

Please explain how the proposed NVS support (activities and budget) will be used to improve coverage and equity of routine immunisation with reference to specifically identified health systems bottlenecks and/or specific populations of concern. For countries that will be receiving Gavi HSS and/or CCEOP funding concurrently with NVS funds, please also highlight how NVS funds will support/complement/leverage specific activities or investments included in those other grants.

NA

Please describe what national surveys take place routinely in country to assess gender and equity related barriers. Highlight whether this application includes any activities to assess gender and equity related barriers.

DHS survey done in 2013 has shown that there is no sex discrimination among vaccinated children, the difference in coverage among childdren is because of other reasons namely mother's education, family's wealth.

Please indicate if sex disaggregated data is collected and used in immunisation routine reporting systems.

No sex disaggregated data is collected

Is the country currently in a situation of fragility (e.g. insecurity, conflict, post-conflict, refugees/and or displaced persons and recent, current or potential environmental disaster, such as flooding, earthquake or drought or others)? If Yes, please describe how these issues may impact your immunisation programme, planning for introduction of routine vaccines or campaigns and financing of these activities.

War, air strikes, direct targeting of health facilities, seige, population displcement, insecurity, economical deterioration and steep rise of prices all have negativley affected access to health services including EPI and caused reduction of about 4% of EPI routine coverage in 2015, though the mitigation measures done by MOPH&P. the situation in the country is still suffering form the same condtions. However, MOPH&P had conducted the mop-up MR campaign in 126 districts during the war and has learnt of that experience.

Armed conflict as well as its ramifications on security, political situation, trade, livelihoods, basic service

delivery have had direct and indirect impact on all spheres of life. The war has involved most of the governorates (esp Aden, Taiz, Sa'ada, Abyan, Lahj, Al-Dhale, Marib, Amran, Sana'a, Ibb, Al-Jawf, Hajja, Al Baida and Hodeida) and led to destruction of both public and private infrastructures; and caused the suspension of most of economic and investment activities. Beside other implications vaccination through fixed site and outreach sessions reduced significantly with Penta 3 and Measles 1 coverage in May/June 2015 being 15 to 25% below the coverage at the same time in 2014 and there were significant delays in starting Integrated outreach and immunization campaigns which were initially scheduled for April & May 2015 but could not be started till July & August, respectively. Measles coverage was tremendously reduced in 1st quarter of 2015. Measles cases were reported from various areas mainly from Sa'ada, Aden, Aljwaf, Lahj, Amran, Abyan Governorates

5.1.4 Data quality

To support country efforts to strengthen the availability, quality and use of vaccination coverage data for strengthened programme management, Gavi requires that countries applying for all types of Gavi support to undertake routine monitoring of vaccination coverage data through an annual desk review; conduct periodic (once every five years or more frequently where appropriate) in-depth assessments of routine administrative vaccination coverage data; conduct periodic (at least once every five years) nationally representative vaccination coverage surveys; and develop and monitor plans for improving vaccination coverage data quality as a part of their own core work plans.

5.2. Baseline and Annual Targets for Routine Vaccines

No NVS Routine Support is requested

5.3. Targets for Preventive Campaign(s)

No NVS Prevention Campaign Support this year

5.4. Targets for One time mini-catchup campaign(s)

No One time mini-catchup campaign this year

5.5 Targets for Follow up Campaign

Table 5.5 Target figures for measles / MR campaign (Please ensure targets are consistent with Section 7 and the Plan of Action in Section 9) COMPLETE SECOND AND THIRD COLUMNS ONLY FOR PHASED CAMPAIGNS.

	Target	Target (if applicable, for phased* campaign)	Target (if applicable, for phased* campaign)
Insert Year	2018		
Target age group	Start 9 months	Start 9 months	Start 9 months
	End 14 years	End 9 months	End 9 months
Total population in the target group (nationally)	13,913,356		
% of population targeted for the campaign	95.00		
Number to be vaccinated with measles / MR vaccine during the campaign	13,217,688.20		

*Phased: If a portion of the country is planned (eg. 1/3 of the country each year for 3 years)

6. New and Under-Used Vaccines (NVS Routine vaccines)

No NVS Routine Support is requested

7. NVS Preventive Campaigns

No NVS Prevention Campaign Support this year

8. NVS Follow-up Campaigns

8.1 Immunization coverage

Please provide in the table below the reported national annual coverage data for the first and second dose of measles-containing vaccine (MCV1 and MCV2) from the WHO/UNICEF Joint Reporting Form for the three most recent years.

Table 8.1: Reported MCV coverage

WHO/UNICEF Joint Reporting Form						
	Trends of reported national MCV1 coverage			Trends of reported national MCV2 coverage (if applicable)		
Year	2013	2014	2015	2013	2014	2015
Total population in the target age cohort	866859	894328	922730	866859	894328	922730
Number vaccinated	673503	670131	692468	477708	476270	450401
MCV Coverage (%)	78	75	75	55	53	49

Q8.1 If a survey assessing MCV1 coverage has been done during the last 3 years, please answer the following questions. If no survey has been done, please tick this box: ☐

Survey date: December 2013

Methodology (DHS/MICS, EPI 30-cluster, LQAS, other): DHS

Sample size: 19517

Number of clusters: 800

Number of children: 3026

Coverage: 63

Please provide in the table below reported national (or sub-national if applicable) coverage estimates for the three most recent measles or MR campaigns. Also provide post-campaign survey coverage estimates, if available.

Table 8.2: Measles / MR campaign coverage

	Reported		
Year	2014	2015	2016
Target age group	Start 9 months	Start 9 months	Start 9 months
	End 14 years	End 14 years	End 14 years
Total population in the target age group	12210081	1863160	2630358
Geographic extent (national, subnational)	national	subnational	subnational
Number vaccinated	11368968	1529635	2421243
Campaign Coverage (%)	93	86	92
Wastage rate (%) for measles / MR campaign	7	7	7

Q8.2 If a survey assessing coverage was done after each of the three last measles / MR campaigns, please answer the following questions (please repeat the following questions for each survey). If no survey has been done for the three previous campaigns, please tick this box: ☐

Survey date: Nov 2014

Methodology (DHS/MICS, EPI 30-cluster, LQAS, other): Post campaign coverage survey

Sample size: 3390

Number of clusters: 3360

Number of children:

Coverage: 91

Survey date:

Methodology (DHS/MICS, EPI 30-cluster, LQAS, other):

Sample size:

Number of clusters:

Number of children:

Coverage:

Survey date:

Methodology (DHS/MICS, EPI 30-cluster, LQAS, other):

Sample size:

Number of clusters:

Number of children:

Coverage:

8.2 Financial support

8.2.1 Government financial support for past Measles / MR campaigns

Country should provide information on the total founding, and amount per targeted person, provided by the government for vaccines and for operational costs for at least the last measles / MR campaign. This should be the actual expenses but if not available, the final budget should be referred to. Please also provide information on funding provided by partners.

Share of financing for last measles / MR campaign

Item	Category	Government Funding (US$)	Partner Support (US$)
Vaccines and injection supplies	Total amount	0.00	9214746.00
	Amount (US$) per target person		67.00
Operational costs	Total amount	11214.00	7533500.00
	Amount (US$) per target person		62.00

Year of campaign: 2014

Estimated target population: 12210081

Are the amounts provided based on final budget or actual expenses? Actual Expenses

8.2.2 Government financial support for past Measles / MR routine vaccines

To be eligible for measles and rubella vaccine support, countries must be fully financing with domestic resources the measles monovalent component of routine MCV1 that is already in their national immunisation schedule or have firm written commitments to do so from 2018 onwards. If your country is not currently fully financing with domestic resources the measles monovalent vaccine component of MCV1, please provide evidence that the country can meet this requirement from 2018 onwards through a decision recorded in the ICC minutes (or equivalent coordination forum) AND a signed letter from the Minister of Health and the Minister of Finance. Please attach these documents as Document Number 30 and 38 in Section 10 – Attachments.

Please provide information on the budget provided by the government for routine measles / MR vaccines and injection supplies for the past 3 years, in total amount and amount per child immunized. Please also provide information on funding provided by partners.

Share of financing for routine measles

Year	Category	Government Funding (US$)	Partner Support (US$)
2014	Total amount	963933.00	0.00
	Amount per child immunized	108.00	0.00
2015	Total amount		488648.00
	Amount per child immunized		53.00
2016	Total amount		732109.00
	Amount per child immunized		77.00

8.2.3 Proposed support for upcoming Measles / MR

Country should provide information on the proposed total funding commitment, and amount per targeted person, that will be provided by the government for vaccines and supplies, and for operational costs, for the measles / MR campaign for which Gavi support is being requested. Gavi's support will not be enough to cover the full needs so please indicate in the table below how much and who will be complementing the government funds (refer to the Plan of Action and/or cMYP). Gavi will not replace government funding. Each country is required to contribute towards the costs of immunising its children against measles, using the past government contributions to measles / MR campaigns as the reference point.

Table 8.2.3a Proposed financing for the upcoming measles / MR follow up campaign for which Gavi support

is requested

Item	Category	Country co-financing (US$)	Other donors' support (US$)	Gavi support requested (US$)
Vaccines and injection supplies	Total amount	88200.00	415959.00	7269729.00
	Amount (US$) per target person			55.00

If you would like to co-finance a larger share than the minimum required, please provide information in Your co-financing row*.

Country group	Preparatory transition phase

	2018
minimum co-financing per dose	0.03
your co-financing per dose (please change if higher)	0.03

* In order to strengthen country ownership, a cost sharing requirement will be introduced for periodic measles and MR follow-up campaigns planned for implementation in 2018 onwards, per Gavi's updated Co-Financing Policy. This cost-sharing will not come into effect for follow-up campaigns planned for implementation in 2017. If the campaign is implemented in 2018 onwards, initial self-financing countries will be expected to co-finance 2%, and preparatory transition and accelerated transition countries will be expected to co-finance 5% of the costs of vaccines used in such campaigns.

Table 8.2.3b Calculation of grant to support the operational costs of the campaigns **

Year of MR support	Total target population (from Table 5.5)	Gavi contribution per target person in US$	Total in US$
2018	13217688	0.55	7269728.51

Estimated target population: 13913356

** The grant is adjusted according to the transition stage of the country. Countries in preparatory transition phase will be provided up to $0.55 per targeted person, and countries which have entered accelerated transition phase up to $0.45 per targeted person. For initial self-financing countries, the amount will remain up to $0.65 per targeted person

Please describe how the grant will be used to facilitate the preparation and timely and effective delivery of the campaigns to the target population (refer to the cMYP and the Vaccine Introduction Plan).

The grant will be used to facilitate the preparation of the campaign including: Planning meeting at all levels, micro planning at district level that insure including all the targeted age group all over the country, identifying HRA and accessibility plans for those areas, Training for Supervisors and workers, social mobilization activities, printing materials and vaccine and supplies delivery.

The grant will be also used to cover the operational cost of the campaign such as perdioms of HWs and supervisors at all levels, transportation cost for HWs and supervisors at all levels, cost of operational rooms, etc.

Moreover, some post campaign activities will be supported by the grant for example, evaluation meetings at different levels and post campaign survey.

- In addition, there are other activities related to the campaign will be supported by this grant like, surveillance, waste management and cold chain..

The detailed activities and timing for each activity are addressed in the plan of action and VIG attached.

Where Gavi support is not enough to cover the full needs, please describe other sources of funding and the expected amounts to be contributed, if available, to cover your full needs.

- The gvernment share will be 2% of the operational costs. Other donors will support the campaign by 2.4% of the total cost.

- Unicef will support in covering the goverment share in costs of the vaccine.

Please complete also the 'Detailed budget for VIG / Operational costs' template provided by Gavi and attach as a mandatory document in the Attachment section.

Detailed budget attached as Document No. 22

8.3 Epidemiology and disease burden data

8.3.1 Epidemiological analysis

In order to plan and execute an effective follow-up campaign, to flexibly adjust key parameters and use tailored strategies to reach the unvaccinated, epidemiological data and modelling (if available) are essential. Please attach measles and rubella epidemiology and disease burden data relevant to the follow-up campaign application, providing a rationale for the timing, target age range, and geographical scope of the campaign should be based on epidemiological data, and modelling wherever possible as document number 39.

9. Procurement and Management

9.1 Procurement and Management of New and Under-Used Vaccines Routine

No NVS Routine Support is requested

9.2 Procurement and Management for NVS Preventive Campaign(s)

No NVS Prevention Campaign Support this year

9.3 Product Licensure

For each of the vaccine(s) requested, please state whether manufacturer registration and/or national vaccine licensure will be needed in addition to WHO prequalification and, if so, describe the procedure and its duration. In addition, state whether the country accepts the Expedited Procedure for national registration of WHO-prequalified vaccines.

Note that the necessary time for licensure should be factored into the introduction timeline and reflected in the Vaccine Introduction Plan or Plan of Action.

No registration needed.

For each of the vaccine(s) requested, please provide the actual licensure status of the preferred presentation and of any alternative presentations, if required.

NA

Please describe local customs regulations, requirements for pre-delivery inspection, special documentation requirements that may potentially cause delays in receiving the vaccine. If such delays are anticipated, explain what steps are planned to handle these.

Please provide information on NRA in the country, including status (e.g. whether it is WHO-certified). Please include points of contact with phone numbers and e-mail addresses. UNICEF will support the process by communicating licensing requirements to the vaccine manufacturers where relevant.

9.4 Waste management

9.5 Procurement and Management for Follow up Campaign(s)

9.5.1 Procurement for MR, 10 dose(s) per vial, LYOPHILISED

Measles / MR vaccines and supplies supported by Gavi shall be procured through UNICEF unless requested otherwise by the country. Using the estimated total for the target population, please describe the estimated supplies needed for the measles / MR campaign in the table below. Please ensure estimates need to be consistent to Tables 5.5 and 8.2.3 a.

Table 9.5 Procurement information by funding source

		Proportion from goverment funds	Proportion from partner funds	Proportion from Gavi funds
Required date for vaccines and supplies to arrive	01/02/2017			
Estimated campaign date	15/03/2018			
Number of target population	13217688			
Wastage rate*	10			
Total number of vaccine doses	14541130	0	727057	13814074

Number of syringes	13880270	0	694014	13186257
Number of reconstitution syringes	1454113	0	72706	1381407
Number of safety boxes	170547	0	8527	162020

9.5.2 Fiduciary Management Arrangement Data

Q8. Please indicate whether funds for operational costs in Section 8 should be transferred to the goverment or WHO and/or UNICEF and when funding is expected to be needed in country. Attach banking form if funding should be transferred to the goverment. Please note that WHO and/or UNICEF may require administrative fees of approximately 7% wich would need to be covered by the operational funds.

The fund for operation cost will be trnsferred to UNICEF.

The cost is expected to be in country 6 months before the campaign.

1. Name and contact information of the recipient organization(s)	
2. Experiences of the recipient organization with Gavi, World Bank, WHO, UNICEF, the Global Fund or other donors-financed operations (e.g. receipt of previous grants)	**Yes or No?** **If YES**, please state the name of the grant, years and grant amount: and provide the following: **for completed Grants:** • What are the main conclusions with regard to use of funds? **for on-going Grants:** • Most recent financial management (FM) and procurement performance rating? • Financial management (FM) and procurement implementation issues?
3. Amount of the proposed grant (US Dollars)	
4. Information about financial management (FM) arrangements for Measles / MR campaign:	
Will the resources be managed through the government standard expenditure procedures channel?	
Does the recipient organization have an FM or Operating Manual that describes the internal control system and FM operational procedures?	
What is the budgeting process?	
What accounting system is used or to be used, including whether it is a computerized accounting system or a manual accounting system?	
What is the staffing arrangement of the organization in accounting, auditing, and reporting?	
What is the bank arrangement? Provide details of the bank account opened at the Central Bank or in a commercial bank and the list of authorized signatories include titles	

What are the basic flows of funds arrangements in place or to be used to ensure timely disbursement of funds to Implementing Entities and to beneficiaries?	
Does the implementing entity keep adequate records of financial transactions, including funds received and paid, and of the balances of funds held?	
How often does the implementing entity produce interim financial reports?	
Are the annual financial statements audited by an external audit firm or Government audit institution (e.g. Auditor General Department…)?	
5. Information about procurement management arrangements for vaccines and devices, other materials and services for the proposed measles / MR campaign:	
What procurement system(s) is used or will be used for the campaign?	
Does the recipient organization have a procurement plan or a procurement plan will be prepared for the campaign?	
Is there a functioning complaint mechanism?	
What is the staffing arrangement of the organization in procurement? Does the implementing entity have an experienced procurement specialist on its staff?	
Are there procedures to inspect for quality control of goods, works, or services delivered?	
goods, works, or services delivered?	

Please provide all of data in table below. It may be submitted as a separate file if preferred.

10. List of documents attached to this proposal

Table 1: Checklist of mandatory attachments

Document Number	Document	Section	File
41	cMYP addendum on measles and rubella		Addendum for Measles _ cMYP.pdf **File desc:** **Date/time :** 03/05/2017 06:24:26 **Size:** 127 KB
Endorsements			
1	MoH Signature (or delegated authority) of Proposal	4.1.1	Government Aproval jan2017.pdf **File desc:** MoH & MoF Signatures **Date/time :** 18/01/2017 11:23:30 **Size:** 272 KB
2	MoF Signature (or delegated authority) of Proposal	4.1.1	Government Aproval jan2017.pdf **File desc:** MoH & MoF Signatures **Date/time :** 18/01/2017 11:23:30 **Size:** 272 KB
4	Terms of Reference for the Coordination Forum (ICC/HSCC or equivalent) including all sections outlined in Section 5.2 of the General Application Guidelines (Note: countries applying before May 2017 can submit their existing Terms of Reference)	4.1.2	TOR of HSCC.docx **File desc:** HSSCC TOR **Date/time :** 18/01/2017 11:24:46 **Size:** 18 KB
5	Minutes of Coordination Forum meeting endorsing Proposal	4.1.3	HSSCC Meeting Minutes_17 Jan. 2017English.docx **File desc:** HSSCC minutes endorsing proposal **Date/time :** 18/01/2017 11:26:56 **Size:** 93 KB
6	Signatures of Coordination Forum members in Proposal	4.1.3	HSSCC approval_Signatu 17 jan 2017r.pdf **File desc:** Signatures of the HSSCC members in Proposal **Date/time :** 18/01/2017 11:26:56 **Size:** 550 KB
7	Minutes of the Coordination Forum meetings from the past 12 months before the proposal	4.1.3	HSSCC Meeting Minutes_17 May 2016English_19-05-16_12.52.36_19-05-16_15.03.56.docx **File desc:** HSSCC meeting minutes 17th of May 2016 **Date/time :** 18/01/2017 11:28:38 **Size:** 93 KB
8	Role and functioning of the advisory group, description of plans to establish a NITAG	4.2.1	NITAG Role and responsiblities.docx **File desc:** Role of NITAG **Date/time :** 19/01/2017 04:59:02 **Size:** 16 KB
30	For countries applying for measles/rubella support that are not yet financing the measles monovalent component of MCV1, ICC minutes committing to finance from 2018 onwards.		Govt payment for MR vaccine 1.pdf **File desc:** **Date/time :** 03/05/2017 06:32:12 **Size:** 220 KB

31	Minutes of NITAG meeting with specific recommendations on the NVS introduction or campaign	4.2	HSSCC Meeting Minutes 17 Jan. 2017English.pdf **File desc:** HSSCC is the competent body to approve the proposal. Minutes of HSSCC is attached **Date/time :** 03/05/2017 06:38:49 **Size:** 630 KB
38	For countries applying for measles/rubella support that are not yet financing the measles monovalent component of MCV1, a signed letter from the Minister of Health and the Minister of Finance committing to finance from 2018 onwards.		Govt payment for MR vaccine.docx **File desc:** **Date/time :** 03/05/2017 06:00:54 **Size:** 11 KB
Planning, financing and vaccine management			
9	Comprehensive Multi Year Plan - cMYP	5.1	YEM-CMYP 2016-2020 draft 5 October.docx **File desc:** Draft copy of the cMYP **Date/time :** 18/01/2017 11:36:39 **Size:** 4 MB
10	cMYP Costing tool for financial analysis	5.1	cMYP V3 9.1 costing too Oct 2015 23.xlsx **File desc:** Draft copy of the cMYP Costing tool **Date/time :** 18/01/2017 11:36:39 **Size:** 3 MB
11	M&E and surveillance plan within the country's existing monitoring plan	5.1.4	Surveillance action plan 2017.xlsx **File desc:** Surveillance action plan 2017 **Date/time :** 19/01/2017 05:03:53 **Size:** 16 KB
12	New vaccine introduction plan (NVIP), New Vaccine Introduction Checklist and Activity List & Timeline for routine vaccines or Plan of Action (PoA) for campaign vaccines	5.1,7.2.3	Plan Introduction of New Vaccines.pdf **File desc:** There are no plan for Introduction of new vaccine in Yemen in 2017-18 **Date/time :** 03/05/2017 06:45:06 **Size:** 12 KB
14	Annual EPI Plan with 4 year forward view for measles and rubella		29. EPI annual plan 2016.xlsx **File desc:** **Date/time :** 19/01/2017 04:30:04 **Size:** 32 KB
20	Improvement plan based on EVM	9.3	EVM improvement plan recommendations implementation.docx **File desc:** EVM improvement plan **Date/time :** 18/01/2017 11:53:17 **Size:** 17 KB
21	EVM improvement plan progress report	9.3	EVM action plan and implementation status April 2015.pdf **File desc:** **Date/time :** 03/05/2017 06:48:01 **Size:** 37 KB
22	Detailed budget template for VIG / Operational Costs	6.x,7.x.2,6.x.2,8.2.3	VIG and Op Cost Detail Template 2016 under 15 - 0.55$ Target reduced.xlsx **File desc:** VIG detailed budget template **Date/time :** 18/01/2017 11:36:40 **Size:** 107 KB

32	Data quality assessment (DQA) report	5.1.4	DQS report 2015.pdf **File desc:** DQS report 2015 **Date/time :** 18/01/2017 11:43:49 **Size:** 1 MB
37	Evidence of self-financing MCV1	5.1.5	Govt payment for MR vaccine 1.pdf **File desc:** **Date/time :** 03/05/2017 06:49:45 **Size:** 220 KB

Table 2: Checklist of optional attachments

Document Number	Document	Section	File
3	MoE signature (or delegated authority) of HPV Proposal	4.1.1	No file loaded
15	HPV Region/ Province profile	6.1.1	No file loaded
16	HPV Key Stakeholder Roles and Responsibilities	6.1.1,6.1.2	No file loaded
17	Evidence of commitment to fund purchase of RCV (in place of the first dose of MCV) / for use in the routine system	5.1.6, 6.1.7	30. Cabinet approval on rubella vaccine cost.pdf **File desc:** **Date/time :** 19/01/2017 04:30:49 **Size:** 113 KB
18	Campaign target population documentation	8.x.1, 6.x.1	Targeted children detailes.xlsx **File desc:** Targeted children detailes **Date/time :** 19/01/2017 05:00:20 **Size:** 27 KB
19	EVM report	9.3	EVM report.doc **File desc:** 2013 EVM report **Date/time :** 18/01/2017 11:53:17 **Size:** 2 MB
24	Risk assessment and consensus meeting report for Yellow Fever, including information required Section 5.3.2 in the General Guidelines on YF Risk Assessment process	5.1	This document is not relevant to this type of requested support.docx **File desc:** This document is not relevant to this type of requested support **Date/time :** 19/01/2017 05:05:20 **Size:** 12 KB
25	Risk assessment and consensus meeting report for Yellow Fever, including information required in the NVS guidelines on YF Risk Assessment process	5.1	No file loaded
26	List of areas/districts/regions and targets to be supported for meningitis A mini catch up campaigns		No file loaded

27	National Measles (& Rubella) elimination plan if available		No file loaded
28	A description of partner participation in preparing the application	4.1.3	Partners' participation in the preparation of the MR follow-up campaign proposal.docx **File desc:** Partners' participation in the preparation of the MR follow-up campaign proposal **Date/time :** 19/01/2017 04:59:31 **Size:** 13 KB
33	DQA improvement plan	5.1.4	DQS Improvement plan.docx **File desc:** DQS improvement plan will be done in Feb 2017 **Date/time :** 19/01/2017 05:06:05 **Size:** 11 KB
34	Plan of Action for campaigns	8.1, 8.x.4	Plan of Action for MR campaign 2018.docx **File desc:** Yemen MR Follow-up campaign March 2018 **Date/time :** 18/01/2017 12:35:10 **Size:** 18 KB
35	Other		No file loaded
36	Strategy for establishing or strengthening a national comprehensive approach to cervical cancer prevention and control		No file loaded
39	Epidemiological analysis/evidence	8.3.1	Measles Risk Assessment Final Report.pdf **File desc:** **Date/time :** 03/05/2017 07:05:51 **Size:** 6 MB
40	Post Campaign Coverage Survey report for MR catch-up applications	5.1.x	No file loaded

11. Annexes

Annex 1 - NVS Routine Support

No NVS Routine Support is requested

Annex 2 - NVS Routine – Preferred Second Presentation

No NVS Routine – Preferred Second Presentation requested this year

Annex 3 - NVS Preventive campaign(s)

No NVS Prevention Campaign Support this year

Annex 4

No NVS Routine Support is requested

No NVS Prevention Campaign Support this year

12. Banking Form

In accordance with the decision on financial support made by the Gavi, the Government of Yemen hereby requests that a payment be made via electronic bank transfer as detailed below:

Name of Institution (Account Holder):			
Address:			
City Country:			
Telephone no.:		**Fax no.:**	
		Currency of the bank account:	
For credit to:			
Bank account's title:			
Bank account no.:			
Bank's name:			

Is the bank account exclusively to be used by this program?

By who is the account audited?

Signature of Government's authorizing official

		Seal
Name:		
Title:		
Signature:		
Date:		

FINANCIAL INSTITUTION		**CORRESPONDENT BANK (In the United States)**	
Bank Name:			
Branch Name:			
Address:			
City Country:			
Swift Code:			
Sort Code:			
ABA No.:			
Telephone No.:			
FAX No.:			

I certify that the account No is held by at this banking institution

The account is to be signed jointly by at least (number of signatories) of the following authorized signatories:

1		
	Name:	
	Title:	
2		
	Name:	
	Title:	
3		
	Name:	
	Title:	

Name of bank's authorizing official
Signature:
Date:
Seal: