



COUNTRY PROGRAMME ACTION PLAN

2012 – 2015

Between

**UNFPA
(THE UNITED NATIONS POPULATION FUND)**

And

THE GOVERNMENT OF YEMEN

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List of Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behaviour Change Communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
CCA	Common Country Assessment
CCT	Central Coordination Team
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CMW	Community Midwife
CO	Country Office
CP	Country Programme
CPAP	Country Program Action Plan
CPD	Country Program Document
CPR	Contraceptive Prevalence Rate
CSO	Central Statistical Office
CSOs	Civil Society Organizations
DFID	Department for International Development
DPPR	Development Plan for Poverty Reduction
EmONC	Emergency Obstetric and Neonatal Care
FGM/C	Female Genital Mutilation/ Cutting
FP	Family Planning
GCA	Government Coordinating Authority
GCC	Gulf Cooperation Council
GCT	Governorate Coordination Team
GIZ	German Agency for International Cooperation
HIV	Human Immunodeficiency Virus
ICPD PoA	International Conference on Population and Development Programme of Action
ILO	International Labour Organization
IP	Implementing Partner
KFW	German Development Bank
LMIS	Logistics Management Information System
MDG	Millennium Development Goal

M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio
MoPHP	Ministry of Public Health and Population
MoPIC	Ministry of Planning and International Cooperation
NGO	Non-Governmental Organization
NMP	National Midwifery Programme
NPC	National Population Council
NRC	Norwegian Refugees Council
P&D	Population and Development
RH	Reproductive Health
RHCS	Reproductive Health Commodity
RR	Reproductive Rights
RRF	Results and Resources Framework
SBA	Skilled Birth Attendant
SC	Steering Committee
SP	Strategic Plan
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
UNDAF	United Nations Development Assistance Framework
WNC	Women's National Committee
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
YMA	Yemeni Midwives Association
Y-Peer	Youth Peer Education Network

The Framework

In mutual agreement to the content of this document and their responsibilities in the implementation of the UNFPA Country Programme 2012 - 2015, the Government of the Republic of Yemen (hereinafter referred to as the Government) and the United Nations Population Fund (hereinafter referred to as UNFPA)

Furthering their mutual agreement and cooperation for the fulfilment of the International Conference on Population and Development Programme of Action (ICPD PoA);

Building upon the experience gained and progress made during the implementation of the previous Programme of Cooperation;

Entering into a new period of cooperation;

Declaring that these responsibilities will be fulfilled in a spirit of friendly cooperation;

Have agreed as follows:

Part I. Basis of Relationship

1. The Standard Basic Assistance Agreement (SBAA) between the Government and the United Nations Development Programme (UNDP), dated 18 May 1992, and the letter of the UNFPA Executive Director of 8 December 1996 to the Ministry of Planning and International Cooperation (MoPIC) and agreed to by the Government on 7 April 1997, constitute the legal basis for the relationship between the Government of Yemen and UNFPA.

Part II. Situation Analysis

2. Yemen ranked 133 out of 169 countries on the Human Development Index in 2010¹. In 2010, 42,7% of the population lived below the national poverty line². Most of the people (73%) live in rural areas³.

3. More than 45% of the population is below the age of 15, and another 23.17% is youth (between 15 and 24 years old), a majority of which are unemployed due to limited availability of job opportunities and the economic crisis⁴. This puts a considerable strain on the country's limited basic resources such as health infrastructure, water and schools. At the same time, during the last decade, the ability of the Government to finance essential services and investments has been decreasing, mainly due to the impact of the global financial crisis and the decline in oil revenue. Since the beginning of 2011 a protracted political crisis has led to a collapse of the economy leading to soaring

¹ UNDP Human Development Report, 2010

² Fourth DPPR, April 2011

³ Common Country Assessment, 2011

⁴ Common Country Assessment, 2011

prices for commodities (on average 40% price increase for food⁵ and more than 100% for fuel between January and September). More than 5 million people are food insecure, while 60% of children are chronically malnourished⁶.

4. The population is estimated at 23 million in 2010, which at the current growth rate of 3% per annum, is expected to double by the year 2033. Unfortunately, inconsistencies, a lack of periodicity and a lack of national capacity limit the availability of reliable data on population trends. Improving consistency and quality of data collection and utilization for policy development, is one of the challenges policy makers face.

5. The population growth is an underlying cause of many of the problems the country faces, such as the depletion of water resources, malnutrition, slow economic growth, insufficient education and insufficient health-care capacity. With this rapid population growth rate, poverty in the country is expected to aggravate, hindering prospects for sustainable development. The Government considers population growth as a key development challenge the country faces.

6. Population growth is related to a number of factors. Early marriage, limited girls education, high female illiteracy, high adolescent fertility rate and the low use of contraceptives, all contribute to the relatively high total fertility rate (TFR) (6.2 births per woman). The unmet need for family planning is high and the latest estimates that it is 37% , and cultural taboos and misconceptions impede access to existing services. Nevertheless, the contraceptive prevalence rate (CPR) for modern methods increased from 13.4 per cent to 19 per cent between 2003 and 2009, indicating a growing demand for FP services. However, the RHCS system is still very weak. In the absence of a functioning Logistics Management Information System (LMIS) and trained staff to use it, reporting is irregular and data for decision making are not reliable. Therefore, forecasting is unlikely to reflect the national needs.

7. Yemen has one of the highest maternal mortality ratios in the region. Maternal mortality is related to poverty, inadequate access to health care services including maternal health services and family planning and low awareness and knowledge about Reproductive Rights.

8. The latest reliable estimate for maternal mortality ratio is 365 maternal deaths per 100,000 live births⁷. While the figures suggest a reduction of the MMR (by 61% since 1990)⁸, progress is still too slow. It is highly unlikely that Yemen will be able to achieve Millennium Development Goal 5 by 2015. Although Yemen is part of the Secretary General's initiative to accelerate progress towards achieving MDG 4 and 5, the MoPHP is still prioritizing and allocating more resources to MDG4 and less attention is given to MDG 5 both politically and financially. Additionally, maternal mortality is expected to rise in the near future as a result of the latest political and economic transformations that the country is going through that are affecting mobility and resources and may therefore, affect access to health care particularly for women. Health services, in general, and primary health care, in particular, are inefficient and of low quality. Yemenis pay more than 50% of their expenditures out of pocket, in spite of the MoPHP policy of free access to health care. This adds burden on the poor and affects poor women needing maternal health services. Additionally, only 43% of the population has access to a public health facility.

⁵ Yemen Humanitarian Response Plan, 2012

⁶ WFP, Food Assessment, 12 October 2011

⁷ DHS 2003. Estimates provided by UNFPA/UNICEF/WHO give 210 per 100,000 living births for 2008 (Trends in Maternal Mortality 1990 – 2008).

⁸ The State of the World's Midwifery, 2011

9. All the major factors leading to the high maternal mortality rate exist in Yemen, particularly, as mentioned, the limited access to maternal health care, including access to skilled birth attendants and EmONC services. The organizational structure of the Ministry of Public Health and Population (MoPHP) separates human resources and planning from the reproductive and maternal health services with negative consequences on coverage by qualified midwives. Additionally, the links between the community, the primary health care and the comprehensive EmONC services are weak.

10. The low utilization of skilled birth attendants (SBAs) is a major issue. Eighty-four per cent of all births take place at home, and skilled birth attendants (SBAs) are present at only 27 per cent of them. This is generally due to limited availability of midwives in the districts, long distances, and lack of awareness of the importance of the role of midwives. In most cases, complicated deliveries cannot be managed on time, nor is a referral organized.

11. The Ministry of Public Health and Population has developed a National Midwifery Strategy to improve training of midwives, deployment and retention, and supervision. This strategy has not been activated yet through a Ministerial Decree. The employment issue is critical to motivate more high school graduates to enrol in midwifery schools and increase midwifery coverage in the country. A number of complementary interventions are now being studied to increase coverage by midwives such as the support of private midwifery practice. Mobile clinics with midwives have been pioneered over the last few years, with some degree of success. In addition, there is a need to focus on recruitment of midwives for the public system through district and governorate councils.

12. Fistula is one of the most serious and important complications of deliveries without skilled birth attendants (SBAs) particularly prolonged labour. Although exact figures of the magnitude of the problem are not available, it is expected to be highly prevalent, especially in rural areas, with high fertility and poor maternal health services. However, the provision of services for repair or social rehabilitation are only being set up now. The capacity to manage fistula cases including repair, follow-up and social readjustment is still limited in Yemen.

13. HIV/AIDS prevalence is low, about 0.1%, mainly in high risk populations like commercial sex workers.

14. The National Reproductive Health Strategy, 2011-2015, recognizes rapid population growth, poor access to maternal health and family planning as major challenges to development in Yemen. However, the institutional capacity to implement pro-poor policies and to address societal and geographical disparities needs to be strengthened. Such policies will have an impact on maternal health.

15. Reproductive Health Commodity Security remains an issue. Yemen is still dependent on multilateral and bilateral donors to fulfil its contraceptive needs. The system of logistics management and distribution of commodities such as contraceptives and medications for emergency obstetric care is inadequate. The system is not fully linked with the essential drugs logistic system. The RHCS technical group has not met in the past year. In order to secure the country's needs and ensure a sustainable system there is a need to strengthen the RHCS system.

16. Gender inequality is considered to be a major obstacle to reducing population growth and the maternal mortality ratio. The illiteracy rate among women is 65 per cent, compared to 27 per cent among men. Although Yemen has endorsed the Convention on the Elimination of All Forms of Discrimination against Women and has adopted the national women's development strategy, there has only been limited improvement in the socio-economic status of women. Gender-based violence remains prevalent. More than one in every three women in the coastal areas has undergone female genital mutilation/cutting (FGM/C). Parliament has suspended the adoption of a law establishing a

minimum age for marriage. Raising awareness amongst women about RR, in particular in rural areas, is considered a pre-requisite to encouraging their demand to access RH services.

17. The prominent representation of youth in the population structure will require efforts to empower youth as well as develop youth-oriented policies. Within the context of high adolescent fertility, high maternal mortality and a high prevalence of gender-based violence, the needs of young women require special attention. The youth revolution that started in January 2011 gives an indication of the frustrations of the youth and their cry for change. For the programme this is an opportunity to engage the youth.

18. Political instability, natural disasters, growing social unrest and the influx of refugees make the country prone to humanitarian crises. In the last five years, several armed conflicts have erupted and more than 300,000 people have fled from their homes to live in camps or within host communities. The year 2011 has seen an acceleration of the conflict situation causing additional displacement amongst the population. By August, about 415,000 displaced persons were registered in the whole of the country⁹. In situations of armed conflict and displacement, women and girls are most vulnerable to violence. Under impulse of UNFPA, GBV has been recognized as an issue in humanitarian settings, and protection has been part of the UN emergency intervention plans, such as the CAP. However, GBV still needs more sensitization amongst decision makers and service providers.

19. The risk of further political destabilization may hinder the development prospects of the country. In order to mitigate the risks of continuing unrest and instability that may impede implementation efforts, the Yemen CO has prepared a contingency plan to ensure business continuity that relies primarily on involving more civil society organizations to facilitate delivery of critical activities.

Part III. Past Cooperation and Lessons Learned

20. UNFPA began its assistance to the Unified Republic of Yemen in 1992. The Third Country Programme (2002 – 2006) focused on two core programme areas: Reproductive Health and Population and Development Strategies. Gender equity and equality were mainstreamed throughout the programme.

The Fourth Country Programme 2007 – 2011 had three components: Reproductive Health, Population Development and Gender.

Both the Reproductive Health and Population and Development components contributed to the same outcome: Effective implementation of the National Population and Reproductive Health Strategy.

The outputs under RH were: 1) Increased availability of reproductive health services, with a focus on the poor, including young people in programme areas, and 2) Increased demand for reproductive health services, including information, educational services and awareness relating to reproductive rights, sexually transmitted infections (STIs) and HIV/AIDS, in targeted programme areas.

⁹ OCHA, Yemen Humanitarian Snapshot, 10 August 2011

The outputs under P&D were: 1) Priority components of the national population and reproductive health strategy are reflected in national, sectoral and local plans, taking into consideration women's empowerment concerns, and 2) National information systems providing disaggregated population and MDG-related data are improved, data disseminated and utilised.

The Gender outcome was: Improved institutional framework ensuring that women and girls have the benefit of their equal rights, with as output increased national and local support for women's empowerment and rights, including reproductive rights.

In the course of 2011, with the intensifying crisis situation in the country, the CP increased the scope of its humanitarian interventions, in particular protection of displaced women and girls and the support of RH services in humanitarian settings, through the provision of MISP.

21. According to the findings of the country programme evaluation, major achievements of the fourth country programme (2007-2011) include:

- a) Health staff, including midwives, was trained,
- b) Improved availability of reproductive health services and good supply of commodities,
- c) Integration of population issues including reproductive health, gender and youth into the fourth National Socio-economic Plan for Poverty Reduction,
- d) Improved capacity of governorates on data analysis and utilization through introduction of RAPID model to identify multi-sectoral population problems and to disaggregate data,
- e) The number of communities in target districts undertaking gender initiatives increased,
- f) Review of all laws from the perspective of gender, with amendments on some of the discriminatory laws against women proposed and approved by the Parliament,
- g) CEDAW action plan for Yemen was adopted by the Cabinet in 2008,
- h) Increased number of women running for office at central and governorate level,
- i) Youth peer education network established.
- j) Development of a new RH strategy 2011-2015 addressing maternal health and family planning challenges.

22. Amongst the lessons learned are:

- a) The previous CPAP was very ambitious and not enough focused on achievable results. A more narrow scope would allow for a smaller number of interventions, with fewer IPs. This would ease the administrative burden and allow UNFPA staff to focus on technical issues.
- b) Each intervention should consist of a comprehensive package of complementary activities in order to achieve results.
- c) Scattering activities over a limited number of districts, belonging to different governorates, should be avoided. Preferably, the programme interventions should cover the whole country, or a number of complete governorates. This will increase the impact of the programme.
- d) Indicators should measure results and outputs and not activities.
- e) Commodity Security should cover the whole chain of interventions (procurement, distribution, warehousing, logistics system) and training should be provided at all levels to cover these different aspects.
- f) It is important to focus on employment opportunities for midwives and not only on training them. Employment of midwives can increase by using several approaches including enhancing the policy dialogue with the MoPHP to improve their human resources policies particularly the recruitment and payment for

midwives at central and governorate levels, strengthening the Yemen midwives association and by further exploring the option of supporting midwives to set up their own private practice.

- g) Scale up work at community level through Community Communicators (or other community actors). Interventions at this level should be complementary to interventions at health facility level.
- h) Working with PSUs seemed not very efficient. The expectations of government staff they had to help were that PSUs would carry out their work for them. This affected the sustainability of the work. It is preferable to support government departments with a special Field Support Team, that can contribute to capacity building, but will not be tempted to take over the work.
- i) The planning and coordination of the interventions of MoPHP on the one hand and NGOs on the other hand was not efficient. The MoPHP complained that they had no control over the quality of the work of the NGOs, nor were reported about their activities. The new programme management structure should allow for MoPHP agreement with NGO work plans in the health sector. At the same time, there should be a coordination team both at governorate and central level. All interventions of NGOs in the health sector should be reported to the MoPHP through the HO Director.

Part IV. Proposed Programme

23. The proposed country programme builds on experiences gained and lessons learned from the previous four UNFPA country programme cycles. It also takes into consideration the government's fourth Five Year Socio-economic Development Plan for Poverty Reduction 2011-2015 (4th DPPR). It reflects the findings of the 2010 Common Country Assessment (CCA) and the priorities of the United Nations Development Assistance Framework (UNDAF) 2012 - 2015. The programme takes into consideration the commitment to the H4+1 framework, contributes to the progress towards MDG 4 and 5 as outlined in the UN Secretary General Joint Plan of Action of 2010 for mothers and children, and is aligned with the National Health and Reproductive Health Strategies.)

24. The 4th DPPR aims at reducing poverty and enhancing state building. One of four priority strategies to achieve this aim is to accelerate progress to achieve the MDGs. Under this heading, the 4th DPPR adopts interventions to increase gender equality and women economic empowerment, reduce population growth, and improve health conditions. The 4th DPPR considers population issues, in particular population growth, coupled with limited local productivity, as key development challenges in Yemen. It stresses the importance of reducing the high fertility rate through expanding the coverage and improving the quality of Family Planning services, adopting the draft law on the legal age of marriage for girls, raise the enrolment rate in primary education for girls, and raising the level of knowledge and practice of RH services and Reproductive Rights. The 4th DPPR was the first to explicitly address gender and reproductive health including family planning. It also mentions that the government is committed to bring down the maternal mortality rate through strengthening reproductive health services, improving awareness on issues related to mother and child, reproductive health, family planning, women reproductive rights, and nutrition, and by setting a minimum age of marriage for girls.

25. The National Reproductive Health Strategy (2006-2010) mentions six components:
- a) Maternal and Neonatal health
 - b) Family Planning, including infertility

- c) Sexually transmitted infections (STIs) and HIV/AIDS
- d) Adolescence and Youth Reproductive Health
- e) Early detection of breast and cervical cancer
- f) Management of menopause related disorders

The main focus of the new National Reproductive Health Strategy 2011-2015 goes to the first two components, namely maternal health and family planning, which are equally core elements of this CPAP. The new RH strategy is much more focused to address national RH priorities.

26. The 2012-2015 UNDAF identifies the following four priority areas: (1) Inclusive and diversified economic growth with a social dividend; (2) Sustainable and equitable access to quality basic social services to accelerate progress towards MDGs; (3) Women and youth empowerment; and (4) Good governance and social cohesion.

The UNFPA CPAP will contribute to the achievement of UNDAF outcomes as described below:

UNFPA CPAP Outcome 1 *By 2015 access and utilization of quality maternal health and family planning services improved* will contribute to UNDAF Outcome 3 (priority area 2): By 2015, vulnerable groups and deprived districts (including those in humanitarian emergency situation) have improved access to sustainable quality basic social services and UNDAF Outcome 6 (priority area 3): Engagement of young women and men in decision-making related to their own well-being enhanced.

UNFPA CPAP Outcome 2 *By 2015, utilization of reliable data about population and development for decision making and planning at national and local level increased* will contribute to UNDAF Outcome 8 (priority area 4): National capacities for evidence-based planning, implementation and monitoring of development programmes strengthened at all levels by 2015.

UNFPA CPAP Outcome 3 *By 2015, women and men empowerment to practice their reproductive rights, including in emergency settings, improved* will contribute to UNDAF Outcome 5 (priority area 3): Enabling environment enhanced for increased women empowerment, participation and protection at family, community and higher level and UNDAF Outcome 6 (priority area 3): Engagement of young women and men in decision-making related to their own well-being enhanced. UNFPA will be the lead agency for outcomes 5 and 6.

27. In line with the MTR of the UNFPA Strategic Plan (SP) 2008 - 2013 and the revised strategic plan (SP) and the new business plan 2012-2013, the Yemen Country Programme will focus on MDG 5, improving maternal health with a focus on the three pillars for reducing maternal mortality namely skilled birth attendants (SBAs), family planning and access to basic and comprehensive EmONC. UNFPA Yemen will focus on young people and women as the main target groups for interventions. Since maternal mortality is one of the priorities of Yemen and is the focus for UNFPA, the outputs of the CPAP will contribute to the reduction of maternal mortality and improving maternal health. Activities related to data collection and synthesis and to gender will also be geared towards strengthening the realization of MDG 5 to align with the UNFPA revised strategic plan (SP).

The main strategy is built around an axis of improving the access to quality maternal and reproductive health services by expanding coverage, supplies and improving quality (supply-side interventions) and at the same time raising awareness and advocating for the utilization of services in the community and advocating to policy-makers to address barriers to utilization of services (demand-side interventions). Interventions will be complementary while strengthening each other. Data collection, including operational research and advocacy for policy change will be integral part of the programme.

Gender and youth issues will be mainstreamed throughout the program. Concern for the realization of Reproductive Rights, particularly of women, will be central in interventions at both the supply and the demand side. Young people, both males and females, and men in the community will be the target of awareness raising activities to improve their knowledge of social and cultural issues that contribute to maternal mortality and morbidity and their prevention. Youth groups will be encouraged to participate in networks that will not only provide them with information on preventing maternal mortality and reproductive rights but also will provide them with skills to be able to advocate for good reproductive health practices. UNFPA will work in partnership with other UN agencies and organizations to enhance youth, civic participation and employability.

Given the deteriorating humanitarian situation in the country special attention will be given to improving humanitarian preparedness and response, with a focus on GBV particularly protection of girls in camps and the provision of maternal health services to women.

28. The programme will be implemented at national, governorate and community/district level. Interventions related to policy and advocacy will be carried out at national level while, more specific interventions will focus on the governorates of Hadramout (coastal districts and Socotra) and Ibb, with a possible expansion to Hodeida governorate in the course of the programme.

29. Capacity building will be a part of the entire programme implementation. Partnerships will involve major relevant government and non-government institutions in addition to international organizations and bilateral donors.

I) Interventions Supply side

30. The interventions described below will contribute to the realization of the following outputs mentioned in the CPD:

- Output 1: Access to maternal health and family planning services, with focus on underserved areas and humanitarian emergencies, in targeted sites increased.
- Output 3: Youth friendly reproductive health services and life skills education enhanced.
- Output 7: Responses to gender-based violence are expanded and improved.
- Output 4: Access to reliable disaggregated socio-economic and demographic data at central and local level improved.
- Output 5: Capacity of government and civil society organisations to utilize data in addressing and planning processes at all level improved.

Interventions will aim at improving coverage and quality of Reproductive Health services, while building government and Civil Society capacity to collect and use data in support of programming and monitoring. Below follows a description of interventions per output.

31. **Output 1:** Access to maternal health and family planning services with focus on underserved areas and humanitarian emergencies in targeted sites increased, **Output 3:** Youth friendly reproductive health services and life-skills education are enhanced and **Output 7:** Responses to gender-based violence are expanded and improved.

The two core interventions are the provision of Family Planning services by strengthening of the RHCS system at central and governorate level, and the activation of the National Midwifery Programme, aiming at providing full coverage of primary health care services by trained midwives in the targeted governorates. Attention will also be given to the provision of EmONC services in the target areas, linking midwives with EmONC facilities, and the expansion and improvement of fistula services in the two big regions of the country. Humanitarian preparedness and response will be strengthened through the provision of MISP services in emergency situations, and improving the

clinical management of GBV. A network of functional health counselling and service centres for youth will be established as well, providing Reproductive Health and other services.

Under this output come seven sub-outputs.

32. *Sub-output 1: RHCS system fully established and functional.*

The Logistics Management Information System (LMIS) will be set up centrally and at governorate level, with capacity building on LMIS for MoPHP staff at central and governorate levels. In the targeted governorates the LMIS will be expanded to district level, with capacity building of local MoPHP staff. UNFPA will continue to ensure that contraceptive needs of the country are secured, at least at current levels. Additionally, EmONC commodities will be secured in the target governorates. Support will be given to the development of RHCS policy and for establishing mechanisms for the continuous distribution of commodities. Existing warehouses will be assessed to identify gaps to be overcome in order to improve the RHCS system.

33. 32. An international RHCS Expert will be recruited to identify gaps in the current RHCS system in Yemen and propose measures for improvement. Software will be installed at central level and in the targeted governorates and MoPHP staff will receive a training to use the software. Equipment needs, as identified by RHCS Expert, will be provided and training given for effective management of RHCS system, including efficient storage and distribution system.

34. To support the above mentioned interventions, the programme will advocate for the revival of the RHCS Group. In the past, members were Ministries, including the MoPHP, donors, UN Agencies, and civil society organisations. The aim is to provide coordination, and administrative, technical and financial support to the continued development of the RHCS system, and ultimately to assure complete coverage of the contraceptive needs of the country.

35. *Sub-output 2: Family Planning services provided in the targeted governorates.*

In addition to ensuring contraceptive commodity security at all levels, the programme will ensure the provision of quality FP services in the selected governorates. The programme will work with partners to improve Family Planning services focusing on counselling through various interventions to ensure that women, men and young people receive the relevant and appropriate information on family planning as well as contraceptives of their choice, including long term methods to enable them to postpone and space pregnancies as desired. Interventions will include:

- Assessing the FP training needs and RH counselling needs at the health facilities level in targeted governorate.
- Ensure continuous supply of contraceptives in the facilities of the targeted governorates.
- Expanding technical and management training programmes to cover selected managers and service providers, such as gynaecologists and midwives, in the targeted governorates in order to ensure the provision of quality family planning services.
- Finalize a plan for RH counselling.
- Strengthening the capacity of service providers at health facilities level in the targeted governorate to provide counselling for family planning services.
- Involve local NGOs to raise awareness and provide services particularly in remote areas.

36. *Sub-output 3: the National Midwifery Programme functional.*

The National Midwifery Programme (NMP), which has been developed, but not yet launched by a government decree, will be activated. UNFPA will support the MoPHP to advocate for a decree to launch the NMP, which will support all interventions aimed at increasing coverage of midwifery services and improving their quality, in particular the finalization of the curriculum for midwives, setting the standards for selection of students for midwifery schools, the training and selection of

teachers, the regulation of issues of employment and the inclusion of midwives in the human resources for health policies, supervision and on the job training, and the allocation of a national budget. Additionally, UNFPA will support the Yemen Midwifery Association to be able to provide the necessary services to midwives.

37. The second part of this output is increasing the availability of midwives in the districts. This is viewed from three possible alternative situations at district level:

1. No midwives are available.
2. Midwives are available, but they do not practice.
3. Murshidat or nurses are available.

In response to these three possible situations, the programme will develop a strategy containing four elements, which may be applied in its totality, or partially, according to the specific needs of each targeted district:

- a) Design and implement an advocacy strategy targeting district and governorate councils and providing them with evidence to encourage them to recruit midwives for the local health facilities.
- b) Encourage trained but unemployed midwives to set up a private practice. Candidates will be supported with loans, in joined collaboration with ILO, training and supervision from the MoPHP.
- c) Mobile clinics with teams containing a trained midwife, operated by NGOs, to access remote areas.
- d) Upgrade the skills of murshidat to become community midwives (CMW) or nurses to become nurse/ midwife with two or one year training for midwife, respectively.

38. The programme will build the capacity of midwives, in particular during pre-service and on the job training and through strengthened supervision. Capacities will include Family Planning counselling, screening of GBV, fistula, and data collection. Midwives will be supported to collect data on vital elements, such as maternal deaths, births, normal and complicated deliveries, and GBV cases.

Given its important advocacy and support role to midwives, the capacity of the Yemeni Midwives Association (YMA) will be strengthened. The possibility to involve the YMA to distribute Family Planning commodities through midwives at community level will be explored.

39. *Sub-output 4: Women in the target areas provided with EmONC services.*

Targeted governorates will be supported to establish EmONC services or rehabilitate existing facilities to respond to the needs of the community. EmONC assessment will be conducted in the target governorates to identify gaps in equipment and skills of health personnel. The governorates shall recruit the required personnel if needed. The programme will provide equipment and training to prioritised facilities and ensure the use of established standard protocols for EmONC including the establishment of blood banks in Comprehensive EmONC facilities. Capacity of general practitioners will be developed to respond to the needs particularly to conduct Caesarean Sections. Additionally, the needed EmONC commodities will be provided for target governorates including medications for eclampsia, post-partum bleeding and infections. The programme will also look at demand side barriers to utilization of health services and will try to identify and support solutions. Additionally, UNFPA will support solutions to respond to EmONC needs of women delivering in humanitarian settings particularly when there is no direct access to facilities.

40. Midwives at community level will be supported to establish links to health centres at district and governorate level, establishing thus a referral mechanism between communities and BEmONC and CEmONC facilities. The community including local NGOs will be invited to support the midwives particularly in the cases of providing transportation as needed.

41. In addition, the programme will advocate for the organisation of a conference on Maternal Mortality with the aim of coordinating interventions by all stakeholders over the total territory of the country.

42. Sub-output 5: Obstetric Fistula services provided and serving the two catchment areas of the country.

Two fistula centres were established in Sana'a and Aden in the previous programme cycle. This effort will be continued through five major interventions:

- a) Assess fistula prevalence in the communities nationwide.
- b) Competency based capacity building of health providers to manage fistula. Teams to manage fistula will be trained on the surgical treatment, follow-up management, treatment of persisting urinary incontinence and social reintegration of survivors.
- c) Establish a referral system, involving midwives, to connect the two regional fistula centres with other health facilities and the communities in the target area in order to be able to refer cases and follow-up on the campaigns.
- d) Develop capacity of surgical repair team in Aden fistula centre and supervise the performance of the team in Sana'a to ensure quality of care.
- e) Establish a rehabilitation programme for women with fistula including social reintegration.

43. *Sub-output 6: Tailored services for young women and men (with particular focus on young married women).*

The aim of this intervention is to establish a network of functional health counselling and service centres for youth. Existing health facilities, community centres, youth clubs, Community Based Organisations, or other facilities/gathering points will be mapped to identify potential hosts for health counselling and service centres. Concurrently, a minimum package of services to be offered at the youth friendly centres will be developed. To gain support for this initiative, advocacy will be carried out for an audience of policy makers and health service managers. The capacity of the latter to manage youth friendly facilities will be strengthened through specific training.

44. *Sub-output 7: MISP services in emergency humanitarian settings provided.*

This will include competency based training of service providers on MISP services, with particular attention to ASRH and response to and prevention of GBV cases. Support will be provided to health institutions, including NGOs, to provide MISP in humanitarian settings, e.g. through building NGO capacity to manage mobile clinics and teams. RH and Dignity kits will be prepositioned in the targeted governorates and distributed in case of emergency. The programme will also support IDP profiling in cooperation with other actors. Furthermore, governorate councils will be supported to develop a preparedness/contingency plan for their governorate. Since the number of GBV cases usually rise in crisis situations, UNFPA will work to build capacities and skills to be able to respond to such conditions if they arise.

45. **Output 4:** Access to reliable disaggregated socio-economic and demographic data at central and local level is improved.

The programme aims at enhancing advocacy and evidence-based policy dialogue to develop and adopt well informed policies and programmes addressing national priorities. Among these priorities as identified in the 4th national development plan, are reducing maternal mortality and population growth rate through increased prevalence of family planning to reduce fertility, improve gender equality and economic empowerment of women, poverty reduction and improving health conditions at large. Programme support to data collection and analysis should help identify sub national disparities with regard to each of these priority issues and identify most disadvantaged groups and characteristics associated with sub national areas and groups. For example, the population census can

be the source of data to inform about areas having high maternal mortality, high rates of population growth, high poverty and gender disparities. The PAPFAM/DHS can provide more detailed data, which facilitate more in-depth and advanced analysis to define direct and root determinants of various issues. Such analysis should help prepare policy briefs and other policy dialogue materials. PAPFAM/DHS survey can help address programmatic issues in targeted governorates in more detail allowing in-depth policy oriented analysis. This can be achieved through over sampling in these governorates.

The programme aims at building the institutional and personnel capacity of the national partners to generate, analyse, and disseminate disaggregated data by sex and age about maternal health, GBV, and humanitarian emergencies.

46. Sub-output 1: Support implementation of PAPFAM/DHS, Census, Rapid Assessments, and dissemination of results.

The implementation of two major events will be supported: the PAPFAM/DHS, and the 2014 Census. The PAPFAM/DHS, which could not be conducted in 2011 because of the unrest in the country, will be supported financially and technically. More in particular, the feasibility of including the maternal mortality (MM) module at governorate level will be assessed. As for the 2014 Census, UNFPA will provide financial and technical support to implement the Census as well as introduce a module on MM, especially because the current available estimates are controversial. In addition, the programme will advocate with international agencies to obtain their financial support for the Census.

47. Given the deteriorating humanitarian situation in the country, the programme attaches a high importance at strengthening the capacities of government and civil society partners in conducting Rapid Assessments.

48. The programme will support government departments to disseminate the results of the DHS, the 2014 Census, and other collected data as they provide evidence for decision-makers on maternal health and other RH indicators.

49. Sub-output 2: Support government (MoPHP and WNC) to generate and analyse data to monitor their work.

The programme will support the government and civil society partners to collect evidence through carrying out operational research related to RH, youth, and gender equality in order to monitor their interventions and inform their programming.

50. **Output 5:** Capacity of government and civil society organisations to utilize data in addressing and planning processes at all level improved.

This output builds on the previous one and aims at encouraging the utilisation of collected data in national and sectoral development plans.

51. Sub-output 1: Government departments integrate population, RH, youth, and gender issues in their annual plans and monitor their implementation.

The programme will advocate for the systematic integration of population, RH, youth, and gender issues into government development plans, governorates and sectoral plans. Build government and civil society staff capacity to access and analyse socio-economic and demographic data to this end. Training will also be provided to help government and civil society staff to monitor programme progress and carry out evaluations.

52. *Sub-output 2: Coordination amongst government institutions on population issues improved.*

A review will be carried out of the current coordination mechanisms with regard to population issues in the country. Based on this review measures will be taken to strengthen the coordination. The Technical Secretariat of the NPC will be supported to carry out its coordination and advocacy role.

II) Interventions Demand Side

53. The interventions described below will contribute to the realization of the following outputs mentioned in the CPD.

- Output 2: Demand for family planning, and other reproductive health services increased.
- Output 3: Youth friendly reproductive health services and life skills education enhanced.
- Output 6: Community knowledge and awareness, in order to empower men, women, boys and girls to exercise their reproductive rights, especially to prevent early marriage, female genital mutilation/cutting (FGM/C) and gender-based violence, improved.

54. **Output 2:** Demand for family planning, and other reproductive health services increased;
Output 3: Youth friendly reproductive health services and life skills education enhanced.

Awareness raising of the benefits of child spacing, delaying the age of marriage and a comprehensive program for health education at the community level to both men and women, will contribute to raising demand for Family Planning services, Skilled Birth Attendants (SBAs), EmONC, and fistula. At the core of this intervention will be awareness raising on Reproductive Rights and the importance of accessing Reproductive Health services in general as well as campaigns to raise awareness of the existence of services to repair fistula and integrate survivors back into their communities. Additionally, by identifying the obstacles to utilization of health services including the issues related to the second delay such as transportation. Communities will also be encouraged to set up support systems to improve access to health facilities.

The capacity of young women and men will be built to improve their knowledge and understanding of their own reproductive rights. Within this context, there will also be an effort to increasing youth participation in Y-peer networks or other networks that will provide them with skills for advocacy and reaching out to their communities, in response to youth aspirations for more social and political participation, expressed during the youth uprising in 2011. Participation in public activities and building the capacity of youth to be involved in open discussions and debates will help them to improve their chances in the labour market and their contribution to their societies. It is expected that the young people, being a dynamic part of their communities, will be actively involved in demand creating initiatives, and facilitating a number of them.

All interventions described below will contribute to the two above mentioned outputs.

55. *Sub-output 1: A Communication Strategy for behaviour change and development with a focus on Reproductive Rights and utilization of Reproductive Health services developed.*

In the first phase, data will be collected, including through a KAP study, on various issues related RR and RH services, youth, and gender. This should provide evidence about the level of awareness on RR, access to RH services, perceptions of Family Planning and birth spacing,

the role of midwives in the communities, attitudes towards fistula, FMG, GBV, youth perspectives on early marriage, youth sources of information on RH, voluntarism and youth participation and adult acceptance.

56. In a second phase, the data will be disseminated in a culturally sensitive way to stakeholders. Different groups of stakeholders will be identified and community leaders involved. Attention will be paid to involve men. The data will be analysed in a participatory manner and consensus will be built on major issues. Target audiences will be identified and support programmes developed for allies. Role models will be identified as well as entry points for development.

The programme will advocate for the integration of the Communication Strategy in the local plans of the targeted governorates, with local budget allocation.

57. *Sub-output 2: An Action Plan for behaviour change and development implemented.*

In a third phase, the Communication Strategy will be translated to an Action Plan to be implemented in each target governorate. Effective channels for communication will be identified and messages developed. Role models will be supported.

58. *Sub-output 3: Peer education/ counselling and life skills strategies scaled up.*

This intervention will focus on strengthening the skills of both peer educators and counsellors. While the existing national Y-Peer Network will be expanded, to reach 1000 core members by 2015, its Knowledge and Skills Management Component will be strengthened through training and expansion of the pool of master trainers. The contents of the training package will be adapted to the Yemen situation, including the needs of illiterate audience, while it will also be adjusted to go beyond HIV/AIDS to include peer counselling, civic participation, and peer education in humanitarian settings. This should strengthen the knowledge and skills of young people on matters related to RH and RR, and improve their chances to realize (self) employment.

Furthermore, the roles and responsibilities of Peer counsellors will be defined, as well as a specific training package for counselling. In addition, referral protocols will be developed, contributing thus to establishing links with youth friendly reproductive health services identified under sub-output 6 described under interventions of the Supply side.

59. *Sub-output 4: The demand of communities for RH services monitored.*

The main issues to be monitored are demand for Family Planning services and safe deliveries. A baseline and end line to measure change in knowledge and attitudes will be established. Variations in demand will be monitored in order to adjust the implementation of the programme if required.

60. **Output 6:** Community knowledge and awareness, in order to empower men, women, boys and girls to exercise their reproductive rights, especially to prevent forms of gender-based violence such as early marriage and female genital mutilation/cutting which contribute to high maternal mortality and morbidity, improved.

61. *Sub-output 1: Legislations and laws related to RR respect gender equality.*

A study of legislations and laws from a gender perspective has been carried out recently, and recommendations for improvement have been formulated. The programme will support financially and technically an advocacy campaign to be carried out by partners from the government and civil

society. This campaign will target key influential persons and decision makers, in particular Members of Parliament to support elements of RR that contribute to maternal mortality.

62. *Sub-output 2: Reports on CEDAW and other international agreements related to RR published.*

The Yemen CO will support the government and other actors with writing reports for CEDAW and other international agreements, and disseminate them to inform advocates of the maternal health challenges in the country.

63. *Sub-output 3: Young women, including disabled women, empowered to practice their RR.*

UNFPA will focus on advocacy, using Role Models and community initiatives to empower women (including the most vulnerable), while providing them with basic life, social and health skills.

64. *Sub-output 4: Men and boys have a positive attitude with regard to gender equality and reproductive rights.*

The above mentioned Communication Strategy will include interventions aimed at men – heads of households and decision makers at family level - elaborating on gender and RR issues, including GBV. It is expected that this will feed initiatives and activities at community level, leading to higher awareness with regard to gender equality and RR, and on the negative impact of GBV on women, children, and households in general, encouraging behaviour change of men.

Part V. Partnership Strategy

65. UNFPA Yemen CO will partner with other UN agencies particularly UNICEF and WHO to implement the Secretary General Joint Action Program for women and children (2010) aiming to monitor the progress towards achieving MDG 4 and 5 at the country level and to support the government's efforts to achieve MDG 5 given the high maternal mortality and morbidity in Yemen.

66. Additionally, UNFPA will support midwifery program, in collaboration with WHO and the World Bank, to provide alternatives for trained midwives to provide maternal health services, including ante-natal care, counselling for family planning, attending to birth at the community level and referring women to EmONC when needed. The program will include providing supervision, on the job training and incentives to work at the community level.

67. UNFPA will partner with ILO to strengthen midwifery in Yemen particularly by creating alternatives to trained midwives who were not employed due to the existing human resources for health policies.

68. UNFPA is also planning to partner with KFW to strengthen the maternal health program and reduce maternal mortality particularly in humanitarian settings.

A partnership will be concluded with Norwegian Refugee Committee (NRC) to strengthen the humanitarian response capacity of the UNFPA Yemen CO.

Partnerships will also be concluded with the Embassy of the Kingdom of the Netherlands to support the provision of Family Planning commodities, with the British Council to provide training in Basic Social and Life skills for women, with GIZ, for the improvement of the quality of RH services at governorate level, with Yamaan to create demand for RH services, and with DFID to support the DHS and Census.

69. UNFPA have selected following Implementing Partners (IPs): Ministry of Public Health and Population (MoPHP), Women National Committee (WNC), National Population Council (NPC),

Yemen Family Care Association (YFCA), Charitable Society for Social Welfare (CSSW), Yemen Midwife Association (YMA), and any other IPs that are deemed to be necessary for the implementation of the CPAP following the UNFPA procedures in selecting the IPs. At the start of the programme, the management and programmatic capacities of all selected IPs will be assessed by independent auditors.

Part VI. Programme Management

70. The management arrangements agreed upon are based on the following principles:

- sustainability of interventions
- building implementation capacity of national partners
- assuring adequate flow of communication, coordination and reporting, in particular at governorate level

71. The Ministry of Planning and International Cooperation (MoPIC), in its role as the Government Coordinating Authority (GCA), will be the Chair of the Steering Committee (SC), which will consist of all partners mentioned in chapter V, and will be held bimonthly or upon need basis. UNFPA will strengthen MoPIC capacity to assume its role of coordinator.

72. UNFPA will conclude partnerships with MoPHP, WNC, NPC, or other partners as mentioned in chapter V and a number of NGOs, who will implement interventions at central level, and interventions at governorate level through their governorate offices.

73. AWP will be developed by each partner in close cooperation with UNFPA programme and operational staff. These AWP will include interventions at central and at governorate level.

74. The interventions will be coordinated at central level by Central Coordination Team (CCT) consisting of and chaired by Director General of Reproductive Health at Population Centre. The interventions at governorate level will be coordinated by the Governorate Coordination Team (GCT), consisting of all implementing partners' offices/branches. The Health Office Director will chair the GCT and assure coordinated planning and implementation of all interventions.

The GCT will report to the Governorate Council to assure the flow of information and accountability locally.

75. UNFPA will provide technical support to build partners capacities in the field of planning, implementation, coordination, reporting, financial management, at central and governorate levels, and to assure that government and/or UNFPA procedural requirements are respected.

76. The implementation modality will be National Execution (NEX) (advances, direct payment by UNFPA or reimbursement of IPs), and/or Direct Execution (DEX), in accordance with the outcome of the assessment of the IPs.

77. All cash transfers to an Implementing Partner are based on the Annual Work Plans agreed between the Implementing Partner and UNFPA. Each Implementing Partner will transfer funds to their offices at governorate level. Each partner will provide technical and financial reports to UNFPA CO, covering both interventions at central and governorate level.

Cash transfers for activities detailed in AWP can be made by a UN agency using the following modalities:

1. Cash transferred directly to the Implementing Partner:

- a. Prior to the start of activities (direct cash transfer), or
 - b. After activities have been completed (reimbursement);
2. Direct payment to vendors or third parties for obligations incurred by the Implementing Partners on the basis of requests signed by the designated official of the Implementing Partner;
3. Direct payments to vendors or third parties for obligations incurred by UN agencies in support of activities agreed with Implementing Partners.

Direct cash transfers shall be requested and released for programme implementation periods not exceeding three months. Reimbursements of previously authorized expenditures shall be requested and released quarterly or after the completion of activities. The UNFPA shall not be obligated to reimburse expenditure made by the Implementing Partner over and above the authorized amounts.

78. Following the completion of any activity, any balance of funds shall be reprogrammed by mutual agreement between the Implementing Partner and UNFPA, or refunded.

79. Cash transfer modalities, the size of disbursements, and the scope and frequency of assurance activities may depend on the findings of a review of the public financial management capacity in the case of a Government Implementing Partner, and of an assessment of the financial management capacity of the non-UN10 Implementing Partner. A qualified consultant, such as a public accounting firm, selected by UNFPA may conduct such an assessment, in which the Implementing Partner shall participate.

80. Cash transfer modalities, the size of disbursements, and the scope and frequency of assurance activities may be revised in the course of programme implementation based on the findings of programme monitoring, expenditure monitoring and reporting, and audits.

81. Strategy for Resource Mobilisation

The Government of the German Federal Republic will provide Euro 8m for Reproductive Health interventions for the first two years of the Programme.

The Government of the Embassy of Kingdom of the Netherlands- Yemen will provide US\$ 800,000 for Family Planning Commodity Security. UNFPA will continue to build a strategic partnership with the Government of the Kingdom of the Netherlands to sustain efforts to improve access to Reproductive Health services in the country.

UNFPA will equally explore the possibility to mobilise resources from the Government of Japan and from countries of the Gulf Cooperation Council (GCC).

Funds will be mobilised from CERF for humanitarian interventions.

Funds will be mobilised for interventions that are part of the Joint United Nations Framework to support the Transition in Yemen (2012 – 2013), through its funding mechanism.

82. Human Resources

The Yemen CO will contain Thirty staff members, cost classified as follows:

¹⁰ For the purposes of these clauses, “the UN” includes the IFIs.

Management: Representative, International Operations Manager, Finance Associate, Personal Assistant to the Representative and Deputy Representative, Administration Associate, Driver

Development: Deputy Representative

Programme: International Reproductive Health Specialist, International BCC Officer, Assistant Representative, Communication Officer, Monitoring & Evaluation Officer, Programme Officers (6), Project Coordinator, Programme Associate (2), Programme Assistant, Information Associate, Administrative Clerk (2), Drivers (3), Cleaners (2)

Part VII Monitoring and Evaluation

83. UNFPA and the Implementing Partners will be responsible for setting up the Monitoring mechanisms, tools, and conducting reviews in order to ensure monitoring and evaluation of the CPAP, with the view to ensuring efficient utilization of programme resources as well as accountability, transparency and integrity. The Implementing Partners will provide quarterly reports on the progress, achievements and results of their projects, outlining the challenges faced in project implementation as well as resource utilization as articulated in the AWP, and a request for funds for the next quarter.

84. Annual review meetings will be held by the Steering Committee (SC), under the Chairmanship of the Government Coordinating Authority (GCA), to assess progress towards achieving outcomes of the CPAP (based on UNDAF results matrix), draw lessons learned, best practices and raise recommendations for a way forward. In addition, periodic programme coordination meetings will be conducted with Implementing Partners, both at central and at governorate level, to monitor progress of AWP's and to facilitate coordination amongst partners and information exchange.

85. Implementing partners agree to cooperate with UNFPA for monitoring all activities supported by cash transfers and will facilitate access to relevant financial records and personnel responsible for the administration of cash provided by UNFPA. To that effect, Implementing Partners agree to the following:

1. Periodic on-site reviews and spot checks of their financial records by UNFPA or its representatives,
2. Programmatic monitoring of activities following UNFPA's standards and guidance for site visits and field monitoring,
3. Special or scheduled audits. UNFPA will establish an annual audit plan, giving priority to audits of Implementing Partners with large amounts of cash assistance provided by UNFPA, and those whose financial management capacity needs strengthening.

86. To facilitate assurance activities, Implementing partners and the UN agency may agree to use a programme monitoring and financial control tool allowing data sharing and analysis.

87. The audits will be commissioned by UNFPA and undertaken by private audit services.

Assessments and audits of non-government Implementing Partners will be conducted in accordance with the policies and procedures of UNFPA.

88. As part of the UNCT, UNFPA will participate in the UNDAF M&E Task Force in the Mid Term Review and the Annual Reviews, to assess the progress and achievements of the UNDAF outcomes and priorities as related to UNFPA mandated interventions.

Part VIII Commitments of UNFPA

89. UNFPA Executive Board has approved a total of financial support of Twenty Five million US Dollar for the period 2012 – 2015, of which Ten million US Dollar are to be secured from UNFPA Regular Resources, pending availability of funds, as well as Fifteen million US Dollar to be mobilised from other resources, subject to donor interest. While these amounts are exclusive of funding required or received in response to emergency appeals, they will be dedicated to the implementation of the earlier described CPAP outputs, their respective sub-outputs and key interventions.

90. Details on yearly allocation of UNFPA funds in support of CPAP interventions will be reviewed and further detailed through the preparations of the AWP. UNFPA funds are distributed by calendar year, in accordance with this CPAP and subject to availability of funds. During the review meetings, respective Implementing Partners will examine the implementation rate for each AWP. If the implementation rate of any programme component is below the annual estimates, funds may be re-allocated to other priority AWP.

91. In case of direct cash transfer or reimbursement, UNFPA shall notify the Implementing Partner of the amount approved by UNFPA and shall disburse funds to the Implementing Partner within two weeks after a formal and signed request.

92. In case of direct payment to vendors or third parties for obligations incurred by the Implementing Partners on the basis of requests signed by the designated official of the Implementing Partner; or to vendors or third parties for obligations incurred by UNFPA in support of activities agreed with Implementing Partners, UNFPA shall proceed with the payment within two weeks.

93. UNFPA shall not have any direct liability under the contractual arrangements concluded between the Implementing Partner and a third party vendor.

94. Where more than one UN agency provides cash to the same Implementing Partner, programme monitoring, financial monitoring and auditing will be undertaken jointly or coordinated with those UN agencies.

Part IX Commitments of the Government

95. The Government will honour its commitments in accordance with the provisions of the Agreement with UNDP of 18 May 1992, which applies *mutatis mutandis* to UNFPA as stated in the letters exchanged between UNFPA and the Ministry of Planning and International Cooperation in December 1996. In line with this Agreement, the Government will grant to UNFPA and its officials, and to other persons performing services on behalf of the UNFPA, such facilities and services as are granted to officials and consultants of the various funds, programmes and specialised agencies of the United Nations. The Government shall apply the provisions of the Convention on the Privileges and Immunities of the United Nations Agencies to the UNFPA's property, funds, and assets and to its officials and consultants.

Starting 1996, the Government of Yemen has pledged for, and paid to UNFPA, a national contribution. The current contribution to UNFPA is in amount of 30,000 US\$ per year.

In addition, the Government will provide in-kind contributions, including staff salaries and the operating costs of clinics.

96. The Government will support UNFPA's efforts to raise funds required to meet the financial needs of the approved CPAP. In that context, it will authorize the publication through various national and international media of the CPAP results and experiences derived.

97. A standard Fund Authorization and Certificate of Expenditures (FACE) report, reflecting the activity lines of the Annual Work Plan (AWP), will be used by Implementing Partners to request the release of funds, or to secure the agreement that UNFPA will reimburse or directly pay for planned expenditure. The Implementing Partners will use the FACE to report on the utilization of cash received. The Implementing Partner shall identify the designated official(s) authorized to provide the account details, request and certify the use of cash. The FACE will be certified by the designated official(s) of the Implementing Partner. The FACE will be supported by a quarterly progress report.

98. Cash transferred to Implementing Partners should be spent for the purpose of activities as agreed in the AWP's only.

99. Cash received by the Government and national NGO Implementing Partners shall be used in accordance with established national regulations, policies and procedures consistent with international standards, in particular ensuring that cash is expended for activities as agreed in the AWP's, and ensuring that reports on the full utilization of all received cash are submitted to UNFPA within six months after receipt of the funds. Where any of the national regulations, policies and procedures is not consistent with international standards, the UN agency regulations, policies and procedures will apply.

100. In the case of international NGO and IGO Implementing Partners cash received shall be used in accordance with international standards in particular ensuring that cash is expended for activities as agreed in the AWP's, and ensuring that reports on the full utilization of all received cash are submitted to UNFPA within six months after receipt of the funds.

101. To facilitate scheduled and special audits, each Implementing Partner receiving cash from UNFPA will provide UN Agency or its representative with timely access to:

- all financial records which establish the transactional record of the cash transfers provided by UNFPA;
- all relevant documentation and personnel associated with the functioning of the Implementing Partner's internal control structure through which the cash transfers have passed.

The findings of each audit will be reported to the Implementing Partner and UNFPA. Each Implementing Partner will furthermore:

- Receive and review the audit report issued by the auditors.
- Provide a timely statement of the acceptance or rejection of any audit recommendation to UNFPA that provided cash. Undertake timely actions to address the accepted audit recommendations.
- Report on the actions taken to implement accepted recommendations to the UN agencies.

Part X. Other Provisions

This CPAP supersedes any previously signed CPAP.

This CPAP may be modified by mutual consent of both parties.

Nothing in this CPAP shall in any way be construed to waive the protection of the UNDG Agency accorded by the contents and substance of the United Nations Convention on Privileges and Immunities to which the Government is a signatory.

IN WITNESS THEREOF the undersigned, being duly authorized, have signed this Country Programme Action Plan on this day of 10 March 2012 in Sana'a, Republic of Yemen.

For the government of the Republic of Yemen

For UNFPA

H.E Mr. Mohammad Al-Saadi

Marc Vandenberghe

Minister of Planning and International
cooperation

UNFPA Representative