This action is funded by the European Union

ANNEX

to the Commission Implementing Decision C(2013) 7581 on the 2013 Annual Action Programme part 2 in favour of Yemen for Health and Livelihoods to be financed from the general budget of the European Union

Action Document for
Enhancing resilience in Yemen: strengthening health systems

INFORMATION FOR POTENTIAL GRANT APPLICANTS

WORK PROGRAMME FOR GRANTS

This document constitutes the work programme for grants in the sense of Article 128(1) of the Financial Regulation (Regulation (EU, Euratom) No 966/2012) in the following sections concerning grants awarded directly without a call for proposals: 5.3.1.2

1. Title/basic act/CRIS number

Enhancing resilience in Yemen: strengthening health systems
CRIS number: DCI-MIDEAST/2013/024-497 Addendum 1
financed under Development Cooperation Instrument

2. Zone benefiting from the action/location

Republic of Yemen
The geographical area(s) where the operation will be executed will be determined at a later stage according to needs, access and coordination issues. The project team will be tentatively based in Sanaa.

3. Programming document

MIP 2007-2013, Annual Action Programme 2013 part 2 in favour of Yemen for Health and Livelihoods to be financed from the general budget of the European Union

4. Sector of concentration/thematic area

Health personnel development
DEV. Aid: YES

5. Amounts concerned

Total estimated cost: EUR 18 000 000
Total amount of EU budget contribution EUR 18 000 000

6. Aid modality(ies) and implementation modality(ies)

Project Modality
Direct management procurement of services
Direct management – grant in direct award to UNICEF

7. a) DAC code(s)

12281 Health Personnel Development; 12110 - Health policy and administrative management

b) Main Delivery Channel

41000 United Nations agency

8. Markers (from CRIS DAC form)

<table>
<thead>
<tr>
<th>General policy objective</th>
<th>Not targeted</th>
<th>Significant objective</th>
<th>Main objective</th>
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<tbody>
<tr>
<td>Participation development/good governance</td>
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<td>Aid to environment</td>
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<td>Gender equality (including Women In Development)</td>
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SUMMARY
The proposed action requires an amendment to the Annex I to the Commission Implementing Decision C(2013) 7581, "Enhancing resilience in Yemen: strengthening health systems", which has been suspended since 2015 due to the military conflict in Yemen (RAC and RAL remain untouched at their initial EUR 18 000 000). The original overall objective of this decision is to improve the health status of the population of Yemen.

It is proposed to relaunch the concerned action, which has been adjusted based on the recent feasibility assessment. Despite the on-going conflict local organisations involved in basic service delivery confirm that access is possible to around 70% of districts in the country, provided that a politically neutral approach is maintained. However, due to constraints related to working with the government, it is proposed to narrow the scope of the capacity development of the Ministry of Public Health and Population and to shift primarily to a bottom-up approach concentrating on community based service delivery to become an integral part of the future primary health care system.

The revised overall objective of this action is to improve the health status of the population of Yemen through supporting an enabling environment of improved resilience in rural areas. The specific objective is to improve access for rural communities to equitable quality primary health care services through a community health workers' network. The expected results are:
(1) the network of community health workers is reinforced and expanded to additional Governorates with capacity to deliver basic health and nutrition services;
(2) essential health and nutrition services to communities in the related Governorates are delivered through the community health workers' network with referral to health facilities when required;

The original implementation modality through Programme Estimates with the government, which became unfeasible due to decreased management capacities of the ministry, is proposed to be replaced with a direct grant to UNICEF to implement the major part of the action at central and local levels, and to complement it with a service contact dedicated to the capacity development of the Ministry of Health and Population.

The narrowed and more feasible scope of the action shall enable delivery of tangible results supporting sustainability and early recovery of local and central state institutions and geographically expanded inclusive coverage of the primary health care system. The centralised implementation modalities will allow for good entries into a wider policy dialogue at the central and local levels, with involvement of WHO and the EU whenever feasible.

The major part of the proposed action will be implemented by UNICEF, which has been engaged in programmes related to access to primary health care services in rural communities and supporting their
long term viability with the Ministry of Public Health and Population, including its field offices, and with CSOs and local authorities. In specific localities where needs are significant and Governorates Health Offices lack capacities UNICEF could sub-grant activities to NGOs already present in the areas.

The on-going operations of UNICEF are supported by the EU through a contract¹, which focuses on support to the policy framework and its implementation in selected geographical areas. While the network is being established and integrated in the overall Yemeni primary health care service delivery system, related life threatening needs burst out and mixed interventions multiply through community health workers and volunteers, community midwives, mobile teams and integrated outreach rounds.

The proposed action will complement the on-going EU assistance, to strengthen and geographically expand the community health workers' network using the consensus and a model agreed with the Ministry of Public Health and Population as well as the existing training and supplies plans.

1 CONTEXT

1.1 Sector/Country/Regional context/Thematic area

Yemen is among the largest forgotten crises in the world, with a looming famine, devastating cholera outbreak, and with the economy and state institutions collapsing. With more than half of the 27.4 million populations already below the poverty line, Yemen has long been a Least Developed Country and the poorest in the region.

The full-blown war that erupted in March 2015 has resulted in an estimated 18.8 million people (more than 68% of the population) in need of humanitarian assistance including 10.3 million who are in acute need and 460,000 children under age five risk severe, acute malnutrition². The displaced population (at least 3.11 million as of November 2016) faces additional constraints in terms of access to shelter, food, health services, education and livelihoods opportunities. Vulnerable groups are, due to their social and economic status within the Yemeni society, likely to have less access to opportunities and are more strongly affected by shocks.

The Yemeni economy is being destroyed. Since 2015, the gross domestic production deficit rate has maintained a downward trend, ranging between 10-15%³. Despite the raising inflation rate that averagely reached 30% in 2015, basic commodity prices rose in 2016 by 30% on average and most goods are only sporadically available in markets. The Disaster Needs Assessment⁴ estimated $19 billion in infrastructure damage and other losses – equivalent to about half of the GDP in 2013.

Further reduced public services exacerbated a plight of people’s lives. Even prior to the conflict, local authority services covered only 35.2% of the population. Currently, many local civil servants do not report to the offices due to insecurity, lack of electricity and transportation, damages of office buildings and more recently non-payment of salaries. Most public sector salaries – on which about 30 per cent of the population depend – have been paid irregularly in the past several months, reducing their ability to cope with the crisis.

The health system faces significant challenges of:
- chronic lack of essential commodities : as of October 2016, at least 274 health facilities have been damaged or destroyed. Only 45% of them are functioning, 38% are partially functional and

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¹ DCI-MED 2014/034-715 signed in December 2015 "Enhancing rural resilience through the creation of a community health workers network in Yemen"
² 2017 Humanitarian needs overview, OCHA
³ 2016 Studies and economic media centre
⁴ Yemen – Disaster Needs Assessment, April 2016, EU, World Bank, UNDP, Islamic Bank for Development
17% are completely non-functional. 18% of hospitals have been affected by damages. The ability of the health system to respond to curative needs, full and general trauma services has significantly decreased, 

- short supply and weak logistic system,
- shortage of health workers in general: as of October 2016, 13 health workers have been killed and 31 injured and female health workers specifically. Many health staff does not report to work and is looking for alternative means of livelihood,
- poor links between health facilities and communities.

The challenges of effectively running the existing health facilities also point to their inability to deliver outreach services with regularity. Over 54% of the population is in need of support to access adequate healthcare including 8.8 million people living in severely underserved areas (mainly the poor and rural segments). Vulnerable segment of the population – children, women, elderly, internally displaced – are at grave risk of excess illness and loss of life.

1.1.1 Public Policy Assessment and EU Policy Framework

In 2016, the MoPHP has defined strategic plans per priorities (in the framework of a EU-EPOS service contract). The 2017 Primary Health Care plan mentions the role of Community Health Volunteers/Workers in in relation to outreach services as one specific component of the plan. The sector intends to provide capacity training for Community Health Volunteers/Workers about the ‘Integrated Management of Childhood Illnesses’. Community Health Volunteers/Workers are normally treated as part of the PHC provider network and considered to be the frontline workers especially in remote areas. In the plan they are tasked with health and nutrition education, promotion and support to immunization campaigns and integrated outreach rounds.

The EU priorities for the health sector are outlined in the 2010 European Commission Communication on the EU Role in Global Health and the related Council Conclusions. This emphasises solidarity, equity and universal coverage with quality health services and prioritizes strengthening health systems through comprehensive support to the main components – health workforce, access to medicines, infrastructure and logistics, financing and management and financial protection. These are also in line with

i) Council Conclusions of 19 May 2017 on Operationalising the Humanitarian-Development Nexus;
ii) The European Commission Joint Communication to the European Parliament and the Council SWD(2017) 227 of 7 June 2017: A Strategic Approach to Resilience in the EU's external action; and
iii) The action will focus on access to basic services in particular to health as defined in the priority 2.1 "People – human development and dignity" of the 2017 European Consensus on Development, which states in the paragraph 27: "(...) the EU and its Member States will support developing countries in health workforce training, recruitment, deployment and continuous professional development. They will promote investment in and empowerment of frontline healthcare and social workers, who play a critical role in ensuring coverage of healthcare services in remote, poor, underserved and conflict areas."

In 2011, EU, WHO and Luxembourg entered into a collaborative agreement called "Universal Health Coverage Partnership" to support policy dialogue with the view of promoting universal health coverage, people-centred primary health care and health in all policies, which entered in its third phase in 2016 in 27 countries including the Republic of Yemen.

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In 2015, the EU and UNICEF engaged a dialogue on strengthening their "partnership for better health and education" out of which was defined in February 2017, an health reference pack to provide practical guidance to Delegations of the European Union and UNICEF Country offices staff in the design and implementation of an action in the health sector. It will provide a common platform for Delegations of the European Union and UNICEF Country Offices to interact more easily during the implementation of the proposed action.

1.1.2 Stakeholder analysis

The health system's main stakeholders are its users. An estimated 14.8 million people lack access to basic healthcare, including 8.8 million living in severely underserved areas. About 3.3 million children and pregnant or lactating women are acutely malnourished, including 462,000 children under 5 suffering from severe acute malnutrition. This represents a 57 per cent increase since late 2015 and threatens the lives and life-long prospects of those affected. An estimated 14.5 million people require assistance to ensure access to safe drinking water and sanitation, including 8.2 million who are in acute need, which adds further to health risks and increased need for medical service. The risk is that thousands of children will continue to face death from preventable causes. Additional limitation of access to health service for women, girls, and households headed by women is linked to cultural barriers related to interaction with pre-dominantly male Community Health Workers. Vulnerable and affected groups, including pregnant or lactating women, and sufferers of chronic or critical illnesses, will be targeted, as well GBV survivors.

The main institutional partner will be the Ministry of Public Health and Population (MoPHP), its Governorate Health Offices (GHOs) and their affiliated District Health Offices (DHOs). The EU Delegation to Yemen has built working relationship with MoPHP and has currently a team of 5 Yemenis working within premises of the MoPHP through a service contract (2014/341-149) aiming at building its institutional capacities and creating coordination mechanism that enables the MoPHP to steer its sectors and departments internally as well as lead the subnational governance levels and development partners. The same service contractor (EPOS) will maintain and enhance its team to foster MoPHP's capacity building in the framework of the MoPHP 2017 primary health care plan and to facilitate the implementation of the proposed action at Governorate level.

Community Health Volunteers (CHVs) and Community Midwives-- while MoPHP leadership is committed to the capacity building of community health volunteers and their voluntarily recruitment without any specific incentives or salaries, their involvement in the network and linkages are agreed to be important. They would benefit from capacity development and establishing a professional career perspective to become integral part of the health care system. Community Health Workers MoHP does not have sufficient financial resources to pay salaries, therefore substantial donor funding expected to be channelled through UNICEF would provide for continuity of service and capacity development. There is a need to increase the limited number of women working as CHVs and CHWs.

Since 2016 and under EU funds, UNICEF has been engaged in development of the CHW network in consultation with the MoPHP providing technical assistance in drafting the strategic documents for the overarching model of the network which will include community health workers, volunteers, community midwives and other health workers who operate at community-level. UNICEF has initiated support to the MoPHP to build its capacity by finalising the establishment of a unit within the Ministry to ensure the functionality and sustainability of the CHWs network in the future. The foreseen main functions of this unit are:

- Administration of the program including planning (preparation of guidelines for annual planning and reporting), reporting and follow up from the Governorate Health Offices, recruitment of health workers, health workers' training, finance and supplies management.
- Coordination of inputs from the different technical programs.
- Monitoring and Evaluation of the program implementation at different levels.
- The following sub-units can be considered within the organizational structure of the unit: finance, supplies, human resources and training and information.

A first step has been made towards the institutionalisation of the unit, which will be governed by a steering committee. The project steering committee was established by a ministerial decree and identified the unit for all community based health and nutrition initiatives in the health sector. This committee will oversee the detailed organisational development of the unit and its functions. UNICEF and MoPHP held a brainstorming session to discuss the structure, role and responsibilities of the unit. UNICEF drafted the Terms of Reference for the unit, discussed and agreed with the MoPHP. Technical assistance has been in place as of the end of February 2017 to assist the steering committee/MoPHP in drawing the structure and the administrative requirements in terms of technical arrangement and internal organisation including the standards operating procedures for the unit work.

The Ministry of Public Health and Population has appointed a full time Director for the Project, within the mandate of Primary Health Care sector in the Ministry of Public Health & Population and under the directorate of Family Health. The unit director is tasked to act as the steering committee secretary.

MoPHP also has allotted the space for the office of the CHWs Project Implementation Unit (PIU). The project steering has been activated in February 2017. The CHWs model has benefitted from extensive discussions. Initially three possible models were devised and they were discussed within UNICEF and also with other stakeholders in detail. After a series of meetings and discussions there was an agreement on the following model: each CHW will supervise 10 CHVs. Each CHV will be responsible for provision of services to 30 households (approximately 210 individuals based on an average family size of 7 in Yemen), each CHW will be indirectly responsible for 2,100 individuals. Terms of references of CHW and training modules have been finalised and will be used for the establishment of the CHW network in initial six governorates – Hajjah, Hodeidah, Lahj, Sa’ada, Sana’a and Taiz.

World Health Organization (WHO) works in close coordination with the Ministry of Health and Population under its specific mandate. WHO is actively supporting information management capacities at the central and local levels through its Health Resources and Service Availability Mapping System (HeRAMS) data platform and underpins its humanitarian health response under the health cluster in Yemen. In 2016, the HeRAMS assessed 3,507 health facilities in 16 Governorates. In addition, the proposed action will use the momentum to activate further the "Universal Health Coverage Partnership" in Yemen so that WHO enhances its support to the MoPHP with the aim to develop a policy dialogue in support of the proposed action (drafting a road map for Yemen in areas related to the community health workers' network such as MoPHP capacity building, decentralisation, or human resources). UNICEF will link with WHO to ensure complementarity and results.

In recent months, the World Bank has announced $500 million in funding for livelihoods, health and nutrition activities in Yemen. Grants will be channelled through UN agencies to provide income opportunities for the poorest families and to support essential social services including health and nutrition services that have been especially hard hit in the crisis ($200 million will be channelled through UNICEF and WHO to support primary and referral health care activities).

1.1.3 Priority areas for support/problem analysis

In 2010, the Government adopted a 15-year National Health Strategy accommodating the needs arising from the sub-national level. The pre-conflict health system was already profoundly challenged by several political and socioeconomic developments, including population growth, food and water scarcity, political instability and economic stagnation. Healthcare services were characterized by significant levels of dissatisfaction among both, patients and providers. The poorly equipped facilities, chronic shortages of drugs and medical supplies, poor
geographical coverage, limited budget allocated for operational costs and staffing, and low institutional capacity in health management skills and systems all contributed to the low quality and quantity of health care services.

Since March 2015, there has been a surge in civilian morbidity and mortality as an indirect consequence of the conflict. These include disease outbreaks, unmet demands for medical treatment, reduced uptake of health services due to increasing levels of poverty, lack of essential drugs and medical supplies, and deterioration of nutrition status leading to a close-to-collapse health system. Medical materials are in chronically short supply, and only 45 per cent of health facilities are functioning. As of October 2016, at least 274 health facilities had been damaged or destroyed, 13 health workers had been killed and 31 injured.

In August 2016, the Ministry of Public Health and Population (MOPHP) in Sana’a announced it could no longer cover operational costs for health services, and by October, only 45 per cent of health facilities in the country were fully functional. Absenteeism among key staff – doctors, nutrition counsellors, teachers is reportedly rising as employees seek alternatives to provide for their families.

While in Yemen there is an overall shortage of health professionals, their unbalanced geographic distribution penalizes first and foremost the rural communities. This is due to security issues. Additionally, the dominance of male health workers decreases the accessibility for women and girls, which needs to be addressed as according to recent assessments increasing number of households are headed by women.

The overarching assumption here is that by supporting increased access to an equitable and essential package of health services, the community resilience will improve. The existing inequities between urban and rural areas that have increased for some interventions in the last few years and the increasing out of pocket expenses effecting poor households’ ability to seek care, both provide strong justification for focus on rural populations for provision of basic health services close to communities at minimal cost or free of cost.

2 RISKS AND ASSUMPTIONS

<table>
<thead>
<tr>
<th>Risks</th>
<th>Risk level (H/M/L)</th>
<th>Mitigating measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Further escalation of the current conflict to a point that the security situation impedes project implementation.</td>
<td>H</td>
<td>Capacity-building of local staff Yemeni partners to ensure continuation of project implementation if no international staff allowed on the ground. Target low conflict intensity areas and use remote management modalities.</td>
</tr>
<tr>
<td>Economic and financial collapse, which includes currency devaluation, hyperinflation, diminishing of foreign reserves, rupture of imports (high import dependency) and restrictions in the banking system. The Government is no longer able to fund the operational costs of the health facilities and there is a likely risk of salaries not being paid to health personnel due to</td>
<td>H</td>
<td>The intervention becomes all the more important as localized economic activity accrues importance. The risk cannot be mitigated through this project. The Yemeni Government in exile has made public announcement to pay all outstanding salaries to public officials.</td>
</tr>
</tbody>
</table>

7 Since the start of the cholera outbreak on 6 October 2016, the number of suspected cholera cases in Yemen has soared to 7700 of which 120 cases were confirmed and WHO reported 82 deaths associated with cholera in 12 governorates as of 14 December 2016.
the acute shortage of public resources.

<table>
<thead>
<tr>
<th>Control of geographical areas by different political and armed factions could lead to interference and inadequate targeting.</th>
<th>H</th>
<th>Direct assistance at community level including, if viable, working with local authorities at districts and communities' levels.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risks related to procurement, importation and transportation may include delay</td>
<td>H</td>
<td>Prepositioning / stockpiling of supplies in Djibouti warehouse to enable maximum use of windows of opportunities for moving supplies into Yemen. Use of different/ multiple ports of entry such as Hodeidah, Aden, Mukalla and Sanaa to deliver supplies into the country. Use of multiple transport companies within Yemen (UNICEF currently maintains LTAs with four such companies). Use of available UNICEF and partner warehouses for stockpiling of supplies for local needs Local procurement of non-medical supplies</td>
</tr>
<tr>
<td>Difficulty for women to participate in the intervention</td>
<td>M</td>
<td>Community outreach to explain the project’s objectives and importance of enrolling women. Awareness raising activities and engagement of local leaders in the process as well as local authorities to mainstream gender issues Include women as community health workers</td>
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Assumptions

The EU Delegation to Yemen will be based in Amman without perspective to have neither permanent nor temporary presence in Yemen. A service contract is foreseen to ensure third party monitoring.

First phase of the project has reached its expected result "policy making and coordination capacities of the system are effective in the design of an effective CHW strategy" and it is sustainable.

Implementing partners continue to operate with a sound financial management. They periodically conduct capacity assessments, together with financial spot checks and audits adapting to the fiduciary risk level identified.

The conflict and stalemate continue at the same current level or improve.

The project will liaise with de facto local authorities when government is not fully present. The project will not address issues which require changes in policies and legal frameworks.

The level of humanitarian crisis remains or will worsen. Focus on service availability to people/communities while public services may be further limited.

The Government will not have (or only limited) development and operational budget for public service delivery while salaries of civil servants will be paid sporadically. Operational support to local authorities will be provided to maintain minimum service delivery to people.

3 LESSONS LEARNED, COMPLEMENTARITY AND CROSS-CUTTING ISSUES

3.1 Lessons learnt

Lessons learnt out of the EU strategic approach to primarily target the Governorates' level and supporting the Health Development Councils (HDC) has been positive in terms of increasing local ownership and accountability.

The 2016 experience of CHW's network in Yemen implemented by UNICEF has showed that in the medium to long term the CHW network has been seen to evolve into more cross sectoral approaches
including water and sanitation, education linkage to safety net programmes, (as acknowledged by the district health policy of the beginning of the 2000s).

One of the key lessons learnt of UNICEF’s policy dialogue with MoPHP is the need for a cadre that is well embedded in the community but also maintains strong linkage with the health facility. Furthermore, the action proposed has taken into consideration the need to preserve and support the technical capacity of MoPHP staff as a core element of sustaining the integrity and future prospects of the health system. Creation of a paid cadre of such workers will also provide employment opportunities for communities and in terms of return on investment would probably be more sustainable than some of the other expenditures in the government fiscal space.

UNICEF had lead advocacy efforts to bring all stakeholders around the table for a discussion and agreement on the way forward to insure sustainability. The action proposes a sustainable extension of the formal health system beyond the health units into the communities. The decentralised approach focuses on behaviour change and skills development, and will ensure that individuals at community level are equipped with knowledge to be used long after support through this action ends. The action also aims to develop a clear career path structure from volunteer to paid health worker and possible beyond. In the current climate, the provision of incentives alongside training for CHVs and CHWs significantly improves the chances of service-providers continuing to provide basic health services in some form in the future.

Simplicity of design and a relative easy feedback mechanism, accounting for the existing scarcity of resources has also been mainstreamed in the on-going CHW’s project.

Considering the current level of fragility at the central level, lessons learned include the need to produce quick results at local level, promoting resilience-focused development approaches to strengthen the "the ability of an individual, a household, a community, a country or a region to withstand, to adapt and to quickly recover from stress and shocks." Working with community leaders is an important step towards establishing or maintaining community networks, supporting security and service delivery at community level, reducing hence the risk to fail in the long-term and contribute to the overall national capacity development. These could be potential entry points for integration of locally embedded early recovery and resilience mechanisms into programming.

### 3.2 Complementarity, synergy and donor coordination

The proposed action is part of a larger package which includes enhancing rural resilience in Yemen though improving livelihoods, using social protection mechanisms to increase communities’ resilience in fragile environment, enhancing rural resilience through the creation of a community health workers network and providing support to improve the security of the most vulnerable populations.

Through the thematic budget lines and the instrument contributing to stability and peace (ICSP), the EU still has complementary projects among which 4 started implementation in 2016, in promoting and protecting children rights, the role of women and marginalized groups in the Yemeni civil society as well as supporting human rights.
Since 2014, the EU is supporting MoPHP in its challenge to improve the health and nutrition status of the population through a service contracts with EPOS\textsuperscript{15} mainly at national level and in Hodeidah, Taiz, Lahj, Hajjah, Al Mahweet, Al Bayda. The successive technical assistance provided under these service contracts created and capacitated the Health Development Councils (HDC) in each Governorate. The HDCs became the platform to prioritize and programme health activities which was reinforced with accompanying skills development in local health systems management. Activities initiated by the HDC included mobilisation and training of community health volunteers who became important actors in disseminating information on reproductive health and promoting services at primary health care facilities.

UNICEF has also been engaged in policy discussion with the Ministry of Public Health and Population with the aim to support a shift of focus from facility based only to facility and community based interventions with continuous support to strengthening the health system. UNICEF has supported community and population based service delivery in Yemen for several years with scale up efforts intensified in 2012. While initial efforts were for nutrition interventions, UNICEF’s programme is evolving into a community based integrated health and nutrition programme. UNICEF has worked to expand the Community Health Volunteer network, to support development of clear national guidelines and Standard Operating Procedures (SOP) with over 7000 CHVs provided with initial training since 2012.

In 2017, UNICEF supported 171 mobile health teams and this year till date UNICEF is supporting 63 mobile health teams through NGOs/INGOs and Governorate Health Offices.

The proposed action will enhance synergies with the EU-UNICEF dialogue to bring it into practice.

The EU has been a strong supporter of integrated service delivery, along with donors such as KfW, GAVI, World Bank and DFID. Programmes including Expanded Programme on Immunization (EPI), Community Management of Acute Malnutrition (CMAM) and Integrated Management of Newborn and Childhood Illnesses (IMNCI) and other pertaining to maternal health were already in place prior to the conflict and some degree of integration was in place. But with the conflict and its consequences, these programmes have acquired increased importance given their life saving nature. The need for an integrated approach to service delivery as close to communities as possible is now more critical than ever not only to address the increasing loss of services since March 2015 but also to strengthen communities.

Other initiatives related to primary health care will be strengthened and rendered more effectively through this proposed intervention, including Linking Relief and Recovery to Development (LRRD) initiatives implemented by humanitarian organizations including those financed by ECHO. 33 iNGOs are currently implementing health emergency programmes in Yemen. Several of them (International Medical Corps, Action Contre la Faim, Médecins du Monde, Relief International, International Rescue Committee, Save the Children, Première Urgence Internationale) are financed by ECHO to implement mobile health teams and community health volunteers as part of integrated health and nutrition services in outreach communities.

Cluster mechanisms are organized through regular meetings (weekly, biweekly and ad hoc) for health (steered by WHO), nutrition and WASH (both led by UNICEF) programmes. Through these clusters a regular update on the 4 Ws is shared (Who, Where, When and What). In addition to UN agencies along with local and international NGOs and the relevant technical persons from government stakeholders are participating in these meetings.

3.3 Cross-cutting issues

Gender equality and empowerment – Gender equality will be supported in the action. It will mainstream effective female inclusion in all stages including and specifically as community health workers. Whenever feasible, data will be disaggregated by gender to track the progress and impact. In

\textsuperscript{15} DCI-MED/2014/341-149 "Support for effective stewardship of the Yemeni health sector"
addition, it will ensure that results for female beneficiaries translate into transformational change, allowing for empowerment through self-reliance in the social sphere.

**Environmental considerations** – The project will promote interventions that respect the environment and encourage local/inclusive procurement of equipment and materials.

**Human rights** – The action will keep in perspective a rights-based approach and fight exclusion and discrimination against marginalised groups, such as the Muhamasheen.\(^{16}\)

**Conflict sensitiveness** – As a country currently suffering from its political-security-development nexus, conflict cannot be omitted from the preliminary analysis or its inter-linkages underestimated. Nonetheless, Yemen is affected by a diverse range of conflicts, including at the most local level. The project will exercise constant awareness and sensitivity at the local level based on “Do no harm” principles. By focusing on inclusion and practical rights, it is expected that the project will contribute to social justice and social peace. Intervention will be implemented where access can be ensured.

4 **DESCRIPTION OF THE ACTION**

4.1 **Objectives/results**

The overall objective is to improve the health status of the population of Yemen through an enabling environment of improved resilience of Yemeni population in rural areas.

The specific objective is to improve access for rural communities to equitable quality primary health care services through a Community Health Workers' network.

The expected results are:
1. the network of community health workers is reinforced and expanded to additional Governorates with capacity to deliver basic health and nutrition services
2. essential health and nutrition services to communities in the related Governorates are delivered through the community health workers' network with referral to health facilities when indicated

The geographical areas of intervention proposed will include at least 8 additional Governorates on top of those targeted in the on-going contract with UNICEF (Hajjah, Al Hudaydah, Taiz, Lahj and Al Mahwit). Given the uncertain and fluid situation in Yemen, the targeted governorates and districts will depend on the opportunities and challenges in these areas.

This programme is relevant for the implementation of the 2030 Agenda. It contributes primarily to the progressive achievement of the Sustainable Development Goal (SDG) 3 "good health and wellbeing", but also promotes progress towards SDG10 "reduce inequalities". This does not imply a commitment by the country benefiting from this programme.

4.2 **Main activities**

Under Expected Result, the existing network of community health workers is reinforced and extended to additional Governorates with capacity to deliver basic health and nutrition services

- Capacity development of the Ministry of Health and Population for sustainable management of the expanded Community Health Workers Programme

\(^{16}\) The Muhamasheen form a marginalized social group in Yemen, up to 10% of the population according to UNICEF/ Social Welfare Fund (Muhamasheen Mapping Survey, 2014), discriminated in the socio-economic and political spheres, with concentration in Sana’a capital, Hodeidah, Ibb but more at large around urban centres.
• Orientation of GHOs and DHOs on the networks' strategy, model and management needs, rights and obligations
• Agreement with Governorates' Health Offices for inclusion of CHWs into the existing network
• Establishment or revival of the villages' development committees
• Training credentials and recognition at local, regional and national level
• Service delivery mechanism tracking and monitoring
• Reporting
• Linkage with health facilities: integration of both monitoring and information systems

Under ER2, essential health and nutrition services in the related Governorates are delivered

• Recruitment, deployment, training and refreshment of the trainers and of CHVs, CHWs and supervisors
• Forecast, procurement and distribution of basic equipment, medical, non-medical supplies
• Household survey to establish targets and supply needs
• Service delivery
• Linkage with health facilities

4.3 Intervention logic

The basic hypothesis of the project is that the population can benefit from restored services which will contribute to increase community resilience in a fragile environment. The key pathway of change is improving access of vulnerable groups to services and capacity development:

i) Advisory services (technical assistance) to MoPHP and its offices at Governorates' and local level,
ii) Capacities of health facilities reinforced to continue operating for vulnerable groups to access their services,
iii) Outreach to remote communities for primary health care.

All of the above is expected to lead to the improved restoration of services for the population and greater social cohesion. This is being supported through the logic of the intervention, enhancing the quality, the access, the targeting of the services delivered. It will also be complemented by improved governance at the local level, reflected in the perception of citizens and the availability of public services.

Based on previous analysis and needs assessments, the major component of the action will focus on improvement of access to healthcare services.

5 IMPLEMENTATION

5.1 Financing agreement

In order to implement this action, it is foreseen to conclude a rider to the initial financing agreement with the partner country (FA DCI/MED/2013/24-497 was signed by both parties on 11 November 2014), referred to in Article 184(2)(b) of Regulation (EU, Euratom) No 966/2012, in the form of a unilateral letter, in line with articles 21.2 of general conditions and 22.8 of the aforementioned financing agreement.

5.2 Indicative implementation period

The indicative operational implementation period of this action, during which the activities described in section 4.2 will be carried out and the corresponding contracts and agreements implemented, is 48 months from the date of the entry into force of the addendum.

Extensions of the implementation period may be agreed by the Commission’s authorising officer responsible by amending this decision and the relevant contracts and agreements; such amendments to
this decision constitute technical amendments in the sense of point (i) of Article 2(3)(c) of Regulation (EU) No 236/2014.

5.3 Implementation modalities

5.3.1.1 Procurement (direct management)

<table>
<thead>
<tr>
<th>Subject in generic terms, if possible</th>
<th>Type</th>
<th>Indicative number of contracts</th>
<th>Indicative trimester of launch of the procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health workers’ network: relevant technical assistance for MoPHP, third party monitoring, accreditation of the training</td>
<td>Service</td>
<td>1</td>
<td>1st quarter of 2018</td>
</tr>
<tr>
<td>Third party monitoring</td>
<td>Service</td>
<td>1</td>
<td>2nd quarter of 2018</td>
</tr>
</tbody>
</table>

One contract for a third party monitoring will be concluded directly by the EU Delegation in the 2nd quarter of 2018 to provide for an additional verification through a contractor able to access the areas of intervention if security conditions allow. Given the difficult security situation in Yemen and the lack of presence of the EU Cooperation team in the country, it is important to have a regular third party monitoring. Progress reports will be transmitted to the European Commission according to needs, with an indicative periodicity of three months.

5.3.1.2 Grant: direct award "community health workers network" (direct management)

(a) Objectives of the grant, fields of intervention, priorities of the year and expected results

The objective of the grant would be to improve access for rural communities to equitable quality primary health care services through a Community Health Workers network (see point 4.1 above).

The expected results would be:
(1) the network of community health workers is reinforced and expanded to additional Governorates with capacity to deliver basic health and nutrition services
(2) essential health and nutrition services to communities in the related Governorates are delivered through the community health workers' network with referral to health facilities when indicated

(b) Justification of a direct grant
Under the responsibility of the Commission’s authorising officer responsible, the grant may be awarded without a call for proposals to UNICEF.
Under the responsibility of the Commission’s authorising officer responsible, the recourse to an award of a grant without a call for proposals is justified because the country is in a crisis situation referred to in Article 190(2) RAP and the action has specific characteristics requiring IO having field and technical experience as well as the capacity to access insecure and remote areas.

(c) Essential selection and award criteria
The essential selection criteria are the financial and operational capacity of the applicant.
The essential award criteria are relevance of the proposed action to the objectives of the call; design, effectiveness, feasibility, sustainability and cost-effectiveness of the action.
The beneficiary of the direct grant shall be obliged to fully comply with the provisions and procedures set out by the restrictive measures concerning Yemen. Specific clauses should be provided in the grant agreement for ensuring the respect of the said provisions and procedures.

(d) Maximum rate of co-financing
In accordance with Articles 192 of Regulation (EU, Euratom) No 966/2012 full funding is essential for the action to be carried out, the maximum possible rate of co-financing is increased up to 100%. The essentiality of full funding will be justified by the Commission’s authorising officer responsible in the award decision, in respect of the principles of equal treatment and sound financial management.

(e) Indicative trimester to conclude the grant agreement
First semester 2018.

5.3.1.3

In case of non-acceptance by UNICEF of the special clauses in the contract related to the restrictive measures concerning Yemen, the EU Delegation to Yemen will consider contracting the World Health Organisation or other international organisations active in the health sector in Yemen.

5.4 Scope of geographical eligibility for procurement and grants

The geographical eligibility in terms of place of establishment for participating in procurement and grant award procedures and in terms of origin of supplies purchased as established in the basic act and set out in the relevant contractual documents shall apply subject to the following provision:

In accordance with Article 9(2)(a) of Regulation (EU) No 236/2014 the Commission decides that natural and legal persons from the following countries having traditional economic, trade or geographical link with neighbouring partner countries shall be eligible for participating in procurement and grant award procedures: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates. The supplies originating there shall also be eligible.

The Commission’s authorising officer responsible may extend the geographical eligibility in accordance with Article 9(2)(b) of Regulation (EU) No 236/2014 on the basis of urgency or of unavailability of products and services in the markets of the countries concerned, or in other duly substantiated cases where the eligibility rules would make the realisation of this action impossible or exceedingly difficult.

5.5 Indicative budget

<table>
<thead>
<tr>
<th>Procurement (direct management)</th>
<th>EU contribution (amount in EUR)</th>
<th>Indicative third party contribution, in EUR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 600 000</td>
<td></td>
<td>N.A.</td>
</tr>
<tr>
<td>16 000 000</td>
<td></td>
<td>N.A.</td>
</tr>
<tr>
<td>200 000</td>
<td></td>
<td>N.A.</td>
</tr>
<tr>
<td>200 000</td>
<td></td>
<td>N.A.</td>
</tr>
<tr>
<td>Totals</td>
<td>18 000 000</td>
<td></td>
</tr>
</tbody>
</table>

5.6 Organisational set-up and responsibilities

UNICEF and the MoPHP will be the main partners providing oversight of the implementation of this action through the steering committee already in place since 2016. WHO will participate to the steering committee in order to support the policy dialogue and propose an institutional framework for the CHW network.

The steering committee will provide strategic direction, management oversight/coordination, advice, and endorses annual work plans. Representation of the host government will be highly encouraged at national level. The EU Delegation to Yemen will participate at steering committee's meetings through tele-conference facilities.
UNICEF will provide overall oversight of the planning implementation, technical assistance, quality assurance, monitoring, reporting and evaluation services. UNICEF will ensure that its Health, Nutrition, Communication for Development and External Communications teams liaise regularly throughout the action. UNICEF will also integrate the action into the EU-UNICEF "partnership for better health and education" and will liaise with EU-WHO "universal health coverage partnership".

The action will be overseen by the UNICEF Yemen Deputy Representative.

The MoPHP will establish a Programme Implementation Unit seconded by a service contract. The Unit will provide training to new CHWs and ultimately manage the expansion of the network to all governorates. The Unit will manage payments to CHWs, oversee monitoring and reporting, distribution and re-stocking of supplies, in addition to supervision visits and ongoing training needs.

NGOs will lead implementation in Governorates where governorate health offices do not have sufficient capacity or access.

Resource experts will provide management, training, supervision and evaluation services to MoPHP. It will be established under the PHC Sector in the MoPHP and will link up with the Population Sector and relevant academic institutes. The staff will be hired technical experts through a service contract as well as seconded personnel from the PHC sector, Population Sector, Governorate Health Offices and academic institutes.

5.7 Performance monitoring and reporting

The day-to-day technical and financial monitoring of the implementation of this action will be a continuous process and part of the implementing partner’s responsibilities. To this aim, the implementing partner shall establish an internal, technical and financial monitoring system for the action and elaborate regular progress reports (not less than annual) and final reports. Every report shall provide an accurate account of implementation of the action, difficulties encountered, changes introduced, as well as the degree of achievement of its results (outputs and direct outcomes) as measured by corresponding indicators, using as reference the logframe matrix (for project modality). The report shall be laid out in such a way as to allow monitoring of the means envisaged and employed and of the budget details for the action. The final report, narrative and financial, will cover the entire period of the action implementation.

The Commission may undertake additional project monitoring visits both through its own staff and through independent consultants (service contract) recruited directly by the Commission for independent monitoring reviews (or recruited by the responsible agent contracted by the Commission for implementing such reviews).

5.8 Evaluation

Having regard to the importance of the action, a final evaluation will be carried out for this action or its components via independent consultants contracted by the Commission. The final evaluation will be carried out for accountability and learning purposes at various levels (including for policy revision), taking into account in particular the fact that further actions will be needed due to the level of vulnerabilities and state fragility.

The Commission shall inform the implementing partner at least 1 month in advance of the dates foreseen for the evaluation missions. The implementing partner shall collaborate efficiently and effectively with the evaluation experts, and inter alia provide them with all necessary information and documentation, as well as access to the project premises and activities.

The evaluation reports shall be shared with the partner country and other key stakeholders. The implementing partner and the Commission shall analyse the conclusions and recommendations of the evaluations and, where appropriate, in agreement with the partner country, jointly decide on the follow-
up actions to be taken and any adjustments necessary, including, if indicated, the reorientation of the project.

Indicatively, one contract for evaluation services shall be concluded under a framework contract at the end of 2020.

5.9 Audit

Without prejudice to the obligations applicable to contracts concluded for the implementation of this action, the Commission may, on the basis of a risk assessment, contract independent audits or expenditure verification assignments for one or several contracts or agreements.

Indicatively, one contract for audit services shall be concluded under a framework contract at the beginning of 2021.

5.10 Communication and visibility

Communication and visibility of the EU is a legal obligation for all external actions funded by the EU. This action shall contain communication and visibility measures which shall be based on a specific Communication and Visibility Plan of the Action, to be elaborated at the start of implementation and supported with the budget indicated in section 5.5 above.

In terms of legal obligations on communication and visibility, the measures shall be implemented by the Commission, the partner country, contractors, grant beneficiaries and/or entrusted entities. Appropriate contractual obligations shall be included in, respectively, the financing agreement, procurement and grant contracts, and delegation agreements.

The Communication and Visibility Manual for European Union External Action shall be used to establish the Communication and Visibility Plan of the Action and the appropriate contractual obligations.
## APPENDIX - INDICATIVE LOGFRAME MATRIX (FOR PROJECT MODALITY)

The activities, the expected outputs and all the indicators, targets and baselines included in the logframe matrix are indicative and may be updated during the implementation of the action, no amendment being required to the financing decision. When it is not possible to determine the outputs of an action at formulation stage, intermediary outcomes should be presented and the outputs defined during inception of the overall programme and its components. The indicative logframe matrix will evolve during the lifetime of the action: new lines will be added for including the activities as well as new columns for intermediary targets (milestones) for the output and outcome indicators whenever it is relevant for monitoring and reporting purposes. Note also that indicators should be disaggregated by sex whenever relevant.

<table>
<thead>
<tr>
<th>Results chain</th>
<th>Indicators</th>
<th>Baselines (incl. reference year)</th>
<th>Targets (incl. reference year)</th>
<th>Sources and means of verification</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall objective: Impact</td>
<td>To improve the health status of the population of Yemen through an enabling environment of improved resilience in rural areas</td>
<td>Under-5 mortality</td>
<td>53 deaths per 1,000 live births (2013)</td>
<td>37 deaths per 1,000 live births (2021)</td>
<td>DHS survey</td>
</tr>
<tr>
<td>Specific objective(s): Outcome(s)</td>
<td>To improve access for rural communities to equitable quality primary health care services through a Community Health Workers’ network</td>
<td>Increased # of treated severe acute malnutrition and moderate acute malnutrition cases</td>
<td>0 (2017)</td>
<td>TBC in the inception phase</td>
<td>UNICEF quarterly project reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MOPH demonstrates a confirmed commitment to establishing a sustainable CHW programme. Availability of funding (GOY/donors) to sustain CHW programme operations. Access to selected local areas of intervention is possible and safety of community health workers is</td>
</tr>
</tbody>
</table>

Mark indicators aligned with the relevant programming document mark with '*' and indicators aligned to the EU Results Framework with '***'.

[17]
| Output | Output 1: the network of community health workers is reinforced and expanded to additional Governorates with capacity to deliver basic health and nutrition services | TBC in the inception phase | TBC in the inception phase | MoPHP monthly reports | ensured by parties to conflict. 
Availability of implementing partners to step in locations with limited government presence and capacities. |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. # of CHWs recruited and trained on primary health care and programme operational procedures, disaggregated by sex</td>
<td>0 (2016)</td>
<td>2000 (2021)</td>
<td>UNICEF &amp; partners quarterly reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. # of additional governorates to which CHW programme has been extended</td>
<td>0(2016)</td>
<td>Min 8 (2021)</td>
<td>UNICEF quarterly project reports and MOHP operational reports</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 3. # of VDCs involved in recruitment of CHWs and involved in supporting their work and monitoring their performance. | 0 (2016) | More than 500 (2021) | UNICEF & partner quarterly reports | Access to selected target localities possible despite the on-going conflict. 
Project activities consulted and coordinated with MOHP at central and local levels to ensure acceptance and ownership. 
Availability of workers to undergo training and become part of the SHW network 
Women are available and able to benefit from capacity development and to become part of the CHW network 
Community health workers acquire skills to counsel mothers and care givers on key IYCF messages and to conduct community meetings, reporting tools are available 
Risks related to procurement, import and transportation of required supplies do not prevent project implementation, extended delays are avoided. |
<p>| 4. Improved availability of essential supplies required by CHW | Very limited stock TBC in the inception phase (2018); Forecasting of supply needs for the CHWs has been initiated | Stock of essential supplies available to enable operations in line with the set targets | MOHP monthly stock reports of CHWs supplies |</p>
<table>
<thead>
<tr>
<th>Output 2</th>
<th>Essential health and nutrition services to communities in the related Governorates are delivered through the community health workers' network with referral to health facilities when indicated</th>
<th>5. MOHP CHW programme institutionalised at central and targeted local levels</th>
<th>2017 by an ongoing UNICEF project supported by EU</th>
<th>Capacitated MOHP Programme units/human resources at central and targeted local levels; policy and regulatory framework in place</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. % of women who receive at least one antenatal care visit during pregnancy.</td>
<td>51% (2013)</td>
<td>70% (2021)</td>
<td>UNICEF and partner quarterly reports produced during review meetings</td>
<td></td>
</tr>
<tr>
<td>2. % of children less than 6 months exclusively breastfed</td>
<td>10% (2013)</td>
<td>20% (2021)</td>
<td>DHS survey</td>
<td></td>
</tr>
<tr>
<td>3. Percentage and # of girls and boys under 2 vaccinated against Measles</td>
<td>63% (2016)</td>
<td>80% (2021)</td>
<td>WHO/ UNICEF JRF / MoPHP monthly reports</td>
<td></td>
</tr>
<tr>
<td>4. Percentage of under two children in targeted communities receive growth monitoring and promotion service</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>---</td>
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<td></td>
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<tr>
<td>14% (2016)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>0 (2017)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>TBC in the inception phase (2021)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Number of 1-year olds immunised with EU support**</th>
</tr>
</thead>
<tbody>
<tr>
<td>50% (2021)</td>
</tr>
</tbody>
</table>

MoPHP monthly reports

UNICEF quarterly project reports