



Country Programme Action Plan  
between  
The Government of Egypt  
and UNFPA

1 July 2013-31 December 2017

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## **Framework**

In mutual agreement to the content of this document and their responsibilities in the implementation of the country programme, the Government of Egypt (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 fulfillment of the International Conference on Population and Development Programme of Action;

**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 Basic Agreement concluded between the Government and the United Nations Development Programme on 19 January 1987 (the "Basic Agreement") *mutatis mutandis* applies to the activities and personnel of UNFPA in **Egypt**. This CPAP together with any work plan concluded hereunder, which shall form part of this CPAP and is incorporated herein by reference, constitutes the project document as referred to in the Basic Agreement. References in the Basic Agreement to "Executing Agency" shall be deemed to refer to "Implementing Partner" as such term is defined in the Financial Regulations of UNFPA and used in this CPAP and any work plans concluded hereunder

### **Part II. Situation Analysis**

2. Since the revolution of 25 January 2011, Egypt has been in a state of transition, with many cabinet reshuffles and ministerial re-organizations. This instability contributes to the economic hardship that continues to hamper development, with a particular impact on the labour market. The unemployment rate for 2012 was 12.6 per cent. Women are more affected than men, with an unemployment rate of 24.1 per cent, three times as high as that of men which is 9.2 per cent. Unemployment among young people (15-24 year olds) reaches 30 per cent (CAPMAS 2013).
3. Foreign exchange reserves have diminished over the last two years and the budget deficit increased. The Government has been in negotiations with the IMF for over two years to receive a 4.8 billion dollar loan that will lead to other sources of funds. The loan has been delayed because the IMF is seeking greater political consensus on the programme, and more robust reforms, including subsidy removals. At the same

time, there have been energy shortages throughout the country due to budget deficits.

4. With a gross national income of \$2,600, Egypt is classified as a middle income country. However, this classification does not necessarily reflect the country's development status. The percentage of people living in poverty in 2010-2011 was 25.2 per cent, an increase from 21.6 per cent in 2008-2009 (CAPMAS 2012). This national estimate masks disparities that continue to exist between and within regions. The Governorates of Assiut and Sohag in the rural Upper Egypt have the highest rates of poverty in the country reaching 69 and 59 per cent respectively.
5. In 2012, Egypt's population was estimated to be 83.7 million with 62 per cent of the population below the age of 29 (SYPE 2009). Young people were a driving force of the revolution and remain vocal in striving for social justice, economic opportunity and human rights. However, public policies continue to not fully reflect the needs of young people, including their social, economic and reproductive health needs. The high unemployment rate among young people has led to delayed age of marriage. This leads to increased exposure to risky behaviours, especially in the context of young people's low civic engagement (5 per cent in 2009) and low participation in policy making. Adolescent girls, especially in Upper Egypt, also have lowest opportunities for civic engagement (SYPE 2009).
6. Other challenges exist for young people, including regional disparities for school enrolment, especially for adolescent girls. The mindset of male dominance in the community has led to certain negative attitudes. One in ten girls aged 15-17 have expressed their desire to migrate. This percentage decreases to half in older young females. 72.7 % of girls aged 15-17 agree that a man is justified to beat his wife if she argues with him. Other attitudes also adversely affect young girls particularly related to FGM, early marriage, sexual harassment and preference of education (SYPE 2009). Adolescent girls represent a unique target group with a special character and needs.
7. Egypt's overall policy environment for reproductive health of young people has been continuously improving, although not yet enabling enough for young people to easily access services and information. Egypt's Constitution provides for the protection of mothers, children, and youth and guarantees the right of women to medical, physical, psychological, and social healthcare.
8. In 2012, Egypt's population growth rate was estimated at 1.7 annually which is relatively unchanged over the last twenty years. Egypt is experiencing a fertility plateau. The contraceptive prevalence rate has remained unchanged at 60 per cent and desired fertility among ever-married women 15-49 is still at three children. According to 2008 data, the unmet need for family planning remains unchanged at 9.2 per cent, with the highest level in Sohag at 23 per cent (DHS 2008). Nationwide, there are an approximate 1.17 million women with unmet need in family planning. Unmet need persists due to various causes in terms of both supply and demand. Inadequacy of family planning services owing mainly to poor counselling services,

and limited method choices are the immediate causes on the supply side. Misconceptions around fertility and family planning, in addition to concerns about side effects of contraceptives are among the main causes on the demand side.

9. In the past, Egypt has relied on donors to fund and support the family planning program, including contraceptives. However, with the sharp decline in donor support in 2006, Egypt consolidated its efforts and is maintaining the program independently. The Government is responding to the advocacy efforts by the Family Planning Sector, supported by UNFPA, and will increase the allocated budget for contraceptive procurement annually to reach around 100 million LE in July 2013. However, there is no specific budget line to secure the procurement.
10. Over a twenty year period, Egypt experienced a very significant reduction in the maternal mortality ratio, from 174 per 100,000 live births in 1992 to 54 by 2010. However, over the last two years, the ratio has increased to 57 per 100,000, with significant increases in Upper Egypt governorates, including Assiut (83) and Sohag (63)(MOHP 2010). Lack of compliance with regulations by private practitioners and inadequate enforcement of the law have contributed to this increase. In 23.5 per cent of reported mortalities, delivery was initiated in a private clinic, which is illegal. Data show that regular antenatal care visits stand at 67 per cent nationwide, with Sohag having one of the lowest figures at 50 per cent. Medically assisted deliveries stood at 79 per cent nationwide with one of the lowest figures in Sohag and Assiut at 56 per cent (DHS 2008).
11. The availability, thorough analysis and dissemination of data is necessary to provide evidence-based interventions, informed policies and to measure results. There are gaps in data on the reproductive health and behavior of young people and key populations and on the incidence of various forms of gender based violence, particularly violence against women and girls, its root causes and its effects on women's and adolescent girls' health and well-being.
12. The most recent data available for domestic violence incidences are 2005 figures in which 47 per cent of ever-married women reported having experienced physical violence since the age of 15 (DHS 2005). In almost all of the cases the spouse was identified as the main perpetrator in at least one of the episodes. A gap remains in legislations criminalizing violence against women and in mechanisms that respond to the needs of survivors and vulnerable women.
13. A 2013 Government study revealed that over 99.3% per cent of Egyptian girls and women surveyed reported experiencing some form of sexual harassment in their lifetime. According to the study 82.6% of the total female respondents did not feel safe or secure in the street. The percentage increased to 86.5% with regard to safety and security in public transportation. Overwhelmingly, the study showed that enactment and enforcement of a law addressing sexual harassment is the first step in addressing the problem.

14. Female genital mutilation/cutting remains highly prevalent in Egypt. This harmful practice has negative implications on women's reproductive health and rights. Recent evidence has shown that the practice is declining among girls and women of younger age. In 2008, the female genital mutilation/cutting prevalence rate was 91.1 per cent among women aged 15-49, but 74 per cent among girls aged 15-17 (DHS 2008). In 2008, 77.5 per cent of the female genital mutilation/cutting in Egypt was carried out by trained medical personnel, up from 17 per cent in 1996, a significant increase in the medicalization of the practice.
15. HIV prevalence is estimated to be less than 0.1 per cent in Egypt. However, data suggest that there is a concentrated epidemic in key populations. Stigma and discrimination affect the quality and accessibility of services for HIV prevention and treatment.
16. The majority of the Egyptian population lives around the Nile Delta, on about 3% of the land. Stress on water, importing of food, climate change and population dynamics are all interlinked and require extensive research and targeted programmes.
17. Egypt has been experiencing an influx of refugees, especially from Syria, over the last two years. As of June 2013, 80,000 Syrian refugees have either been registered or awaiting registration through UNHCR. The GOE offers free basic services (health and education) to all Syrians; presenting a burden upon the infrastructure. If the situation remains, the number of registered Syrians is expected to increase to 200,000 by the end of 2013.

### **Part III. Past Cooperation and Lessons Learned**

18. The eighth country programme (2007-2011) was approved for \$18 million. Of this amount, \$12 million was designated from regular resources and \$6 million from other resources. Due to 25 January Revolution, the CP was extended until Mid-2013. Regular resources provided during the whole cycle reached \$20,430,487 and \$2,852,432 was spent under other resources.
19. The program focused on: a) developing the capacity of providers of RH services and strengthening the national health systems; b) building local capacities in planning and monitoring of population data and generating evidence; c) training various groups of advocates to promote SRH/GE and combat GBV. The programme included national-level interventions as well as focused interventions in selected areas with poor social indicators.
20. The programme also facilitated a) institutionalization of participatory planning process and introducing a monitoring system nationally for assessing gender projects, b) development of a reference manual and training guide for religious leaders on GBV and population and reproductive health issues that was adopted by Ministry of Awkaf; c) successive increase in the national budget allocation for contraceptives procurement; d) conduction of a national representative survey of

young people in Egypt; e) promotion of national in-house expertise in conducting local trainings and development of manuals that fostered efficiency, sustainability and ownership; f) development of population database and a yearly population report; g) production of a number of operations research and studies to promote evidence-based interventions and to assist the policy making;

21. The independent country programme evaluation took place prior to the Revolution, and highlighted the following achievements: a) programme interventions were relevant, effective and sustainable due to their linkage mostly with government institutions; b) the added value in terms of capacity development of service providers (FP, VCT, YFC) contributed to increased utilization of RH services, d) some attitudinal change in religious leaders that may lead to reduced GBV e) integrating YFS with other RH services proved beneficial in attracting clients; f) peers prove to be an effective strategy for spreading RH messages to adolescents; g) sensitizing media personnel is effective to underscore sexual harassment in the street; h) UNFPA is one of the few agencies supporting VCT;

Lessons learned point to the need for:

- a) improved monitoring and evaluation interventions to better analyze development progress, identify lessons learned and demonstrate results to beneficiaries, partners, and donors;
- b) baseline data because there was a missed opportunity for capturing the real impact of interventions by not completing baseline surveys before inception;
- c) embracing partnerships and overall coordination to enhance quality and accountability of the programme;
- d) strengthening the integration and focus of interventions during planning/design phase to yield visible results; the new CP is focused in two governorates
- e) focusing on men and out of school adolescents in the new interventions and more involvement of communities; the new CP has an RH community-based intervention;
- f) female physicians because the lack of female physicians has a negative impact on service utilization and changing it is a key factor for attracting women; the task shifting/sharing of nurses to RH services is a component of the planned intervention
- g) establishing a mechanism to regularly update produced training materials, curricula, IEC and ensure usage by other interventions to strengthen linkages among them;
- h) creating alliances between trained preachers and MoHP trained physicians to combat GBV and FGM/C utilizing the built capacity in data management to contribute to build and improve the quality of data nationally;
- i) coordinating the available multiple research institutions through a national plan to regulate data protection, dissemination, and support new specialized surveys
- j) continuing and retaining working with current outputs (work remains to be done to integrate FP with RH and MCH services/ scale up VCT services and strengthen its linkage with STI services, and improve the skills of providers in

monitoring, establish OJT mechanism to work with turnover challenge) clearly there are gaps and challenges in establishing linkages between SRH and HIV at all levels

- k) national ownership for an effective capacity development strategy that has a long lasting impact, yet the realities of the socio-political environment might change and become adverse to what it used to be.

#### **Part IV: Proposed Programme**

- 22. The proposed programme is aligned with national development priorities, the United Nations Development Assistance Framework 2013-2017 and the UNFPA Strategic Plan. It builds on lessons learned from the evaluation of the previous programme. The Programme adopts a human rights based and participatory approaches. The programme will focus on joint programming with a number of United Nations organizations, including UN Women, UNICEF, WHO, UNDP, UNHCR, and UNV, to ensure synergies and complementarities, optimize utilization of resources, respond to humanitarian needs and address culturally sensitive issues.
- 23. UNFPA will work on the following areas of the 2013-2017 UNDAF: (a) Poverty alleviation through Pro-Poor Growth and Equity; (b) Quality Basic Services, (c) Democratic Governance through Decentralization, Civic Engagement and Human Rights.
- 24. UNFPA's 9<sup>th</sup> Cycle Country Program contributes to the following three UNDAF outcomes: i) Women in reproductive age, men and young people have increased access to quality FP/RH services, ii) National institutions and CSOs are strengthened to further protect, respect and fulfil Human Rights in line with Egypt's international commitments, with special focus on women, children, disabled, refugees, the aged and migrants, iii) The voice, leadership, civic engagement and political participation of women and young people are visible and effective in public spheres.
- 25. The programme seeks to accelerate the achievement of universal access to reproductive health services through the reduction of inequities in accessing safe deliveries, and family planning services and to assist Egypt to meet the goals of MDG 5a around maternal health. Systems enhancement, advocacy and evidence based policy dialogue will be conducted at the central level, while capacity development and community-based interventions will focus on Assiut and Sohag.

The program has three outputs:

- 26. ***Access to sexual and reproductive health services for young people***

Output 1: Strengthened national capacities for community-based interventions in reproductive health to empower women and young people.



This output will be achieved through:

(a) integrating youth friendly reproductive health counselling and services in selected primary health care units to enable young people to make informed health choices, (b) empowering young people through support to institutions as well as social media to raise their awareness about reproductive health and gender issues and to promote their civic engagement (c) building capacity of the youth peer education network to engage young people in decision-making and advocacy, (d) developing and implementing a behaviour change communication strategy at the community level to induce demand for reproductive health services, (e) conducting targeted advocacy campaigns to increase utilization of HIV voluntary counseling and testing services in different venues.

Key interventions under this output include:

- Support establishment of 30 model urban primary healthcare units redesigned and refurbished to become youth friendly. In that process, a training curriculum will developed for service providers, a capacity building program will be designed and implemented, in addition of the application of a monitoring system to ensure adequacy of services provided to young people.
- Create linkages between youth civic engagement in Egypt and youth sexual and reproductive health and reproductive rights, in line with UNFPA regional youth strategy. To be achieved through building capacities of youth centres, mainly in Assiut and Sohag, with the active engagement of civil society, to accommodate the needs of young people by providing a safe space where young people can work on self-development, peer development and community development.
- Develop a social media strategy (inclusive of internet platforms, mobile applications and accessibility to other interactive platforms) with the aim of empowering young people through providing them with adequate information on reproductive health and rights and linking them to volunteering and capacity building opportunities, in addition to supporting career counselling.
- Support the Youth Peer Education Network (Y-PEER) geographical expansion, as well as, the extension of membership and outreach channels. To be achieved through; endorsing the membership of additional NGOs implementing standards for peer education and using peer education methodology for youth behavioral change in reproductive health and civic engagement, and support building an edutainment component to the Y-PEER network providing alternative channels and approaches for behavioral change among young people.
- Support the development of Behavior Change Communication (BCC) strategy for married couples to make informed decisions to achieve healthy pregnancy outcomes. An assessment will be conducted to understand the role of socio-cultural influences, where the findings will be used to inform the development of the BCC strategy. The aim is to promote Healthy Timing and Spacing of Pregnancy (HTSP) education and services as a family planning intervention, and to clarify to targeted groups that long-acting methods are reversible and highly effective for spacing purpose. A prospective impact evaluation (IE) is planned to be conducted to measure the true impact of the intervention. The *pilot* will cover a limited number of communities to be scaled up based on the IE results.

- Support the provision of comprehensive HIV prevention programs, including VCT services for key populations through NGOs and CBOs , in addition to capacity building of young people to foster advocates for HIV prevention
- Support MOHP to mainstream HIV prevention programs in selected interventions for vulnerable population

This output aims to raise awareness and increase demand for reproductive health, family planning and VCT services among youth, women at the reproductive age, and new couples.

## 27. ***Maternal and newborn health***

### Output 2: Improved capacity of the national health system to provide quality maternal health services to women of reproductive age

This output will be achieved through:

(a) advocating and providing policy advice to enforce rules and regulations and strengthen the capacity of the Ministry of Health and Population in combating mal-practices by private obstetricians, (b) building capacities of nurse-midwives in Assiut and Sohag to increase coverage of antenatal care and skilled deliveries through task-shifting (c) building capacity of specialized nurses in primary health care units to provide family planning and maternal health services; (d) reviewing the family planning method mix and improving contraceptive choices based on the capacity of the service delivery system and clients needs; (e) expanding the service delivery monitoring system by linking the different sources of health facility data at the district level; (f) strengthening partnerships to address gaps in procurement of contraceptives, and (g) supporting operational research and data collection and analysis to guide policy and decision making on provision of reproductive health services including for refugees.

Key interventions under this output include:

- Map existing regulations related to health private sector practice and work on strengthening the capacity of the regulatory body in the Ministry of Health and Population, as well as, the medical syndicate in Sohag and Assiut to ensure operationalizing existing regulations while reinforcing the accountability of regulatory bodies overseeing physicians and malpractices.
- Strengthen community role to report malpractices of the health private practice, through behavioural communication change campaigns aimed at raising awareness on the hazards of medical malpractices (including FGM/C widely practiced by physicians in the private practice).
- Support the Maternal and Child Health department at the Ministry of Health and Population in building cadres of nurse-midwives to assist in home-deliveries, in response to the needs in rural Upper Egypt where home deliveries constitute approximately 50% of all deliveries.
- Introduce the optimization of health workforce for effective family planning services through support of capacity building programs implemented by the MoHP with the aim to have at least one trained/specialized nurse on FP stationed in every service delivery point in the target areas. The intervention aims to address the high turnover of doctors that negatively affects the FP service provision in Egypt.

- Support the revision of the contraceptive method mix in terms of clients' need and system capacity. The intervention will support strategies to make long acting methods (LA) available and acceptable, as well as provision of training and ongoing supervision for IUD and Implant insertion/removal techniques. Specifically, in Upper/Rural Egypt, a rapid expansion of the use of injectable (short-acting) is evident, and the unmet is highest, thus long-acting methods may better serve those who want to space/limit their childbearing.
- Support the expansion of the monitoring system of service delivery through upgrading available applications on beneficiaries, LMIS, indicators on quality of service and effectiveness of supervision. The intervention aims at increasing demand for information and to facilitate its use to enhance evidence-based decision making (at national and district levels), to strengthen the program management and implementation and to advocate for additional resources (e.g. funding, personnel, services). Conducting Service Provision Assessment in the intervention governorates is being considered by CO prior to implementation, as well as utilization of GIS to help in evaluating changes in geographic access to health services.
- Support the production of national surveys such as the Survey of Young People in Egypt (SYPE) and DHS and policy papers to ensure evidence based programming and policy making. In addition to promoting websites and social media platforms for dissemination of information to target audience, to conduct small scale opinion polls and knowledge assessment and initiate events and relevant celebrations to ensure wider dissemination of information.
- Build the capacity of national relevant institutions to work with available data, produce policy briefs for advocacy purposes and to initiate informed and results based decision- making.

This output aims at reducing malpractice in deliveries and unmet need for FP services through assisting the government manage gaps and provide improved adequate reproductive health and family planning services responsive to clients' needs, preferences and lifestyles.

## 28. ***Gender Equality and Reproductive Rights***

### Output 3: Enhanced institutional mechanisms to protect and respond to gender-based violence against women and girls.

This output will be achieved through:

(a) generating evidence and analysing the effects of gender-based violence on women's and girls' reproductive health, wellbeing and social and economic participation; b) advocating for the adoption of a national gender-based violence strategy and the enactment of protection legislations(c) developing medical protocols and services referral frameworks and strengthening capacity of service providers on management of gender-based violence; (d) building capacities of religious leaders to combat gender-based violence through raising the awareness of communities; (e) combating medicalization of female genital mutilation/cutting by creating awareness among service providers and supporting community-led initiatives, and (f) addressing sexual

harassment through the support of community service organizations advocacy, building alliances and school interventions with engagement of men and boys.

Key interventions under this output include:

- Support the development of a comprehensive national study on the prevalence of gender-based violence in Egypt, its' effects on women's reproductive health, as well as, general physical and psychological wellbeing with a special focus on the economic direct and indirect economic costs of GBV endured yearly.
- Support the National Council for Women in developing a national Gender-based Violence Strategy following a participatory process comprising relevant Ministries, Councils and NGOs. In addition, to providing needed support to implement the interventions of the GBV strategy in areas specific to UNFPA technical expertise and advocate for the adoption of legislations and policies to address all forms of GBV.
- Support the Ministry of Health and Population throughout the process of developing the GBV Medical protocol for clinical management and referral of GBV cases. In addition to, capacity strengthening programs for Health services providers and relevant referral networks/entities such as Ombudsperson offices, specialized police forces, psychological support centres, etc.
- Continue to support capacity building programs targeting Religious Leaders of, endorsed by the Azhar and the Church, to ensure religious leaders in Greater Cairo, Assiut and Sohag are well informed and have the required capacity to address issues related to GBV, FGM and reproductive health and rights and are able to disseminate positive messages advancing human rights of women and youth in target communities.
- Endorse the development and mainstreaming of a curriculum on FGM/C into the Gynaecology curriculum and build the capacities of University Gynaecology and Obstetrician staff in target Universities to efficiently teach this curriculum.
- Support the Ministry of Health and Populations and the National Council for Population to strengthen the enforcement of the FGM/C banning legislation through a number of interventions including the enhancement of supervisory mechanisms over private health practitioners and the strengthening of public hospitals patients' admissions /registration system for timely detection of incoming GBV and FGM/C complication cases.
- Continue to support advocacy and community interventions targeting school teachers, parents of students, local NGOs and other duty bearers, as well as, community interventions to empower duty holders (including young boys and girls and youth watchdogs) to combat sexual harassment and FGM/C and continuously advocate for safer environments in the target communities of greater Cairo, Assiut and Sohag. In addition to, forging partnerships and networks with public and private sectors to combat sexual harassment.
- Support the development and launch of edutainment and advocacy campaigns for targeted audience to address the problem of sexual harassment combined with tools promoting reporting and criminalization of sexual harassment incidents.

This output aims to combat all forms of gender –based violence including gender discrimination, sexual harassment, abuse, FGM/C and rape to enhance women's

reproductive health and wellbeing and to empower them to make healthy informed decisions related to their reproductive lives.

## **Part V: Partnership Strategy**

29. UNFPA will involve a wide range of governmental institutions, including the Ministry of Health and Population, the Ministry of International Cooperation, the Ministry of Youth, the National Council for Women, the National Population Council, non-governmental organizations, academic and research institutions and other UN agencies to implement the 9<sup>th</sup> programme cycle between June 2013 – December 2017.
30. UNFPA will continue to partner with the Ministry of Health and Population in the 9<sup>th</sup> cycle to train nurse-midwives in Assiut and Sohag, perform capacity building for nurses in deprived rural primary healthcare units through empowering the role of nurses and building their capacities. The partnership will also invest in expanding contraceptives method mix in the two governorates. This partnership will also continue to empower the VCT facilities.
31. Partnership with Ministry of Health and Population is expected to lead to inclusion of youth friendly services and developing a medical gender based violence protocol and operationalizing it in selected primary healthcare units. This partnership is also vital to regulation of private sector to reduce maternal mortalities.
32. UNFPA will partner with UN Women, UNDP, UNICEF , UNODC , UN Habitat and IOM to implement , the safe cities and trafficking joint programs and the FGM/C trust fund Joint program
33. UNFPA will partner with UNV, UNICEF, UN Women and ILO to build capacities of young people effectively and include reproductive health and rights in a holistic manner, by including issues related to employability and civic engagement, especially of young women and adolescent girls and to implement the next Survey of Young People.
34. Partnerships will be built with the Ministry of Youth, INGOs and NGOs to support the youth centers in Assiut and Sohag in order to expand their role and make them youth friendly, especially to young women and adolescent girls.
35. Partnership strategies in Assiut and Sohag to implement BCC interventions with the community and young people will include active engagement of community based organizations through umbrella NGOs.
36. UNFPA will continue to partner with UNAIDS, UNICEF and the NGO Al-Shehab to

prevent HIV among most vulnerable women.

37. UNFPA will continue to chair the UN youth taskforce which includes more than 15 UN agencies and takes the lead on youth joint programmes and initiatives.
38. Partnership with International NGOs will be strengthened, especially those with branches in Assiut and Sohag such as Save the Children, Plan and Care; in order to effectively implement behavioural change communication program and working with youth centers.
39. UNFPA will partner with NGO coalitions and local NGOs to implement interventions related to combating GBV, sexual harassment and FGM/C. Collaboration with umbrella INGOs or well established local NGOs may be considered to ease implementation through smaller local NGOs in villages.
40. UNFPA will strengthen its partnership with faith-based organization such as the International Islamic Center for Population studies and research at Al Azhar and the Coptic and evangelical churches to raise the awareness of the community members on the view of religion vi-a-vis relevant issues including RH, Population, FP and GBV.
41. UNFPA will partner with national research institutions such as CAPMAS as well specialized consultancy firms to carry out the study on GBV, to support the process of the development of the national GBV strategy and the GBV medical protocol.
42. Partnership with donors, will be strengthened, mainly in the fields of strengthening capacities of Ministry of Health and Population, combating sexual harassment and strengthening youth peer education network.
43. UNFPA will invest in partnering with universities, especially the university of Assiut and Sohag, to generate evidence from the field on the impact of interventions being implemented.

The main partners for UNFPA in the 9<sup>th</sup> program cycle include, but are not limited to:

#### **Government**

- Ministry of Health and Population (MOHP)
- Ministry of Planning and International Cooperation (MOPIC)
- Ministry of Foreign Affairs (MOFA)
- Ministry of Youth (MOY)
- National Council for Women (NCW)
- National Population Council (NPC)
- Information for Decision Support Center (IDSC)

- CAPMAS

**Multilateral and Bilateral Partners such as:**

- UN Organizations – mainly WHO, UN Women, UNV and UNICEF
- Embassy of Norway
- Embassy of Sweden
- USAID

**Educational and Technical Institutions**

- Al-Azhar University (International Islamic Center for Population Studies and Research (IICPSR).
- Bishopric of Public Ecumenical and Social Services- the Coptic church
- Council of Services and Development- the Evangelical Church
- University of Assiut
- University of Sohag

**Local and International NGO's such as:**

- Plan International
- Save the Children
- CARE
- Egyptian Center for supporting NGOs
- Population Council
- Egyptian Center for Women's Rights (ECWR)
- NGOs Coalition against FGM
- Other local NGOs in Assiut and Sohag

**Part VI: Programme Management**

44. The Ministry of Planning and International Cooperation (MOPIC) will be the overall government coordinating body of the programme with UNFPA. Through such mechanisms as the UNDAF Steering Committee, MOPIC and UNFPA will work together to monitor the implementation of the programme.
45. Joint programme management will ensure sustainability of interventions; building implementation capacity of national partners and assure adequate flow of communication, coordination, and reporting.
46. National execution will continue to be the preferred implementation modality. Assessment of the partners and risk assessment and mitigation will be conducted jointly with the rest of the UNDG ExCom Agencies.
47. Programme implementation will be less centralized with focus in two Upper Egypt governorates (Assiut and Sohag). Decentralized implementation will be, in coordination with the local government authorities and non-governmental organizations in the two intervention governorates. Certain interventions will take

be implemented at the central level to ensure commitment and to enhance the policy role of the central offices.

48. Annual workplans (AWPs) will be developed by each partner, in close cooperation with UNFPA programme staff. These AWPs will include interventions at central and governorate levels.
49. UNFPA will provide technical support to build partners capacities in the field of planning, implementation, coordination, reporting, financial management, at central and governorate level, and to assure that UNFPA procedural requirement and regulations are respected.
50. UNFPA will explore all possibilities to mobilize resources to expand the implementation of the programme in all districts of the two intervention governorates.
51. UNFPA will collaborate with UN agencies on joint programmes such as UN Women on combating GBV; UNICEF on eliminating medicalized FGM; WHO and UNAIDS on integrating youth-friendly series in the PHC services.
52. In collaboration with MOPIC and MOFA, UNFPA will conduct yearly review meetings with IPs and stakeholders. In addition, UNFPA will carry out annual reviews of the programme and will conduct thematic and end of country programme evaluations with other UN Agencies. UNFPA will ensure implementation of all audit recommendations.
53. In the event of extenuating circumstances, UNFPA may – in consultation with the Government of Egypt – re-orient activities to better respond to emerging issues.
54. The UNFPA Representative in Egypt will oversee the programme. The CO includes staff, funded from the UNFPA institutional budget, who perform management and development effectiveness functions. UNFPA will allocate programme resources for staff to provide technical and programme support.

All cash transfers to an Implementing Partner are based on the Annual Work Plans agreed between the Implementing Partner and UNFPA.

Cash transfers for activities detailed in AWPs can be made by a United Nations 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 United Nations 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. UNFPA shall not be obligated to reimburse expenditure made by the Implementing Partner over and above the authorized amounts.

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

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-United Nations 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. (Where Government wishes, add: The Implementing Partner may participate in the selection of the consultant.)

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.

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## **Part VII: Monitoring and Evaluation**

55. Planning, monitoring and evaluation come together as Results-Based Management (RBM), which is UNFPA broad management strategy that supports achieving improved performance and demonstrable results. CO will continue to apply corporate standards and provide relevant inputs to HQ for continued quality enhancement. As appropriate, CO will support national capacity-building and will conduct country-level workshops.
56. Building on the lessons learnt during the 8<sup>th</sup> CP, this CP will have greater emphasis on results delivery. RBM key elements will be further mainstreamed in the procedures of new CO interventions that include:
- Problem analysis phase of the relevant national challenges to identify root causes
  - Strategy development using chain of results approach, and identifying performance indicators
  - Results focused monitoring
  - Evaluation of interventions
  - Results focused reporting/use of information
57. The CO will participate in the UNDAF M and E taskforce according the management

arrangements of UNDAF 2013-2017. The taskforce is to support the PWGs on the annual review reports.

58. The program will implement UNFPA mandatory M and E activities, which include AWP monitoring, regular field visits, progress reports and update of the CPAP Planning matrix for M and E accordingly. A program cycle evaluation plan is developed and will be implemented in the course of the cycle. Different types of evaluation are planned starting with studies, impact evaluation, assessments and mid-term reviews and summative evaluation. To the extent possible, monitoring data will come from national Mand E systems. The 9<sup>th</sup> CP has a clear geographical focus for results delivery at national and sub-national levels.

Implementing partners agree to cooperate with UNFPA for monitoring of all programmatic 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:

- Periodic review of their financial records by UNFPA or its representatives, following UNFPA's standards and guidance,
- Periodic review and monitoring of their programmatic activities following UNFPA's standards and guidance,
- Special or scheduled audits: UNFPA, in collaboration with other United Nations agencies (where so desired: and in consultation with the [coordinating Ministry] GCA) 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.

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

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

### **Part VIII: Commitments of UNFPA**

59. The UNFPA Executive Board approved a total commitment not to exceed the equivalent of US\$11.25 million from UNFPA regular resources, subject to the availability of funds for the period 1 July 2013 to 31 December 2017, in support of the Country Programme and the CPAP. The Board has also authorized UNFPA to seek additional funding to support the implementation of the CPAP, referred therein as Other Resources, to an amount equivalent to US\$2.75 million. In this respect, UNFPA will advocate to the donor community, both in Egypt and internationally to obtain such financial support. The Country Programme approved by the UNFPA Executive Board, totals US\$14 million. These resource allocations do not include Emergency funds that may be mobilized in response to any humanitarian or crisis situation.

60. Specific details on the allocation and yearly phasing of UNFPA's assistance in support of the CP will be reviewed and further detailed through the preparation of the AWP. UNFPA funds are distributed by calendar year and in accordance with this CPAP and subject to availability of funds. During the review meeting, respective partners indicated in the AWP will examine with UNFPA the rate of implementation for each programme. Subject to the review meetings conclusions, if the rate of implementation in any programme component is substantially below the annual estimates, funds may be re-allocated by mutual consent between the Government and UNFPA.

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 of a signed request.

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 [here insert the number of days as per agency schedule].

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

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

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## **Part IX: Commitment of Government**

61. The Government will honor its commitments in accordance with the provisions of the Standard Basic Assistance Agreement (SBAA) of 19 January 1987. The Government shall apply the provisions of the Convention on the Privileges and Immunities of the United Nations agencies to UNFPA's property, funds and assets and to its officials and consultants. In addition, the Government will accord to UNFPA and its officials and to other persons performing services on behalf of UNFPA, the privileges, immunities and facilities as set out in the SBAA.
62. The Government will provide in-kind contributions, including staff salaries, office space and operating costs of clinics and youth centers.
63. The Government will support UNFPA's efforts to raise funds required to meet the financial needs of the CPAP. The Government will coordinate with UNFPA by encouraging potential donor governments to make available to UNFPA the funds needed to implement the unfunded components of the programme. The Government will support efforts to raise funds from the private sector and

Foundations in Egypt and internationally to support the programme, and which will be tax exempt.

64. The Government shall facilitate and cooperate in arranging periodic programme reviews, including planning meetings, the UNDAF annual review and field visits and will also facilitate coordination and participation of donors and NGOs, where relevant.

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.

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

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 are not consistent with international standards, the United Nations agency regulations, policies and procedures will apply.

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.

To facilitate scheduled and special audits, each Implementing Partner receiving cash from UNFPA will provide United Nations 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 (and where the SAI has been identified to conduct the audits, and to the SAI).
- Undertake timely actions to address the accepted audit recommendations.
- Report on the actions taken to implement accepted recommendations to the UN agencies (and where the SAI has been identified to conduct the audits, and to the SAI), on a quarterly basis (or as locally agreed).

## **Part X: Other Provisions**

This CPAP supersedes any previously signed CPAPs between the Government of Egypt and UNFPA and will come into effect upon signature for a period of four and half years until 31 December 2017.

The CPAP may be modified by mutual consent of the Government of Egypt and UNFPA based on the outcome of annual reviews, midterm review or compelling circumstances.

Nothing in this CPAP shall in any way be construed to waive the protection of UNFPA 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 Thursday 27 June 2013 in Cairo, Egypt.*

For the Government of Egypt:

For UNFPA:

H.E. Minister Amr Darrag  
Ministry of Planning and  
International Cooperation

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Mr. Jaime Nadal  
UNFPA Representative

### List of Abbreviations

|                  |  |
|------------------|--|
| <b>AWP</b>       | Annual Workplan  |
| <b>BCC</b>       | Behavior Change Communication                                    |
| <b>CAPMAS</b>    | Central Agency for Public Mobilization and Statistics            |
| <b>CO</b>        | Country Office   |
| <b>CPAP</b>      | Country Programme Action Plan                                    |
| <b>CPR</b>       | Contraceptive Prevalence Rate                                    |
| <b>DHS</b>       | Demographic and Health Survey                                    |
| <b>FP</b>        | Family Planning  |
| <b>FGC</b>       | Female Genital Cutting   |
| <b>FGM</b>       | Female Genital Mutilation  |
| <b>GBV</b>       | Gender Based Violence  |
| <b>GOE</b>       | Government of Egypt  |
| <b>GE</b>        | Gender Equality  |
| <b>HIV/AIDS</b>  | Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome |
| <b>ICPD</b>      | International Conference on Population and Development           |
| <b>ILO</b>       | International Labor Organization                                 |
| <b>IMF</b>       | International Monetary Fund                                      |
| <b>MDG</b>       | Millennium Development Goals                                     |
| <b>MCH</b>       | Mother and Child Health  |
| <b>MOHP</b>      | Ministry of Health and Population                                |
| <b>MOFA</b>      | Ministry of Foreign Affairs                                      |
| <b>MOPIC</b>     | Ministry of Planning and International Cooperation               |
| <b>MMR</b>       | Maternal Mortality Ratio   |
| <b>M &amp; E</b> | Monitoring and Evaluation  |
| <b>NPC</b>       | National Population Council                                      |
| <b>NCW</b>       | National Council for Women                                       |
| <b>NCCM</b>      | National Council for Childhood and Motherhood                    |
| <b>NCHR</b>      | National Council for Human Rights                                |
| <b>NGOs</b>      | Non Governmental Organizations                                   |
| <b>NAP</b>       | National AIDS Programme  |
| <b>PD</b>        | Population and Development                                       |
| <b>RH</b>        | Reproductive Health  |
| <b>RR</b>        | Reproductive Rights  |
| <b>RRF</b>       | Results and Resources Framework                                  |
| <b>RHCS</b>      | Reproductive Health Commodity Security                           |
| <b>STI/RTI</b>   | Sexually Transmitted Infections – Reproductive Tract Infections  |

|               |  |
|---------------|--|
| <b>SYPE</b>   | Survey of Young People in Egypt                    |
| <b>SRH/RR</b> | Sexually Reproductive Health / Reproductive Rights |
| <b>USAID</b>  | United States Agency for International Development |
| <b>UNDAF</b>  | United Nations Development Assistance Framework    |
| <b>UNFPA</b>  | United Nations Population Fund                     |
| <b>UNHCR</b>  | The UN Refugee Agency                              |
| <b>UNICEF</b> | United Nations Children Fund                       |
| <b>VAW</b>    | Violence Against Women                             |
| <b>VCT</b>    | Voluntary Counselling and Testing                  |
| <b>WB</b>     | World Bank   |
| <b>WHO</b>    | World Health Organization                          |
| <b>YFS</b>    | Youth Friendly Services                            |
| <b>Y-PEER</b> | Youth Peer Education Network                       |



**CPAP Results and Resources Framework (based on the CPD RRF)**

UNDAF Outcome # 1 The voice, leadership, civic engagement and political participation of women and young people are visible and effective in public spheres.

UNDAF indicators:

(a) percentage of young people volunteering and actively participating in structures such as student unions, youth non-governmental organizations and youth centres; B 2010: 5% (15-29), Target 2017: 8%

| UNFPA Strategic Plan Outcome  | Country programme output(s)   | Output indicators, targets & baselines, as well as means of verification  | Implementing Partners  | Indicative resources by output (per annum, USUSD) |      |      |      |      |       |
|---|---|---|--|---|------|------|------|------|-------|
|   |   |   |  | Yr 1 (6mths)                                      | Yr 2 | Yr 3 | Yr 4 | Yr 5 | Total |
| Improved access to sexual and reproductive health services for young people | Output 1: Strengthened national capacities for community-based interventions in reproductive health to empower women and young people | <p>Output 1 Indicators:</p> <p>1.1 Number of community leaders implementing behavioural change interventions for reproductive health. Baseline 2013: 0 Target: 240 (target is evenly distributed between Assiut &amp; Sohag)<br/>MoV: Process evaluation reports</p> <p>1.2 Number of young people reached by social media initiatives<br/>Baseline 2013: 74,479<br/>Target: 750,000<br/>MoV: Socialbakers</p> <p>1.3 Number of primary health care units supported by UNFPA with youth friendly health services<br/>Baseline:2013: 0 Target: 30<br/>MoV: Records of PHC sector</p> | <p>-NGOs (local/national &amp; international)<br/>-State Information Service<br/>-MoHP/Communication<br/>Dept/Ra'edat Refeyat (at governorates' level)<br/>-Center for Project Evaluation &amp; Macroeconomic Analysis (PEMA) – Social Research Center/AUC</p> <p>-Ministry of Youth,<br/>-Youth Peer education Network</p> <p>-MoHP</p> | Regular Resources                                 |      |      |      |      |       |
|   |   |   |  | 0.3   | 1    | 0.5  | 0.5  | 0.2  | 2.5   |
|   |   |   |  | Other Resources                                   |      |      |      |      |       |
|   |   |   |  | 0.1   | 0.25 | 0.2  | 0.1  | 0.1  | 0.75  |

## UNDAF Outcome #2 Women in reproductive age, men and young people have increased access to quality family planning and reproductive health services

UNDAF indicators: : (a) Unmet need for family planning B: 2008, 9.2% - T: 6%;

(b) contraceptive prevalence B:2008, 60%-T:65%; (c) existence of a national strategy for integrating gender based violence in health service delivery; (d) number of service facilities in target governorates integrating gender based violence in service delivery; (e) percentage of female genital mutilation/cutting practiced by medical professionals; and (f) maternal mortality B: 57/100,000-T:47/100,000

| UNFPA Strategic Plan Outcome   | Country programme output(s)  | Output indicators, targets & baselines, as well as means of verification   | Implementing Partners  | Indicative resources by output (per annum, USUSD) |      |      |      |      |       |
|--|--|--|--|---|------|------|------|------|-------|
|  |  |  |  | Yr 1 (6mths)                                      | Yr 2 | Yr 3 | Yr 4 | Yr 5 | Total |
| Increased access to and utilization of quality maternal and new-born health services | Output 2: Improved capacity of the national health system to provide quality maternal health services to women of reproductive age | <p>Output 2 Indicators:</p> <p>2.1 Percentage of primary health care units covered by at least one nurse trained on maternal health and family planning services in intervention governorates<br/>Baseline 2013: 0 Target: 80% (target is set for ea governorate)<br/>MoV: Health Governorate records</p> <p>2.2 Percentage of primary healthcare units covered by at least one trained midwife<br/>Baseline 2012: 46% Assiut-30% Sohag<br/>Target: 100%<br/>MoV: Health Governorate records</p> <p>2.3 Percentage of primary health care units in intervention governorates offering at least two long-term contraceptive methods<br/>Baseline: 2012: 5.7% Target: 15%<br/>MoV: MoHP/LMIS</p> <p>2.4 % of facilities with monitoring system that supports service delivery<br/>Baseline: 0 Target: 25%<br/>MoV: Health district records</p> | <p>-Health Governorate in Assiut &amp; Sohag<br/>-Assiut/Sohag Universities<br/>-Technical Institute for nursing</p> <p>-Health Governorate in Assiut &amp; Sohag<br/>-Egyptian Family Health Society</p> <p>-</p> <p>MoHP/FP (both local &amp; central levels)<br/>-Local NGOs</p> <p>-MoHP/FP/NPC/IDSC</p> | Regular Resources                                 |      |      |      |      |       |
|  |  |  |  | 0.25  | 2    | 2    | 1    | 0.25 | 5.5   |
|  |  |  |  | Other Resources                                   |      |      |      |      |       |
|  |  |  |  | 0.1   | 0.5  | 0.4  | 0.25 | 0.05 | 1.3   |

**UNDAF Outcome #3** National institutions and civil society organizations are strengthened to further protect, respect and fulfil human rights, in line with Egypt's international commitments, with a special focus on women, children, the disabled, refugees, the aged and migrants.

**UNDAF Indicators:** :

(a) percentage of female genital mutilation/cutting among girls and adolescents aged 15-17 B: Prevalence 2008,74%- T: 2016, 65%;

(b) number of civil society-led programmes addressing the rights of women, young people and key populations, especially persons living with HIV/AIDS B:2010,12 -T:TBD by population size estimates

| UNFPA Strategic Plan Outcome   | Country programme output(s)   | Output indicators, targets & baselines, as well as means of verification   | Implementing Partners   | Indicative resources by output (per annum, USUSD) |      |      |      |      |       |
|--|---|--|---|---|------|------|------|------|-------|
|  |   |  |   | Yr 1 (6mths)                                      | Yr 2 | Yr 3 | Yr 4 | Yr 5 | Total |
| Gender equality and reproductive rights advanced particularly through advocacy and implementation of laws and policy | Output 3: Enhanced institutional mechanisms to protect against and respond to gender-based violence against women and girls | <p><b>Output 3 Indicators:</b></p> <p>3.1 Number of national institutions with the capacity to combat diverse forms of gender-based violence<br/>Baseline 2013: 7 institutions;<br/>Target: 25 institutions<br/>MoV: AWP Monitoring reports</p> <p>3.2 Existence of a national medical protocol to manage gender-based violence cases<br/>Baseline: no protocol currently exists<br/>Target: existing protocol<br/>MoV: MoHP /Women H sector records</p> <p>3.3 Number of health-service delivery points adopting the medical protocol developed to manage services to address gender-based violence<br/>Baseline: 2012:0; Target: 24<br/>MoV: UNFPA GBV standard assessment</p> | <p>Civil society organizations; coalition of non-governmental organizations against female genital mutilation/cutting; FBOs, Egyptian Centre for Women's Rights; research and training centres</p> <p>Ministry of Health and Population;<br/>National Council for Women</p> <p>International Organization for Migration; UNDP; UNICEF; UN-Women</p> | Regular Resources                                 |      |      |      |      |       |
|  |   |  |   | 0.5   | 0.5  | 0.5  | 0.5  | 0.5  | 2.5   |
|  |   |  |   | Other Resources                                   |      |      |      |      |       |
|  |   |  |   | 0.1   | 0.2  | 0.2  | 0.1  | 0.1  | 0.7   |



| Results   | CP output indicators and baselines   | Targets and achievements |             |        |             |        |             |        |             |        |             | Means of verification                 | M&E activities   | Timing/frequency of M&E activities                                       | Persons/units responsible for M&E activities | Resources available for M&E activities                  | Monitoring risks  |
|---|--|--------------------------|-------------|--------|-------------|--------|-------------|--------|-------------|--------|-------------|---------------------------------------|--|--|--|---|---|
|   |  | Year 1                   |             | Year 2 |             | Year 3 |             | Year 4 |             | Year 5 |             |                                       |  |  |  |   |   |
|   |  | Target                   | Achievement | Target | Achievement | Target | Achievement | Target | Achievement | Target | Achievement |                                       |  |  |  |   |   |
| <b>SP outcome 1: Increased access to and utilization of quality maternal and new-born health services</b>   |  |                          |             |        |             |        |             |        |             |        |             |                                       |  |  |  |   |   |
| <b>UNDAF outcome 4: Women in reproductive age, men and young people have increased access to quality family planning and reproductive health services</b> |  |                          |             |        |             |        |             |        |             |        |             |                                       |  |  |  |   |   |
| CP output2: Improved capacity of the national health system to provide quality maternal health services to women of reproductive age                      | Indicator 1<br>% of PHCUs covered by at least one nurse trained on MH and FP services<br>Baseline 2013: 0<br>Target: 80%<br>(target is set for ea governorate) | 0                        | 20%         |        | 20%         |        | 20%         |        | 20%         |        |             | Health Governorates/districts records | 1-Routine monitoring activities (progress reports, review meetings, field visits & development of process indicators)<br>2- Training evaluation<br>3- Operational Research<br>4- End of CP Evaluation  | 1- quarterly & mid-year review<br>2- parallel to training implementation | TBD<br>1. CO<br>2. IPs                       | 1- \$20,000<br>2- \$10,000<br>3- \$40,000<br>4-\$20,000 | Deterioration of Security situation in the country hinders field visits monitoring & travel in general<br><br>-Rely on e-communication<br>-Outsource monitoring activities at local level |
|   | indicator 2,<br>% of PHCUs covered by at least one trained midwife<br>Baseline2012: 46%Assiut-30%Sohag<br>Target: 100%   | 10%<br>10%               | 14%<br>15%  |        | 10%<br>15%  |        | 10%<br>20%  |        | 10%<br>10%  |        |             | Health Governorate/districts records  | 1-Routine monitoring activities (progress reports, review meetings, field visits & development of process indicators)<br>2- Training evaluation<br>3- Operational Research<br>4- End of CP Evaluation  | 1- quarterly & mid-year review   | TBD<br>1. CO<br>2. IPs                       | 1- \$30,000<br>2- \$30,000<br>3- \$40,000<br>4-\$20,000 | Deterioration of Security situation in the country hinders field visits monitoring & travel in general<br><br>-Rely on e-communication<br>-Outsource monitoring activities at local level |
|   | Indicator 3,<br>% of PHCUs offering at least two long-acting contraceptive methods<br>Baseline:2012: 5.7% Target: 15%  | 1%                       | 2%          |        | 2.3%        |        | 2%          |        | 2%          |        |             | MoHP/LMIS                             | 1- Review LMIS distribution reports<br>2- Review national BUD allocation/ method<br>3- Review Contraceptives procurement plan<br>4- Field visits<br>5- Operational Research<br>6- End of CP Evaluation | 1- quarterly<br>2- annual<br>3- annual<br>4- quarterly                   | TBD<br>1. CO<br>2. IPs                       | 4-\$10,000<br>5-\$50,000<br>6-\$20,000                  | Deterioration of Security situation in the country hinders field visits monitoring & travel in general<br><br>-Rely on e-communication<br>-Outsource monitoring activities at local level |

| Results  | CP output indicators and baselines  | Targets and achievements |             |        |             |        |             |        |             |        |             | Means of verification | M&E activities | Timing/frequency of M&E activities | Persons/units responsible for M&E activities   | Resources available for M&E activities  | Monitoring risks  |   |   |  |
|--|---|--------------------------|-------------|--------|-------------|--------|-------------|--------|-------------|--------|-------------|-----------------------|----------------|------------------------------------|--|---|---|---|---|--|
|  |   | Year 1                   |             | Year 2 |             | Year 3 |             | Year 4 |             | Year 5 |             |                       |                |                                    |  |   |   |   |   |  |
|  |   | Target                   | Achievement | Target | Achievement | Target | Achievement | Target | Achievement | Target | Achievement |                       |                |                                    |  |   |   |   |   |  |
| <b>SP outcome 5: Gender equality and reproductive rights advanced particularly through advocacy and implementation of laws and policy</b>  |   |                          |             |        |             |        |             |        |             |        |             |                       |                |                                    |  |   |   |   |   |  |
| <b>UNDAF outcome 3.2 : National institutions and civil society organizations are strengthened to further protect, respect and fulfil human rights, in line with Egypt's international commitments, with a special focus on women, children, the disabled, refugees, the aged and migrants.</b> |   |                          |             |        |             |        |             |        |             |        |             |                       |                |                                    |  |   |   |   |   |  |
| <b>CP output 3: Enhanced institutional mechanisms to protect against and respond to gender-based violence against women and girls</b>  | Indicator 3.1<br># of national institutions with the capacity to combat diverse forms of gender-based violence<br>Baseline 2013: 7 institutions;<br>Target: 25 institutions |                          |             | 3      |             | 5      |             |        | 5           |        |             | 5                     |                |                                    | Service records/ institution (assessment against GBV Standards)  | 1-Routine monitoring activities (progress reports, review meetings, field visits & development of process indicators)<br>2- Monitor usage curve<br>3- Operational Research<br>4- End of CP Evaluation | 1- quarterly & mid-cycle review<br>4- penultimate CP year | TBD<br>1. CO<br>2. IPs                      | 1- \$10,000<br>2- \$<br>3- \$40,000<br>4-\$ 30,000  | -Deterioration of Security situation in the country<br>- Conservative powers dominates |
|  | indicator 3.2<br>Existence of a national medical protocol to manage GBV cases<br>Baseline: no protocol exists<br>Target: existing protocol                                  |                          |             |        |             |        |             |        |             |        |             |                       |                | MoHP Record                        | 1-Routine monitoring activities y (progress reports, review meetings, & development of process indicators)<br>2- Operational Research<br>3- End of CP Evaluation | 1- quarterly & mid-cycle review<br>3- penultimate CP year   | TBD<br>1. CO<br>2. IPs                                    | 1&2- \$30,000<br>2- \$30,000<br>4- \$40,000 | -Deterioration of Security situation in the country<br>- Conservative powers dominates                            |  |
|  | Indicator 3.3<br># of SDPs adopting the developed medical protocol to manage services to address GBV<br>Baseline: 2012:0;<br>Target: 24 /governorate                        |                          |             | 6      |             | 6      |             |        | 6           |        |             | 6                     |                | UNFPA GBV standard assessment      | 1- Visits to PHCUs to monitor documenting & adopting GBV protocol<br>2- Monitor service usage<br>3-SPA   | 1-quarterly<br>2- annual<br>3-pen-ultimate year   | TBD<br>1. CO<br>2. IPs                                    | 1-\$10,000<br>3-\$50,000                    | Deterioration of Security situation in the country<br>- Harmful attitudes of service providers toward GBV victims |  |

