**Terms of Reference**

**Community Engagement**

**Strengthening Resilience through Enhancing Health Service Facilities in Yemen (P22160-001)**

1. **BACKGROUND**

All essential service sectors have been impacted by the current conflict in Yemen, not only in terms of the people in need of assistance, but also in terms of the institutional capacity and the sectoral infrastructure. According to the 2019 Yemen HRP, in the health sector, 203 out of the total number of 333 districts are classified as being in acute need. Furthermore, 19.7 million Yemenis are in need of health-related assistance, which is an increase of 3.1 million people since 2018. This is mainly due to poor access to health services, displacement, and deterioration of the socio-economic conditions. Lack of access to health services is especially prominent in rural areas due to the location of health facilities, insecurity, inadequate staff, high cost of services, and high levels of poverty. Significant barriers also impede female access to health care: twice as many men as women can afford medical care, preventative care, regular visits, and medications. Furthermore, women must often be accompanied by a male relative for visits to health care facilities, further restricting their access.

Amid these and other challenges, essential services provided by the public institutions have all but collapsed. Urgent life-saving assistance remains critical, while incremental investments in resilience and rehabilitation are needed to prevent further destitution and promote recovery. Primary, secondary and tertiary care, including trauma, emergency, reproductive health and referral care, are considered a priority in terms of provision of assistance by the international community, including through rehabilitation and fixing of the damages, provision of equipment, medicines, furniture, etc.

In light of this national catastrophe and as a timely response, ***the Strengthening Resilience through Enhancing Health Service Facilities in Yemen Project (SRHSP)*** funded by KFW and being implemented by UNOPS, has an overall objective of strengthening the resilience of both the supported health facilities, as well as the targeted communities, through providing sustainable access to healthcare services in targeted communities. The project is also aligned with the objectives of the Health Cluster under 2019 Yemen HRP, which prioritizes the health sector as one of those in need of coordinated international support.

The Health Cluster has organized the assistance priorities in three strategic objectives:

1. Improve access to primary, secondary, and tertiary health care, including district hospitals in priority districts;
2. Help ensure that health facilities in priority districts are able to respond to epidemics and outbreaks; and,
3. Help restore functionally of the closed or damaged health facilities in high priority districts.

In addition, the 2030 Agenda for Sustainable Development provides an integrated framework for action aimed at improving lives, protecting natural resources, and fostering peaceful, just, and inclusive societies. In 2017, in order to support achievements of the SDGs enshrined in the 2030 Agenda, the United Nations developed an analytical framework on risk and resilience, under the instruction of the High Level Committee on Programmes[[1]](#footnote-1). The framework is organized around three elements: a) system thinking (on the part of the UN agencies) on how the present risks interact with sustainable development issues at global, regional, national, and subnational levels; b) the risk and resilience equation, that defines an approach to be used across programme pillars - peace, security, development, and humanitarian to reduce risks and define collective outcomes; and, c) a prevention “lens” in order to ensure, to the extent possible, proactive approach that lowers risks and impacts of the overall environment. The Framework is being operationalized within the mechanisms of the United Nations Development Group, and is seen to serve practical implementation of the humanitarian-development nexus.

Similarly, according to the Draft Strategy for Transitional Aid of the German Federal Ministry for Economic Cooperation and Development, which will be applied within this project, resilience is referred to as the capacity of both the institutions and people to adapt to and cope with new/changing contexts, risks and challenges, and the mobilization of their transformative energy/forces.

Within the two frameworks above, and in line with the 2019 Yemen HRP, under this project UNOPS will apply a local participatory approach, strong focus on the priority needs of the vulnerable people, and concentrated interventions geared at strengthening the core capacities of both institutions and people, in order to ensure local resilience and sustainability.

Accordingly, the activities will reflect the humanitarian-development nexus achieved through the following:

* Delivering integrated and coordinated infrastructural, equipment, and capacity development interventions to support and enhance the functional capacity of selected health facilities, in order to enhance the local health services referral system, increasing access to health services for the beneficiaries in the target communities, and enable the operational sustainability of the health facilities;
* Ensuring local participatory planning of proposed interventions through conducting local community engagements in order to ensure inclusive consultations with beneficiaries and local ownership; and,
* Conducting a stakeholder mapping to capture the activities of other actors in the health sector in the target districts, and ensure integration, coordination, and complementarity of UNOPS proposed activities to interventions already under way.
* Ensuring that the achieved results meet the needs and satisfaction of the target beneficiaries, through employing a third party monitoring mechanism.

Projects in conflict environments carry numerous risks: (i) risk of elite capture and/or corruption can exacerbate existing tensions, (ii) risk of infrastructure being built that is not sustainable, or does not correspond to community and individual beneficiaries' (women and men’s) priorities and needs among others; and/or (iii) risk that emergency processes inadvertently undermine local institutions. Gender sensitive community engagement can be an important tool to address some of these risks. In addition, community engagement can help build ownership of projects by all stakeholders including local councils, citizens of both sexes, and representatives of vulnerable groups by providing concrete methods for engagement and building on local methods of participation where they exist.

The main objective of community engagement is to enable a participatory intervention planning and ownership, through which the local stakeholders, especially vulnerable and marginalized groups, are engaged in gender-sensitive consultations to identify local priority needs and interventions that the project can address and undertake to ensure strengthening the resilience of both institutions and people. These engagements should enable local stakeholders to recognize that the project is implemented with their engagement and due-diligence and that it ensures proper prioritization of needs, equitable access to vulnerable and marginalized groups and appropriate means of monitoring progress and achieved results in a transparent and accountable manner.

Community engagement is integrated into various ways in the project including through a) gender-sensitive participatory intervention planning, b) grievance redress mechanism, c) transparency and information disclosure, and, d) and gender-sensitive community monitoring and feedback. The project aspires to demonstrate in concrete terms principles of transparency, accountability and citizen engagement while keeping processes simple and defined enough to match its scope and nature.

**Participatory Intervention Planning**

In accordance with a “Dot No Harm” and conflict sensitivity approach, the participatory planning will be used to get a better understanding of the specific vulnerabilities and relevant needs to increase resilience concerning access and use of health services and understand what would be the highest priority services and related supporting measures from the point of view of the communities in particular vulnerable parts of the community.

**Reporting and disclosure**

The community engagement framework will include critical reporting and disclosure of project related documents including results of comprehensive baseline needs assessments, interventions selection, budget details, project progress, and finally, citizen feedback on delivered interventions.

**Grievance Redress Mechanism (GRM)**

The project will include a project-related grievance redress mechanism. UNOPS will be responsible for setting up the GRM that includes a simple protocol, and multiple gender-sensitive uptake mechanisms (i.e. telephone, complaints box, email, and text messaging). The GRM system will include communication to all groups of citizens (women and men) on the GRM process regarding beneficiaries’ rights and as well as defining the boundaries regarding what project-related issues the GRM would handle. Complaints received by the GRM will be registered (disaggregated by sex), tracked, investigated, and promptly resolved by dedicated project personnel who will be reporting to the Project Manager. The GRM protocol will be developed and approved during the Inception Phase of the project in consultation with KFW.

**Third party monitoring**

The project also includes a Third-Party Monitoring (TPM) component. TPM entails independent monitoring of subprojects funded under the project.

1. **OBJECTIVE OF THE CONSULTANCY**

The objective of this consultancy is to engage target local communities in particular vulnerable groups of the community and enable a participatory planning and ownership, through which local stakeholders and beneficiaries, especially vulnerable and marginalized groups, are engaged in gender sensitive consultations based on a “Dot No Harm” and conflict sensitivity approach to understand and identify local priority needs and interventions that the project can address and undertake to ensure strengthening the resilience of both institutions and people.

These engagements should be undertaken in accordance with a “Dot No Harm” and conflict sensitivity approach, which deliberately must seek to avoid or mitigate negative impacts such as worsening divisions between conflicting groups or increasing danger for participants while equally tries to create positive impacts. The engagements should enable local stakeholders to recognize that the project is implemented with their engagement and due-diligence, and that it ensures proper prioritization of the needs, equitable access to vulnerable and marginalized groups, and appropriate means of monitoring progress and achieved results in a transparent and accountable manner. In addition, the consultancy will also provide information on available GRM methods and how to use them.

1. **SCOPE OF WORK**

The consultant will need to:

1. **Conduct Context Analysis:**

The context analysis shall be conducted for the following preselected districts and health facilities:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **#** | **Name of HF** | **Name in Arabic** | **District** | **Governorate** | **Type** |
| 1 | AlThawrah Hospital | مستشفى الثورة | At Ta'iziyah | Taiz | General Hospital |
| 2 | Ibn Khaldoun Hospital | مستشفى ابن خلدون العام | Al Hawtah | Lahj | General Hospital |
| 3 | AlSalam Rural Hospital | مستشفى السلام الريفي | Yafa'a | District Hospital |
| 4 | Obstetrics and Gynecology at AlSadakah Hospital | مبنى النساء والولادة في مستشفى الصداقة | AlMansourah | Aden | General Hospital |
| 5 | Al Ra'zi General Hospital | مستشفى الرازي العام | Khanfir | Abyan | General Hospital |
| 6 | Al-Sabeen Maternity and Children Hospital | مستشفى السبعين للولادة والأطفال | As Sabain | Amanat Alasimah | General Hospital |
| 7 | Heart Medical Center | مركز القلب الطبي | Shu'aub | Medical Center |
| 8 | 22 May Educational Hospital | مستشفى 22 مايو التعليمي‎ | Hamadan | Sana'a | District Hospital |
| 9 | Al-Thawra Hospital | مستشفى الثورة | Ibb | Ibb | General Hospital |
| 10 | Republican Hospital | المستشفى الجمهوري | Hajjah | Hajjah | General Hospital |
| 11 | Sayoun Hospital | مستشفى سيئون | Sayoun | Hadramout | General Hospital |
| 12 | Aljumhori Hospital | المستشفى الجمهوري | Al Mahweet | Al Mahwet | General Hospital |
| 13 | Shibam Hospital | مستشفى شبام | Shibam | District Hospital |

Context analysis shall comprise the following elements:

1. ***Stakeholder Analysis:*** The stakeholder analysis would cover:

* Identification and brief descriptions of key stakeholders and identity gender and marginalized and vulnerable groups (i.e. Muhamasheen and IDPs) in each target local community.
* Description of the geographic distribution of stakeholders and whether divergent stakeholder/ identity groups are concentrated in different areas of the local districts or near by the preselected health facilities.
* A rough mapping of key power relationships, including gender power relations, among different groups.
* An assessment of the underlying interests and incentives for stakeholders to participate or not to participate in the planning process.
* Description of the relationship of local government officials to the major stakeholder/identity groups, as well as an assessment of whether these groups communicate with their local councils and local government officials including local offices of line ministries and local independent corporations.

1. ***Project-based analysis:***

* Verify the selection criteria of preselected communities and health facilities. See Annex 3 for Selection Criteria.
* Identify access issues and health priority needs that are especially specific to certain target groups such as women, youth, IDPs and other marginalized group/s.
* Identify issues/ challenges facing the health service delivery processes in the preselected local communities and health facilities.

1. **Develop a gender-sensitive community engagement methodology and plan:**

Based on the context analysis and in accordance with a “Do No Harm” and conflict sensitivity approach, a detailed methodology and plan shall be developed for carrying out the participatory Gender base community public consultations (engagements) that provide relevant feedback on priority needs and potential challenges and bottlenecks. The consultant shall take into account the following important considerations:

* Level of engagement and representation: The engagement process needs to be set at a level of the Project’s scope and nature to get a better understanding of the specific vulnerabilities and relevant needs from the point of view of the communities in order to avoid unduly raising expectations.
* Structure of engagement: The role of the consultant is to develop the most context-appropriate, gender-sensitive, and effective methods for structuring gender base representative and inclusive engagements.
* Vetting the proposed participatory planning process: After a clear engagement plan has been identified, the consultant would be expected to vet the process with key informants in target communities and with organizations that typically work on community engagement (i.e. CSOs), including women’s organizations where such exist, to test its feasibility on the ground.
* A comprehensive participatory process: A comprehensive participatory plan will outline the engagement process, identify the methodology for gender base consultation, identify stakeholders, and define the mode for reporting back on progress and decisions made. In addition, clear guidelines for the monitoring of engagement process with explicit indicators that can be tracked to monitor progress

***Guidelines on a well-structured community engagement methodology are outlined in Annex 1.***

1. **Effectively communicate relevant information to the community and collect feedback:**

The Consultant shall communicate accurately the project’s scope and interventions as well as its GRM and provide any suggestions for improvement. This includes various aspects of the GRM process such as[[2]](#footnote-2):

* + What are the best channels for uptake of grievances for women and men respectively? At what level should they be located? If the use of ICT is envisaged (e.g., through websites, also comment on the Internet coverage and accessibility for women and men respectively)?
  + Are there any cultural barriers to citizens/ beneficiaries making complaints? How can they be ameliorated? (For example, citizens may prefer to make complaints in person and verbally.)
  + What would be the best channels for communication with citizens/ beneficiaries (women and men respectively) regarding the status of their complaints?
  + Are there current GRM mechanisms available to all citizens?

***Guiding principles for a successful Participatory Investment Plan are outlined in Annex 2***

1. **QUALIFICATIONS AND BID SUBMISSION**

The contract will be awarded through a competitive bidding process. The bid must at least include the following:

* Clear Technical Proposal detailing how the Consultant would implement this assignment as per the TOR.
* Clear Financial Proposal explaining the cost break down as per the proposed Technical Proposal.

Titles, names, roles, and resumes of the proposed team members who will undertake the implementation of this assignment. At minimum:-

* + 1. The Team Leader (or Project Manager) must have an advance degree (Master degree and above) in social science or relevant fields with a minimum 5-year working experience in similar projects.
    2. The Context Analysis Consultant must have an advance degree (Master degree and above) in social science or relevant fields with a minimum 5-year working experience in similar projects.
    3. The Community Engagement Consultant must have a university degree in social science or relevant fields with a minimum 7-year experience in conducting social researches and engagements.
* Proposed teams consist of more than 40% of women, including management, is desired and preferred.
* The Consultant’s collective international and/ or local minimum experience of 12 years in conducting similar assignments
* The Consultant’s proof of field presence in Yemen and a capacity to responsibly perform the contract’s terms with satisfactory dlivery.

**Failure to submit any of the above will result in an immediate dismissal of the consultant during the bidding process.**

1. **DELIVERABLES AND TIMETABLE**

| **Deliverable** | **Due date**  **(after the award of the contract)** |
| --- | --- |
| Inception Report (Consultant’s understanding of the TORs) | Week 1 |
| Detailed methodology and plan | Week 2 |
| Collected data from the field work for the gender-sensitive Context analysis that include:   * Profiles of preselected communities and health facilities * Stakeholder and project-based analysis, * Gender analysis, * Guidelines for the monitoring of engagement process with explicit indicators, and * Vetting process report. | Week 4 |
| Final Gender-Sensitive Context analysis report | Week 5 |
| A report outlining suggestions for GRM process | Week 5 |
| Final Community Engagements with findings and recommendations | Week 6 |

1. **SUPERVISION AND REPORTING**

Under the supervision of the Project Manager of SRHSP and UNOPS Program Advisor in Yemen, the Consultant shall provide regular updates to the project’s assigned team, with briefings at least every two weeks on progress. The **Consultant will be solely responsible for developing and implementing the above agreed deliverables and for maintaining all necessary safety and security risk management measures including the attainments of all relevant permissions to access the preselected facilities and to conduct the community engagements.**

1. **PAYMENT:**

**The payment is due to:**

1. 50% of the signed contract after the Successful Submission of the Data Collection and Final Gender-sensitive Context Analysis Report and The GRM Report and approved by UNOPS project manager and Program Advisor.
2. 50% of the signed contract after the successful submission of the Final Community Engagement Report with findings and recommendations and approved by UNOPS project manager and Program Advisor.

**Annex 1: Community Engagement’s Methodology**

**Preselection of research sites*:*** *The preselected sites are per the following table:*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **#** | **Name of HF** | **Name in Arabic** | **District** | **Governorate** | **Type** |
| 1 | AlThawrah Hospital | مستشفى الثورة | At Ta'iziyah | Taiz | General Hospital |
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| 5 | Al Ra'zi General Hospital | مستشفى الرازي العام | Khanfir | Abyan | General Hospital |
| 6 | Al-Sabeen Maternity and Children Hospital | مستشفى السبعين للولادة والأطفال | As Sabain | Amanat Alasimah | General Hospital |
| 7 | Heart Medical Center | مركز القلب الطبي | Shu'aub | Medical Center |
| 8 | 22 May Educational Hospital | مستشفى 22 مايو التعليمي‎ | Hamadan | Sana'a | District Hospital |
| 9 | Al-Thawra Hospital | مستشفى الثورة | Ibb | Ibb | General Hospital |
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| 11 | Sayoun Hospital | مستشفى سيئون | Sayoun | Hadramout | General Hospital |
| 12 | Aljumhori Hospital | المستشفى الجمهوري | Al Mahweet | Al Mahwet | General Hospital |
| 13 | Shibam Hospital | مستشفى شبام | Shibam | District Hospital |

The aim should be to choose participants from the above preselected districts who have different social make-up from each other to provide variation regarding the level of social capital and level of social cohesion.

***Identifying and identifying/enlisting/recruiting participants/respondents:*** For recruiting participants within the preselected districts, the Consultant would use two methods – purposive and snowballing. The first method involves identification of specific categories of participants including but not limited to the following:

* Local council and municipal level officials
* Management of the preselected health facilities
* Members of Executive Councils
* CSOs including NGOs, INGOs and women’s rights organizations
* Donors, multilateral organizations
* Local beneficiaries (women and men, marginalized [Muhammasheen] and IDPs)

Most of these participants can be identified and selected through city profiling (See next section). Citizens and beneficiaries will be selected using informal structures for example through local leaders and health facilities’ patient records as well as GIZ and Yamaan that could also be consulted to get some contacts in the areas where they are active. Beneficiaries can also be recruited through snowballing, i.e., by asking health facilities and other entities to recommend individuals that can be contacted. In some cases, they may also help arrange interviews and focus groups. The focus group participants and interviewees would also be asked to recommend other people that the research team can interview or invite to focus groups. The snowball method has been demonstrated to be effective in ensuring participation of marginalized and vulnerable groups.

It would be ensured that residents and beneficiaries from different groups are included in the sample. The Consultant will engage local communities representing the spectrum of various ethnicities, religious affiliation, and tribal memberships, as well as different socio-economic conditions. It would be ensured that there is a balance between identity groups. An effort will be made to ensure that the sample is appropriately disaggregated by sex. The Consultant will work closely with UNOPS local Safeguards and Gender Officer in Sana’a and UNOPS Gender Specialist in Amman to identify the specific participant selection methods.

***Sample size:*** The adequacy of a sample size must be continuously evaluated during the analysis process, and should be discussed with UNOPS. It is estimated the Consultant will conduct:

* 10 Key Informant Interviews (KII) at the district level
* 5 KIIs at the governorate level of each preselected district
* Three focus groups in each preselected district with 15-20 participants.

Focus groups must be conducted separately for women and men. Furthermore, KIIs must be conducted by a person of the same sex as the interviewee as well as be gender sensitive in its content.

**Data collection process**

The context analysis should proceed in two steps:

1. *Conduct a brief profile of the preselected community (district) and health facilities.*

The Consultant would start with a brief profiling exercise that will aim to collect basic information about the preselected community and health facility including availability and access to various services, basic social and political structure of customary institutions, inter-tribal relationships, etc. The exercise should also examine the geographical spread of different identity groups. This profile will inform the identification of marginalized/specialized groups and will inform the sampling of the preselected communities (see above). Profiling will also help the Consultant to start identifying individuals for KIIs and recruit beneficiaries for participation in focus groups and individual interviews. This exercise would use data from statistical services, UN agencies, research groups, published reports, NGOs and any other viable source. When all required data is not available, key informant interviews with women as well as men should be conducted. These KIIs do not cover the required number of KIIs at the district level as mentioned above.

1. *Data collection and data instruments*

The Consultant would use key informant interviews, focus groups, and in-depth individual interviews to collect the required data to respond to the research questions, especially regarding the community’s access to health services and identifying local gender-related constraints and needs. Local researchers who are experienced in qualitative research will be trained in the use of gender-sensitive interviews and focus group methods as necessary.

A protocol describing the process for the KIIs, individual interviews and focus group will be developed to ensure, insofar as possible, that the data collection methods used are consistent. The Consultant will collaborate with the UNOPS team to finalize the research instruments and propose a detailed methodology and field plan. The local researchers will plan for and carry out the data collection based on an agreed upon schedule and process and will keep detailed records of the data collection (e.g., number of completed interviews by category and sex), helping to ensure that the fieldwork is completed promptly.

**Data analysis**

The data collected through various instruments, individual interviews, community profiles, and desk study will be analyzed using various methods. To aid in data analysis, the Consultant can also consider computer programs such as Nvivo to help with coding, text interpretation and content analysis.

It is imperative that data from different sources and methods is triangulated to answer the research questions. Data triangulation refers to the process of using different methods and sources to investigate the same social issue to check and validate the results. This is particularly important in crisis-affected and fragile contexts, where discourses and narratives are typically polarized.

**Other things to keep in mind**

* In situations of conflict, the research team may need to adapt the methods of interviews (i.e., in some cases face-to-face interviews, in others being introduced by trusted community members, and in others by telephone calls). This should be kept in mind when designing research instruments.
* Interviewers/surveyors should be carefully selected for each neighborhood to ensure that the identity group and sex of the interviewer does not clash with that of the respondent.
* It would be necessary to include male and female surveyors/ social researchers in each research team for each target district.

**Annex 2: Guiding principles for a successful Participatory Investment Plan**

* Community engagement must be in accordance with a “Dot No Harm” and conflict sensitivity approach, which must be based on a solid context analysis and must seek to avoid or mitigate negative impacts while equally tries to create positive impacts.
* Community engagement should generate ownership and build a strong base for the investment in the community. It should ensure that planned interventions have credibility in strengthening the resilience of both the supported health facilities as well as the targeted communities.
* It should provide an opportunity for often disenfranchised groups to be heard and include their voice in investment planning decisions.
* An important aim of the community engagement process should be to build trust between the implementing agency and the community and among the individuals involved. This trust can serve as a foundation for future community-led development and participatory processes at the local level. Building trust requires more than receiving input on priorities. It involves investing in transparency, systematic communication and reporting back on decisions or the summary of consultations (including when priorities cannot be implemented for technical reasons) as well as having mechanisms to submit grievances should things not go as planned.
* A community engagement process in a conflict setting requires careful analysis of context, potential risks, and tailoring the methods of feedback and engagement to those that community members of both sexes are likely to trust and use. In fragile environments, community engagement must start with creating an environment for trust to build and strengthen over time. Engagement events should be planned and designed with this in mind. Especially, if there are factions in the community or a history of failed attempts at community engagement, the task of engaging citizens/ beneficiaries in the participatory process can be difficult. Therefore, specific strategies should be devised to overcome these barriers.
* Try to avoid creating parallel structures and build upon existing norms. In cases, where legitimate local groups exist (for example, in the form of development committees, councils, street committees), use those as a base to form representative structures for community engagement. Approaches based on existing structures tend to be most successful and legitimate. On the other hand, establishing committees or groups parallel to local-level formal or informal groups can result in competition between the existing and new structures, which can lead to discord. At the same time, it is important to be careful and expand the base of engagement of the existing structures, as they can sometimes reinforce existing social hierarchies and patterns of exclusion (for example, by not involving women).
* In addition to citizens/ beneficiaries (who are representatives of vulnerable groups e.g. women, marginalized, and IDPs), communities and local traditional leaders, it is vital to include local elected and non-elected officials in the engagement process.

**Annex 3: Selection Criteria**

**District Selection Criteria:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| # | **Criteria** | **Requirements** | **Yes/No** | **Source of data for verification** |
| **1** | **High Health Needs** | District that has at least **20%** of its population in acute and moderate health needs should be eligible. |  | OCHA Yemen (Human data)\*, WHO assessments, MoPH priorities and plans |
| **2** | **Security and Safety** | There is **NO** nearby conflict and ground fighting in the district. |  | UNDSS reports |
| **3** | **Local population's size and segments** | Districts with a local population of at least **20,000** persons including marginalized, IDPs and/or other vulnerable groups. |  | 2019 HNO/ Total Population Movements Reports\* |

\* <https://data.humdata.org/organization/ocha-yemen>

**Health Facility Selection Criteria:**

| **#** | **Criteria** | **Requirements** | **Yes/No** | **Source of data for verification** |
| --- | --- | --- | --- | --- |
| **1** | **Public Ownership** | Must be 100% public facility (excluding military and police health facilities) |  | Facility's establishment decree/ UNOPS Baseline Needs Assessments |
| **2** | **Accessibility to beneficiaries** | No need for targeted beneficiaries to have any permits or security clearance to access the facility. Other barriers should be included for consideration |  | UNOPS Baseline Needs Assessments/ Community Engagements |
| **3** | **Functionality and capacity** | Must be functional or partially functional mainly because of lack of rehabilitation and equipment support |  | UNOPS Baseline Needs Assessments/ Community Engagements |
| **4** | **Ongoing or Contracted Support by other organizations** | Must not have similar ongoing or planned contractual rehabilitation support; namely rehabilitation works, by other organizations. Complementary ongoing or planned contractual support such as incentive payments and operational support by other organizations are accepted. |  | UNOPS Baseline Needs Assessments/ UN Health Cluster/ MoPH/ Community Engagement |
| **5** | **Available Human Resources** | Must have available and sufficient number of specialized staff such as doctors, midwives, and nurses and support staff to provide the needed health services that are associated with the type of preselected facilities. Benchmarks will be developed in the Baseline Needs Assessments to determine the "Sufficient and available" human resources of each preselected facility. |  | UNOPS Baseline Needs Assessments (Benchmarks)/ Community Engagements |
| **6** | **Structure and status (Rehabilitation needs, not reconstruction need)** | The facility's original structure must be intact and in need of rehabilitation support and not severely damaged or destroyed. Temporarily structures such as mobile containers, cabins, tents in the vicinity of a preselected facility cannot fulfil this requirement because reconstruction is beyond the scope of the project. |  | UNOPS Baseline Needs Assessments |
| **7** | **No. of daily beneficiaries** | At least 20 (in & out) patients treated a day |  | Facility's patients register/ UNOPS Baseline Needs Assessments/ Community Engagement |
| **8** | **Girls and women** | At least 30% of registered cases to ensure that females have a notable existing access to the pre-selected facility. Less than 30% may suggest local social exclusion of females to primary health services that will further be substantiated by the Community Engagements. |  | Facility's Records/ UNOPS Baseline Needs Assessments/ Community Engagement |
| **9** | **Reach and logistics (safe inland movements to and from target sites)** | Ability of private contractors/ suppliers to reach the target site safely without enduring excessive costs or exposing to risks in order to conduct the rehabilitation works or the delivery of equipment and training. |  | UNOPS Logistics Reports/ UNOPS Baseline Needs Assessments |
| **10** | **Land access and availability of working space** | Involuntary resettlement, no restriction to land or a need for land acquisition for contractor's working space or facility infrastructure improvements |  | UNOPS Baseline Needs Assessments/ facility's official confirmation/ Community Engagement |

1. <https://www.unsceb.org/content/hlcp> [↑](#footnote-ref-1)
2. Gender-sensitive context analysis should also inform this exercise [↑](#footnote-ref-2)