THE WORLD BANK World Health Organization unicef UNOPS

Yemen Emergency Human Capital Project

Project **O**perational **M**anual

Version 2

July 2022

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POM Focal Points	Version	Sent	WB Focal Point	Approved	Major Changes
- Dr. Kahtan Al-Shabi *Health & Knowledge Management Officer, WHO.* - Dr. Khaldoon Mohammed *Programme Advisor, UNOPS.* - Dr. Abdulbaset Al-Dubai *Health & Nutrition Officer, UNICEF.* - Lara Lababdeh *Programme Assistant, WHO.*	1	September 2021	- Takahiro Hasumi *Health Specialist, WB.*	October 2021	
- Ms. Nicole Sarkis *Project Manager, WHO.* - Dr. Khaldoon Mohammed *Programme Advisor, UNOPS.* - Dr. Abdulbaset Al-Dubai *Health & Nutrition Officer, UNICEF.*	2	July 2022	- Takahiro Hasumi *Health Specialist, WB.*		Reflecting $150 million in additional financing for continuation of activities and some new activities

ABBREVIATIONS AND ACRONYMS

AF	*Additional Financing*
ANC	*Antenatal Care*
APA	*Alternative Procurement Arrangement*
APW	*Agreement for Performance of Work*
asl	*Above Sea Level*
AUs	*Autonomous Utilities*
BEmONC	*Basic Emergency Obstetric and Neonatal Care*
BSP	*Bilateral Service Provision*
CBO	*Community-Based Organization*
CCRT	*Catastrophe Containment and Relief Trust*
CEmONC	*Comprehensive Emergency Obstetric and Neonatal Care*
CEN	*Country Engagement Note*
CERC	*Contingency Emergency Response Component*
CFSs	*Child-Friendly Spaces*
CISO	*Chief Information Security Officer*
CHNV	*Community Health and Nutrition Volunteer*
CHV	*Community Health Volunteer*
CHW	*Community Health Worker*
CIFD	*Conflict of Interest and Financial Disclosure*
CMW	*Community Midwife*
COVID-19	*Coronavirus Disease 2019*
CPHL	*Central Public Health Laboratories*
CRC	*Contract Review Committee*
CRI	*Corporate Results Indicator*
CWIS	*City-Wide Inclusive Sanitation*
DAF	*Director of Administration and Finance*
DCT	*Direct Cash Transfer*
DFC	*Direct Financial Cooperation*
DGO	*Director General Office*
DH	*District Hospital*
DHIS2	*District Health Information Software 2*
DHO	*District Health Office*
DI	*Direct Implementation*
DLA	*District Local Authority*
DLP	*Defect Liability Period*
DNA	*Damage and Needs Assessment*
DNP	*Defect Notification Period*
DOI	*Declarations of Interest*
DPIA	*Data Protection Impact Assessment*
DTC	*Diarrhea Treatment Center*
ECG	*Electro-Cardiogram*
ECM	*Enterprise Content Management*
ECRP	*Emergency Crisis Response Project*

ECT	*Emergency Cash Transfer*
ED	*Executive Director*
EFSNA	*Emergency Food Security and Nutrition Assessment*
eIDEWS	*Electronic Integrated Disease Early Warning System*
ELISA	*Enzyme-Linked Immunosorbent Assay*
EOC	*Emergency Operation Center*
EOD	*Executive Office Directive*
EOI	*Executive Office Instruction*
EPI	*Expanded Program on Immunization*
ER	*Emergency Room*
ESCP	*Environmental and Social Commitment Plan*
ESF	*Environmental and Social Framework*
ESMF	*Environmental and Social Management Framework*
ESMP	*Environmental and Social Management Plan*
ESP	*Essential Service Package*
ESS	*Environmental and Social Standard*
FAO	*Food and Agriculture Organization*
FPA	*Fiduciary Principles Accord*
FCV	*Fragility, Conflict and Violence*
FM	*Financial Management*
FMD	*Fuel Monitoring Devices*
FMFA	*Financial Management Framework Agreement*
FS	*Food Security*
GAFSP	*Global Agriculture and Food Security Program*
GAM	*Global Acute Malnutrition*
GARWSP	*General Authority for Rural Water and Sanitation Project*
GBV	*Gender-Based Violence*
GDP	*Gross Domestic Product*
GES	*General External Services*
GHO	*Governorate Health Office*
GIZ	*German Corporation for International Cooperation*
GM	*Grievance Mechanism*
GMP	*Growth Assessment and Promotion*
GPE	*Global Partnership for Education*
GR	*Goods Receipt*
GRM	*Grievance Redress Mechanism*
GRS	*Grievance Redress Service*
GSM	*Global Management System*
GTFCC	*Global Taskforce on Cholera Control*
H&N	*Health and Nutrition*
HC	*Health Center*
HeRAMS	*Health Resources and Services Availability Monitoring System*
HF	*Health Facility*
HKM	*Health and Knowledge Management*
HNP	*Health, Nutrition and Population*
HQ	*Head Quarter*

HR	*Human Resource*
HU	*Health Unit*
IARC	*Director of the International Agency for Research on Cancer*
IASC	*Inter-Agency Standing Committee*
ICCM	*Integrated Community Case Management*
ICU	*Intensive Care Unit*
IDA	*International Development Association*
IDH	*Inter-District Hospital*
IDP	*Internally Displaced Person*
IEHK	*Interagency Emergency Health Kit*
IFA	*Iron-Folic Acid*
IFPC	*Integrated Food Security Phased Classification*
IFR	*Interim Unaudited Financial Reports*
IMCI	*Integrated Management of Childhood Illness*
IMF	*International Monetary Fund*
IMO	*Information Management Office*
INGOs	*International Non-governmental Organizations*
INSS	*Integrated Nutrition Surveillance System*
IP	*Implementing Partner*
IPC	*Integrated Food Security Phase Classification*
IPC AMN	*Integrated Food Security Phase Classification for Acute Malnutrition*
IPO	*Imprest Purchase Order*
IR	*Invoice Receipt*
IRM	*Insecticide Resistance Monitoring*
IRS	*Indoor Residual Spraying*
ITB	*Invitation to Bid*
ITN	*Insecticide-Treated Net*
IYCF	*Infant and Young Child Feeding*
JMP	*Joint Monitoring Program for Water Supply, Sanitation and Hygiene*
KAP	*Knowledge, Attitude and Practices*
LEG	*Legal Counsel*
LLIN	*Long-Lasting Insecticidal Net*
LMIC	*Low- and Middle-Income Countries*
LMP	*Labor Management Procedures*
LNGO	*Local Non-governmental Organization*
LTA	*Long Term Agreement*
LSM	*Larval Source Management*
LSS	*Logistics Support Systems*
M&E	*Monitoring and Evaluation*
MC	*Medical Complication*
MENA	*Middle East and North Africa*
MHPSS	*Mental Health and Psychosocial Support*
MNH	*Maternal and Newborn Health*
MOPAG	*Mean of Platts Arabian Gulf*
MoPHP	*Ministry of Public Health and Population*
MOSAL	*Ministry of Social Affair & Labor*

MS	*Multi Sectoral*
MSP	*Minimum Service Package*
MUAC	*Middle Upper Arm Circumference*
MWE	*Ministry of Water and Environment*
MWM	*Medical Waste Management*
MWMP	*Medical Waste Management Plan*
NBTC	*National Blood Transfusion Support*
NC	*Nutrition Cluster*
NCD	*Non-Communicable Diseases*
NCP	*National Cholera Control Plan*
NGO	*Non-governmental Organization*
NMCP	*National Malaria Control Program*
NQPS	*National Quality Policy and Strategy*
NSS	*National Surveillance System*
NWSA	*National Water and Sanitation Authority*
O&M	*Operations and Maintenance*
OCV	*Oral Cholera Vaccination*
OHS	*Occupational Health and Safety*
OP	*Operational Policy*
ORS	*Oral Rehydration Solution*
OTC	*Outpatient Therapeutic Center*
OTP	*Outpatient Therapeutic Program*
PATEO	*Project Award Task Expenditure Type Organization*
PAD	*Project Appraisal Documents*
PBO	*Piperonyl Butoxide*
PDO	*Project Development Objective*
PHC	*Primary Health Care*
PHCF	*Primary Health Care Facility*
PHI	*Protected Health Information*
PII	*Personally Identifiable Information*
PIN	*People in Need*
PMC	*PubMed Central*
PMU	*Project Management Unit*
PO	*Purchase Order*
POM	*Project Operations Manual*
PPE	*Personal Protective Equipment*
PSEA	*Prevention of Sexual Exploitation and Abuse*
PSS	*Psychosocial Support*
PWP	*Public Works Project*
RDO	*Regional Director Office*
RF	*Resettlement Framework*
RFP	*Request for Proposal*
RFQ	*Request for Quotation*
RH	*Reproductive Health*
RMS	*Results Measurement System*
RRT	*Rapid Response Team*

SAM	*Severe Acute Malnutrition*
SBO	*Strategic Behavioral Objectives*
SEA	*Sexual Exploitation and Abuse*
SEP	*Stakeholder Engagement Plan*
SH	*Sexual Harassment*
SIA	*Supplementary Immunization Activity*
SMART	*Standardized Monitoring and Assessment of Relief and Transitions*
SMP	*Security Management Plan*
SOP	*Standard Operating Procedure*
SMS	*Short Message Services*
SSA	*Special Service Agreement*
SSK	*Surgical Supply Kit*
SUN	*Scaling Up Nutrition*
TESK	*Trauma & Emergency Surgery Kit*
TFC	*Therapeutic Feeding Center*
TMA	*Tailor Made Agreement*
TOR	*Terms of Reference*
TOT	*Training of Trainers*
TPM	*Third-Party Monitoring*
TSA	*Technical Services Agreements*
UHC	*Universal Health Coverage*
UI	*Uncertainty Interval*
UN	*United Nations*
UNDP	*United Nations Development Program*
UNGM	*United Nation Global Market*
UNICEF	*United Nations Children's Fund*
UNOCHA	*United Nations Office for the Coordination of Humanitarian Affairs*
UNOPS	*United Nations Office for Project Services*
USAID	*United States Agency for International Development*
USD	*United States Dollar*
UW-PMU	*Urban Water – Project Management Unit*
VRA	*Vulnerability and Risk Assessment*
WASH	*Water, Sanitation and Hygiene*
WB	*World Bank*
WBG	*World Bank Group*
WCO	*WHO Country Office*
WFP	*World Food Program*
WHO	*World Health Organization*
WSLC	*Water and Sanitation Local Corporation*
WSS	*Water Supply and Sanitation*
WR	*WHO Representative*
WTP	*Water Treatment Plant*
WUA	*Water User Association*
WWTP	*Wastewater Treatment Plant*
YAP	*Yemen Action Plan*
YCRP	*Yemen COVID-19 Response Project*

YEEAP	*Yemen Emergency Electricity Access Project*
YEHCP	*Yemen Emergency Human Capital Project*
YEHNP	*Yemen Emergency Health and Nutrition Project*
YER	*Yemeni Rial*
YIUSEP	*Yemen Integrated Urban Services Emergency Project*

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1. Introduction

The purpose of the Project Operations Manual (POM) is to establish and maintain a system of project implementation and management procedures to ensure the Yemen Emergency Human Capital Project (YEHCP or Project) will be implemented effectively.

The POM is intended to be a living document that could be updated in response to changes in the project's operating environment and implementation realities with prior consultations between all stakeholders and no objection from the World Bank (WB).

Table 1: Implementing Agencies

Implementing Agencies	World Health Organization (WHO)
	United Nations Children's Emergency Fund (UNICEF)
	United Nations Office for Project Services (UNOPS)

The POM contains the main project rules, methods, guidelines, specific development plans, standard documentation and procedures for the implementation of the YEHCP, including:

- Description of YEHCP activities, their sequencing and related benchmarks;
- Project administrative, financial, accounting, auditing, procurement and disbursement procedures, including relevant standard documents; and
- Procedures that are related to the disbursement of Project funds.

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Project Overview

The YEHCP is the successor to the Yemen Emergency Health and Nutrition Project (YEHNP), and its underlying rationale is to protect the human capital of the population of Yemen. It intends to do this by continuing to support the provision of essential services; support core public health and population-based interventions as well as restoring water supply and sanitation services, including response to emergencies and disease outbreaks; and build national and local capacities/institutions for health and WASH service delivery and system management in Yemen. The project is financed by International Development Association (IDA) grants totaling US$300 million, including $150 million in initial financing and $150 million in additional financing. Each implementing agency is responsible for several activities based on the project design and the implementation experience under the YEHNP, Yemen COVID-19 Response Project (YCRP) and Yemen Integrated Urban Services Emergency Project (YIUSEP).

Table 2: Project Cost per Implementing Agency

Agency	Original financing, 2021	Additional financing, 2022
UNICEF	$74,540,000 *SDR 51,600,000*	$74,5400,000 *SDR 55,300,000*

WHO	$45,400,000 *SDR 31,500,000*	$45,400,000 *SDR 33,700,000*
UNOPS	$30,000,000 *SDR 20,800,000*	$30,000,000 *SDR 22,300,000*
Total	**$150,000,000** ***SDR 103,900,000***	**$150,000,000** ***SDR 111,000,000***

The project follows a three-pronged approach that groups different project activities together and helps address: i) Response to the short-term needs for health, nutrition and Water and sanitation Services (WSS) at the community, facility and hospital levels; ii) Prevention of acute and chronic malnutrition, disease outbreaks, e.g. Cholera, Diphtheria, Dengue fever, etc.; and iii) Institutional and capacity building that will help ensure long-term development outcomes through relying on the local systems. Supporting the local health institutions and key water utilities and institutions will maintain the operational and technical capacity of the staff. Under this project, provisions of WSS services for the population of Yemen will be supported through rehabilitation of medium to large WSS infrastructure, response to COVID-19 and flash floods, emergency provisions
of fuel to WSS facilities and water trucking for key HFs subject to updating, development and implementation of exit strategies and strengthening the capacity building of the local water and sanitation institutions at the decentralized level.

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Accordingly, the YEHCP is aligned with the World Bank Group (WBG)'s strategic objectives at the global, regional and country level. The project will help restore, sustain and expand the delivery of integrated health, nutrition and WASH services, aligning itself with the WBG twin goals of ending extreme poverty and boosting shared prosperity. It will do so in a sustainable manner as it aims for social inclusion and achieving progress in non-monetary dimensions of welfare, including health, with particular emphasis on underserved and vulnerable groups. Aligned with the emphasis in the Country Engagement Note (CEN) on full coordination with stakeholders and partners on the ground, the project through its implementing Agencies (WHO, UNICEF, and UNOPS) would collaborate closely with national institutions and local entities where relevant, to ensure both project implementation and knowledge transfer.

The YEHCP aims at sustaining basic service delivery while progressively supporting economic and human capital development and further strengthening public service delivery mechanisms aimed at improving health and nutrition service delivery while also stepping up focus on restoring water and sanitation services at selected urban, pre-urban and rural areas. The project is organized into the following components (more details are provided under the Project Components section):

Table 3: Project Components' Cost

Project Components	Cost (US$ million)			Implemented by
	Original financing	Additional financing	Total	
1. Improving Access to Healthcare, Nutrition, and Public Health Services	104.95	103.96	**209.9**	WHO UNICEF
2. Improving Access to Water Supply and Sanitation (WSS) and Strengthening Local Systems	26.24	26.24	**52.48**	UNOPS
3. Project Support, Management, Evaluation and Administration	18.81	19.86	**37.62**	ALL
4. Contingent Emergency Response	**-**	-	-	ALL

Project Beneficiaries

The project interventions will be implemented nationwide. All activities will be guided by the security situation of each governorate[1]. Areas with ongoing conflicts will be reached once the security situation allows and the service delivery can be ensured. Similarly, the package of services will vary among governorates based on the population's health and nutrition as well as WASH needs and the implementation capacity of the existing local providers.

Based on the proposed activities, the project is expected to: (i) reach 5.18 million people in Yemen with essential health, nutrition and population services; (ii) train 6,140 health personnel; and (iii) establish disease surveillance and early warning system for cholera and other outbreaks in 388 new sites. In addition, cholera suspected cases will be managed, and the entire population will be targeted for health education messages, as well as for public health programs for polio, cholera, malaria, schistosomiasis, and trachoma. These will be integrated within the package to sustain service delivery.

The primary beneficiary of the WASH component will be the residents of the selected urban, peri-urban and rural areas in Yemen (1,275,000), including IDPs, marginalized groups such as women, girls and children who are the primary beneficiaries of improved WSS services by having more access to improved drinking water and improved wastewater collection and treatment services. Autonomous National and local institutions having partnerships with UNOPS under this component and their staff will also benefit from technical assistance and investments that will strengthen their performance and improve the provision of WSS services, which in turn will improve their social contract with the customers and general credibility in their communities. The Technical assistance includes training packages that will be delivered under the Capacity building subcomponent in full coordination with activities under YIUSEP-II+AF. With

[1] *All UN agencies are guided and advised by the regular UNDSS updates.*

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potential support from the World Bank, a needs assessment may be conducted to assess the actual capacity needs of local institutions at a decentralized level.

Project Development Objective (PDO)

The project development objective is to provide essential health, nutrition, water and sanitation services to the population of Yemen.

PDO Level Indicators

- People who have received essential health, nutrition, and population services.
- People provided access to improved water and sanitation services in selected urban, pre-urban and rural areas.

Result Framework

- Given the integrated package of services supported by the project and the unique implementation arrangements through three UN agencies, it is important that the results of the project are calculated and reported jointly by WHO, UNICEF and UNOPS to minimize double counting and address the reporting issues at the facility, district or Third-Party Monitoring (TPM) levels.
- The results framework consists of the following indicators:

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PDO Indicators

Table 4: PDO Indicators

Indicator	End Target
Provision of Essential Health and Nutrition Services	
Beneficiaries of health, nutrition and/or population services provided through the project (Number)	**5,180,000**
Beneficiaries of health, nutrition, and/or population services provided through the project, of which female (Number)	**2,340,000**
Beneficiaries of health, nutrition, and/or population services provided through the project - of which children under 5 (Number)	**2,170,000**
Percentage of beneficiaries of health, nutrition, and/or population services provided through the project - IDPs (Percentage)	**10**
Provision of Essential Water and Sanitation Services	
People provided with access to improved water and sanitation services in selected urban and rural areas (Number)	**1,275,000**
People provided with access to improved water and sanitation services in selected urban and rural areas - female (Percentage)	**48**

Intermediate Results Indicators

Table 5: Intermediate Results Indicators

Indicator	End Target
Improving Access to Health, Nutrition, and Public Health Services	
Outreach rounds conducted (Number)	**38,000**
Health facilities provided with equipment and medical/non-medical supplies (Number)	**2,300**
Pregnant women receiving antenatal care during a visit to a health provider (Number)	**374,000**
Health personnel receiving training (Number)	**6,140**
People receiving mental health and psychosocial support (Number)	**168,000**
Nutrition surveillance sites established (Number)	**337**
Women receiving breastfeeding and complementary feeding counseling (Number)	**530,000**
People receiving essential drugs for non-communicable diseases (Number)	**130,000**
Promotion of good hygiene and sanitation practices to prevent the spread of diseases exacerbated by climate change (Yes/No)	**Yes**
New electronic integrated disease early warning system (eIDEWS) data collection sites established (Number)	**2,379**
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)	**4,130,000**
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement) (CRI, Number)	**2,000,000**
Children immunized (CRI, Number)	**2,043,000**
Women and children who have received basic nutrition services (CRI, Number)	**794,000**
Deliveries attended by skilled health personnel (CRI, Number)	**270,000**
Improving Access to Water Supply and Sanitation and Strengthening Local Systems	
People provided with access to improved water sources (CRI, Number)	**450,000**
People provided with access to improved water sources - Female (RMS requirement) (CRI, Number)	**216,000**
People provided with access to improved water sources - rural (CRI, Number)	**150,000**
People provided with access to improved water sources - urban (CRI, Number)	**300,000**
People provided with access to improved sanitation services (CRI, Number)	**825,000**
People provided with access to improved sanitation services - Female (RMS requirement) (CRI, Number)	**396,000**
People provided with access to improved sanitation services - rural (CRI, Number)	**75,000**

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People provided with access to improved sanitation services - urban (CRI, Number)	**550,000**
Percentage of WASH focus groups attendees who were satisfied with the participatory approach in the planning process of the project (Percentage)	**80**
Percentage of WASH focus groups attendees who were satisfied with the participatory approach in the planning process of the project - of which female (Percentage)	**40**
Number of people trained from government institutions to improving local WASH capacity at the institutional level (Number)	**300**
Schools with improved WASH facilities (Number)	**30**
Health care establishments with improved WASH facilities (Number)	**20**
IDPs benefiting from emergency WASH response (rural and urban) (Number)	**7,500**
People who have access to water monitored for quality using critical parameters related to cholera and water borne diseases (Number)	**200,000**
Water and sanitation facilities using solar power generation (Number)	**30**
Project Support, Management, Evaluation and Administration	
Local NGOs involved in service provision (Number)	10
Beneficiaries satisfied with services provided (Percentage)	85
An action plan to follow up on the findings from TPM surveys is prepared and monitored (Yes/No)	Yes

For more information about the definition and methodology of the indicators, please see Annex 1.1.

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2. Project Components

Component 1: Improving Access to Healthcare, Nutrition, and Public Health Services

Implementing Agencies: WHO and UNICEF will work in partnership with Governorate Health Offices (GHOs), District Health Offices (DHOs), local health institutions and facilities and will seek to integrate as much as possible the health and nutrition activities under Component 1 with the WASH activities under Component 2.

This component aims to ensure continuity of delivery of MSP services and provision of an integrated package of services at primary and secondary health care levels including facility, outreach, mobile, and community with a particular focus on integrating the Maternal & Neonatal Health (MNH), and child nutrition services. In addition to treating children with Severe Acute Malnutrition (SAM), the component will sharpen the focus on strengthening prevention of acute malnutrition and introduce activities focused on the prevention of chronic malnutrition. The component has the aims of ensuring continuity of services, strengthening quality of treatment, and scaling up to reach the most vulnerable and marginalized populations. It will also place emphasis on the integration of coordinated MHPSS interventions between primary and secondary levels with health and nutrition services. Inputs from this project will include per diems for health workers conducting outreach services, operating costs (fuel, water, electricity, etc.), basic supplies, equipment, maintenance, medical and non-medical supplies, essential drugs, vaccines,

micronutrients, therapeutic foods, fortified nutritious supplements, training, per diem and transportation allowances for training and supervision, and minor rehabilitation of existing facilities. Solarization of selected Primary Health Care Facilities (PHCFs) as an exit strategy from fuel and some central and governorate cold stores to minimize the expenses on fuel for backup generators will be explored[2]
In discussion with MOPHP on MNH support through EHCP, the need to upgrade at least 50 health centers to be able to provide BEmONC services to pregnant women was raised as a priority intervention given the limited access to skilled dellivery services which may contribute to low skilled birth attendance in Yemen. This includes preparing a delivery room with the required equipment and supplies, as those HCs already have midwives that can conduct deliveries.

Table 6: Component 1 Implementing Agencies and Cost

Component 1: Improving Access to Healthcare, Nutrition, and Public Health	Agency	EHCP Cost (US$ millions)	EHCP AF Cost (US$ millions)	Total
Subcomponent 1.1: Improving Access to the MSP at Primary Healthcare level (UNICEF)	UNICEF	45.19	42.66	**87.85**
	WHO	-	1.00	
Subcomponent 1.2: Improving access to essential preventive and curative nutrition services (UNICEF)	UNICEF	20.00	20.00	**40.00**
Subcomponent 1.3. Improving Access to the MSP at Secondary Healthcare Level (WHO)	WHO	26.25	26	**52.25**
Subcomponent 1.4. Sustaining the National Health System Preparedness and Public Health Programs (WHO)	WHO	13.51	11.26	**24.77**
Subcomponent 1.5. Health System Strengthening	UNICEF	0.5-	1.5	**2.00**
	WHO	-	1.5	**1.5**
Total		**104.95**	**111.0**	**215.95**

The MSP is the overarching guiding framework for the health and nutrition components of the YEHCP. It focuses on preserving and strengthening the health and nutrition system. Given the situation in Yemen, the MSP will be the guiding methodology and basis of shaping interventions at the district level. Review of the MSP in 2022 has highlighted the need to increase the focus on non-communicable diseases (NCDs) and MHPSS, particularly at the primary health care level, in line with the disease burden in Yemen. WHO will collaborate with UNICEF to take forward action on NCD prevention and control for communities.

The priority health interventions selected from within the context to make up the components of the MSP are the following:

1) General services and trauma care
2) Childcare at all levels
3) Nutrition
4) Communicable diseases

[2] *While solarization of health facilities and cold chains is a priority for environmental protection and sustainability, it may not be feasible within the allocated budget. UNICEF will explore the requirements for implementing this option and it may be considered in subsequent additional financing agreements.*

5) Reproductive, maternal and newborn health (including BEmONC and CEmONC)
6) Non-communicable diseases
7) Mental health
8) Environmental health

Three main criteria were used to select the interventions of the MSP:

1. Relevance in addressing the main health problems (i.e. prioritization).
2. Proven effectiveness (and cost effectiveness given the limited available resources).
3. System's capacity to deliver the services.

One of the main elements of the MSP is activating and strengthening the referral system within targeted Districts. Implementation is also strongly dependent on developing the GHOs' and DHOs' managerial capacity and having a reliable and functional DHIS2.

Sub-Components 1.1 and 1.2 of the YEHCP support the coverage of the population of Yemen with well-defined packages of health and nutrition services at community and primary health care facility (health centers (HCs) and health units (HUs)) level, and relevant referral centers (particularly for nutrition interventions). The services are intended to cater to the essential and most urgent needs of the population through integrating the primary health care (PHC) model and thus ensuring a continuum of care for the population. In addition, these two sub-components will support the integration of some mental health services, specifically psychosocial support services (PSS) to children and counselling to pregnant and lactating women, into the package provided. The component will also emphasize the life cycle approach and prioritize the targeting of the most disadvantaged groups based on needs within the context of conflict, namely: women of reproductive age, children, and IDPs. The first two sub-components will also integrate preventive approaches in complement to curative services and seek multi-sectoral collaboration as relevant. Sub-Component 1.3 of the YEHCP will support Improving Access to the MSP at Secondary Healthcare Level (WHO), Sub-component 1.4 will support sustainability of the National Health System Preparedness and Public Health Programs, and sub-component 1.5 will support Health System Strengthening.

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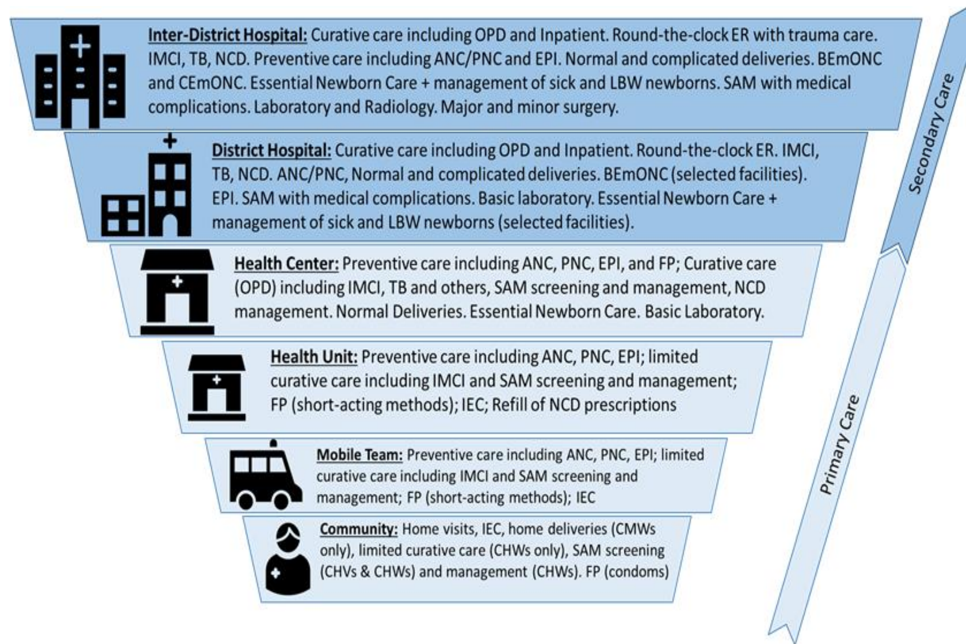

Figure 1 Yemen Health System Referral Pathway

Subcomponent 1.1: Improving Access to the MSP at Primary Healthcare Level

Implementing Agencies: UNICEF and partly WHO

This subcomponent will ensure continued delivery of:

- MSP services at the PHC level through
  - Currently supported and additional PHC facilities (permanent and temporary fixed sites) including Health Units (HUs), Health Centers (HCs), and Polyclinics (PCs);
  - integrated outreach (outreach and mobile teams for the population in remote areas and IDPs);
  - community-based service delivery and referral [CHWs and community midwives (CMWs)]; and
- Support the provision of the four basic essential services including Integrated Management of Childhood Illnesses (IMCI), Immunization, Maternal & Newborn Health and nutrition services through facilitating the human resources and supplies required, capacity enhancement and support supervision. This will include sustaining and continuing integrating oral rehydration corners within existing PHC and re-establishing Diarrhea Treatment Centers as per the epidemiological situation.
- Scaling up BEmONC services at PHC level with provision of appropriate MNH equipment and supporting minor renovations to provide the space required for quality MNH services.
- Facilitating community engagement and generating demand for health and nutrition services through community sensitization and promoting key healthy behaviors.
- MHPSS services delivered through a network of health and social workers who are available within the primary health care facilities (PHCFs) or in adjacent structures or catchment communities.

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- Prevention and control of non-communicable diseases through development of protocols, capacity-building of health workers and provision of supplies at the primary health care level by WHO in collaboration with UNICEF.

This subcomponent will also identify entry points to support critical health system functions at different levels of the health system. This includes supporting technical capacities to effectively manage health services and improving quality of data management through developing health information system /DHIS2 tools. The focus will be directed to the decentralized level at DHOs and building on the ongoing expanding and rollout at the health facility level in some targeted governorates through the building the capacity and providing the related equipment.

Support to Primary Health Care Facilities

Support provided to primary health care facilities by UNICEF through the YEHCP will be comprised of the following key elements:

- Operational Costs (water, cleaning, fuel and gas, stationeries, transportation and maintenance)
- Integrated Supportive Supervision
- Medical and non-medical supplies and furniture
- Health worker per-diems for routine outreaches to also include general practitioners in selected Health Centers

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Selection of Health Facilities

In principle, PHC facilities are to be supported in all 23 governorates and 333 districts across Yemen. Prioritization and selection of the geographic areas of focus is guided by the Humanitarian Needs Overview (HNO), the deliberations in Health Cluster (HC) and Nutrition Cluster (NC) and closely linked to

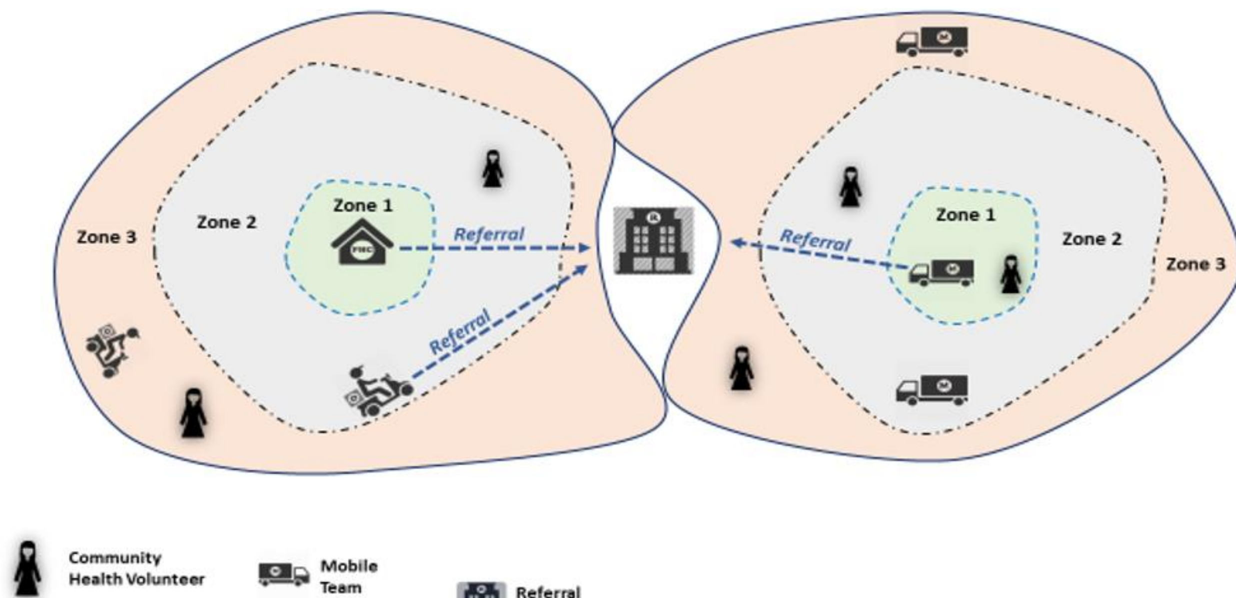

Figure 2 Referral System from Community Health Workers to PHC Facilities

selection of the hospitals/ referral facilities supported through the WHO-led component of this project. The selection of PHC facilities is based on clearly defined criteria that are revisited before each scale-up in view of the evolving context. At the end of the EHNP, UNICEF was supporting a list of 1,962 primary health care facilities that had been phased into the project between 2017 and 2019. With the start of the YEHCP, UNICEF will continue with the same package of support to the same list of health facilities. UNICEF has had discussions with both the Ministry of Public Health & Population (MoPHP) and World Bank regarding scaling up further to an additional 1,000 (total approximately 3,000) primary health care facilities, however the funding available in the first YEHCP agreement is not sufficient to accomplish this. Scale-up will be considered if and when sufficient funding becomes available.

Selection of HFs for support is undertaken in close coordination with the GHOs and DHOs as key stakeholders, as well as with other UNICEF projects at primary care level, WHO, and the HC, to ensure complementarity of approaches, avoid duplication of resources, and ensure value for money / return on investment. Measures taken by UNICEF to minimize duplication of support with other partners and ensure equitable access to resources include:

1. Collaborating with GHOs and DHOs to jointly develop lists of proposed HFs to be supported under the project
2. Securing letters from GHOs officially confirming that the selected HFs are not supported by any other partner
    a. Sharing the lists with the HC and sub-HCs for review
    b. Conducting verification visits (either by UNICEF staff or by TPM agents) to selected HFs before support is initiated, to observe first-hand that no other partner is supporting the HF
    c. A series of questions is included in the TPM checklist asking whether any other partner is providing support to the HF; if the answer is 'yes,' questions follow about which partner(s) and which services / inputs are being supported; TPM results are reviewed and any duplicative support identified is followed up by the field offices directly with the GHOs. If duplicative support is confirmed, the HF is removed from the list and replaced with a HF with no active partner.
3. Regular sharing of the updated YEHCP HFs list with WHO and the HC, so other health sector partners are aware of the project's support and avoid duplicating in the same HFs.

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Selection of Health Facilities for targeted technical areas

Using the above selected PHC facilities, further selection will be conducted in two technical areas;

1. Support to GPs for clinical mentorship at health center level – The AF will support 100 HCs to pilot improvement of quality of care. The facilities to be selected will need to have a general practitioner who will be willing to support HFs in the catchment area. HFs with large catchment population will be given priority
2. Health Centers to be upgraded for provision of BEmONC services – The selection of the proposed 50 HCs for upgrade will be based on;
    a. HCs that are currently not providing BEmONC Services
    b. HCs with availability of a midwife
    c. HCs with a general practitioner available

Operational Costs

One of the key forms of support provided to health facilities is monthly operational costs. Operational costs are essential for maintaining the functionality of primary health care facilities and preventing collapse of the primary care system. Based on previous years of experience with amounts needed for operational costs, the MoPHP and UNICEF have set standard monthly rates for operational cost for health centers, health units, and polyclinics. In total, UNICEF provides 167$- per month to Health Centers, 100$ per month to Health Units, and 250$ per month for poly clinics (health centers in big cities like in Sana'a and Aden). These amounts are intended to cover a range of operational expenses required to keep the facility open and functional, including water and electricity bills, cleaning supplies and staff, fuel and gas for running a generator and cold chain equipment, stationery, transportation for health facility staff for official purposes, minor maintenance, and equipment and spare parts. While the amounts paid to each type of health facility are based on an estimate of how much an average health facility will spend on each of these costs per month, health facility managers have had some flexibility to decide how much they use for each item each month, within the overall budget ceiling.

Health Centers and Health Units do not have dedicated bank accounts or any mechanism to manage their own resources. Following the Internal Audit of the UNICEF Yemen country office in 2019 and resulting risk pivot and change in operational modalities, the process for paying operational costs has been reviewed and updated. UNICEF developed the option of using a third-party contractor to provide in-kind support to fill the operational needs of health facilities under EHCP. With this modality health facilities received their payments through the firm through a reimbursement modality within the agreed ceiling.

For the additional financing , UNICEF is moving the payment of Operational costs to health facilities from the third party to payments through the UNICEF Yemen Service Center (YSC) previously known as PMU. The reimbursement modality will be maintained and PMU will make the payments to health facilities through a financing agent (banks etc).Verification on use of payment by the health facility will be done through third party monitoring, programme monitoring visit and spot checks.
Health facilities may cover their own costs and maintain receipts and proof of receipt of goods and services which will be verified when required. Each HF will be expected to have a small committee comprising of health manager, HF administrative staff, GHO/DHO and a community member to be alerted every time payments are made. There will be two signatories required to receive the funds.

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Table 7: Operational Costs Provided to Primary Health Care Facilities (USD)

Description of operational cost items	Monthly cost in USD ($)		
	Poly Clinics In Aden & Al Amanah	HC	HU
Water & Power (bill)	50	27	13
Cleaning	67	22	10
Fuel & Gas (priority for gas cylinder)	33	33	30
Stationaries	17	10	7
Transportation	25	25	17
Maintenance (equipment & buildings & spare parts etc.)	58	50	23
Total Running cost /Ops	250	167	100

Considering frequent currency fluctuations and availability of supplies in local markets, the operational cost is likely to change from time to time; and the ceiling maybe adjusted if budget permits.

Workflow for Payment of Operational Costs to Primary Health Care Facilities, please check annex 2.

Integrated Supportive Supervision

Each of the programs in the MoPHP, GHOs, and DHOs (including nutrition, IMCI, immunization, MNH, and others) conduct technical supportive supervision focusing on their specific program components. However, it is also critical that the health and nutrition program managers at all levels conduct integrated supportive supervisions (ISS) jointly to understand how the processes, systems, and procedures are working for the various programs and what needs to be improved across the health system.

Objectives of ISS:

To bring together the different program specialists in the governorate / district to understand the overall performance of the health system in each district to:

- Identify bottlenecks of overall health system performance, identify solutions, foster cross-fertilization of best practices among districts and programs
- Collect information on district level health system performance in an objective manner to ensure that the health system reviews are evidence-based
- Provide information on the available human resources, their technical capacities, and areas where capacity strengthening / training is needed
- Ensure functional supply chain systems
- Ensure the effectiveness of information management systems, including reporting (data completeness and quality)

Team Composition:

The team is led by the director general (DG) of the GHO or someone nominated by the DG. Representatives of the different programs from the GHO are the members of the team. It is additionally recommended that focal persons of health and nutrition programs at DHOs be added to the governorate level ISS team to encourage cross-fertilization of best practices.
A GHO may deploy multiple teams depending on 1) the size of the governorate; 2) the level of the health and nutrition programs implementation in the governorate / district; and 3) the availability of staff in the GHO and DHOs. Each HF visit lasts for one day, so the number of days of ISS per quarter is the same as the number of HFs to be visited.

Methodology:

In order to conduct an integrated review of the primary health care system in a district, the team reviews service delivery data at all levels of the health system including selected HCs, HUs, outreach, mobile teams, and community-based services. The team uses a standard checklist, capturing all levels of the primary health care system and the core program interventions. The standard checklist (English and Arabic versions) is attached as annex 3.
DHOs are expected to conduct ISS to each YEHCP-supported health facility in their district every month, while GHO teams undertake ISS to districts quarterly. The GHO ISS team is expected to visit all districts under the governorate, but a sampling (rather than a census) of facilities – approximately 25% to 30% per quarter. At the conclusion of the visit, the ISS team leaves comments in a Supervision Register in the HF with their comments; the next time they come, they are able to review the comments from the previous visit to see if improvements have been made. Once the ISS is completed in a given district, the team is expected to conduct a debriefing session with the DHO and GHO teams to present key findings and recommendations. The GHO is further expected to organize a governorate-wide integrated review meeting once all districts are complete, in which all ISS teams and DHOs are expected to participate. The GHO additionally compiles reports on findings and recommendations from each team and submits a report on all ISS conducted to the UNICEF Field Office quarterly.

Specific Financial Support to ISS:

Funds for conducting ISS are provided to the focal points of the four maternal, newborn and child health programs (EPI, IMCI, Nutrition, and reproductive, maternal and newborn health (RMNH)) in both the GHOs and DHOs, and the DGs and Directors of PHC at both governorate and district levels.

Table 8: Payment Rates for ISS Supervisors per HF Visit

Item	Unit	# of HFs to Visit	Unit cost per HF visited (USD)
GHO			
Focal point (EPI, Nutrition, RMNH and IMCI)	4	(According to # of HFs) 25% of HFs to be visited each quarter	13.8$
Rental car	1	(According to # of HFs) 25% of HFs to be visited each quarter	41.6$

General Governorate Supervisors (DG and PHC director)	2	Sample of HFs visited by the governorate programs FPs (10%-15%)	13.3$
Rental car for general Governorate Supervisors	2	Sample of HFs visited by the governorate programs FPs	41.6$
DHO			
District Focal point (EPI, Nutrition, RMNH and IMCI)	4	(according to # of HFs) All HFs in the district should be visited every six months	13.3$
Rental car	1	according to # of HFs to be visited	33.3$
General district Supervisors (DHO and PHC directors)	2	Sample of HFs visited by the district programs FPs (10%-15%)	13.3$
Rental car for general district Supervisors	2	Sample of HFs visited by the district programs FPs	33.3$

UNICEF provides YEHCP funds to ISS on a bi-annually basis using the 'direct payment' modality. In order for payments to be processed, the GHO will submit a request before the implementation of the activity, usually to cover a period of three months. The request from the GHO must contain detailed information about the number of supervisors and cars needed to implement the ISS and number of HFs to be visited by each team. GHOs then submit a liquidation every six months after completion of ISS for that semester, upon which the payment will be made directly to the payees' accounts. The GHOs submit to UNICEF a report on ISS conducted and the key findings quarterly.

Procurement and Distribution of Medicines, Supplies, Furniture, and Equipment

The MSP is accompanied by a list of medicines, supplies, and equipment required to provide the package of services outlined at each level of care. This is the list UNICEF uses to guide its in-kind support to HFs under the YEHCP.

At each scale-up phase of the project, UNICEF and the GHO conduct a HF gap assessment. Based on the findings, UNICEF develops its procurement and distribution plan for the furniture and medical equipment to the selected PHC facilities based on the gaps identified in the specific HFs. Any individual HF might be eligible to receive the whole set, or part of the set or even none depending on the assessment findings.
For medicines and other supplies[3], MoPHP and UNICEF distribute to all of the selected HFs using the standard list agreed with the MoPHP, which is different for HCs and HUs. The list of medicines and supplies that has been negotiated with the MoPHP as a "Primary Health Care Kit" (PHCK). These supplies are planned, procured, and distributed for all supported health facilities annually using UNICEF standard procurement procedures.

[3] *The medicines and supplies procured to the HFs, are in compliance with the global WHO model list of essential medicines.*

When new health facilities are added to the project, they are also assessed for furniture and equipment needed to provide the expected MSP services. Where gaps are found, UNICEF will provide a one-time distribution of furniture and equipment in line with the needs assessment. The list of equipment and furniture required by primary health care facilities under the MSP is attached as annex 4.

Vaccines are stored in cold chain equipment to minimize the risk of damage due to exposure to temperatures not recommended for vaccine storage. The EHNP along with Global Alliance for Vaccines and Immunization (GAVI) and other donors has provided the investments needed in the cold chain equipment to avoid damage to vaccines as a result of temperature exposure. Mitigation measures to minimize the risk of vaccine expiration in the country include:

- Only commencing shipment of vaccines after firm commitment of the MoPHP to implement activities, especially campaigns
- Continuous collaboration with UNICEF Supply Division for supply with long shelf life
- Monitoring of stock at different supply chain levels with the recent introduction of data4action platform being piloted to capture real time stock status at governorate and central level
- Monitoring of storage and stock by GAVI supported consultants.

Investment in solarization of governorate and central level cold store will support reduction in the expenditure for fueling generator for power supply for vaccine storage. While this is under discussion between UNICEF and the World Bank, funding in the YEHCP is not currently sufficient to support this initiative.

Outreach Services

Routine Outreach

Achieving full coverage of essential health and nutrition services in the current context in Yemen requires innovative approaches and diversified service delivery modalities to ensure that every child who is at risk of ill health or death is reached. Through the EHNP, UNICEF has introduced a new service delivery modality in which health workers at PHC HFs conduct regular weekly community outreach covering their tier one and tier two catchment populations.[4] A team of four health workers – one focal point each for IMCI, EPI, RMNH, and CMAM – travels to communities that have difficulties accessing the HF and provides screening and treatment for childhood illnesses, immunization, antenatal and postnatal care, and screening and treatment or referral for acute malnutrition. Each week, the team of four health workers are expected to visit a minimum of two communities/villages. The HF Manager is expected to supervise the outreach sessions. HFs are expected to maintain separate registers for outreach services, so that the contribution of outreach sessions to the overall service delivery achievements of the facility can be differentiated.
Through the YEHCP, UNICEF will provide a per diem to each of the health workers who conducts outreach, and to the supervisor. The per diem rate is determined on a sliding scale, depending on whether the district in which the HF is situation has received government salaries regularly, irregularly, or not at all. To mitigate the effects of currency fluctuation on health worker compensation and motivation, the rates are determined in USD equivalent, and paid in YER according to the UNDP Guidance Note, i.e. using the daily published market rate by the Currency Traders Association in Sana’a and Aden.

[4] *For each PHC facility there are three tiers surrounding it as the catchment area. Tier 1: area of about half an hour walking distance from the facility (people reach HF easily), tier 2: area within one-hour walking distance or equivalent of 5 Km from the facility and tier 3: more than one-hour walking distance or more than 5 Km from the facility (people are in hard-to-reach areas and car transportation is necessary).*

Table 9: Per Diem Rates for Routine Weekly Outreach

Cadre of HWs	Per-diem rates for one month (USD) – four visits		
	HWs in governorates where salaries are regularly paid	HWs in governorates where salaries are irregularly paid	HWs in governorates where salaries are not being paid
Health Manager	25	50	100
Health Worker	40	80	160
Medical Assistant	40	80	160
Vaccinator	40	80	160
Midwife	40	80	160

The HF manager is responsible for appointing responsibility for conducting outreach to one focal point per program, with a maximum of four staff on each outreach team. In facilities with fewer than four staff, all staff working in the HF may be involved in conducting routine outreach and must be able to offer the full scope of four MNCH services.

For additional financing, in order to improve quality of care, Health Centers with available general practitioners (GPs) will be engaged to provide clinical mentorship to health workers in the HFs within their catchment areas for improved quality of care. Currently, there are 276 EHCP supported Health Centers with availability of a GP (135 in the North and 14l in the South) It is estimated that the GP will be making up to 10 visits in one month for the mentorship sessions. The GPs will be taken through the ministry of health quality of care approaches prior to initiation of the program. The UNICEF Yemen Service Center will be used to make the payments together with other HWs Per-diems.

Payment of per-diems to the health workers is managed by the Project Management Unit (PMU)[5] of the UNICEF Yemen Country Office. The Project Management Unit was established in 2017 to deliver the Emergency Cash Transfer (ECT) Project, also funded by the World Bank; and it disbursed unconditional cash transfers to beneficiaries identified through the Social Welfare Fund beneficiary list. The ECT project benefits from robust risk mitigation measures which enabled the successful delivery of cash across Yemen's 22 governorates and 333 districts, reaching over 1.4 million beneficiaries across all six payment cycles implemented to date.

The design and operationalization of the model for delivery of per diems to HWs benefits from a strong risk mitigation approach. The model encompasses three main steps which include (1) generation, verification and approval of the beneficiary list; (2) verification of beneficiary's identity, eligibility and performance; and (3) payment against confirmation of identity; transversally supported by a grievance redressal mechanism and a TPM component.

Step 1. Generation, verification and approval of the beneficiary list

[5] *This is not the same as the YEHCP PMU, but rather is a separate PMU that acts as a "service center" for humanitarian cash transfers within UNICEF Yemen country office.*

The beneficiary list will be prepared on a quarterly basis with support from Health authorities. The DHO focal points will collect data from HF Managers on which HWs conducted outreach, number of sessions, services delivered, and clients reached. This data will be shared with the GHO focal points, who will check it and submit it to UNICEF. UNICEF focal points at field office will validate the information received, approve it and compile one single list which will then be shared with the PMU.

Step 2. Verification of beneficiary's identity, eligibility and performance
The PMU will share the list with an independent service provider responsible for conducting a one-time face-to-face verification of the identity of each beneficiary against an ID accepted by the project; and verification of eligibility against contractual status. Only those who successfully complete verification step and validation of performance will be allowed to collect the cash. This process, which will be mandatory for all beneficiaries prior to cash collection, is a key risk mitigation measure to ensure that the right people are paid. The verification data will be uploaded to the project's management information system (MIS) to enable the generation of the payment list by the PMU.

Step 3. Cash disbursement
The amount of the per-diem for each health worker will be calculated, following the criteria for calculation of the daily rate agreed for this project. This will enable the generation of the payment list which will be shared with the payment agency(ies) contracted to disburse the cash, using encrypted servers.
The payment of the per-diems will be delivered to the health workers through a contracted payment agency which will be responsible for establishing payment sites in locations carefully selected based on their distance to the HFs. The cash will be disbursed against the presentation of one of the IDs accepted by the project.[6] The payment agencies will be responsible for replicating all payment data into the project's MIS for data reconciliation purposes.

Monitoring
The PMU will engage a third-party to monitor the payments process against standards and collect data on selected indicators to inform progress against targets. To enable a quick identification of any issues arising during the implementation and allow a quick response, the PMU will perform its own monitoring through field visits, daily meetings with service providers, media monitoring and real-time dashboards. This process will be separate from the overall TPM of the technical programmatic aspects of the YEHCP.
In addition, the comprehensive quarterly TPM of the YEHCP interventions at HF level includes a section on outreach services. Monitors collect data from every supported HF on whether health workers conducted outreach, whether outreach services are recorded in a register, the utilization data, and whether the health workers who conducted outreach services have received their per diem payment. Any health workers who were paid but were found not to have conducted the required outreach services, and remain as one of the outreach workers for the subsequent quarter, will have the amount for the previous period deducted from their subsequent payment. If the health worker is found to continuously not conduct outreach, they will be removed from the payment list.

Other risk mitigation measures
The YEHCP-MIS: The project's MIS will store all project related data and ensure the technical functionality and infrastructure that facilitates the cash disbursement process. The MIS integrates strict data protection features

[6] The primary forms of identification accepted by the project are National ID Cards and Passports, but other forms may be considered if these are not available, especially in remote areas where renewal / replacement of expired or lost IDs is not currently possible.

which ensure that data is shared with relevant service providers through secured channels and accessed only by selected users.

Contract management and administration: The verification, payment and third-party components of the project will be delivered through contracted service providers identified through a comprehensive procurement and contracting process. The PMU developed standard operating procedures for contract management and contract deviations; and all contracts will have tight measures on beneficiary data protection, and robust provisions to prevent loss of funds by the project in case of confirmed fraud or corruption.

Fraud investigation: All cases of alleged fraud and corruption will be sent for investigation by an independent third-party, which will be responsible for collecting the necessary evidence on the ground. Where fraud is confirmed, the necessary measures will be taken by UNICEF to compensate those affected.

Integrated Outreach Rounds

Planning, implementation and monitoring mechanisms

Early in 2000s, the MoPHP with GAVI support initiated the implementation of outreach rounds activities. However, these outreach rounds were irregular and limited to the delivery of only vaccination services. In 2005, an integrated package of PHC services (IMCI, Reproductive Health, Nutrition and Referrals) was introduced in 64 districts in 17 governorates building on EPI experience. The Health and Population Project (HPP) supported by the World Bank contributed to the implementation of integrated outreach in five governorates the result of which encouraged development partners to invest more in the health systems strengthening activities and ensuring rounds of delivery of integrated package in remote and hard to reach areas. Since 2010, MoPHP with support from the World Bank, GAVI HSS, and others including JICA, DFID, USAID OFDA, KFW, KSA, EUA, implements four to five rounds (six days/round) every year as part of the routine EPI activities, which contributes about 27-35% of the national annual vaccination coverage in Yemen.

UNICEF and WHO meet with the MoPHP at the beginning of the year to discuss the plan for the year including the number of rounds and implementation schedules. The three partners then regularly review the plans at monthly EPI Taskforce Meetings; ad hoc task force meetings may also be called to address emerging issues or emergencies as they arise. The implementation of the integrated outreach is through the HWs in the facilities to the communities especially at the third tier. The GHOs/DHOs own and lead the implementation of the activities, under the technical guidance and supervision of EPI program supported by WHO and UNICEF. MoPHP supervisors use a standardized monitoring tool to guide supervision and quality assurance of Integrated outreach rounds (IOR), please check annex. 5. During the implementation, MoPHP from the central and district levels, WHO and UNICEF staff from the country and field offices conduct monitoring and supervision. YEHCP planned to support operational cost for one Integrated outreach round before the end of this year (2021).

Financial Contribution and Funds Transfer Mechanisms

Operation cost for the IOR is shared between UNICEF and WHO based on the number of rounds in the year. While the central level of the MoPHP submits the formal request for funding to UNICEF, funds have previously been transferred to the governorates for implementation using the 'Direct Cash Transfer' modality. Following the UNICEF Yemen internal audit findings released in 2019, the payment modalities for activities including integrated outreach activities are to follow either reimbursement or direct payment and this has been already applied starting from 2020. UNICEF has assurance mechanisms including program monitoring visits and spot

check through third party (following standard HACT procedures) to ensure funds disbursed have been used for their intended purposes.

How the results of IOR are integrated into the reporting of project achievements

A reporting mechanism for the IOR activities has been established through the MoPHP operation center. Daily achievements are submitted from teams to district, and from districts to governorate level and finally to the central operation room. The central room shares a daily update and feedback to GHOs, WHO and UNICEF. The National EPI program shares a result for each round to UNICEF and WHO which are also discussed at the EPI taskforce. The final achievements compiled are then incorporated by UNICEF in donors' progress and final reports

Mobile Teams

Due to the very scattered population in Yemen and the limited number of HFs, around 40% of the population has no access to HFs. Due to this, deploying mobile teams is one of the key implementation strategies to reach the hardest to reach villages with an integrated package of health and nutrition interventions. YEHCP will contribute to support the operational cost of part of MTs.

Mobile teams are primarily deployed to target the below locations:

- The villages in the 3rd tier from the HFs (> 1.5 hours walking distance).
- The IDPs settlements where there are nearby HFs.
- The location of the HFs which are totally destroyed.

The package of services provided by mobile teams are:

- Early identification of children with acute malnutrition (severe and moderate);
- Management of SAM without complications;
- Management of MAM (currently in some governorates only, it is being scaled up by WFP);
- Micronutrient powder supplementation for children 6 – 59 months;
- Iron folate supplementation for pregnant and lactating women;
- Vitamin A supplementation for children 6 – 59 months;
- Counselling of pregnant and lactating women on optimal IYCF to prevent undernutrition;
- Deworming for children 1 – 5 years;
- Immunization for children under two years and women in the reproductive age;
- Antenatal care for pregnant women, postnatal care and family planning; and
- Management of common childhood illnesses as per IMCI guidelines.

The mobile teams are usually composed of four health workers who provide the above-mentioned services. If the mobile team is working in a village which has an active CHV, the CHV plays a key role in mobilizing the community, referring the malnourished children and supporting the mobile teams to organize the session.

Each mobile team covers between six and twelve villages in every round. The same villages are visited weekly or fortnightly (depending on the size of the villages and the attendance rates). The same villages are covered for at least three months, but it usually continues for longer periods if there is need.

The cost of each mobile team includes the per diem for the health workers ($18 / day / health worker) and the rental of the car which ranges between $50 – $80 / day. The supervision cost for the district's nutrition and

health officers is included and is based on the harmonized rates of supervision visits. Health workers engaged in mobile teams are not HWs that engage in outreach from the facilities; thus, the amounts for per diems are different.

The UNICEF target is to deploy 200 MTs each year; however, this number is not covering the entire need as per the above targeting criteria due to the limited capacity of implementing partners and the gap in the health workers in some governorates. - YEHCP support part of those mobile teams (average of 30 mobile teams). Most mobile teams are operated by GHOs, but in a minority of cases, UNICEF funds NGOs to manage the teams. This is done only in cases where the GHO has limited access – for example, where there is a line of conflict through the governorate or different districts are controlled by different authorities, it is easier for an NGO to work across these lines than for the GHO. In either case, the payment modality for mobile teams was previously through to the implementing partners; however, after the change in the payment modalities post audit recommendations, the payment will be changed to direct payment to the health workers and drivers.

Routine immunization and Vaccination Campaigns

The operational guideline and plan of action of any campaign and routine immunization services in Yemen places different roles and responsibilities on the partners in the country. Roles related to the procurement and supply and logistics management of vaccines and communication and community engagement for awareness and demand generation are usually assigned to UNICEF in support of Government's Ministries of Health in country, while WHO provides technical pre-qualification and specifications for vaccines and provides operational support to campaigns in the country. YEHCP will contribute to the cost of vaccine procurement and demand generation activities for routine immunization and preventive or outbreak campaigns.

1. Selection / Identification of Vaccines: Vaccines which have been used in Yemen for campaigns over time have included OCV, Oral Polio Vaccine, Pentavalent vaccine, Tetanus diphtheria (Td) vaccine and MR vaccine. These vaccines are also used among others for routine immunization services in the country except the OCV. All vaccines used in the country for either routine or SIAs are prequalified by WHO.

2. Procurement: UNICEF procures vaccines and related devices for routine immunization and campaigns in the country. This follows the forecast which references the comprehensive Multi-Year Plan (cMYP) and finalization on the specifications and presentations of the vaccine by the EPI taskforce with technical leadership of WHO and UNICEF along with the MoPHP. WHO leads in the development of the cMYP with the support of UNICEF. All the vaccines are procured through UNICEF supply division in Copenhagen based on an official request from the MoPHP. For all vaccines into Yemen, UNICEF procures, ensures shipment of vaccines in proper condition, supports the customs clearing processes, and delivers the consignment to the MoPHP's central cold room. The MoPHP officially acknowledges the receipt of deliveries with the submission of vaccine arrival report.

3. Warehousing and cold chain system: UNICEF has the mandate to support the MoPHP with immunization supply chain management across all levels of the health system. In 2017 UNICEF conducted a comprehensive cold chain assessment to ascertain the state of cold chain equipment in the country. The findings of this assessment now inform the current planning and support provided. Each HF providing immunization services should have cold chain equipment - either a refrigerator or cold box - and vaccine carriers for storage and transport of vaccines. At central level, UNICEF procures walk-in cold and freezer rooms. Where vaccines are stored at the district and HF levels, UNICEF provides electrical refrigerators, Solar Direct Drive equipment, vaccine carriers, and cold boxes and supports distribution to the governorate, districts and HFs.

UNICEF supports the establishment of functional warehouses at the central level in Sana'a and Aden and at the governorate, districts and HF levels where vaccines are stored throughout the country. Following the delivery of vaccines at the central cold store, the MoPHP assumes the responsibility for storage and management of the stock in the country. The MoPHP distributes the vaccines from the central cold room to all Governorates in the country. UNICEF supports the operation of the central and governorate cold stores with provision of generators and fuel.

4. Logistics and Distribution: While the MoPHP is responsible for the cold storage, warehousing, and distribution of all vaccines, UNICEF provides technical, operational and monitoring support, including:

1. Technical support during the development of distribution plan for vaccine and supplies and capacity building of the MoPHP staff in the warehouses

2. Leveraging UNICEF long-term agreements (LTA) for the direct distribution of supplies

During campaigns and quarterly for routine immunization service delivery, UNICEF supports the development of distribution plans and provides logistics support for the distribution of the vaccines and related supplies for the exercise from the central levels to the governorate and to the districts and HFs. For the campaigns, based on the targets for the campaign, a plan for required logistics (printing of recording and reporting books, social mobilization materials, vaccines, safety of injection equipment, cards, cold boxes and vaccine carriers, ice pack/ ice blocks, transportation and distribution, etc.) is developed. The required supplies and materials are distributed at least 14 days before the start of the campaign to give the governorates enough time to distribute the logistics to the lower levels.

5. The Micro-planning, Training, and Operational costs for the vaccination teams, Supervision, Monitoring and Reporting is predominantly WHO's responsibility, with UNICEF assuming a supportive role across all these functions. UNICEF is responsible for the advocacy, communication, and social mobilization aspects of the campaigns and routine immunization, including involving the MoPHP and other relevant Ministries in this critical and cross-sectoral function.

6. Waste Management and Disposal: The routine immunization services and campaigns in Yemen are implemented with consideration for immunization safety for all involved (HFs, injection providers and communities). Sharps waste management is an important component of the immunization safety strategy within the main campaign plan. All vaccinations, especially injectables, are conducted using AD syringes and safety boxes. The logistics plan is elaborated for distribution of bundled supplies, i.e., one vaccine – one AD syringe; one vial – one reconstitution syringe; 100 syringes – one safety box. Locally adapted technical guidelines on how to deal with the sharp waste are prepared based on the local context of the area, by reviewing the available options for waste management (waste burial pit or encapsulation, burning <400°C, including brick oven burners, drum burners, pit burning, or Incineration> 800°C). The MoPHP is responsible for waste management and disposal with technical, operational, and monitoring support from UNICEF. If the disposal is at the central level, there is a disposal committee appointed by the MoPHP to manage the process and the disposal is observed by relevant stakeholders and reported. At lower level, the Governorate Health team coordinates the disposal and documents it in a report or stock management record.

7. Monitoring and Supervision: Monitoring and supervision of the campaigns and routine immunization services in general is the responsibility of the MoPHP at different levels with technical and operational support from UNICEF and WHO. Specifically, for vaccine storage, distribution, handling, and disposal, UNICEF follows to ensure proper storage at the central, governorate, district and HFs level through the UNICEF EPI staff at

central and field office level. Distribution is also monitored to ensure enough quantity of vaccine based on the target population reached each level to avoid a situation where children are missed due to stock out. Balance of vaccine after campaigns are also tracked and where the quantities are not much, they are used at the facility for routine services or encouraged to be returned to the higher level for storage. UNICEF further supports third party monitoring of all vaccination campaigns.

Community-Based Services

UNICEF works across its programs to strengthen community health system delivery and establish strong referral links between communities and HFs. This includes supporting three cadres covering the various aspects of the MSP at community level: CHWs, CHVs, and CMWs.

The current vision in the MoPHP is to have at least two community health and nutrition frontline health workers in each village that is located more than 10 kilometers away from a HF. Given that there are an estimated 30,000 such villages, the total workforce in these communities is therefore expected to total around 60,000. These workers will be supervised and supported from the HFs; hence their work will be complementary to the HFs. They will deliver a component of the MSP in line with their training, capacity, and specific roles. CMWs will conduct deliveries as well as health and nutrition and WASH prevention interventions and promotion, CHWs will deliver a set of IMCI services as well as WASH and nutrition prevention interventions and promotion while the CHVs will predominantly deliver health and nutrition prevention interventions and promotion- screening and follow-up. All the community-based cadres will promote birth registration.

Community Health Workers

CHWs provide basic PHC package endorsed by Ministry of Public Health & Population CHWs services as the following:

1. Health and nutrition promotion services including handwashing, vaccination, antenatal care, postnatal care and danger signs for mothers and children, use of oral rehydration solution, treatment of common child diseases, skilled birth attendance, birth spacing, IYCF counselling, maternal nutrition micronutrient supplementation including vitamin A, micronutrient sprinkles, iron/folic acid supplementation and deworming.
2. Integrated Management (diagnosis and treatment) of common childhood illnesses including diseases such as diarrhea, pneumonia, malaria and other common conditions.
3. Screening and treatment of malnourished cases, referral of complicated cases, and counter-referral follow up.
4. Support of EPI program activities, including:
    a. Community mobilization for vaccination campaigns
    b. Assisting the facility health workers during outreach activities and rounds
    c. Advocacy for vaccination in their communities
    d. Defaulter tracing (identification of defaulters and referral of children to EPI centers/HFs)
5. Reproductive health services including antenatal care, and postnatal care with referral of mothers with danger signs.
6. First aid and basic trauma care: Ensure that respiratory pathways remain open until transportation to HFs.
7. Surveillance services include notifications of deaths, births, and outbreaks such polio, measles, cholera and others.

Planning and Selection of CHWs:
The MoPHP plans to cover remote villages in all governorates of Yemen by CHWs. Remote villages are defined as all villages in Tier Two and Zone Three of the HF catchment area[7]. Each CHW is expected to cover a population of about 1,000 people.
Individual CHW are selected based on the following criteria:

- Prefer to be a female.
- Priority for secondary school or advanced educational stages.
- Priority for married women, because of the ease of communication with mothers, and to ensure that she does not leave work if she gets married later.
- The candidate must be acceptable to the community.

Geographically, UNICEF supports the following governorates: Sana'a, Ibb, Hajjah, Al Hodeida, Sa'ada, Lahj, Amran, Hadramout, Abyan and Taiz. The criteria for selecting these governorates was based on where rural populations lack access to primary health care (PHC) services, availability of female candidates to become CHWs, acceptance and support of local authorities and where security situation allows for success of the program. YEHCP will participate to support the CHW program through funding for their per-diem payment, training, supplies, supervision, monitoring, data management and review meetings.

CHWs Training:
The duration of the training for qualified candidates is 64 working days (three months training course) including clinical practice. The training duration for 'school graduates' candidates will be longer in duration to ensure skills building of trainees. Training is conducted separately for those with health qualifications candidates and school graduates, in order to tailor the content to address the qualification and capacity gaps of the different types of candidates.[8]

The training package equips CHWs to provide the MSP at community level. Training of CHWs follows the available national guidelines for PHC programs such as the training guidelines on integrated package for PHC programs, training on communication and health education, and training guidelines for Community-based Maternal and Newborn Care. Supplemental training courses outside of the core curriculum may also be provided to CHWs as needed to cover additional services. For CHW training program modules and topics, please refer to annex 6.

Allowances for training participation are determined by the MoPHP and paid by UNICEF. Payment of training allowances is conditional upon submission of a technical training plan and detailed training report (Hard and Soft).

CHW Payments:
CHWs are entitled to receive YER 50,000 monthly allowances for their work in the community to deliver the CHW service package, as part of the national model. UNICEF processes payments to CHWs using the Direct

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[7] For each PHC facility there are three tiers surrounding it as the catchment area. Tier 1: area of about half an hour walking distance from the facility (people reach HF easily), tier 2: area within one-hour walking distance or equivalent of 5 Km from the facility and tier 3: more than one-hour walking distance or more than 5 Km from the facility (people are in hard to reach areas and car transportation is necessary).

[8] 'Qualified candidates' are trained paramedical staff who are not employed in the formal health system. 'School graduates' indicate candidates who have completed secondary school but have no prior medical or paramedical training.

Payment modality: The GHO receives and verifies CHW reports. After verification, the GHO will submit a request containing detailed information about each of the CHWs, then the payment will be paid directly to the CHWs' accounts (funds are not channeled through the GHO, but rather directly from UNICEF to the individual CHW) on a quarterly basis. As part of the audit recommendations, all CHW payments are made and verified by PMU (Now known as Yemen Service Center) , after approval is given to pay by DHOs/GHOs and UNICEF. [9]

CHWs are monitored through both programmatic monitoring visits conducted by UNICEF staff, and by TPM agents. There are plans for monitoring and supportive supervision of CHWs from three levels of public health office (central, governorate, and district). This mechanism has been piloted in Sana'a governorate and is under discussion with the MoPHP but has not yet been fully approved.

Community Midwives

CMWs are required to complete three years pre-service training, which may be supplemented by other shorter-term follow-up trainings on topics such as the updated Community-based Maternal and Newborn Care protocols. Through a combination of the YEHCP and other donors / projects, UNICEF pays the costs of 1-3 years of pre service training institutions and candidates incur to run these pre-service and in-service training programs. YEHCP also provides the costs required to supervise CMWs and collect data from them – supervision and data collection are a time-intensive task, as CMWs are usually located in communities in Tier 3 of the HF catchment area, and thus are hard to reach areas. UNICEF also uses the YEHCP and other funds to procure and distribute midwifery kits, clean delivery kits, midwifery bags, and other needed supplies. UNICEF does not pay incentives to CMWs.

Payment for the costs of training is made using either direct payment modality or reimbursement to GHOs and governorate-level training institutes. UNICEF uses its usual HACT procedures (spot checks and routine audits) to ensure partners (GHOs and training institutes) document and report their expenditures accurately. UNICEF field office staff regularly monitor the work of CMWs and visit the health institutes to directly observe the training program in progress. UNICEF has signed LTAs with events management companies in the future, the training payments can be managed by them.

Mental Health and Psychosocial Support (MHPSS)

MHPSS will be delivered through the Child Protection section in UNICEF with strong coordination with WHO to expand and integrate MHPSS services to children in need. This project will help expand the coverage of PSS for improved access at the community level service providers and PHCFs and strengthen referral networks to integrate the mental health and PSS services at the primary care and hospital levels where severe cases are referred for appropriate management. The PSS will be delivered through community based structured recreational activities or more focused but nonspecialized programs such as psychosocial first aid (PFA) or counselling through health or social workers, based on the Inter-Agency Standing Committee (IASC) guideline on MHPSS in emergency settings (2007). Depending on the availability of the social workers in a specific location, the social workers either are based in these health facilities or visiting them through mobile team with strong linkages between the health facilities and the case managers within MOSAL Offices. Vulnerable children such as IDPs and marginalized groups will be prioritized in the PSS. UNICEF and WHO will work together to establish and strengthen referral linkages between community and PHC service providers and

[9] This will most likely change in 2020 however, as part of the audit recommendations, and all CHW payments will be made and verified by PMU, after approval is given to pay by DHOs/GHOs and UNICEF. UNICEF will update WB about this.

secondary health care service providers level for more specialized mental health services. The development of such a referral pathway will be a priority and in line with a national referral pathway system. This system will lay down the steps for managing individuals with MHPSS problems. The project will support the development of such a document, field test it then amend as fit. The second part of the support will be linked with training and the provision of continuous support/supervision for workers in charge of the follow up – referrals. This will cover the referral at PHC, SHC and beyond – both horizontally and vertically.
Following the consultation meetings with the MoPHP, Additional Financing for EHCP will target general practitioners in PHC level for basic MHPSS training to reduce the burden on referral hospitals and create better linkages with community based MHPSS services.

Subcomponent 1.2: Improving Access to essential preventive and curative nutrition services

Implementing Agency: UNICEF

This subcomponent will support the delivery of a package of essential nutrition services. This will include maternal and child nutrition services and will be delivered at PHC facilities and community level through mobile teams and an extensive network of CHNVs. The package will include the following prevention package, curative package and interventions to enhance environment for the nutrition response. nutrition:

Prevention Package

Child Nutrition (0-5 years; with a focus on children under 2 years)

- Counselling on early and exclusive breastfeeding
- Counselling on age-appropriate timely complementary feeding
- Growth monitoring and promotion
- Vitamin A supplementation
- Multiple micronutrient powder supplementation
- Zinc in the treatment of diarrhea
- Deworming
- Active case finding, screening and referral for treatment of malnutrition as a prevention of chronic malnutrition
  YEHCP will support IYCF training and service delivery and will support CHVs who provide IYCF, growth monitoring services and active case findings along with referral.

Adolescent Nutrition (10-19 years)

- Iron folate supplementation or Multiple micronutrient powder supplementation.
- Deworming
- Nutrition Counselling

Maternal Nutrition

- IFA supplementation
- Regular weight measurement
- Nutrition counselling on adequate dietary diversity, consumption of adequate quantities of food, importance of compliance of consumption of iron and importance of rest
- Deworming after first trimester

All categories

- Community mobilization and participation in health programs, particularly during vaccination campaigns, health camps, outreach campaigns, or during interventions in case of outbreaks.
- SBCC by H&N personnel at all delivery platforms and through media outlets and in collaboration with C4D.

- EHCP will support micronutrients specific to different age groups.

Curative Package

Treatment of Severe Acute Malnutrition (children 0-5yrs) through Outpatient Therapeutic Program (OTPs) and Mobile Teams (MTS) across the country

- Scale up treatment of children with SAM without complications through additional OTPs in priority districts (that showed deterioration in the IPC or those in IPC4) and use of Mobile teams in hard-to-reach areas.
- Pilot the treatment of acute malnutrition at community level through CHWs
- Strengthen the referral mechanism of severely acute malnourished child with medical complication between OTP’s and TFC’s to the nearest Therapeutic Feeding Centers.
- Strengthen community active screening and referral of children with malnutrition for treatment.
- Enhance the quality of treatment of SAM services across the country by
    - i) Supporting quality monitoring, and supportive supervision for HWs’ to strengthen technical capacity, and strengthen integration with another program
    - ii) using a Continuous Quality Improvement through selected model learning sites. Quality Improvement Teams at different levels will be used to provide regular on job mentoring and supervision of SAM treatment service.

Enabling Environment for Nutrition Response

Multi-sectoral nutrition policies, planning and coordination:

- Support the evidence generation through implementation of periodic SMART surveys to assess and monitor the nutrition situation, and inform the prioritization for the geographical areas, and calculate the annual burden and targets for SAM & MAM management.
- Technical and financial support for Scaling Up Nutrition (SUN) Secretariat and its related structures
    - Support coordination functions in Sanaa and Aden
    - Support multi-sectoral coordination meetings at the technical and higher level.
    - Support Civil Society Network and UN Network.
    - Finalize and roll out of the Yemen Action plan for the prevention of wasting.
    - In line with the Global Action Plan for the prevention of wasting the YAP will identify the key strategic interventions to prevent wasting as already outlined in government policies and plans, across Health, Food, Social Policy and WASH sectors, and under four outcomes to prevent acute malnutrition.
    - The YAP will build on the current accelerated multi-sectoral response to the nutrition crisis that UNICEF has been spearheading since December 2020 to strengthen the multi-sector response.
    - A 3-5 year costed plan will be developed to support implementation of these priority activities.

  - UNICEF will support the advocacy and linkages around the respective actions in other sectors and continue to support health and nutrition related interventions in this plan.

- Support for Nutrition Social mobilization, advocacy, and communication
- Establish MS Nutrition Advocacy Group – Through SUN Secretariat, the UN agencies and in collaboration with the Nutrition Cluster and through this group, identify priority advocacy activities by sector and support their implementation and follow up…
- Operationalize the existing MS Nutrition Advocacy Action Plan for Yemen, with focus on prevention and community actions
- Update and support the roll out of the Nutrition Cluster Advocacy plan (2018-2020).
- Operationalize and roll out the existing national strategy for Social and Behavior Change and communication for Nutrition.

Capacity building on nutrition

- Analysis of institutional HR capacity for nutrition and gaps for future programming (study)
- Support the capacity of health cadres to provide preventative and curative services (HWs and CHNVs), through in-service training which includes basic and refresher training courses for health workers and community health and nutrition volunteers on CMAM, IYCF, and information management.
- Support capacity building of Nutrition Coordinators at decentralized levels.

Streamlining and strengthening the Nutrition Information System in Yemen

- Piloting innovative SMS based or online reporting approaches targeting CHNV's
- Operationalize the ACCESS database[10] for CHNV program monitoring
- Supporting and strengthening the capacity of MoPHP (at governorate level) to roll out DHIS2 nutrition component (based on experience from initial piloting in two governorates) – which will include ongoing capacity building and training support, material/tools development, printing and dissemination and routine support supervision and mentoring including regular data audits and quarterly data/monitoring review meetings.
- Nutrition evaluation and studies (e.g., potentially CHNV review and HR capacity assessment)

Nutrition Supply Chain Management

- Conduct a comprehensive nutrition supply chain review and use this to develop a supply chain management plan and support its roll out.
- Review will be conducted through consultation with users and managers of the current supply system to identify key challenges and plan to enhance the supply system – plan likely to include
  - Support of transportation system
  - Strengthening warehousing capacity
  - Support for quality warehousing management.
  - Support with the shift of paper based to electronic based supply data.

Under both Packages EHCP will support IYCF training and service delivery, CHVs who provide IYCF, Growth Monitoring Services and active case findings along with referral. EHCP will also support micronutrients specific to different age groups.

[10] *A new reporting tool based on MS Access is on use in 2021 by all CHNVs reporting actors to track and manage CHNVs records and manage CHNVs monthly reports per CHNV level whereas it used to be on health facility level in previous years.*

Community Health and Nutrition Volunteers (CHNVs):

The community health volunteers are the cornerstone of community health and nutrition interventions. Currently, there are more than 24,000 active CHVs already deployed in their communities. UNICEF will support 4,000 CHVs from this project with the cost of the regular review meetings for the CHVs to ensure the continuity of the community nutrition services. The CHNVs will provide the following services:

- Screening for malnutrition for U5 children and refer the acute malnourished children to health facilities / mobile teams.
- Tracking of defaulters from the malnutrition management program.
- Micronutrient supplementation for children U5 and PLW
- Deworming for children 1 – 5 years.
- IYCF counselling and support mothers on optimal feeding practices including during COVID-19 context.
- Iron folate supplementation for pregnant and lactating women.
- Awareness raising individual session on prevention measures for COVID-19. CHVs will link the suspected cases with the rapid response teams.

To keep motivated and continue their work voluntarily, UNICEF is supporting the CHNVs through conducting quarterly review meetings at health facility and district levels, refresher training courses, and support the supply and monitoring. The review meetings are considered as a way of motivation for the CHNVs where they exchange their experiences and lesson learnt with the other CHNVs and health workers in the same community. Each CHNVs is receiving a transportation allowance to attend the review meetings which is ranging from 100 -200 USD per quarter.

The CHNVs' needs include the reporting and registration tools, micronutrient supplements, anthropometric tools, and IEC materials. Those requirements are procured by UNICEF and delivered to the CHNVs through DHOs and HFs.

Integrated Nutrition Package

The targeting of the nutrition interventions in the YEHCP is based on the Emergency Food Security and Nutrition Assessment (EFSNA) and the Integrated Food Security Phased Classification (IFPC) in the context of the worsening food security and nutrition situation in Yemen. The Food Security (FS) and Nutrition Clusters (NC) in the country work together to identify the highest priority and high priority districts on the basis of criticality of the food insecurity situation and high global acute malnutrition rates. Selected highest and high priority districts will be the focus of this project, please refer to annex. 7. Priority districts may be revisited over time as updated data becomes available.

Subcomponent 1.3: Improving Access to the MSP at Secondary Healthcare Level

Implementing Agency: WHO

This subcomponent will ensure the continuum of care at the first referral centers and hospitals by supporting the following activities:

- Management of SAM cases at in-patient Therapeutic Feeding Centers (TFC) for patients with complications or who failed home-based Outpatient Therapeutic Program (OTP).
- Provision of Basic Emergency Obstetric and Neonatal Care (BEmONC) and Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) services in targeted referral centers.
- Management of cholera cases through supporting the Diarrhea Treatment Centers (DTCs).

- Screening and case management of non-communicable diseases (NCD) and their complications including diabetes, hypertension, tumors, and MHPSS.
- Sustaining the national capacity of blood banks.
- Strengthening the capacity of Central Public Health Laboratories (CPHLs).

Support to Health Facilities

At the level of facilities providing secondary and tertiary services, WHO will provide direct logistical, operational, medicines, medical supplies, equipment and capacity building support to these facilities. WHO will support hospital care and management capacity building for hospital managers, hospital senior staff, GHOs and DHOs in the areas of leadership, governance, strategic planning, quality and safety, supply chain management, information systems management and emergency preparedness and response (please refer to the capacity building section).

In principle, Health Facilities (HFs) are to be supported in all 22 governorates. The selection of the districts and facilities will continue to be based on selection criteria used for the EHNP. Selection of facilities will be guided by overarching principles such as needs-based, patient-centered, utility and cost-efficiency.8.
Selection of public hospitals must encompass governorate, inter-district and district hospitals for referral purposes and ensure the provision of health services at different levels of the health system. The program is intended to cover a considerable percentage of the existing public hospitals in the country to ensure an integrated approach with the WHO and UNICEF supported facilities at both primary and secondary referral levels.

A vulnerability and risk assessment (VRA) has been done for all districts to identify the highest vulnerability. The vulnerability risk assessment matrix is a key tool and reference for determining vulnerability across the districts of Yemen. According to the VRA, the most vulnerable districts receive the highest vulnerability impact score.

The VRA is based on the following criteria:

I. Hazards.
II. Impact on exposed population.
III. Health system capacity.
IV. Morbidity.
V. Nutrition.
VI. Food security.
VII. WASH.
VIII. Social determinants and health outcomes.

The YEHCP is planning to continue supporting around 80 hospitals based upon the VRA score and hospital performance as well as other factors. It is possible that the VRA will be updated during the project lifecycle.

Following the process of identifying the needs and challenges in the selection of HFs; the efforts shall be steered towards carrying out the arrangements for procuring the items of support such as, medical supplies, drugs and equipment.

Fuel provision to Health Facilities

YEHCP hospitals are supported with fuel to allow facilities to stay open and functional. A key aspect of the YEHCP will be the provision of fuel to district, inter-district, and governorate hospitals. This provision will enable hospitals to power their generators, a critical factor to maintaining, sustaining or restoring the functionality of the hospitals.

To determine how much fuel should be provided for each hospital per month, the PMU considered a variety of factors, such as catchment population of the hospital, service utilization rate, number of days per month in operation, number of beds, functions and services provided by the facility, as well as the quantities of fuel the hospital was receiving in the past (where applicable) and phasing increases. Support of fuel to HFs has to be tailored depending on the specific needs.

Additionally, public health labs are also supported with fuel in order to maintain their functionality. Support of fuel to CPHLs has to be tailored depending on the specific needs as well.
Due to some logistical challenges faced by the World food Programme (WFP), there is sometimes a slight variation between the actual deliveries to HFs and the requested quantities.9.

Additional parameters shall be applied as follows:

- If a hospital is a “first-time receiver,” meaning that they have never received fuel from WHO, the hospital shall be phased in with 3,500 L per month depending on the type of the hospital.
- If a hospital is a “return receiver,” meaning that the hospital has received fuel from WHO before, this hospital should not receive less fuel than what they previously received.
- If needed, hospitals may be entitled to receive higher quantities of fuel per month on a case-by-case basis, based on factors such as, but not limited to being a crisis “hotspot,” an increase in caseload, taking on extra responsibilities (i.e. hosting a DTC), MoPHP requests, approvals from WR during Micro-Planning Exercises, etc.
- GHO may assert that they need less than what can be provided.

It is noteworthy to mention that based on the progress of the project and the change of the needs, the plans of support with fuel will change with the time accordingly.

Fuel Monitoring: The fuel provision to the HFs is based on the assessment done by WHO, and the planned quantities allocated to each HF is based on previously mentioned parameters where quantities provided are only a proportion of the need, in order to ensure the prevention of diversion of fuel from the HFs. There is transparency in the quantities delivered to each facility – across facilities, MoPHP, SCHMCHA and partners. To safeguard fuel supply, to ensure that it is provided to HFs as planned, and that it is used for the intended purpose of facilitating health service provision, WHO has the following main mechanisms in place:

1- **WFP is the main service provider of fuel**: fuel is currently supported through WFP which is a reliable source to provide the fuel to the HFs on a monthly basis for the following factors:

- WFP is a logistic organization with many years of experience in that field, not depending on national distribution systems and equipped with the necessary personnel.
- WFP is providing fuel to major water plants in the north of Yemen on behalf of UNICEF; UNICEF reported their satisfaction.
- The price is determined based on the Mean of Platts Arabian Gulf (MOPAG) which is an international price announced publicly unlike private companies that depend on the price of the local market which is unstable due to the situation in the country, a private company can easily change the prices since there are no legal implications against them.
- WHO is in full control of the distribution plans.
- Reliability of WFP; WHO can rely on WFP that they will not take advantage of the security situation in the country and stop the delivery to increase prices, this is not guaranteed with the private companies as such companies are driven toward maximizing profitability.
- Once the fuel is provided to the HFs, the supervisor of WFP ensures fuel quantity and records the correct quantity in the receipts, which is then verified by the HF, signed and stamped by the HF Director. These receipts are then given to a WHO technical officer.

2- **Third-Party Monitoring (TPM):** The TPM will be conducting field visits to HFs in order to verify the quantities from the registers of the HFs and compare them with the quantities in the receipts stamped at the time of fuel supply to HFs.

3- **Internal Monitoring and Evaluation (M&E)** team in WHO conducts field visits to verify the quantities in the HFs compared to the plan. They are also in continuous telephone contact with fuel focal points (facility directors and statisticians) on any fuel challenges that arise. WHO also monitors service utilization statistics for each health facility, including monitoring that there is a correlation between quantity of fuel provided and quantity of services delivered.

4- **Fuel Monitoring Devices (FMDs):** This innovation is implemented by WFP through Bilateral Service Provision Unit (BSP), it involves installing fuel consumption monitoring devices in WHO-supported hospital tanks. The aim of the project is to ensure fuel quality and reduce the possibility of fuel diversion in real-time. The devices being installed can provide the following real-time alerts:

- Fuel tank levels reach low or critical limit alert.
- Refueling and draining alert with details.
- Biosensing functionality alert if a foreign substance is mixed with the fuel.
- Fuel leakage or loss alert.
- Genset status alert (on/off).

FMD application is designed for gathering of onboard reports through the internet, their processing and displaying of operational data on the area map as well as storage of data and generation of analytical reports at user request. Operating the fuel consumption devices needs approvals from authorities, installation of fuel monitoring devices for each tank, hardware items such as server and software applications. All should be worked on for the operation of these monitoring devices. Lack of internet connectivity, installation refusal by health facilities and inaccuracy of reports generated are challenges that may hinder the functionality of the FMDs.

In instances of continuous hindrances to the functionality of FMDs, manual meters will be installed by September 2022. In the event that this timeline is not met, the Bank and relevant implementing agencies will work together to assess the risks and address remaining challenges. To ensure the effective prevention of the misuse of fuel and ensure the timely detection of any misuse, the fuel provision and storage will be closely monitored using a four-pronged approach of proper controls: (1) FMDs (or manual metres where FMD installation/functioning is continuously impeded), (2) daily monitoring of fuel by fuel focal points, with raising of critical issues immediately to the WHO M&E team, (3) quarterly field visits by TPMs to all EHCP hospitals (to monitor timely fuel delivery, quantities received and used, and purposes for which fuel was used), and (4) monthly monitoring and quarterly field visits by WHO M&E teams to all EHCP hospitals. Findings by TPMs are routinely cross-checked by the WHO M&E team. These four overarching sources of information will provide an acceptable level of assurance that the fuel is being used as intended to facilitate the provision of health services.

5- **Briefings and awareness raising:** Briefings were provided for facility fuel focal points in April and May 2022 on the importance of tanks remaining sealed, how to use monitoring tools for FMDs, the criticality of safe/secure fuel storage, no tampering, close monitoring etc. Further facility-level campaigns and materials to raise awareness of proper fuel processes will be carried out as needed.

Oxygen for Hospitals

The quantities for the provision of oxygen refilling cylinders to YEHCP supported hospitals were calculated based on their routine utilization of oxygen, monthly consumption, and the presence of oxygen stations in the facilities with consideration to its daily capacity of production, also the quantities are crosschecked with the MoPHP. The allocated amounts are delivered on a monthly basis through several companies that have been contracted to provide the oxygen refilling cylinders to supported HFs. Lastly, TPM and internal M&E teams monitor oxygen distribution and confirm the delivered quantities in a process similar to the fuel and water supplies mentioned in previous sections.

Equipment, Medical Supplies and Medicines

The provision of critical equipment is an important aspect of the YEHCP that enables larger referral facilities to function and provide needed services. Governorate hospitals were given the opportunity to specify the equipment, medicines, and items needed and followed by further assessment for the request before proceeding with the procurement. Medical supplies, drugs and equipment were ordered for DH / IDH as per the MSP (the guiding methodology for interventions and health service delivery in EHNP supported facilities). Additional key medicines and supplies to complement the MSP were identified and put into the pipeline.

Such equipment will be delivered include but not limited to:

- Surgical and ICU equipment.
- ECG.
- Ventilators.
- Patient monitors.
- Ultrasound.
- DC shock.

- Mobile X-Rays.
- Fixed X-Rays.
- Electricity generators.
- Infant incubators and phototherapy.
- Other core medical equipment and devices.
- Laboratory equipment.

Medical supplies and medicines are to be delivered in the target facilities include but not limited to the following:

- TESK kits (Trauma & Emergency Surgery Kit).
- ER Kits.
- Trauma Kits.
- IEHK Kits (Interagency Emergency Health Kit).
- SAM Kits (Severe Acute Malnutrition).
- Cholera Kits.
- SSK (Surgical Supply Kit).
- Pneumonia Kits.
- Loose Essential Medicines and Medical Supplies (as separated items; not enclosed in kits).
- Others.

Medical supplies and medicines will be ordered based on needs and project interventions under the YECHP. The provision of items will include installation, training to operate and maintenance if applicable. Item delivery is confirmed using the receipt of the Health Facility Official, and waybills copies in the facilities and is monitored through the TPM.

Coordination with MoPHP and local authorities for distributing medical supplies:

Aside all needed coordination and approvals by the MoPHP and local authorities that are required from the time of the arrival of supplies to the point of entries within Yemen, most of the related procedures for distributing equipment, medical supplies, and medicines to supported HFs should be coordinated and approved by the MoPHP and local authorities (such as SCMCHA in the northern governorates) and should be in line with authorities' requirements that are frequently amended and challenging, which include the following:

1- Distribution plans: Plans are prepared by WHO technical officers in the Yemen World Health Organization country office (WCO) and shared with the MoPHP for technical inputs and final approvals, then based on the approved distribution plans, the supplies are distributed and delivered accordingly to HFs.
2- Road permissions: They must be provided by the MoPHP and local authorities for transporting supplies to HFs in order to facilitate the transporting trucks and vehicles passing through the check points.
3- Release orders: They must be provided by the MoPHP to release the supplies out of WHO warehouses.

4- Final inspection document: In order to for the equipment to be distributed to the supported HFs a committee composed of members from the MoPHP and from WHO must sign and confirm on the inspection of equipment.

Monitoring of provided medical supplies:
Monitoring the provided medical supplies to HFs is conducted through the following procedures:

1- Logistics Support System (LSS), records the detailed data of delivered supplies such as name of HFs, items, quantities, PO numbers, etc.
2- Coded waybills must be signed by HFs at the time of each delivery and signed copies must be returned to WHO logistics unit.
3- TPM agencies conduct field visits at HFs level on a regular basis to monitor the provided supplies under the project.
4- Regarding maintenance of equipment: If the provided equipment need maintenance passed the insurance period agreed up on with suppliers. Then requests are to be submitted to WHO by the MoPHP through the official correspondence to arrange for a responsible biomedical engineer to assess the equipment. Once the final recommendations are examined the required amount of maintenance will be done according to the project agreement and availability of allocated budget.

Support to Therapeutic Feeding Centers (TFC)

Severe acute malnutrition (SAM) is defined by a very low weight for height (below -3 Z scores of the median WHO growth standards), by visible severe wasting, or by the presence of nutritional oedema. Decreasing child mortality and improving maternal health depends heavily on reducing malnutrition, which is responsible directly or indirectly, for at least 45% of deaths among children under five years. Although the median under-five case-fatality rate for SAM typically ranges from 30% to 50%, it can be reduced substantially when physiological and metabolic changes are taken into account. Management of SAM according to WHO guidelines can reduce the case-fatality rate by about 55% in hospital settings.

In Yemen, WHO is one of the leading agencies involved in nutrition response with the responsibility to assure access to safe and lifesaving medical and nutrition care for the management of SAM with medical complication (SAM with MC). Acute malnutrition has reached an unprecedented rate among children under five years in Yemen and is of great public health concern or an emergency in almost all districts. WHO Yemen supports Therapeutic Feeding Centers (TFCs) across the country making accessible to vulnerable populations critical nutrition services, the support in centers is not exclusive to life-saving services but also extends to cover preventive measures.

WHO approach to manage the TFCs is mainly composed of: (i) country-level coordination with MoPHP and nutrition cluster for evidence generation, needs assessment and response planning (ii) provide technical support to MoPHP and implementing partners in regards to technical and operational guidelines, capacity building and service delivery quality assurance measures (iii) Increase coverage and access to quality nutrition care for the most vulnerable, by establishing TFCs in all priority districts, (iv) in the context with minimal/absent governmental support, WHO ensures continuum of care by provision of running and operation cost to all TFCs services, (v) ensure continuum of quality services by ensuring the availability of lifesaving drugs and standard package of service provision. (vi) Referral pathway support; with the deteriorating economic situation of the

vulnerable population, WHO ensures the availability of free services and enforces better utilization of the established services by supporting referral cost from Outpatient Therapeutic Programme (OTP) to TFCs.

The areas with the highest risk of famine and malnutrition in Yemen are prioritized based on the yearly conducted Integrated Food Security Phase Classification (IPC)[11] analyses, Standardized Monitoring and Assessment of Relief and Transitions (SMART) surveys'[12] results and other multisectoral assessments.

To respond to the malnutrition crisis in Yemen, the YEHCP supports the management of SAM/MC by scale up and support operation of TFCs. As TFCs services are inpatient secondary health services the planning for TFCs establishment entails supporting the 6 pillars of health system operation and considered costly in comparison to outpatient but is a lifesaving service on the other hand for desperate children on the brink of death. Thus, the total number of TFCs that would be required to manage children with SAM and medical complications in any area (whether a governorate or a group of districts) will depend upon the prevalence of SAM, expected incidence and case load of children with SAM with medical complications, existing health infrastructure, accessibility, and population inequities. A list of all supported TFCs under the project attached in annex 10.

EHCP will continue the support to TFCs, which started under the EHNP. The selection is based on the HeRAMS results on fully functioning hospitals, the TFCs should be established at GH, IDH and DH. Sub- District Hospitals and upgraded HCs plus can be considered where facilities can manage pediatric emergencies and complications in children with SAM. Referral Hospitals that do facility-based management should in addition have an intensive pediatric care unit for critical cases and function as a training facility for capacity building of medical and para-medical staff besides playing a mentoring role and providing support to other TFCs.

In addition, for cost-effective planning, WHO considered grouping of districts to get at least the caseload enough to operate a minimum capacity TFC with 8 beds and 80% occupancy rate which is a minimum of 234 cases per year per group of districts. The grouping of the districts was done based on caseload as follows:

1. Grouping of adjacent districts (no more than three districts) to reach a minimum of 120 cases by TFC catchment. The rationale for 120 is that we put in consideration the possibility of under-estimation of the prevalence as per last IPC-AMN recommendations. As evidence, WHO analysis last year revealed that some districts had 200% of their caseload, therefore it is possible to have per year more than 300 cases with at least 80% bed occupancy rate
2. If there is no 24/7 operational health facility, a fully functional HC is to be upgraded.

The standard way of calculating the number of beds in TFC is as the following steps:

1. Total population of the targeted area.
2. Total under age 5 population (based on nutrition cluster caseload estimation file published in nutrition cluster website and updated biannually).
3. Total under age 5 children with SAM (based on nutrition cluster caseload estimation file published in nutrition cluster website and updated biannually).
4. Total SAM with Medical Complications (10%).
5. Average stay in Hospital for management of acute complications 10 days.
6. Total bed days = total SAM with Medical Complication X 10.
7. Total beds required (with 100% bed occupancy) = total bed days/365 days.

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[11] *The Integrated Food Security Phase Classification (IPC) is a set of analytical tools, and processes, to analyze and classify the severity of a food security situation according to scientific international standards.* *https://reliefweb.int/sites/reliefweb.int/files/resources/IPC_Yemen_Acute_Malnutrition_2020Jan2021Mar.pdf*
[12] *SMART Methodology is the reference and standard tool amongst organizations and governments collecting nutrition assessment data, both during emergencies and in developing contexts.*

The SAM/MC cluster target is calculated differently than the SAM target, as the prevalence for SAM/MC is 10% of the SAM population with more than 55% mortality rate if appropriate treatment is not provided (based on WHO global guidelines). putting into consideration that, TFCs target includes under six months of age while OTP target above 6 months of age. Additionally, the service is at the secondary level and affected by the access, functionality and capacity rate of secondary health facilities. For these reasons, it was agreed by the cluster to reach 60-70% of the SAM/MC caseload or People in Need (PIN) including IDPs and refugees. Based on the latest published IPC AMN (integrated phase classification for acute malnutrition) 2020/ 2021, 83 districts classified with very high global acute malnutrition (GAM) rates, 56 with high GAM rate and the rest with medium GAM rate 194. Based on the cluster caseload estimation exercise, which is based on SMART surveys, the SAM prevalence across all districts varied from 3.6 % in some to 7% in others.

TFC Monitoring activities

Monthly reports from the TFCs shall continue being sent with recently new reporting forms developed to follow international guidelines and disseminated and reinforced in the training of trainers (ToT). In addition, monitoring and supervision visits for nutritional activities are conducted in hubs supported by WHO and jointly done with the GHO/ DHO nutrition focal points.

In order to enhance monitoring of nutrition activities, the MoPHP is developing an integrated dashboard with different nutrition-related indicators, technically supported by WHO and UNICEF, the monthly infographics are posted on the WHO website through a dedicated page (*click here to visit the website*). Different meetings and workshops have been conducted with different stakeholders to develop the dashboard and the timeline of the reporting tools.

Internal monitoring: As TFCs case management is considered a specialized lifesaving service, MoPHP with WHO and its donors technical and financial support, ensure 2 types and three levels of monitoring scheme as follows:

- First: technical monitoring; MoPHP with WHO support trained 60 TOT certified TFCs experts across the country who in turn conduct quality assurance visits to TFCs with low-performance rates to ensure adherence to global/ national guidelines (technical and operational). They have regular quarterly visits to TFCs in their assigned regions and conduct on-the-job training visits for 3 days as needed.
- Second: administrative monitoring; this is conducted at MoPHP three levels of operation as well as WHO 2 levels of operations.

1. At MoPHP level:
    a. DHO level: the nutrition focal point at DHO level visits the TFC in his/ her district twice a month to ensure adherence to the standard operating manual. Including health workers' attendance schedule and shifts, registration of cases and completeness of reports, documentation of operation cost payments and clearances, stock management and urgent gaps in supplies, etc. in addition to documenting challenges in referral of the cases in his region. He/ she reports findings to the GHO nutrition coordinator and shares a copy to the WHO/ hub focal point.
    b. GHO level: the nutrition coordinator at GHO should visit all TFCs in his governorate once per month. Similarly, the visit purpose is to ensure the same administrative aspects are

monitored by the DHO, in addition to verify the reported findings and ensure timely response to any gap or correction measures. GHO coordinators also report on the TFC/ OTP referral pathway strength and challenges in their governorates with possible solutions. They report to the MoPHP nutrition department with a copy to the WHO/ hub focal point and WHO central office.

c. MoPHP central team: they visit a random sample of TFCs each month to ensure adherence to both technical and administrative guidelines and SOPs.

2. At WHO level:
    a. WHO nutrition team monitoring: WHO has a nutrition focal point in each operating hub, they visit all TFCs in their hubs once per month (in hubs with a high number of TFCs, WHO has 2 focal points) to ensure the adherence to both technical and administrative procedures, report on any gaps and conduct corrective measures for any technical malpractice and follow up on action points.
    b. At the central level, WHO technical officers for nutrition visit the field regularly to ensure service provision, need assessment and follow up on action points raised by MoPHP.
    c. WHO internal M&E team: It is composed of the WHO internal monitoring team, the team conducts their visits monthly in collaboration with the nutrition team at central and hub levels.

TPM: for each project, WHO ensures TPM field visits to monitor the implementation of the technical and operational package of each project in accordance with the donor’s requirement. Each report from TPM, will be reviewed by the assigned technical officers from WHO side and provide feedback to each of the reported findings.

National Blood Transfusion Centers (NBTCs)

Blood transfusions services are an integral part of the healthcare system. The project offers lifesaving interventions for patients during acute emergencies, supports patients with chronic medical conditions, prevents maternal deaths and enables complex medical and surgical procedures to be conducted.
There is a growing demand for blood transfusion services in the country. Transfusion is mostly used in the treatment of chronic medical conditions but also Yemen being one of the countries with high maternal mortality (365/100,000), and infant mortality of (75 per 1,000 live births), blood transfusion is required as a medical intervention to correct underlying anemic conditions. Also, due to war and civil conflicts, transfusion is required as an emergency life-saving intervention for surgeries and medical management of frontline casualties of war.

Data from 6 NBTCs in the republic of Yemen show about 70,000 blood or blood components were transfused to patients mostly with chronic conditions in 2019. In transfusion services, the safety of the donated blood or blood components is of paramount importance to avoid the transmission of bloodborne infections. Thus, there is a need to maintain extreme quality assurance in every step of the process – from vein-to-vein.

With support from YEHCP, the operational workplan below aims to streamline WHO programme response and facilitate the activities of NBTCs so that this life saving intervention is available and accessible in a timely manner to thousands of patients.

Key programmatic areas supported include

- Improving leadership and governance at MoPHP
- Improving access through a network of regional blood banks
- Supporting the recruitment and retention of voluntary and non-remunerated blood donors
- Provision of diagnostics, reagents and consumables in a timely manner
- Implementing quality management system in blood banks
- Proper waste disposal
- Capacity building for blood safety staff at technical and management level
- Routine monitoring and evaluation

Central Public Health Laboratories (CPHL)

For the governorates along the coastal Yemen coastline, the start of long rains is always occasioned by the outbreaks of dengue, a delipidating viral infection as accumulation of water in abandoned buildings and unused tires creates suitable environments for the breeding of mosquito vectors. Other vector-borne diseases like Chikungunya, West-Nile and other viral diseases are suspected to be circulating even though the CPHL in Yemen does not have the capacity to perform diagnosis and confirmation of any of these diseases, especially by using molecular diagnostic methods. Without a strong surveillance system supported by a reliable laboratory service, it will be impossible to detect disease outbreaks on time and institute public health interventions in a timely manner.

This plan is aimed at continuing support to the CPHLs that were supported under EHNP and ensuring that the CPHLs and microbiology labs established through the support of the YEHCP program are fully operational.

This operational support describes the activities required for ensuring a reliable laboratory service with sufficient capacity for clinical laboratory tests and to support surveillance for outbreak-prone diseases. The objective of the plan is to:

- Improve the technical capacity of surveillance laboratory so that emerging and dangerous infectious pathogens, vector-borne diseases like dengue, Chikungunya, and West-Nile, and diarrheal diseases like cholera are detected in a timely manner.
- Ensure continuity of laboratory services required for the routine clinical management of patients including tests for complete blood counts, clinical chemistries, diagnosis of chronic diseases and for rare diseases such as thalassemia and sickle cell diseases.
- Ensure quality standards are established for routine diagnostic tests so that the laboratory meets the requirements for international accreditation.

Improving Quality of Healthcare

Quality of health care is defined by the Institute of Medicine as “the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge”. This definition, which is used by the MoPHP, establishes the basic goal of positively impacting health outcomes at both the individual and population levels and emphasizes the central importance of evidence and professional knowledge. A more working definition that is widely used, suggests that, to improve the quality of healthcare, a health system should seek to make improvements in six quality

dimensions. These dimensions require that health care to be safe, effective, efficient, timely, patient centered, and equitable. More recently, the WHO Framework on Integrated people-centered health services has described "high-quality care" as "care that is safe, effective, people-centered, timely, efficient, equitable and integrated".

The drive for Universal Health Coverage (UHC) requires focused attention on access to quality essential health care services. Sixty percent of deaths in low- and middle-oncome countries (LMICs), from conditions requiring health care occur due to poor quality care, whereas the remaining deaths result from non-utilization of the health system. Inadequate quality of care imposes costs of US$ 1.4–1.6 trillion each year in lost productivity in LMICs. It has been estimated that high-quality health systems could prevent 2.5 million deaths from cardiovascular disease, 900 000 deaths from tuberculosis, 1 million newborn deaths and half of all maternal deaths each year [13]. As summarized by WHO Director-General Tedros Adhanom Ghebreyesus, without quality, UHC remains an empty promise.

In Yemen, limited efforts towards improving the quality of care were existing prior to the crisis in 2015. It is worth to mention that in late 2014, there were discussions at higher level to start working on developing the national quality strategy and the national quality standards, however, with the beginning of the war, these plans were suspended in 2019, WHO as the health cluster leading agency, has led the quality task team to develop the critical quality standards' lists, for both primary and secondary care levels. This action was taken with the aim to cover a serious gap, related to quality of care, that was existing back then This action was taken with the aim to cover a serious gap, related to quality of care, that was existing back then. Based on the quality standards, WHO has then led the process of developing the quality of care assessment tools for primary and secondary health care levels, for critical quality standards assessment tools, please see annex 11.These tools were then used to initiate the quality improvements processes in several hospitals during 2021, focusing on eight components: leadership and management, training and staffing, service delivery, Infection, Prevention and Control, infrastructure, medicines and equipment and finally patients' rights and participation.

In early 2021, an assessment was conducted at 18 DHs and IDHs in Yemen using the above-mentioned tool. The assessment showed that the majority of the critical quality standards are not in place in these hospitals. Moreover, the hospitals' management as well as the staff do not have the knowledge of the basic concepts of quality of care. The institutional system is very weak in the hospitals targeted by the assessment, for instance, most hospitals do not have strategic plans, organograms, job descriptions and even financial systems and human resources units. Furthermore, the majority of the assessed hospitals do not have any medications management system and do not apply the critical quality standards medicines and equipment, endangering the patients' safety. Additionally, the assessed hospitals do not have Infection, Prevention and Control (IPC) Programs, neither staff nor budgets are existing for IPC. The majority of the minimum IPC requirement are not in place, and only 2 hospitals out of 18 have IPC guidelines, policies and procedures. Hence, the results of this assessment, which is the first of its type, show that the status of quality and patient safety in the assessed hospitals puts the both the patients and the staff at danger and increases the risk of mortality and morbidity associated with poor quality of care. As a response to this assessment, WHO supported MoPHP to start its quality improvement programs in the above-mentioned hospitals. The activities that started in these hospitals have resulted so far in an improvement across many of the quality standards including the initiation of the quality and IPC programs in the 18 hospitals, the development of the quality policies and procedures across all

[13] *Quality Health Services, World Health Organization, 2020*
https://www.who.int/news-room/fact-sheets/detail/quality-health-services *(accessed August 2021)*

the quality standards used, the training of the hospitals' staff on the quality standards, policies and procedures and the increase awareness regarding the significance of quality programs at different level of care.

Under the YEHCP, WHO will support the MoPHP to work on improving quality of health care at both a strategic level and hospital level. This will be done through supporting the MoPHP to develop its National Quality Strategy and Policy which will guide later on all the activities related to quality of care in the country. At the hospitals' level, WHO will support MoPHP to improve quality of care by expanding its existing efforts to include additional hospitals in the quality improvement program already supported by WHO.

Activities:

A- WHO will support quality improvement processes in selected facilities by (1) conducting quality trainings at central level to build the capacity of facilitators and teams to support and lead the process, (2) on-the-job training at targeted facilities, (3) technical support to facilities to start their quality of care programmes and to develop and implement quality policies and procedures, (4) initial and final evaluations to measure improvements from the above activities, (5) finalization of quality improvement tools by utilizing lessons learned from these activities. (see training topics in Capacity Building section).

B- WHO will support MoPHP to develop its National Quality Policy and Strategy (NQPS) that will then guide the quality improvement process in healthcare. The development, refinement and execution of NQPS represents an organized effort to promote and plan for improved quality of care. An effective national direction on quality can bring together multiple quality initiatives under a systematic and organized effort; secure high-level commitment to quality; and clarify structures for accountability and monitoring.

Hospitals' Selection Criteria:

1- The hospital has the management capacity to lead the quality improvement process and change.
2- The hospital has adequate staffing, clinical and non-clinical, to support the quality improvement process and change.

Output indicators:

1- Number of quality field visits/training conducted at each targeted hospital.
1- Number of hospitals' staff trained on quality of care during each round of field visits/training.
2- Number of hospitals implementing quality programs and activities (e.g. formed quality committees, prepared strategic plans, prepared quality policies, implemented quality policies, etc.) as a result of the quality activities conducted under this project.

Outcomes Indicators:

1- Percentage of hospitals that achieved improvement in applying the critical quality standards by the end of the project.

Monitoring and Evaluation:

The activities to be done at the level of hospitals will be monitored by WHO monitoring and evaluation team. The M&E team will conduct the field visits to monitor the implementation of the activities as well as the quality-of-care status at the targeted hospitals. This will be done to guide the health authorities quality consultants/facilitators to improve the activities, throughout the implementation period. Additionally, as mentioned above, an initial assessment will be done at the beginning of the activities and then final evaluations will be done after completing the activities to measure the improvement across the selected quality standards. The initial assessment and final evaluations will be done in coordination with MoPHP. Moreover, MoPHP will supervise the activities during the implementation period and will join the quality teams in the field visits and training.

Subcomponent 1.4: Sustaining the National Health System Preparedness and Public Health Programs

Implementing Agency: WHO

This subcomponent will support nationwide public health programs and measures, including:

- Nationwide public health campaigns
- Integrated Nutrition Surveillance System (INSS), which is meant to provide ongoing nutrition, health, and food security information to inform decisions in a timely manner.
- System strengthening and resilience-building measures to support the epidemiological and diagnostic laboratory capacity of the local institutions particularly the reference labs at the governorate level.
- Maintaining the eIDEWS and enhancing the public health system preparedness to respond to disease outbreaks through supporting nationwide Rapid Response Teams (RRTs) at the district and governorate levels.
- Activities under this sub-component will contribute to climate adaptation by monitoring climate-sensitive diseases (such as vector-, food- and water-borne, diseases and neglected tropical diseases (e.g., schistosomiasis) through eIDEWS, updating seasonal mapping, forecasting and conducting preventive campaigns to reduce the impacts of potential outbreaks. Climate change adaptation will also be strengthened by enhancing preparedness to respond to the health and nutrition impacts of acute events such as flooding, drought and locusts, including by ensuring continuity of essential health and nutrition services during and after climate-related emergencies and providing such services to areas expected to be impacted by climate change (e.g. droughts, floods); this will not only have an impact on acute nutrition outcomes like wasting but also increase resilience both in a disaster context as well as generally capacity-building activities under this subcomponent will also include sessions focused on awareness-raising for climate change adaptation.

Support National Public Health Campaigns:

The project will support the implementation of the nation-wide as well sub-national immunization and treatment campaigns for diseases such as, but not limited to, polio, measles, diphtheria, trachoma, and schistosomiasis. The mass public health campaigns will help the country overcome risks associated with episodes of a major disease outbreak, the risk of which has been exacerbated by the presence of a large number of IDP communities as well as large groups of immigrants from the Horn of Africa region. The funds

will finance the costs associated with procurement of vaccines/medicines, costs associated with operational and administrative activities of the campaign.

Generally, prior to the outset of any public health campaign for any given disease, the MoPHP is responsible to provide WHO with a multi-faceted country review covering several parameters as they would significantly impact the planned intervention, thus any minimal changes might affect the proposed plan of action. These parameters include but are not limited to; total population, the epidemiological background which entails the number of affected districts, number of cases in different districts, diagnosis, and treatment in addition to the justification of the proposed plan of action. This information must be taken into consideration during the planning process for each health campaign.

In the context of Yemen, the MoPHP takes lead on the campaigns along with technical support (supporting micro planning, training, monitoring, data collection/ analysis and report writing) from WHO and UNICEF depending on the various components of the vaccination activities.

A detailed arrangement for any given public health campaign should consider the below themes:

- Micro planning: The foundation of every successful campaign, especially vaccination campaigns, is a comprehensive micro plan which captures in detail all the different, yet interrelated components of the campaign. The micro plan is a comprehensive and detailed plan for the campaign which includes all relevant details including logistics, human resources involved and team composition, detailed activity plans, stakeholders' engagement, mapped areas and number of served beneficiaries, distribution of needed vaccines and any other materials such as guidelines, registration forms, etc...). In addition to training of involved staff including HCWs, supervisors as well as independent monitors. Other detailed plans are made covering vaccine distribution and (for vaccination campaigns) social mobilization, communication plans, and reporting plans.
- Risk area mapping/assessment (criteria, map, etc.) are prepared in advance and are especially focused in pre-campaign and during campaign activities by closely monitoring and providing the needed guidance and support.
- Social mobilization: Raising awareness in the community by conveying messages relevant to the intended campaign to the target audience through TV channels, radio stations and any other feasible communication channels as appropriate to avert the audience misconception about vaccination and create awareness, acceptability and demand for vaccination.
- Supportive Supervision: Supportive supervision during the campaign is one of the key factors to ensure good campaign quality. During micro-planning the number of teams is calculated based on agreed criteria and the number of teams then determines the number of supervisors in the respective area of operation and team which will be under the leadership of each assigned supervisor.
  Supervisors participate in team selection, training, developing team micro plans, supervise the team to identify any shortcomings and take corrective actions as required. They also provide on-the-job training, provision of additional supplies where needed, addressing refusal issues faced by the team and collecting data at the end of the day.
  Supervisors use standardize supervisory checklists at all levels and share data with the control room on a daily basis. The WHO central supervisors submit their data and report to WHO staff in addition to sharing their daily findings with the respective district/governorate health team and central control room.

- Reporting (how, who, when, tools, etc.): post-vaccination coverage Report serves as a tool for identifying areas for improvement and as a relevant detail including campaign justification, fund, planning and all needed arrangements and most importantly comprehensive representation of the independent monitor results.

Post campaign survey: Independent post-campaign assessment is conducted following the conclusion of any vaccination to estimate the coverage achieved through immunization activity at the time of the campaign at each Governorate and nationally. This is considered as the primary objective of the post-campaign surveys. Other objectives may include confirming the proportion of the targeted population who received their vaccine through the campaign, investigate the reasons for not receiving their vaccines as well as find out which social mobilization and awareness interventions were most effective. The post-campaign survey is necessary to spearhead the way forward and take any corrective or further actions.A post-campaign coverage survey should be conducted as soon as it is feasible after the completion of a campaign to reduce recall bias.

Ensuring the preparation of the individualized campaign plan, the strategy and campaign outcomes should be developed to ensure the design of a well-structured campaign aiming to achieve the intended objectives. The distinct plan for each campaign will be consolidated along with the five-year country plan. Hence afterward, the technical and financial proposals are submitted by the MoPHP and reviewed by the WHO technical officer. As soon as the proposals are consented by WHO, the grant is provided and the financial aid for the desired public health campaign begins right away where funds are allocated as per the agreed-upon procurement plan and pre-set activities.

The YEHCP fund will be only requested if there are no funds available from any other source or donor or if there is a funding gap between the funds requested and available funds for the vaccination campaign.

Campaigns that may be supported under the YEHCP include:

- Diphtheria campaigns.
- Measles and rubella campaign.
- Oral cholera vaccination campaigns (OCV).
- Schistosomiasis and Soil Helminthiasis campaign.
- Onchocerciasis campaign.
- Trachoma campaign.
- Leishmaniasis interventions and case management.
- Nationwide or sub-national polio campaign. Vitamin A is also administered mostly during these campaigns.

Vector Control:

Integrated Community Case Management (ICCM)
ICCM is defined as an equity-focused strategy that complements and extends the reach of public health services by providing timely and effective treatment of malaria, pneumonia, and diarrhea to populations with limited access to facility-based health care providers, and especially to children under 5 years.

The ICCM has been promoted by the National Malaria Control Program (NMCP) and UNICEF in Yemen as a key lifesaving strategy to provide timely and effective management of malaria, pneumonia and diarrhea, especially in the most affected districts by the current crisis with limited access to public health services. A national policy

for the community Health Volunteers was endorsed by MoPHP in 2015. Three training manuals were developed and used for the training of Community Health Volunteers.

The ICCM strategy targeted the 2nd and 3rd tiers, the targeted districts were selected based on certain criteria based on the burden of the diseases and other factors that enhance the provision of the services.

The provided services: screening all suspected cases to confirm and treat malaria cases, refer severe malaria cases, classify pneumonia and treat simple cases with amoxicillin, refer severe pneumonia cases to HFs, classify and evaluate diarrhea and treat simple cases with oral rehydration solution (ORS) and zinc. Severe cases will be referred to the nearest HFs.

The community health volunteers (CHVs) are assigned to detect, manage and follow-up malnourished children at the community level (as stated in CHVs manuals) and investigate the cases by Middle Upper Arm Circumference (MUAC).

The current core vector control interventions are insecticide-based. The two core interventions, (i) insecticide-treated nets (ITNs) mainly in the form of pyrethroid-only long-lasting insecticidal nets (LLINs) prequalified by WHO; and (ii) indoor residual spraying (IRS) with an insecticide prequalified by WHO, are recommended by WHO for the deployment for the prevention and control of malaria in children and adults living in areas with ongoing malaria transmission. WHO recommends ensuring access to effective vector control using ITNs or IRS at optimal coverage levels for all populations at risk of malaria in most epidemiological and ecological settings[14].

WHO conditionally recommends the regular application of biological or chemical insecticides to water bodies (larviciding) for the prevention and control of malaria in children and adults living in areas with ongoing malaria transmission as a supplementary intervention in areas where optimal coverage with ITNs or IRS has been achieved, where aquatic habitats are few, fixed and findable, and where its application is both feasible and cost-effective[14].

In Yemen, pyrethroid-only LLINs prequalified by WHO is distributed through mass campaigns, free of charge, 1 LLIN for every two people[15], to protect everyone in the areas targeted by this intervention, mainly the rural communities within malaria-endemic areas at altitudes between 0 and 1,500 meters above sea level (asl), which include the highest burden governorates (Al Hudaydah and Hajjah). Replacement campaigns are planned three years following the mass campaigns as recommended by the WHO.

IRS with a new mode of action next generation insecticide (prequalified by WHO) is also implemented for insecticide resistance management in pyrethroid resistance areas and to target high burden/epidemic-prone malaria-endemic areas below 1,000 meters asl.

In response to the recurrent dengue/chikungunya outbreaks, the NMCP in Yemen, using available limited resources, also conducts emergency space spraying/fogging, with insecticides prequalified by WHO. The targeted sites are those identified with cases to reduce the vector density of *Aedes aegypti* (*Stegomyia aegypti*) mosquitoes transmitting the disease.

[14] *WHO Guidelines for malaria. Geneva: World Health Organization; 2021* (https://www.who.int/publications/i/item/guidelines-for-malaria). Online platform
[15] *WHO. Recommendations for achieving and maintaining universal coverage with long lasting insecticidal nets for malaria control. Global Malaria Programme Geneva: World Health Organization; Revised December 2017.*

In addition, larval source management (LSM) is also carried out by NMCP during the dengue/chikungunya outbreaks to eliminate the vector breeding sites in parallel with health education at household level in targeted areas with high number of cases. Massive health education by school students to provide awareness on source reduction to the affected communities has played an important role to contain dengue outbreaks.

Entomological surveillance

Entomological surveillance is a continuous, systematic collection of entomological data, analysis and interpretation of entomological indicators to generate evidence-base for the selection of the most appropriate vector control intervention and also serve as an early warning system for a rapid response to outbreaks of vector-borne diseases. Entomological surveillance is an important component of vector control programmes, operational activities and research.
To date, a total of 15 sentinel sites for routine vector surveillance which include insecticide resistance monitoring (IRM), have been established in the endemic areas where malaria vector control interventions are currently implemented and within agricultural areas where pesticides are sprayed.

Insecticide resistance monitoring: Insecticide resistance monitoring is used as an early warning system to trigger preventive and mitigation measures for insecticide resistance management and generated data can be interpreted to guide vector control decision making.
In insecticide resistance monitoring, the first step is to conduct phenotypic monitoring with discriminating concentration bioassays, using either WHO susceptibility tests or CDC bottle bioassays. If the resistance is confirmed (% mortality is < 90%) using the discriminating concentration, further investigations are needed that include measuring the resistance intensity which measures the strength of resistance in a vector population.
Once resistance is confirmed, the resistance mechanisms can be identified using synergist-insecticide bioassay, molecular or biochemical assays. The synergist-insecticide bioassay is used to assess the involvement of metabolic resistance mechanisms in the production of
resistance phenotypes. The synergist assays can provide evidence to identify the areas to prioritize for the deployment of PBO nets.
The WHO test kits/supplies for conducting the susceptibility tests/bioassays are supplied by the Universiti Sains Malaysia, a WHO collaborating center and the only supplier. The insecticide resistance monitoring data can be visualized in generated maps in the Malaria Threats Map (https://apps.who.int/malaria/maps/threats/).

Currently, the NMCP is using mobile applications to collect field data which is considered a useful tool to map breeding habitats over wide areas at unprecedented spatial and temporal resolutions. In Yemen, *An. arabiensis* has been demonstrated to breed in a variety of breeding habitats[16] which demonstrates that malaria prevention by larval control may not be effective in many of the malaria risk areas. However, with the rapid spread of insecticide resistance in the sentinel sites monitored in Yemen, LSM should be considered as a supplementary intervention in areas where feasible.

Under the previous project, the ENHP, multiple activities and interventions are implemented within the framework of vector control outbreaks to improve the national response to vector-borne diseases such as malaria, dengue, chikungunya, and other similar diseases. These activities include but are not limited to; interruption of transmission by reducing vector population through indoor residual spraying and indoor &

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[16] *Al-Eryani SM, Kelly-Hope L, Harbach RE, Briscoe AG, Barnish G, Azazy A, McCall PJ. Entomological aspects and the role of human behaviour in malaria transmission in a highland region of the Republic of Yemen. Malaria journal. 2016 Dec;15(1):1-7.*

outdoor fogging, conducting entomological surveillance and health education programs for community awareness.

YEHCP is providing continued support to the national malaria control programme to strengthening the response to vector-borne diseases through the following interventions:

1. Strengthening case management (diagnosis and treatment) of malaria and dengue fever by providing diagnostic materials, training of HCWs and implementing the Integrated Community Case Management (ICCM) to increase access to malaria diagnosis and treatment at the community level in remote and under-served areas.
2. Conducting effective entomological surveillance to monitor and reduce the mosquitoes' vectorial capacity to a point at which transmission is interrupted.
3. Supporting vector control interventions/campaigns: indoor residual spraying, indoor & outdoor space fogging and health education programs for community awareness to prevent the occurrence of malaria/dengue and similar outbreaks.
4. Conduct insecticides resistance testing to monitoring the susceptibility of mosquitoes to insecticides *(Please click here for more information on country status)*

Support to Integrated Nutrition Surveillance System (INSS)

Over 2.25 million cases of children aged 0 to 59 months, and more than one and a half million cases of pregnant and lactating women, are projected to suffer from acute malnutrition in the course of 2022 in Yemen[17] . WHO in collaboration with local health authorities and through World Bank support have established Integrated Nutrition Surveillance System (INSS) to find and refer for the appropriate treatment all children affected by acute malnutrition. The nutrition surveillance system prioritizes and closely monitors communities at elevated risk of famine.

INSS support will include the following activities:

1. **Strengthen Nutrition surveillance into Health services:** In a context presenting alarming rates of acute and chronic malnutrition, screening, detection and referral for acute malnutrition and appropriate complementary feeding for preventing stunting in children are top priorities. Through the INSS, health facilities now are representing a key entry point for screening/detection/referral/nutrition promotion.
2. **Fill an information gap:** the system generates ongoing nutrition data, otherwise missing in the existing nutrition information system. Current sources of nutrition information are surveys, mass Mid-upper arm circumference (MUAC) screening and program data.
3. **Share timely information for early warning:** The system releases a 2-page monthly bulletin with key highlights and trend analysis, that raises the level of risk perception among partners, and potentially triggers and advocates for alert verification.
4. **Promote growth assessment and promotion:** In the health facilities where regular screening for all forms of malnutrition is routinely conducted and fully integrated into the health system, it is an opportunity to assess and promote children growth for their wellbeing. This is a prevention activity which will contribute to reducing the level of malnutrition. the concept of Growth assessment and Promotion (GMP) recommends that child nutrition status be assessed by weight for age, and that

[17] *http://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/docs/IPC_Yemen_Acute_Malnutrition_2020Jan2021Mar.pdf*

counselling and follow-up services be provided[18]. In INSS the nutritional status of children has been assessed for height, weight and age which allow health workers to inform the caregiver on child's nutrition status (growth assessment) and refer him for appropriate nutrition and counseling services (promotion).

INSS Selection Criteria

The selection of surveillance sites is agreed upon between WHO and MoPHP Department of Nutrition. The methodology for selection is based on the list of functional facilities in Yemen, as per the latest Health Resources and Services Availability Monitoring System (HeRAMS) available results. The selection is initiated by WHO and vetted by MoPHP. Then WHO/MoPHP finalizes the number of sites to be established, in close coordination. WHO determines the targeted population based on planned and ongoing sites. The minimum attendance rate of 250 children per facility per month, as recommended by MoPHP, is also considered for planning and monitoring purposes. A list of all supported INSS under the project is attached in annex 12.

Based on the targeted population and number of sites, WHO develops and initiates the procurement plan. The procurement of items to surveillance sites includes furniture for the site, structural elements to set up the corner, medical supplies and equipment, anthropometric tools, stationery, registers. Additionally, a technical team from WHO and MoPHP conducts assessment visits to sites to determine the capacity and technical needs whereas a technical team of engineers conducts assessment visits to sites to assess the structural status of the site and rehabilitation needs. After the assessment visits and procurement plan for the surveillance sites are conducted, training plan is developed by WHO to cascade knowledge on INSS methodology (data collection, management and reporting, identification of cases and referral) to HCWs. The training plan includes foundation training and TOT, for HCW, GHO and DHO focal points. The capacity-building program enables MoPHP staff to implement INSS.

Detection of cases and referral is the primary objective of INSS. Monitored indicators include:

- Chronic malnutrition.
- Acute malnutrition.
- Undernutrition.
- Exclusive breastfeeding.
- Anaemia.

Acute malnutrition cases are immediately referred for treatment based on the nutrition status of children which include referring to TFCs for SAM with MC cases, OTP for severe and moderate acute malnutrition cases, and for Infant and Young Child Feeding (IYCF) for counseling for all children. Anaemic patients are referred to the appropriate health service. Mothers of infants who are not exclusively breastfed are referred to IYCF services.

A system of monitoring visits and quarterly meetings has been designed by WHO to gather all staff involved in INSS at the governorate level to ensure data quality and timely submission of data. In addition, meetings are an opportunity to strengthen knowledge on INSS methodology and identify needs. Data is collected at the WHO central level (nutrition and IMO teams at WCO), which is currently at the top of the data flow system, where data are transmitted from the facility to the DHO, GHO and MoPHP Central level.

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[18] *WHO, UNICEF. Integrated Management of Childhood Illness. IMCI chart booklet. http://www.who.int/maternal_child_adolescent/documents/IMCI_chartbooklet/en/index.html (accessed 5 July 2012)*

In order to ensure the operation of the NSS, the following activities have been put in place:

INSS Monitoring related activities

- Monitoring visits to surveillance sites conducted by the WHO Nutrition team to evaluate the quality of procedures, data accuracy, challenges and needs at the site level.
- Monitoring visits conducted by APWs at the hub level, to ensure thorough monitoring and supervision at the facility level.
- Surveillance scaleup groundwork conducted through assessments of facilities and provision of equipment supported in collaboration with MoPHP.
- The monitoring of INSS activities is conducted via involving the WHO team in all data chain flow core groups communication and WHO hubs focal points and central team attend meetings, share feedbacks and follow up action points.
- Internal WHO M&E team or TPM involved INSS in their evaluation rounds

INSS products and data management or analysis

- Training on surveillance for GHO, DHO and HW, with a comprehensive package, including nutritional assessment, data collection, data quality control and reporting.
- Surveillance quarterly meetings with GHO, DHO and HW.
- Surveillance monthly infographics have been designed, technically validated and regularly disseminated.
- Nutrition Surveillance guidelines for health Workers have been drafted by WHO and it is currently in use, to ensure the quality of the overall procedure.
- During the project period, WHO is working to roll-out the use of tablets to improve timely data transmission and minimize data entry errors and challenges. The application for mobile devices has been already created and piloted. The integration as a DHIS2 application module will depend on DHIS2 development in the health information system and INSS will be part of data program flow, however, the roll-out of application will be in stages as agreed with MoPHP to ensure the effectiveness of implementation.
- Data are processed at WHO Sana'a and used to produce monthly infographics.
- Monthly infographics are posted on WHO website through a dedicated page (*click here to visit the website*). The link to the latest updates is shared with key partners involved in the humanitarian response in Yemen.
- Surveillance application has been developed to streamline data collection and ensure data quality, reporting regularity directly from the facility to the central level, thus minimizing data manipulation and errors.
- The updates are presented by WHO to the Health and Nutrition Cluster and shared with partners in relevant fora.

Moreover, in close coordination with MoPHP, WHO is planning to increase the coverage of INSS sites and TFCs to increase the accessibility of quality and life-saving services for the most vulnerable population in Yemen. The scale-up plan for surveillance is based on the HeRAMS assessment of health care service functionality and availability and includes the establishment of sentinel sites in all rural, districts and inter-district hospitals in Yemen, to cover additional 25 sites in the North and an additional expected 25 in the South, for a total number of 242 in the North and 95 in the South (337 sites) by the end of 2022. Growth assessment and promotion

activities as surveillance sites will be established in PHC in child health platforms to expand the surveillance system. WHO planned to establish 30 sites by the end of 2021. In addition to the capacity building for nutrition data generation and quality assurance, health workers will also be skilled to provide interpersonal discussions with mothers to inform them on the child growth trend before referral.

Cholera management

A multifaceted approach is supported by YEHCP to prevent and control cholera and to reduce deaths. This approach is in line with the global strategy to end cholera, as it aims to support surveillance (through eIDEWS), laboratory confirmation of suspected cholera cases, case management, treatment interventions, OCV and long-term WASH activities in Yemen. The project also supports procurement of medicines, supplies, and materials for the prevention and control of cholera outbreaks. As an endemic state continues in the country, where a low incidence of cholera is reported compared to the previous years, there is a need to consolidate interventions to target priority areas referred to as “cholera hotspots'' to maximize resources. To this end, identification of the hotspots is done using a tool developed by the Global Taskforce on Cholera Control (GTFCC) to ensure evidence-based decision-making regarding interventions, please check annex 13.

Cholera hotspots were identified and ranked based on epidemiological indicators. Two indicators recommended by GTFCC were used:

1. Historical incidence of suspected cholera cases.
2. Persistence of cholera in the area.

Table 10:The Two Indicators Recommended by GTFCC on Cholera Hotspots

Indicator 1 – Mean Annual Incidence	
Definition	Mean annual incidence over period of last 5 years
Calculation	The annual cholera incidence in an administrative unit was calculated by dividing the number of suspected cholera cases reported in a given year by the population in the area. Then the mean of the annual incidence for the period was calculated for each administrative unit.
Period used	Last five years
Source of information	Suspected cholera cases from cholera master line list and population figures from OCHA and Central bureau of statistics Yemen.

Indicator 2 – Persistence	
Definition	Proportion of weeks with reported cases over period of last 5 years
Calculation	Total number of weeks with reports of suspected cholera cases# divided by total number of weeks in the period of interest (i.e. 261 weeks for a five-year period)

Period used	Last five years
Source of information	Suspected cholera cases from cholera master line list by administrative unit (number of suspected cases reported by week, including community cases)

The current strategy for cholera prevention and control in Yemen derives from the global strategy to focus on the following three main axes:

1. **Early detection and quick response to contain outbreaks at an early stage:**
   The early containment of cholera outbreak will be achieved through a combination of the following approaches:
   - Strengthening early warning surveillance (through eIDEWS) including the confirmation of suspected cholera cases.
   - Pre-positioning stocks of essential supplies including ORS, Intravenous fluids, and other treatment and infection prevention and control supplies for patient care.
   - Preparedness of the healthcare system including setting-up of DTCs and Oral Rehydration Centers (ORCs) and training/refreshers of health care workers.
   - Training of healthcare workers on infection, prevention, and control in DTCs and ORCs
   - Strengthening and equipping Health RRTs for immediate response and field investigations.
   - Maintenance of stocks of WASH supplies including rapid microbial test kits, chlorine tests, water disinfection technologies including chlorine, water tanks (if not available), hand washing soaps and monitoring and enforcing food safety and water quality standards will be maintained in all DTCs/ORCs.
   - Community engagement and community-based interventions promoting hygiene practices.
   - Implementation of reactive large-scale mass vaccination campaigns with OCV.

2. **Prevention of cholera occurrence by targeting multi-sectoral interventions in cholera hotspots**
   The core of this approach will be:
   - Identification of cholera hotspots and characterizing districts by high, medium and low-risk category to target multisectoral interventions in hotspots. The risk and vulnerability assessment in hotspots will include identification of vulnerable populations and specific local risk factors, as well as a mapping of existing safe water sources, sanitation systems, capacities for surveillance (including laboratory), existing isolation treatment facilities and quality of health service delivery and community engagement.
   - Implementing multisectoral interventions in identified hotspots including strengthening of surveillance system, implementation of long-term sustainable WASH solutions, health system strengthening, large scale use of OCV, community engagement and strengthening of cross governorate/districts collaboration.

3. **An effective mechanism of coordination for technical support, resource mobilization and partnership at local, regional, and global levels**
   The country-level coordination will be built on:
   Development of a multi-year national cholera control plan (NCP). The National Cholera Program will work at the operational level and will include representation from each of the different ministries, agencies, and partners involved in cholera-control efforts. The structure of the National Cholera Program will be tailored according to Yemen's specific needs and conditions.

YEHCP supports sustaining the existing DTCs and ORCs and equipping them with necessary medications, supplies and consumables. Supplies will also be pre-positioned as needed. In addition, as part of the preparedness plan, contingency stocks will also be prepositioned in priority Governorates/Districts that are at high risk of cholera. Furthermore, while YEHCP may continue to support the per diem and transportation cost of health RRTs at the district and governorate levels to verify, investigate, and respond to outbreaks, it will do so as it concentrates on the capacity building of those at the governorate level. In this approach, the supported response will be more likely evidence-based and driven by teams of highly technical experts, eventually at the governorate level, which is a generally more globally accepted model of rapid response teams. Moreover, this approach not only aims to add depth to the technical programs and teams but also addresses long-term sustainability of outbreak response and surveillance teams in the country. Procurement of lab supplies and capacity building to lab staff will be supported to ensure rapid diagnostics capacity is available and is strengthened for early detection and confirmation of outbreaks.

Building on the previous experience supporting cholera management at the health facility level, it is clear that the area of clinical case management and treatment must continue to be strengthened. However, it is important to note that WHO is not a direct clinical care provider. Through the YEHCP, WHO aims to continue supporting the existing DTCs and ORCs, and augment cholera response activities of other locations, as needed. As with all other cholera support, WHO's case management will be guided by clinical evidence, with the determination of support to be in line with the local response capacity, epidemiological situation, and needs assessment.

Electronic Integrated Disease Early Warning System (eIDEWS) and Rapid Response Teams (RRTs)

Since the beginning of the war in March 2015, the routine national disease surveillance system (paper-based system) became increasingly dysfunctional and eventually collapsed triggering an urgent need to gradually integrate all the surveillance systems within eDEWS. In response to the need for electronic expansion of the existing public health surveillance system and improving the speed and efficiency of data collection, analysis, and public health response, WHO in collaboration with MoPHP has scaled up the system with sentinel sites expanded from 400 health facilities in 16 governorates in 2015 to 1,991 health facilities in all Yemen's 333 districts by the end of 2020. These sites are electronically reporting on 28 different highly pathogenic diseases such as cholera, dengue, viral hemorrhagic fever, measles, diphtheria, pertussis, and acute flaccid paralysis.

eIDEWS collects data from health facilities which is directly implemented by MoPHP at various levels (health facility, district, governorate, and central levels) with the close support of WHO. The aim of the eIDEWS is to reduce morbidity and mortality through early detection and rapid response to disease outbreaks. The eIDEWS generates alerts, which flags the need for epidemiological investigations to take place in affected districts within Yemen. In this regard, WHO in coordination with MoPHP supported several public health interventions to strengthen the health system; establishment of rapid response teams (RRTs) at central, governorate and district levels to ensure appropriate and timely verification and investigation to contain any potential outbreak. The combination of the eIDEWS and the RRTs at all levels has allowed for reporting, verification, and investigation of notifiable diseases in a timely manner that is also shared among health partners and other stakeholders for preparedness, prevention, and response.

After the collapse of the routine national disease surveillance systems and the full integration within eIDEWS; eIDEWS remains the only system that provides regular data on communicable diseases in Yemen.
To enhance the current electronic disease surveillance tool (eIDEWS), WHO is supporting the upgrade of the reporting platform to permit the systematic and automatized collection, analysis and reporting of surveillance data, with the capacity to manage individual case data during outbreaks and to integrate laboratory data, as well as other tools such as mapping, SMS alerts and mobile phone reporting.

WHO is technically and financially supporting the operationalization of the surveillance system in coordination with MoPHP. WHO covers the operational budget and field visits per-diem of the eIDEWS focal points to enable verification, investigation and response to epidemic-prone diseases. In addition, WHO in coordination with MoPHP provided capacity building to 4,610 eIDEWS focal points and RRT staff at all levels. To facilitate secure automatic electronic transmission and analysis of data and dissemination of information to main stakeholders, WHO equipped eIDEWS focal points and RRTs at various levels with one of the following electronic devices (mobile phones, tablets…) utilizing existing IT infrastructure and communication means. Other means of technical support provided to the surveillance system are the standardization, development and dissemination of notification and investigation forms and line list logbooks to the health facilities and district, governorate, and central levels.

eIDEWS team plays an important role in reviewing and verifying the data received from the system on a weekly basis and follows-up with MoPHP on the immediate notifications (alerts) ensuring that RRTs are deployed and accordingly findings are shared with WHO concerned units and programs and health cluster. In addition, the team monitors system performance indicators (completeness, timelines, etc.) to ensure the functionality of the system.
Under the support of the YEHCP, eIDEWS sites will expand from 1,991 HFs to 2,379 HFs, please see the eIDEWS HFs expansion plan in annex 14.

The team is targeted to respond within 24-48hrs of receiving the notification and response time depends on the distance and the accessibility to targeted areas. Some of the RRTs expected tasks during outbreak investigation and confirmation are as following:

- Collect relevant samples from suspected cases;
- Gather evidence about the cause;
- Verify
  diagnosis/identify cases using standard case definitions;
- Implement quick response such as managing cases
  based on approved protocols, referral to the nearest treatment center, provide health awareness and hygiene sessions; and
- Prepare a detailed report of the investigation findings/ response to the next level (governorate, district, central and WASH RRT).

The constituency of district RRT members are:

- Surveillance officer (team leader).
- Head of the district health office.
- Clinician.
- Health promotor.

Laboratory technician.

WHO Capacity Building Activities Under Subcomponents 1.3 and 1.4

In line with the YEHCP continuous efforts to build capacity of HWs and efforts to reduce morbidity and mortality through improving the quality of services, WHO, through the YEHCP supports the training of various programs in different Governorates all over the country. The types of training covered by the YEHCP are those covered under each component and accordingly covers, but is not limited to, the following aspects as some topics will be included based on the needs observed from the field:

- Hospital Care and Management training
  The aim of this training program is to build the capacity, enhance the knowledge and skills of hospital managers, hospital senior staff, GHOs and DHOs in the areas of
    1. Leadership, governance, strategic planning.
    2. Healthcare quality and safety.
    3. Information systems management.
    4. Supply chain management.
    5. Disaster/emergency preparedness and response.

- Nutrition SAM Management
    - Foundation training: at the start of the TFC operation or change of HCWs; this training on the case management of SAM with medical complications.
    - Refresher training: at least one refresher training per year for all TFCs HCWs.
    - On-the-job training: based on the feedback from the TFCs' regular technical monitoring system, any TFC with low-performance rate, will receive an on-the-job mentoring visit from one of the master trainers in TFCs for 3 working days.

- Nutrition Surveillance
    - Foundation training for new NSS: at the start of the NSS activity where HCWs are trained on anthropometric and health measurement to collect health and nutrition indicators.
    - Refresher training for ongoing NSS: at least one refresher training per year for all HCWs at ongoing NSS.
    - TOT training for NSS governorates focal points: where they trained to be able to supervise NSS activities, revise collecting data on regular basis, feedback to HCWs and DHOs and provide on job training to HCWs during their field visits.
    - Anthropometric measurement training: this training will target HCWs and focal points in other health programs where nutrition indicators will be integrated such as EPI, RH and IMCI to build their capacity on correct anthropometric measurement and improve their reporting skills for collecting indicators.
    - Community Surveillance component training: the training will target GHOs, DHOs and HCWs in specifically selected districts where community surveillance activities will be implemented.
    - Institutional capacity-building for data quality assurance towards enhancing data utilization.

- Disease Surveillance and Outbreak Response (RRTs and eIDEWS):
    - Refresher training reporting through the system at each level including weekly, immediately and line list reporting.

- Verification and validation of data at various levels.
- System performance indicators (completeness, timeliness, alerts, 24 hrs verification, 48-72hrs investigation, etc.)
- Case definitions, alert and epidemic thresholds.
- Principles of outbreak investigation and response.
- Data management and feedback.
- Revision of main outbreaks/alerts reported through the system and lessons learned.
- Revised list of diseases/conditions under surveillance.
- SOPs eIDEWS upgraded system.
- Field Epidemiology Training Programme (FETP): empowerment course and intermediate course

- Case Management (Cholera) (as needed in response to any spike in cholera cases)
  - Conducting refresher training for already trained HCWs in DTCs during previous case management training rounds [374 DTCs were targeted for case management training in 2019-2020 which included 327 DTCs from northern governorates (13 governorates and 263 districts) and 47 DTCs from southern governorates (11 governorates and 41 districts). 3 physicians, 3 nurses and 1 director were trained per DTC. A total of 2,695 HCWs were trained]
  - The target for refresher training will be to reach at least 60% of HCWs already trained (1,617). The refresher training will be planned in a phasic manner starting from highest priority to lowest priority districts in 374 DTCs from northern and southern governorates from January 2022 through June 2023.
  - Conducting new training rounds for HCWs who were not trained during previous case management training and targeting 2 physicians, 4 nurses, 1 IPC health worker and 1 director per DTC (8 participants per DTC).
  - The target for new training rounds will be to train at least 60% of new HCWs not previously trained (1,800). The new training will be planned in a phasic manner starting from highest priority to lowest priority districts in 374 DTCs from northern and southern governorates from January 2022 through June 2023 and will be subject to epidemiological and security situation of the country.
  - The total target for both refresher and new training from Jan 2022 through June 2023 will be to train at least 3,417 HCWs.

- National centers for public health laboratories
  - Training on specific technical skills for diagnosis of infectious diseases including bacterial culture and susceptibility testing, ELISAs, and other techniques.
  - Training on good laboratory practices and laboratory quality management system.
  - Training infectious substance shipping.

- National Blood Transfusion Centers (NBTC)
  - Training on quality management system as relates to blood safety program.
  - Training on blood component separation and storage.
  - Training on the management of blood transfusion services.

- Vaccine-Preventable Disease Surveillance (measles, rubella, rota, meningitis, etc.)
  - Training of vaccination teams and their supervisors for various Supplementary Immunization Activities (SIAs) related to polio, measles, COVID-19, diphtheria and cholera.

- Vector Control: YEHCP will focus on building the national capacity at the district level to improve the knowledge and skills of malaria unit technicians on vector collection, classification, identification, estimating the abundance of vectors in the affected areas, identifying vector resting and biting behaviors, estimating the current risk and risk of spreads of epidemic into other geographical areas.
  To enhance the community participation in an integrated vector control management, the project will be promoting the use of the "Malaria Guide Manual for Providers of Community Health Education awareness for the Yemeni Family". The manual contains a guide for the local health authorities, HCWs, NGOs, and leaders/planners of other developmental sectors on how to involve malaria/dengue control and prevention in their plans and intervention at the community level. YEHCP will expand malaria/dengue case management training to health workers in both public and private sectors as well as train the community health volunteers on the provision of integrated community case management to increase access to malaria diagnosis and treatment in remote and hard to reach areas.

- Social and Environment safeguards: for adequate implementation of the Project Environmental and Social requirements the below training topics will be covered to enhance the overall knowledge of the Project workers:
  - COVID-19 Infection Prevention and Control Recommendations.
  - Grievance mechanisms for workers and communities.
  - GBV, including Code of conduct to prevent GBV and SEA.
  - Occupational Health and Safety (OHS) requirements.
  - Stakeholders engagement Principles and community health and safety.
  - Labor Management Procedures Requirements and Implementation.

- Quality of Care:
  - Quality of care concepts, dimensions, significance and requirements for quality improvement, national quality improvement program, guides, tools.
  - Facility organograms.
  - Initiating quality programmes/activities and forming/activating quality committees and teams.
  - Strategic planning.
  - Roles and responsibilities of each staff at the hospital/preparing the job descriptions/ToR.
  - Quality of care critical standards and how to prepare them e.g. leadership and management, training and staffing, service delivery, infection, prevention and control, medications management and equipment, information management, infrastructure, and patients' rights and participation, childbirth guidelines and checklist, surgical safety, clinical guidelines and procedures, patient satisfaction and hospital staff satisfaction, referral mechanism, health information system.
  - Quality of care performance indicators.
  - The international patient safety goals.
  - Quality policies and procedures, for example, policies and policies related to: Infection, Prevention and control including WASH, patients' identification, surgical safety, childbirth guidelines and checklist, medication management system policies and procedures, clinical guidelines and procedures, patient satisfaction and hospitals' staff satisfaction, informed consent, patients' rights, communication, human resources and hiring, referral mechanism, health information system, etc.

- **Climate change awareness:** to contribute towards increasing the understanding of climate change issues and factors, climate change awareness will be included in all project supported training sessions as part of the overall environmental and social awareness. The below aspects will be covered:
    - Environmental factors contributing to the climate change.
    - Communities and individuals roles in reducing the environmental footprints.
    - Resources efficiency and sustainable environment.
    - Waste, energy and water reduction factors.
    - Waste management principles including the reduce, reuse and recycling methods.

A Mechanism was developed to monitor the mentioned training through WHO internal monitoring and evaluation team and/or the TPM.

Subcomponent 1.5: Health System Strengthening

To continue building individual and institutional capacities, the proposed AF will support better health information systems. As part of the new activities introduced under the AF, are the quality-of-care improvements, and enhanced project and public financial management for the health sector. For quality of care, WHO will use the indicator framework developed under EHCP to strengthen capacities at the facility level via training and performance monitoring, including supportive supervision. Learning from WHO experience, UNICEF will improve quality of care at PHC level using the same approach with adaptation of appropriate interventions at this level mainly using available General Practitioners at Health Centers to conduct clinical mentoring. For public financial management, WHO will support a needs assessment and subsequent rollout of training for health workers. With the Harmonized Approach to Cash Transfer (HACT), UNICEF conducts micro-assessment for all its implementing partners on their financial management capacities and capacity enhancement done where gaps have been identified. For all EHCP implementing partners, especially with the ministries of public health and populations including GHOs, capacity building on financial management will be done.

Currently, there are over 2,000 health facilities (all levels) in the northern governorates reporting through DHIS2. Under the proposed AF, a new activity being supported is the roll out of the DHIS2. UNICEF and WHO will roll out DHIS2 in Yemen to additional governorates, based on global WHO metadata packages to ensure data comparability across countries. UNICEF and WHO will work together on capacity-building and ensuring coherence across DHIS2 platforms used in Yemen. The packages will include different modules, such as reproductive, maternal, neonatal, child, adolescent health, immunization, nutrition, and COVID-19 vaccine delivery. Based on an assessment conducted by WHO in the southern governorates and lessons from UNICEF-led implementation in the northern governorates, WHO and UNICEF will support the MoPHP in developing policy and guidelines, training, data quality and DHIS2 infrastructure.

Under the AF, another new activity being supported is the Multiple Indicator Cluster Survey (MICS). Yemen has not conducted a comprehensive, nationally-representative household survey since the war began in 2015. The last MICS was conducted in 2006. Generating more current data is very critical in Yemen. There is a need to mainstream development approaches to the current humanitarian response in order to ensure long term development for the people. Rapid assessments and Humanitarian Plan Monitoring (HPM) do not meet the needs of sustainable development. A multi-sectoral nation-wide household survey, such as MICS, is required to provide the much-needed data for planning, monitoring and reporting on development programs and

policies necessary for reconstruction and recovery. UNICEF has been working with authorities over the years to conduct MICS which will provide current information on key indicators on health and nutrition, including how climate change is expected to impact on future trends and needs. The AF will support UNICEF on data collection, analysis and dissemination of findings in collaboration with WHO before the end of 2022. Lessons learned from the MICS 2022 will be used to inform development of Yemen's next DHS in future.

Component 2: Improving Access to Water Supply and Sanitation (WSS) and Strengthening Local Systems

This component aims to support the provision of WSS services for the population of Yemen through rehabilitation of medium to large WSS infrastructure, prevention and response to communicable diseases and strengthening the capacity building of the local water and sanitation institutions at decentralized level. It will help preserve and strengthen the WSS system through supporting, inter alia, procurement and contract management, low carbon and climate resilient infrastructure, technical design, asset management, O&M of WSS facilities for medium and long term, information management, safeguard and leadership capacities of local water and sanitation institutions.

To this extend, activities will cover rehabilitation of WSS infrastructure, basic supplies such as water and fuel, equipment, maintenance, water trucking, WASH consumables and kits (e.g. iodine tablets, menstrual products for women, soap for health facilities and schools, alcohol-based hand rubs, etc.), training, travel cost (per diem and transportation, if needed), for key staff of WSLCs at the decentralized levels and minor rehabilitation of existing WASH facilities in key selected health centers and schools based on clear criteria including integration with other sectors' rehabilitation needs specifically health.

The design of these activities is consistent with the Yemen WASH Poverty Diagnostic Study published by the World Bank Water and Poverty Global Practices (June 2017), Damage Assessment Study conducted by GIZ (2018), Sanitation Services Chain Mapping of Sana'a and Aden, Yemen (2020), and the DNA of the World Bank (2020). The design builds on results achieved and lessons learned from YEHNP, YIUSEP-I and other Bank-financed projects in Yemen and from Bank engagements in emergency health and nutrition and WSS operations in other fragility, conflict and violence (FCV) countries.

UNOPS is the main implementation agency and responsible for the WASH component management and supervision. UNOPS will work with the autonomous national institutions Urban Water – Project Management Unit (UW-PMU in Sana'a and Aden) and Public Works Projects (PWP), local institutions including: WSLCs, their branches, AUs and branches of GARWSP that are key implementing partners based on signed project partnership agreements (following satisfactory detailed capacity micro-assessment carried out by UNOPS). UNOPS' main responsibilities are: (i) implementing the WASH component to achieve its objectives:

1. implementing the WASH component – 2 to achieve its objectives.
2. Consultation, Coordinating and collaborating with national and local institutions in terms of needs, priorities, implementation, supervisions and O&M to ensure the sustainability of services and investment.
3. Contracting the private sector to implement interventions. For the implementation of WASH activities, UNOPS will work with qualified contractors / private sector with an established track record in the implementation of WSS interventions under YEHCP.

UNOPS will ensure having and supervising a 12-month Defect Notification Period (DNP) for all implemented WSS sub-projects (works, parts and equipment).

Table 11: Component 2 per Implementing Agency and Cost

Component 2: Improving Access to Water Supply and Sanitation (WSS) and Strengthening Local Systems	Agency	Cost (US$ millions)
Subcomponent 2.1: Restoring Access and Improving Quality to WSS Services in Selected Urban and Rural Areas	**UNOPS**	**21.51**
Subcomponent 2.2: Emergency Support for WASH Interventions in Response to COVID-19 Pandemic and Flash Floods	**UNOPS**	**4.37**
Subcomponent 2.3: Enhanced Capacity Building of Water and Sanitation Institutions at the Local Level	**UNOPS**	**0.35**
Total		**52.48**

Under AF, the WASH component will continue to support the same interventions with more focus on rehabilitation of WSS facilities, including networks, water wells, boosters and pumps station, etc. and development and utilization of solar panel, emergency support to the functionality of WSS system and health facilities. The AF will fill a financing gap to support emergency provision of fuel, water trucking, key activities under the exit strategies from fuel provision and water trucking as well as strengthening the capacity of local institutions. The Fuel Exit strategy will cover solarization of water and sanitation facilities, intervention's related to reducing water losses, supply and installation of water meters, supply and installation of fuel meters, rainwater harvesting system etc. The water trucking exit strategy will include connecting Health Facilities to more sustainable sources such as public water networks, water well, rehabilitation of water wells etc. In addition, the capacity building will be expanded to cover additional local institutions in rural, peri-urban and urban areas that are not covered under YIUSEP-II + AF.

Subcomponent 2.1: Restoring Access and Improving Quality to WSS Services in Selected Urban and Rural Areas

This subcomponent aims to restore access and improve the quality of WSS services at a decentralized level. It will be implemented by UNOPS in partnership with autonomous national and local water and sanitation institutions e.g., UW-PMU, PWP, respective WSLCs in selected priority urban and peri-urban areas (that have WWTPs), and local branches of the GARWSP in selected rural areas based on clear and transparent selection criteria. Given the strong linkage between the level of water and sanitation services and environmental and health issues, this subcomponent will focus on restoring access to improved water and sanitation services, with particular emphasis on priority sanitation needs, by investing in related urgent areas (i.e., rehabilitation and scaling up of medium to large scale facilities including rehabilitation of water and sanitation infrastructure, main water and sewerage pipelines and networks, water treatment plants (WTPs), WWTPs, water wells, pumping and booster stations, related civil works of building and structures, etc.) to improve service provision. The closing date of YEHCP is June 30, 2025 to allow sufficient time for completing the activities and reconciling accounts by the implementing agencies. This also includes a 12-month Defect Notification Period (DNP) for works activities, parts and equipment.

Despite the component will continue financing fuel for WSS facilities, this subcomponent will improve energy efficiency as an exit strategy by supporting the operation of main water and wastewater facilities by providing efficient electro-mechanical equipment (e.g., submersible motor, control panel, transformers, electrical diesel generator as per the international standards (i.e. low carbon emission and real time control), etc.) and alternative sustainable energy solutions, in particular, solar panels to provide a clean, cost effective, and reliable power source for disadvantaged areas.The subcomponent will help monitor the quality of water and sanitation services through rehabilitation of public laboratories for water and wastewater quality testing and enhancing and strengthening the operational capacities of the WSLCs and their branches, AUs, branches of NWSA and GARWSP in the target areas in the delivery of safe water and sanitation services (e.g., installing small decentralized WWTPs on a pilot basis, purchase and use electrical generators; purchase, installation and storage of O&M materials such as; spare parts, measuring devices, manholes, sewage maintenance vehicles, machines, tools, laboratory equipment and consumable supplies. In addition, this subcomponent will support the operation of main water and wastewater facilities by providing electrical materials (e.g. submersible motor and control panel, transformers, etc.) and alternative sustainable energy solutions, in particular, solar panels to provide a clean, cost effective, and reliable energy source for disadvantaged areas.

Subcomponent 2.2: Emergency Support for WASH Interventions in Response to COVID-19 Pandemic and Flash Floods

This subcomponent aims to strengthen Yemen's readiness and capacity to prevent and respond to communicable diseases, caused by natural disasters and/or exacerbated by poor sanitation and hygiene, through interventions at decentralized levels based on transparent selection criteria that include vulnerability to climate change and will be implemented by UNOPS in partnership with the autonomous national and local institutions (UW-PMU, PWP), respective WSLCs and their branches, AUs and branches of NWSA and GARWSP to improve their readiness and capacities to respond to communicable diseases (e.g., cholera) exacerbated by poor sanitation and hygiene.
This subcomponent will focus also on WASH rehabilitation in health facilities (HFs) and schools ensuring complementarities with the completed works under EHNP (494 HFs and 118 schools) and considered under the ongoing Education project (REAL). WASH rehabilitation of selected health facilities and schools will be conducted based on clear and transparent criteria and planned integration. Furthermore, this subcomponent will consider a combination of sewerage network and non-network solutions whenever possible to ensure maximizing the impact and would, among others, adopt the prioritization tools developed under the Bank's City-Wide Inclusive Sanitation (CWIS)[1]. Given the persistent challenges on the ground, AF will focus on the following:

Emergency Fuel Provisions

Fuel supply (mainly diesel) has become a critical activity to ensure functionality of wastewater treatment plants (WWTPs) and water supply facilities. Fuel supply is required to ensure continuity of safe WSS services under 37 WSLCs in 15 governorates, essential for minimizing vulnerability to waterborne and other related diseases. About 30 solar energy solutions (or up to 7,500 kw) will be used to reduce usage of fuel as part of the existing strategies. UNOPS will coordinate with UNICEF and other implementing partners and donors to ensure that the AF continues to support fuel provisions only when there are emergency needs, no available fund from other donors and well-developed exit strategies are prepared and adopted in which Subcomponent (2.2) can fund the fuel provisions while implementing the adopted exit strategies. UNOPS will review and update the Fuel Exit Strategy prepared under the EHNP, based on detailed consultations with stakeholders taking into

consideration sensitivity of the interventions and limitations of the available funding to implement both interventions at the same time. The Fuel Exit Strategy that may include supply and installation of solar systems, connecting the pumping stations, water wells, sanitation system, WWTPs to main electricity grid lines whenever possible, reduce water losses as well as improving the operation and revenue's collections of WSLCs. On fuel delivery, UNOPS will ensure close coordination with WFP and will use its own logistical capacity based on the detailed assessment. TPM verification has to be carried out at the supply site and throughout the supply and usage chains and link that with the provided WSS services. The operational costs also include per diem and transportation costs for the key technical staff of PMUs and WSLCs; supply of equipment and spare parts; and rehabilitation of water and sanitation facilities as needed.

Emergency water trucking

Access to clean water for health facilities (HFs) is critical, and an emergency water trucking will be supported to selected health facilities. Although an Exit Strategy from water trucking has been initiated under the EHNP, out of 47 health facilities that have been supported under the EHNP, 35 health facilities are still relying on water trucking. Twelve health facilities have been connected to more sustainable Local Water and Sanitation Corporation (LWSC) sources. Additional health facilities, supported under Component 1, will be identified which have the potential to be connected to more sustainable water source of public networks. UNOPS will review and update the Exit Strategy from water trucking based on detailed consultations with stakeholders, emergency needs, and availability of funding to carry out the water trucking while implementing the Exit Strategy. The Exit Strategy may include connecting health facilities to more sustainable sources such as public water networks, functional water wells, and rehabilitation of wells within the targeted health facility. While water trucking to health facilities and IDP camps will be provided, water quality will be monitored at water sources, distribution points, tanker trucks, and household levels through testing water quality for public and private providers. UNOPS will be engaged with qualified private water trucking suppliers to ensure supply of the urgent and required water to the needed health facilities and Diarrhea Treatment Centers, supported under Component 1.

UNOPS will update the Exit Strategies for fuel and water tracking implemented under the EHNP and ensure implementation of all possible sustainable alternatives. Implementation of the Exit Strategies will be reviewed and assessed periodically to ensure gradual shift toward more low-carbon and sustainable solutions.

[1] The Urban Sanitation Rapid Assessment tool is designed to guide task teams and their government counterparts to understand the sanitation context of the city. CWIS's tools are free-to-use, open-database online tool which allows planners to compare the capital and running costs of different types of sanitation solutions along the whole sanitation service chain at the component, system, and city levels – for both sewered and onsite interventions

Subcomponent 2.3: Enhanced Capacity Building of Water and Sanitation Institutions at the Local Level

This subcomponent aims to strengthen the resiliency of key local WSS institutions at a decentralized level. Because the capacity building for the local institutions in urban areas will be covered under the Yemen Integrated Urban Services Emergency Project (YIUSEP-II) implemented by UNOPS, this subcomponent will mainly target strengthening the capacity of local institutions in selected peri-urban, rural areas and WSLCs in urban cities and their branches in peri-urban areas that are not covered under YIUSEP-II. This includes training

on technical and non-project-related aspects (including planning around when it is most convenient for women to join) to support the local institutions to assume their service delivery mandate more effectively beyond the boundaries of the project. The support may include provision of per diem to key staff if needed based on clear terms of reference (ToR) with associated deliverables and clear timelines. Support will build medium and long-term capacity at the local level and cover topics including procurement and contract management, social and environmental standards, low carbon and climate resilient infrastructure, technical design, asset management, grievance redress and gender-sensitive citizen engagement, building WSLCs capacity on gender parity in recruitment, the advantages of gender diversity in the workplace, etc., and other critical needs which may be identified. This subcomponent will take in consideration the findings and recommendations of the capacity assessment carried out by WB for UW-PMU and Sana'a and Aden Local Water and Sanitation Corporations and ensure coordination with implementing partners including GIZ.

Defects Notification Period (DNP):

Project's activities involving works (i.e. construction, rehabilitation, repairs, and installation) will be subject to UNOPS quality assurance and HSSE requirements; including the Defects Notification Period (DNP), which is the 12-month period between handover and final certificate for completion of the works. Sufficient time will be included in the project work plan to account for DNP and any close-out processes till DNP completion. Final completion occurs when the DNP has come to an end and all defects notified to the contractor have been addressed.

EXCLUSIONS.

UNOPS shall exclude the following type of activities as ineligible for financing under the Project:

1. Activities that may cause long term, permanent and/or irreversible adverse impacts (e.g., loss of major natural habitat).
2. New constructions or expansions that may involve permanent resettlement or land acquisition or adverse impacts on cultural heritage.
3. Activities that have a high probability of causing serious adverse effects to human health and/or the environment not related to treatment of COVID-19 cases.
4. Activities that may have significant adverse social impacts and may give rise to significant social conflict.
5. Activities that may adversely affect lands or rights of vulnerable minorities.
6. Activities that might involve significant impacts on biodiversity or living natural resources.
7. Activities that might have a significant impact on tangible or intangible cultural heritage.

Any other excluded activities offset out in the ESMF of the project.

Component 3: Project Support, Management, Evaluation and Administration

The Activities that fall under this component are as follows: Project Management; Project Administration; Grant Management; Project Reporting/Results Framework; Monitoring and Evaluation; Assistance to the Project; and Communication Management.

Table 12: Cost of Component 3

Component 3: Project Support, Management, Evaluation and Administration	US$ millions		
Component 3: Project Support, Management, Evaluation and Administration	Parent	Additional	Total
Indirect Cost	7.14	7.14	14.28
Project Staff and Personnel	11.67	11.67	23.34
TPM and Evaluation			
Direct Costs			
Technical Assistance			
Total	**18.81**	**18.81**	**37.62**

This component supports project administration and monitoring and evaluation activities to ensure smooth and satisfactory project implementation. For project administration, the component finances general management support for WHO, UNICEF and UNOPS. The staff supported by the project funds shall be fully dedicated to the project activities. The staffing of the project task teams shall strike a balance between safeguarding the interventions through international staff while ensuring operational sustainability through locally hired staff.

The largest component of the monitoring support consists of UNICEF, WHO and UNOPS hiring TPM agency/ies. The terms of reference (TOR) for TPM are attached as annex 28, 309 and ……. and are updated regularly throughout the project as the needs evolve.

UNICEF, WHO and UNOPS will perform project core management and implementation support activities through their multidisciplinary teams located in their offices in Sana'a and satellite offices all over Yemen and support hubs in Djibouti, Dubai and Amman. This will be achieved through the following:

1) Monitor the project targets and evaluate the program results in coordination with the existing local health and WASH workforce.
2) Handle procurement, financial, and disbursement management, including the preparation of withdrawal applications under the project (as noted in the Project Appraisal Document(PAD)).
3) Ensure that audits of the project activities are carried out.
4) Ensure that all reporting requirements for IDA are met according to the Financing Agreements.

The field supervision and program evaluation activities will be supported by the combination of existing resources and systems of organizations and supplemented by the project funds. The project will fund monitoring and evaluation activities to measure results and to extract lessons and recommendations for future interventions.

CERC: UNOPS shall.

1. Prepare an annex to the ESMF when the CERC is triggered, if activities to be financed under the CERC go beyond activities covered under the approved updated ESMF.
2. Ensure that the CERC Operation Manual includes a description of the ESHS assessment and management arrangements including CERC-ESMF. Addendum that has been included or referred to in the CERC Operation Manual for the implementation of Component 4 of the Project (CERC Part), in accordance with the ESSs.

3. Prepare, consult, disclose, and adopt any environmental and social (E&S) management plans or instruments which may be required for activities under Component 4 of the Project, in accordance with the CERC Operation Manual and, CERC-ESMF Addendum and the ESSs, and thereafter implement the measures and actions required under said E&S management plans or instruments, within the timeframes specified in said E&S management plans or instruments.

TECHNICAL ASSISTANCE: UNOPS shall ensure that the consultancies, studies, capacity building, training, and any other technical assistance provided under Component 2 and 3 of the Project is undertaken pursuant to terms of reference (ToRs) reviewed and approved by the Association, incorporating the relevant requirements of the ESSs.

LABOR MANAGEMENT PROCEDURES. UNOPS shall:

1. Adopt and implement the updated Labor Management Procedures (LMP) in coordination with the implementing partners. The Project shall carry out activities in accordance with the updated LMP and the applicable requirements of ESS2 , including through, inter alia, implementing adequate occupational health and safety (OHS) measures (including emergency preparedness and response measures), prohibiting employment of persons under 18 years of age), setting out grievance mechanism arrangements for Project workers, and incorporating labor requirements into the ESHS specifications of the procurement documents and contracts with contractors and supervising firms.
2. Cause its implementing partners to ensure that all Project workers sign a code of conduct (CoC) to uphold ethical standards and comply with relevant E&S obligations and national legislation, prior to carrying out activities under the Project AF, all in accordance with ESS2.

Staffing

The project is run by a PMU in each organization. These teams have been assigned to have an oversight on all activities supported by the project by each organization. The members of the team have been agreed with the World Bank to be fully dedicated to the work of the project.

Implementing agencies will establish a PMU to carry out key functions including coordination, technical design and oversight, fiduciary, monitoring and evaluation, and reporting. The YEHCP-PMU will be responsible for day-to-day coordination of the Project activities, including:

- Carrying out Project financial management and procurement activities.
- Monitoring and evaluating project activities and preparing Project progress reports and monitoring and evaluation reports.
- Ensuring compliance with the Environmental and Social Commitment Plan (“ESCP”) requirements and environmental and social instruments referred to therein.
- Coordinating with other stakeholders on Project implementation.
- Issuing Project Award Task Expenditure Type Organization (PATEO) for approved activity as per the work plan.

In addition to these staff required for the full duration of the project, the Project may hire other technical consultants for a limited duration based on specific needs (International and/or national experts hired on a short-term basis). In addition, several other staff will contribute to project implementation who will also be supported financially by the project.

Table 13: UNICEF PMU Structure

No	Position Title	Qty
1	Project Manager	1
2	Budget Officer	1
3	Health and Nutrition Specialist (Grants Management and Reporting)	1
4	Health and Nutrition officer	1
5	Program Officer: Supplies and logistics (H&N)	1
6	Environmental and Social Safeguards Specialist	1
7	Communications specialist	1
8	Programme Assistant (Health)	1
9	Program Officer: Monitoring and Data Management	1
10	Sub-Total Project Management	10

Table 14: WHO PMU Structure

No	Position Title	Qty
1	Project Manager (Public Health Officer)	1
2	Project Management Officer	1
3	Health & Knowledge ManagemenOfficer	1
4	Supply Chain Management Officer	1
5	Grant Management Officer	1
6	M&E Officer	1
7	Environmental Safeguards Officer	1
8	Social Safeguards Officer	1

9	Grievance Redress Mechanism Officer	1
10	Environmental Health Officer	2
11	Technical Officers	2
12	GBV Officer	1
13	Communication & Visibility Officer	1
14	Team Assistants	3
	Total	**18**

Table 15: UNOPS PMU Structure

No	Position Title	Qty
1	Programme Manager	1
2	Project Management Officer/ WASH Specialist	1
3	Procurement Specialist	1
4	Finance Specialist	1
5	Field Security Advisor	1
6	Procurement Officer	1
7	Finance Officer	2
8	Social & Environmental Safeguards Officer	1
9	M&E Officer	1
10	Gender Mainstreaming Officer	1
11	Communication & Visibility Officer	1
12	IT Officer	1
13	Procurement Associate	1
14	Grievance Mechanism Associate	1
15	City Engineer	4
	Total	**19**

Monitoring and Evaluation Arrangements

Overview of TPM in UNICEF Yemen Country Office

In the context of UNICEF Yemen, TPM is a monitoring approach that is largely used as a result of the humanitarian crisis that began in 2015. This humanitarian situation restricts UNICEF Yemen Country Office (YCO) staff to access certain geographical locations. Additionally, the magnitude of the humanitarian response and the need for specialized monitoring expertise in some projects has necessitated the use of TPM in YCO. TPM is contracted under a Special Service Agreement (SSA), or Long-Term institutional Agreement (LTA). In some instances, donors have their own TPM service provider/ consultant to monitor UNICEF projects that they fund.[19] Third Party Monitoring LTAs and contracts are managed through UNICEF Yemen's Program Monitoring and Evaluation unit.

Principles of TPM in Yemen Country Office

In order for TPM to add value to UNICEF YCO program, the following five principles apply.

- Clear Purpose and Scope – Prior to initiation of any TPM process, the purpose and scope of the monitoring is made clear and is clearly explained to the TPM service provider.
- Timeliness – The core purpose of monitoring is course correction - identifying problems and suggesting alternative practical solutions for UNICEF programs, therefore monitoring is done in a timely manner to feed into decision making.
- Relevance – TPM concerns itself only with parameters which are relevant to program objectives
- Field Level Engagement - Effort is made to ensure participation and full engagement of UNICEF Field Offices throughout the TPM process.
- Resource Availability & Accessibility - The resources to be used for the monitoring are made available and accessible.

Scope of TPM:

In June 2019, YCO advertised LTAs widely across Yemen and Internationally to conduct TPM. After a thorough selection process, YCO has signed LTAs with 10 institutions. The validity of the LTAs is 2019 –2022, PMR are working now to extend the LTAs to 2023.
The LTAs signed with the 10 institutions cover the following objectives:

- Field Monitoring
- To verify assessments of progress received through other channels and sources, primarily partner reporting;
- To identify bottlenecks and barriers in implementation and provide UNICEF with the information needed to trigger solutions and corrective actions;
- Supply Monitoring – Monitoring of high value supplies procured by UNICEF and those procured using UNICEF-provided funds by implementing partners
- End User Monitoring - To provide an opportunity for beneficiaries to actively engage in sharing feedback on the quality and delivery of services, including implementation of program interventions to improve programming. This includes but is not limited to beneficiary satisfaction and voices as well as Sexual Exploitation and Abuse (SEA) risk identification and mitigation.

[19] *UNICEF Humanitarian Performance Monitoring Toolkit - Field Monitoring Guidance and Model Checklist - EMOPS, July 2012*

Monitoring of construction/ rehabilitation of schools and WASH facilities
Monitor construction/rehabilitation of schools across Yemen
Verify and monitor rehabilitation WASH facilities
Ensure that all UNICEF related construction work is monitored in a timely and effective manner
Research/Assessments – Collect data needed for UNICEF to carry out research studies/ assessments like smart surveys, market analysis, situation updates, Knowledge Attitudes and Practices survey, environmental and social safeguard, behavior indicators monitoring, consultations with targeted groups such as women and girls on project-related SEA risk and risk mitigation etc. as and when needed.

Types of TPM Activities

There are five main types of TPM possibilities or categories in Yemen country office as described below

1. Category 1: Project specific TPM - This is TPM requested by program sections. It is usually project specific with a time bound TOR and deliverables.
2. Category 2: HACT Assurance Plan Triggered TPM - This type of TPM is triggered by the HACT assurance plan and is predominantly programmatic visits.
3. Category 3: Donor Managed TPM- This is TPM requested and managed by donors. Any donor may request to conduct its own TPM for Projects/Grants which they fund.
4. Category 4: TPM requested by Program Monitoring and Evaluation as part of the Monitoring function - This type of TPM is that requested by PME. This is focused on specific issues such as Beneficiary voices or Data quality assessments.
5. Category 5: TPM requested ad hoc by Management or program sections – An example of this type of TPM is where management may request to see a Programmatic Visit report before signing an Note for the Record for an extension of a Program Document.

Where UNICEF engages third parties to conduct monitoring on its behalf, they are obliged to implement appropriate data security measures. UNICEF data, including intellectual property rights, are the exclusive property of UNICEF and the contracted TPM service provider has a limited, nonexclusive permission to access and use the data. As provided in the contract, the data will be used solely for the purpose of performing its obligations under the contract. The contractor has no other rights under the contract, whether express or implied, to any UNICEF data or its context. To maintain the integrity of stored data, TPM data should be protected from physical damage as well as from tampering, loss, or theft by limiting access to the data.

Data stored on paper, such as on data collection tools should be kept in a safe, secure location away from public access, e.g., a locked filing cabinet. Confidentiality and anonymity should be assured by replacing names and other personal information with encoded identifiers.
All data collected by TPMs on UNICEF’s behalf is the sole property of UNICEF. The TPM agency will hand over all data to UNICEF upon satisfactory completion of TPM deliverables and will destroy any other copies. In terms of disposal, the TPM data will be retained for a minimum of 3 months after UNICEF approval of the TPM report and data set. Paper documents will be shredded, and digitally stored information destroyed or securely overwritten. The TPM service provider will be expected to provide UNICEF with a letter confirming that the data has been disposed appropriately.

Data collection and use of data:

After the data collection conducted, UNICEF produces analytical reports and maintains an action tracker to follow the TPM findings. Based on the reports produced some corrective actions can be taken for program improvement through conducting some review meetings with implementing partners.

Capacity Building

All TPM service providers require adequate training and/or orientation by UNICEF.

UNICEF provides training for all TPM service providers so that they are able to apply the YCO-agreed guidance for TPM adequately including programmatic visits. Essentially, capacity is built in the following areas:

1. Data collection and preparation for site visits i.e. formalities on arrival on site; use of data collection templates and required methods; triangulating data and formulating substantiated conclusions and prioritized action points
2. Understanding of UNICEF's mandate and programmes
3. Humanitarian Policy & Principles
4. Roles and Responsibilities of Third-Party Monitors
5. Code of Conduct and Ethical Behaviour
6. Etools TPM Module
7. Prevention of Sexual Exploitation and Abuse (PSEA)
8. Reporting Lines and Administrative Issues.

TPM Performance Assessment

UNICEF YCO assesses the performance of TPM service providers every six months and at the end of the contract. A standard performance assessment form is used. Renewal of contracts is only accepted if the performance of the TPM service provider is evaluated as satisfactory. The performance assessment focuses on evaluating the following attributes:

Table 16: Performance Assessment Attributes

Attribute	Focus of Performance Assessment
Deliverables Achieved	Checks whether the deliverables outlined in the Terms of Reference have been timely met or are underway
Quality of work	Checks quality of deliverables as specified in the ToR, i.e. quality of PVs, quality of reports etc.
Technical skills	Checks whether TPM service provider deployed the right skill set for the assignment /PV as specified in the ToR
Value for Money (VfM)	Checks if the TPM services were delivered efficiently and effectively
Meeting time schedule	All deadlines established in the Terms of Reference have been met on time
Adherence to the code of conduct	Checks adherence to the code of conduct, ethical behavior, PSEA measures, and humanitarian principles
Overall performance rating	An overall performance rating is given as follows by each of the attributes ● Excellent

	● Very Good ● Satisfactory ● Requires Improvement ● Unsatisfactory

Based on the overall rating, a decision is made whether to re-engage the service provider again or not. All vendors with unsatisfactory rating are not re-engaged. The program sections as well as field offices are given a chance to review the performance evaluation and add their comments on the service providers performance. The overall rating takes into consideration all comments from PME, Programme sections and Field Offices.

Key objectives of the TPM for supported HFs

UNICEF will conduct TPM of supported primary health care facilities on a quarterly basis, as far as possible, throughout the project implementation period. The TPM will use a census coverage model, with all supported heath facilities monitored during every TPM round. UNICEF has committed to contract three TPM agencies for each round to jointly cover this activity from rounds six forward. This is necessary as a mitigation measure to avoid the risk of any one TPM agency gaining too much influence over the project, prevent the project from contributing to a monopoly in the local market for TPM expertise, and to improve the efficiency and speed of each TPM round.
The key objectives of the TPM of HFs interventions are to verify progress reports submitted by implementing partners to:

1. Assess appropriateness of UNICEF's related interventions to the needs of the affected populations under the YEHCP;
2. Assess the quality of services provided under YEHCP;
3. Identify gaps in delivery of services / implementation inputs (including supplies);
4. Identify any emerging issues related to the affected population which needs urgent attention by the project, and
5. Assess the outputs and the outcomes of the intervention.

The contracted TPM agencies will be expected to collect data from YEHCP UNICEF-supported primary health care facilities using a series of five data collection tools, as follows:

Table 17: Data Collection Tool Description

Tool	Description
HF	Collects data on: ● Inputs provided and their use (operational costs, health worker per diems) ● Services provided in the HFs with a focus on four key maternal and child health (MCH) services: EPI, IMCI, MNH, and CMAM
MSP	Collects data on MSP services other than the four key MCH services mentioned in the first tool, including non-communicable diseases, communicable diseases

	in adults, general services and trauma care, and mental health including psychosocial support (in selected facilities that offer the service)
Environment	Collects data on water, sanitation, hygiene, and medical waste management in the HF
Supplies	Monitoring of presence, storage, and tracking of supplies and equipment distributed within the monitoring period
Beneficiary Satisfaction	A combination of exit interviews with patients served in the HF on the day of the TPM visit, and home visits to patients served in the HF within the past month as identified through the registers. Approximately 15 beneficiaries to be surveyed per HF.

The complete data collection tools are included in annex 20 of this manual.
The TPM agencies are expected to submit the following deliverables:

1. A final report on YEHCP-supported facilities directly to the World Bank and to UNICEF
2. All raw data
3. Participate in review meetings with five UNICEF hub offices to present data and make recommendations
4. Participate in international project review meeting with UNICEF, donor, and other project partners

Table 18: UNICEF Planned TPM Reporting Schedule

TPM Rounds	Period covered	Desk review	Data collection	Submission report
TPM R1	Oct 2021 – ~~Nov~~ Mar202~~1~~2	~~Nov~~Jun, 2022	~~Dec~~ Jul– ~~Jan~~ Aug2022	~~Jan~~ Sep2022
TPM R2	~~Dec~~ Apr– ~~Feb~~ ~~Oct~~2022	~~Feb~~Oct, 2022	~~Mar~~ Dec22– Jan 2023	Feb 2023
TPM R3	Nov 2022 – Mar 2023	Apr, 2022	May 2023	Jun 2023
TPM R4	Mar - Jun 2023	Jul, 2023	Aug 2023	Sep 2023
TPM R5	Jul - Sep2023	Oct 2023	Nov 2023	Dec 2023

TPM Action Tracker

UNICEF ensures that all the actions resulting from the TPM findings, including feedback from UNICEF Field Offices and GHOs, are effectively documented and implemented. UNICEF keeps an action tracker for all the

red flags that are raised by TPM. The tracker includes corrective actions and follow up actions that will be taken by UNICEF and MoPHP/GHO.

Action tracker helps:

1. To increase efficiency in the follow-up processes after the TPM is conducted.
2. Easy user management due to controlled access rights to different program areas
3. Fast, real-time availability of information (reports and actions)
4. Ensures appropriate action required is taken to address the red flags raised by TPMAs

Overview of TPM in WHO Country Office

The YEHCP design has an independent monitoring mechanism where an independent TPM firm/s are contracted to ensure the implementation of the project as per the design specified in the PAD.

The M&E Officer who is a member of WHO PMU supervises the activities and the contracts of the TPM. The TPM conducts field visits to HFs to check the areas of interventions of the project and to report the findings later to WB and WHO to take corrective actions accordingly.

Scope of TPM:

The key objectives of the assignment are to verify interventions, activities supported, and progress reports submitted by implementing partners (and within this context WHO), with a focus on: The overall objective of contracting the TPM is to provide necessary technical expertise to monitor and validate the interventions of the YEHCP implemented by the WHO (at National, Governorate and District levels) and provide independent feedback and reporting on these interventions

- To verify / validate specific interventions reported by WHO under project;
- To identify gaps/deviations in the implementation of those interventions including delivery of supported supplies; and,
- To timely highlight any emerging issues related to the affected population, which needs urgent attention/actions by WHO.
- In coordination with WHO focal points, to support following-up on the progress of corrective measures to be taken by WHO in response to flagged issues timely raised up by TPM.
- When applicable, to assess the availability, readiness and quality of services provided in the main HFs under YEHCP.

The TPM is expected to:

- Access all sites/activities implemented by the project.
- Monitor implementation of the project.
- Report on implementation and complete the reporting cycle by reporting feedback and following up on corrective measures.

TPM Performance Assessment

WHO assesses the performance of the TPM with the end of each contract (6 months or 1 year). The forms use standard questions in this regard as following:

Table 19: Performance Assessment Attributes

A. *Supplier performance report / Contract compliance*	Yes	No	N/A*
1. Was the service delivery made in accordance with contractual timelines?	☒	☐	☐
2. Did the supplier deliver in conformity with Terms of Reference?	☒	☐	☐
3. Was the service delivered in compliance with the contractual terms and conditions?	☒	☐	☐
4. Has the supplier performed in accordance with any post-delivery service or support arrangements incorporated in the contract?	☒	☐	☐
5. Was the supplier receptive and responsive to queries during Service period?	☒	☐	☐
6. Has the supplier established and maintained collaborative relationships during the execution of the contract?	☒	☐	☐
7. Has the supplier been acting professionally and ethically all along the execution of the contract?	☒	☐	☐
8. Would you deal with the supplier again? If not, attach an explanation.	☒	☐	☐
9. Was the end user satisfied with the quality of service? If No, state reason given by end user:	☒	☐	☐

The TPM will be expected to perform the following tasks:

1- At Inception:

- Hire highly competent TPM management team the following main specialties: M&E, Health & Nutrition, Environmental & Social Safeguards, Quality Assurance & Control, and Statistician/Health Data Management and Visualization and f
- Hire well qualified field monitors (knowledgeable about health and nutrition, gender, supply and assurance specialists, environmental safeguards) and train them to undertake field monitoring and spot checks for YEHCP activities in Yemen.
- Hold initial (inception) meeting with WHO responsible team for orientation on objectives, monitoring strategy, YEHCP components and intervention strategies, YEHCP implementation plan, activities and interventions, project development objectives and intermediate indicators, etc. and for development of TPM work plan.
- Review and understand project background documents including PAD, financing agreement, reporting requirements and obligations, etc.
- Review the project's environmental social management framework (ESMF), medical waste management plan (MWMP), to gain an understanding of the waste management practices required during the project's implementation and expected results to be monitored.
- Organize training sessions for field monitors on sector-specific and component interventions to ensure conceptual clarity.

- In consultation with WHO, develop and finalize monitoring indicators, checklists, data collection tools, reporting formats that are in line with the components of the project, and project follow-up matrix.
- Be knowledgeable about project proposals and contracts approved by WHO for emergency/development interventions to understand target sets, planned activities, and implementation strategy.
- Coordinate with all concerned stakeholders' collection of information on activities using prescribed checklists/tools for reporting to WHO and WB and conducting field verification.

2- Periodically:

Carry out independent monitoring and reporting of WHO- YEHCP interventions in the field and submit comprehensive quarterly monitoring/assessment reports comprising, but not limited to, the following: (weekly/monthly updates on specific activities could be requested from TPM as required)

- Documentation and reporting on the implementation of all activities and delivery of WHOs supplies (fuel, water, medical supplies and drugs, equipment, training, etc.), nutrition support (TFCs and nutrition surveillance) and any identified gaps observed during the field visits (including feedback on access, use, quality, relevance and satisfaction from end-users).
- Identification of any specific issues/bottlenecks with regard to implementation of WHO interventions, i.e. health, nutrition, disease surveillance, public health programmes, including the effectiveness of the approach from the view of the end-user and gender perspective.
- Verify, to the extent possible, whether goods and support (if relevant), non-consulting and consulting services contracted were supplied/completed according to the required specifications and technical standards.
- Monitor, assess and report on the implementation processes and their compliance with the set plan and established standards.
- Identify cases of non-compliance with the provisions of grant agreements, inappropriate practices or questionable decisions/actions, including those that may have financial implications, or related to any potential corrupt or fraudulent practices (if any).
- During site visits to project locations, verify the adequacy of implementation and compliance with environmental safeguards (as defined in the ESMF), waste management practices, and procedures as defined in the MWMP.
- Investigate the reliability of the data reporting system from the level of the beneficiary to the service provision level (hospitals/HFs) to the DHO, to the GHO and finally o the national level.
- Arrange video and audio recording of key events in the field, evidence of development interventions, gaps/issues in project activities where required.
- Hold regular coordination and de-briefing sessions with WHO and relevant field offices to present and discuss field-monitoring reports containing pictorial presentation and submitting a follow-up matrix.
- Prepare and submit field-monitoring reports and follow-up matrix to WHO as per the agreed schedule and format.
- Monitor, document and report on security-related incidents and other impediments to humanitarian activities/access.

- Develop corrective measures in consultation with WHO / WB (if needed).
- Report on information about unmet needs of women and children and key emerging issues arising from the field affecting children, adolescents, or women, i.e., disease outbreaks, malnutrition, movement of the affected population and systematic exclusion of certain groups of people including minorities.
- Any special assignments required by the management with regard to quick assessments, in-depth analysis of specific case/s.
- Document human-interest stories/case studies and share with WHO where required/as identified.
- In coordination with WHO team, develop and implement innovative web-based/digitalized applications for reporting of findings and tracking of actions taken by various stakeholders.
- At the end of the contract, submit a final completion report with lessons learned best practices and recommendations.

The last updated version of monitoring data collection tools package along with an initial draft of ToR are included in annex 19 & 21 of this manual. Both tools and ToR will be undergone to multiple revision and update rounds according to need.

Table 20: WHO Planned TPM Reporting Schedule

Round	Period covered	Data collection	Report submission	Responding to comments	Final Report
1	2022 January–June	July–August 2022	15 September 2022	30 September 2022	10 October 2022
2	2022 July–October	December–January 2022	15 February 2023	30 February 2023	10 March 2022
3	2022 November–2023 March	April–May 2023	15 June 2023	28 June 2023	10 July 2023
4	2023 March–June	July–August 2023	15 September 2023	31 September 2023	10 October 2023
5	2023 July–September	October–November 2023	15 December 2023	31 December 2023	10 January 2024

Overview of TPM in UNOPS Country Office

In respect of results monitoring and evaluation for Component 2 of the project, UNOPS will be responsible for (i) reporting and follow up on overall achievement of indicators defined in the results framework of the PAD and, (ii) quality assurance of the project and the necessary data verifications at sub-projects and programme levels through frequent monitoring assurance processes.

UNOPS will use a range of conventional and innovative monitoring approaches. The Programme Manager (PM) based in Sana'a will have the overall responsibility for monitoring and evaluation (M&E) activities. An M&E

Officer will provide the necessary coordination, support and oversight to the local implementing partners in conducting M&E activities (data collection and verification) in line with the Results Framework of the project component (2). City Engineers will conduct regular project site visits, meetings with key stakeholders; verifications and quality checks to ensure a programmatic approach of sub-projects.

The project team will undertake monitoring of the activities under the overall guidance of the PM and technical guidance from M&E Officer. Formal and informal feedback will be solicited from beneficiaries and other relevant stakeholders as part of field visit, community engagement and consultation, and analysis of grievance redress mechanism.

In addition, innovative techniques including GIS mapping, real-time monitoring using mobile technologies and engaging local communities are the extra measures to be taken in support of transparent and accountable monitoring mechanisms. All monitoring activities will be closely reviewed and adjustments will be made throughout the life of the project to ensure it remains effective, efficient, and relevant to the operational context while ensuring quality and reliability of data and reporting, to the extent possible.

No later than two (2) months after the Effective Date, UNOPS shall update the contract with the third-party monitoring agency (TPM) and thereafter maintain throughout its Project implementation, said Third-Party Monitoring Agent(s), on the terms of reference satisfactory to the Association, including the mechanism related to the TPMs' enhancement actions of flagging and tracking systems, to be financed out of the proceeds of EHCP. UNOPS shall share with the Association summary of qualifications of the recommended candidate entity(ies) for the contract of the Third-Party Monitoring Agent(s) prior to concluding the update of the contract. The TPM will be contracted and supervised by UNOPS while operating independently in verifying the results of identified sub-projects and Project's activities. The key Objective of the TPM will be to undertake independent results verification of subprojects and identified activities funded under the Project to report on the outputs, the restoration of services for the intended beneficiaries, communities' consultations, and the fiduciary and safeguard processes.

The main tasks of the TPM will be as follows:

1. **Physical verification of deliverables and results including** (i) physical verification and spot check on site, at least twice per subproject life, reporting on timely progress and quality of the deliverables as per technical requirements and standards of the approved contracts; (ii) physical verification at the moment of completion of subprojects; and (iii) post-completion spot checks and site visits to assess whether the repaired facilities remain operational and the restored services continue to be provided to the beneficiaries, at least semi-annually or more frequently for the locations with high potential risks for red flags. Such verification shall be supplemented by the feedback from the communities, including youth, women and other marginalized groups, on the satisfaction with the relevant services. Physical verification shall include taking date stamped digital record photographs where appropriate together with the GPS readings for each location.

2. **Verification of Community Participation** in selection of investment subprojects included in the annual investment program, and, when applicable, confirmation that the grievance redress mechanism (GRM) provisions and procedures set out in the PAD and the POM have been satisfied.

3. **Safeguards Compliance Verification** includes two phases of subprojects' implementation:
    a. Compliance check with the environmental and social safeguards requirements per project safeguard documents in regard to the subprojects preparation/design and existence of these requirements in the bid and contract documents or other related implementation arrangements; and,
    b. Verification of conformity with safeguards' requirements during implementation of subprojects; and compliance check with all environmental, social, health, and safety safeguard requirements per the project safeguard documents.

4. **Verification of procurement by local implementing partners** includes, on a random sample basis and for specific subprojects when requested by UNOPS:
    a. verification that the contracts administered by local implementing partners are signed without modifications to the ones for which UNOPS' no objection was provided at the time of UNOPS' review of the bidding and evaluation documents for respective sub-projects (in particular, with the technical specifications, bill of quantities, contract amounts);
    b. verification that the awarded contracts represent "best value for money";
    c. ascertain that contract amendments and variation orders, if any, were agreed with UNOPS; and,
    d. Verification of procurement and financial documents' retention system maintained by local implementing partners to ensure completeness of all records throughout the procurement cycle for each awarded contract including full documentation (including invoices and payments' documentation) related to implementation of contract/s.

5. **Financial Oversight.** All accounting procedures, and financial management and auditing requirements are subject to UNOPS standard procedures and are outside the purview of the TPM. UNOPS may request the TPM, under UNOPS' supervision, to verify that these procedures/systems are in operation and are being implemented by local implementing partners to satisfactory standards. In the event that UNOPS determines that the TPM should perform this function, the TPM would agree with UNOPS on the reporting format and verification protocol.

TPM Performance Assessment

In UNOPS, various requirements are built into the standard contracts and the extent to which suppliers; including TPM agents, fulfil these requirements is used to measure the achievement of performance indicators. The performance indicator is instrumental in evaluating the supplier's performance in an ongoing contract (e.g. quality standards, delivery times, inspections, milestone dates, etc.). While monitoring the contract, control of performance ensures that the supplier's performance is in accordance with the contract and that if there are any variances then they must be justified, the contracts are amended to reflect agreed changes to the scope of work. And that sustainability benefits are actually delivered, KPIs and other soft progress indicators are

assessed and monitored. Throughout the contract management phase, it is paramount that open communication is maintained with the suppliers about the expectations of UNOPS and supplier performance. Lessons learned and sustainability improvement that has taken place in this phase should be fed back into subsequent procurement processes.

During Contract Execution (Monitoring Supplier Performance)

When contracting services such as the TPM, performance indicators, milestones and checkpoints on the supplier's sustainability performances must be included in the tender documents clearly detailed in the ToRs. These indicators, milestones and checkpoints are then later on adopted into the contract. During contract management, the supplier's performance shall be regularly monitored by the Project managers, ensuring timely receipt and acceptance of the deliverables specified in the contract (e.g. inception reports, progress reports, reports from workshops or training sessions, video films/recordings, etc.).

The deliverables under the contract must be acknowledged and approved by the Project Manager, and also by the end user if applicable. Further, suppliers, requisitioners/business units, and end users must be kept informed of changes or modifications to the contract (e.g. change of mission dates, number of visits, changes in location, start-up date, stakeholders contact details, etc.). Some of the key performance indicators used for monitoring of service contracts:

- Timely delivery of outputs as per the contract;
- Timely response to UNOPS requests;
- Quality of services rendered (this includes level expertise and knowledge by key personnel)
- Adherence to all the contractual terms and conditions

If there is any divergency from what was agreed in the contract or notable unsatisfactory performance, the contract manager/project manager may engage with the service provider to take corrective action thus the need for open and constant communication during the contract execution. Otherwise, persistent deficiencies in performance may lead to contract termination following the due process.

Post Contract Execution (This is known as Supplier Performance Evaluation)

Once the contract has been completed, UNOPS shall conduct Supplier Performance Evaluation, supported by the procurement official (and with input of the end user where relevant). The evaluation against the set performance indicators must take into account the experience with the supplier during the entire contract period. This must be clearly documented using the UNOPS Supplier Performance Evaluation (SPE) form in order to provide evidence of the performance of the supplier; in the event of disputes; in order to form an institutional memory, and for audit purposes. SPE must be performed in a timely manner that shall not exceed one month after contract completion.

The following topics/ performance indicators shall be, at minimum, covered in the SPE:

- Timely delivery of the services.
- Quality of services delivered in accordance with the contract.
- Effective and timely communication and documents handling.
- Demonstrated commitment to sustainability (social, environmental and economic.
- Compliance with other contractual terms and conditions.

If a supplier shows significant or persistent deficiencies in the performance of a UNOPS contract leading to early termination of the contract, any other action taken against them must be documented in the SPE. The UNOPS Director - Procurement Group through the Vendor Review Committee may decide upon review of the process documentation that such a supplier is suspended from doing business for UNOPS further to the provisions of the UNOPS Procurement Policy i.e vendor ineligibility.

Data Protection and Security

UNICEF Policy on Personal Data Protection

Rationale

1. UNICEF uses personal data in a range of activities, whether it is to carry out beneficiaries' needs assessments, to implement child protection programmes, to tailor supporters' engagement or to manage human and supply resources. Examples of personal data include data that directly identify an individual (e.g. a name, a date of birth) or combinations of data (e.g. demographic data, location data) that make the individual identifiable. What constitutes personal data is dynamic and contextual. A single data source may not make an individual identifiable. However, in combination, and with the application of new technologies, data sources may make the individual identifiable. Therefore, each data source should be assessed for actual or potential personal data content.
2. UNICEF must consider opportunities and risks in the use of personal data, including in combination with evolving technologies (e.g. biometrics, artificial intelligence). The protection of this data is essential to upholding fundamental rights to privacy and the UN-system wide personal data protection and privacy principles. This Policy implements these UN principles and governs the processing of personal data by UNICEF. The Policy stipulates a compliance framework for appropriate personal data protection throughout the data life cycle (e.g. collection, storage, analysis, transfer, deletion, or collectively, 'processing').

   UNICEF commits to process personal data in ways that are appropriately: i) justified; ii) for defined purposes; iii) limited in scope to that necessary for defined purposes; iv) performed for accuracy and currency; v) secure and confidential; vi) limited in time; vii) transparent to the persons the data is about, and allows requests for access, change, deletion, or limits on processing (including automated decision-making); and viii) protected upon transfer to others. Related implementation measures are provided.

3. This Policy is without prejudice to the 1946 Convention on the Privileges and Immunities of the United Nations.

Scope Of Application

This Policy applies solely to the processing of the personal data of living individuals and applies only to personal data collected and/or further processed by UNICEF filing systems, and provides protection that is appropriate to the risks and sensitivity regarding the personal data processed by particular filing systems.

All UNICEF personnel are required to process personal data in accordance with this Policy. This Policy complements other UNICEF regulations relating data or information, such as the Information Disclosure Policy and the Procedure on Information Management. This Policy shall be implemented subject to: i) overriding legal obligations, such as relevant resolutions, regulations, rules or decisions of the General Assembly, Secretary General or Executive Board; ii) the Office of Internal Audit and Investigation Charter and iii) fundamental rights and freedoms of the data subjects or other persons.

Policy Statements

- In its interpretation and application to the personal data of a child, the best interest of the child shall be a primary consideration, and an interpretation and application that does no harm shall be sought.
- UNICEF personnel shall take particular care in processing the personal data of children and vulnerable categories of data subjects.
- - The processing of particularly sensitive personal data is allowed only where necessary to carry out UNICEF's mandate. Where such processing occurs, appropriate organizational and technical safeguards shall be used to protect the data subjects against identified risks associated with the processing, including the risk of discrimination.
- The respective roles and responsibilities (as a controller or a processor) of UNICEF and UNICEF associates must be defined prior to the collection and further processing of personal data to ensure accountability under this Policy.
- As a controller, UNICEF may only engage with processors, including UNICEF associates, that provide appropriate commitment and assurance of meeting the requirements of this Policy or equivalent personal data protection standards.
- As a processor, UNICEF will notify data controllers of its data protection requirements and will not knowingly process personal data received that were not collected in compliance with this Policy. UNICEF may only process data on documented instructions from the controller, subject to any pre-existing obligations UNICEF has to process that were disclosed to the controller. UNICEF may only engage with (sub-)processors, including UNICEF associates, upon consent of the controller, and where the (sub-)processor agrees to assume the same data protection obligations as UNICEF made to the controller.
- Risks associated with the processing of personal data shall be managed in accordance with UNICEF's Enterprise Risk Management Policy, including by considering the confidentiality and level of sensitivity of the personal data that are processed.

Policy Elements

Personal data protection principles

Legitimate and fair processing:

- One or more legitimate bases is required for the processing of personal data. The legitimate bases are: (i) the consent of the data subject, or the child's representative where appropriate ("consent"); (ii) to prepare for or perform a contract with the data subject, including a contract of employment ("contract"); (iii) to protect the life, physical or mental integrity of the data subject or another person ("vital interests"); (iv) to protect or advance the interests of people UNICEF serves, and particularly those interests UNICEF is mandated to protect or advance (this legitimate basis would constitute "UNICEF's legitimate interest" as well as the "beneficiary interest"); (v) compliance with a public legal obligation to which UNICEF is subject ("legal obligation"); (vi) other legitimate interests of UNICEF consistent with its mandate, including the establishment, exercise or defense of legal claims or for UNICEF accountability ("other legitimate interests").

- Consent, often supported by other legitimate bases, is the preferred basis for processing. In some cases, obtaining consent may be impractical, including because: the data subject is an under-13 child or a child whose age cannot be determined, and consent cannot be sought from a child's representative; the capacity of the data subject to consent cannot be reasonably assessed, and substitute alternative consent is unavailable; or there is urgency and the timely grant of consent by the data subject is not expected.
- Personal data shall be processed in a manner that is transparent to the data subject.

Purpose specification.

- Personal data shall be processed for specified and limited purposes, which are consistent with the mandate of UNICEF and are determined prior to the time of collection.
- UNICEF may further process personal data for purposes other than those specified at the time of collection: i) if consent is obtained to further processing; ii) if such further processing is compatible with those original purposes and the risks of further processing do not outweigh the benefits it entails for the data subject; iii) if UNICEF is required to process further for statistical, historical or scientific purposes; iv) to establish UNICEF accountability; or v) for the establishment, exercise or defense of legal claims.
- Necessity and proportionality:
- The processing of personal data shall be relevant, limited, and adequate to what is necessary in relation to the purpose(s) specified for processing. This requires, in particular, ensuring that the personal data collected are not excessive for the purposes for which they are collected, and that the period for which the data are stored in the UNICEF filing system, is no longer than necessary, in conformity with paragraph 24.

Accuracy:

Reasonable efforts shall be made to process personal data with accuracy and currency. The accuracy of the personal data to be retained shall be reassessed periodically. Frequency of accuracy review will depend on factors such as the relative time sensitivity of the personal data. Determination of reassessment frequency shall be substantiated and documented. Personal data in archives need not be reassessed, corrected, or kept current.

Security:

- Personal data shall be classified in accordance with a contextual assessment of its sensitivity, in accordance with UNICEF information security standards.
- Appropriate organizational, administrative, physical, and technical safeguards and procedures shall be implemented to protect the security of personal data, including against or from accidental or unauthorized destruction, loss, alteration, disclosure, access, or unplanned loss of availability. Such measures may include logging access, changes to or deletion of personal data.

Limited retention:

Personal data shall be retained in the UNICEF filing system: Permanently, if and only if the criteria under UNICEF's policies and procedures on archiving are met or for the time required to achieve the purposes for which the personal data were collected.

Data subject requests to interact with their personal data:

Access, correction, deletion, objection and restriction to processing of personal data, and objection to automated decision-making may be requested, subject to the conditions below, by an individual who provides sufficient evidence of being the relevant data subject or associated child representative.

Such requests shall be limited to personal data within UNICEF's filing system that directly identify the data subject and not to data that could indirectly identify the data subject.
Where such requests relate to personal data held in unstructured format, including written reports, and other files from which personal data extraction would not be possible employing reasonably available resources, UNICEF would generally decline to fulfill the request, unless overriding considerations demanded otherwise. Such overriding considerations could include upholding the best interest of the child or fundamental rights and freedoms of individuals.

Access:
Unless it adversely affects the rights and freedoms of others, upon request, the data subjects or child's representatives shall be provided with confirmation as to whether personal data concerning the data subject are being processed, and, where that is the case, information about requested categories of personal data held by UNICEF. Access to UNICEF archives shall be provided in accordance with applicable policies and procedures specific to archives.

Correction:
A request from the data subject or associated child's representative to update or correct personal data shall be granted, unless the requested change would be inaccurate, or the data are contained in a record held in the UNICEF archives.
In order to preserve the integrity of UNICEF archives, a note may be included in the relevant archival file to indicate that a correction request has been made.

Deletion:
A request by a data subject or child's representative to have personal data deleted from the UNICEF filing system shall be granted when: i) the personal data were not processed in compliance with this Policy; ii) retention of the personal data would not be in compliance with this Policy; iii) in cases where the only legitimate basis for processing is consent, the data subject withdraws the consent on which the processing was based.
Personal data shall not be deleted in the following circumstances: i) there are overriding vital interests, beneficiary interests, legal obligations or other legitimate interests; ii) UNICEF is required to process further for statistical, historical or scientific purposes.
Records held in UNICEF archives shall not be deleted, in order to preserve the integrity of UNICEF records.
Objection to and restriction of processing:

Data subjects or the relevant child's representatives may, at any time, object to or request restriction of the processing of their personal data if: i) the processing would not be in compliance with this Policy; ii) in cases where the only legitimate basis for processing is consent, the data subject withdraws the consent on which the processing is based; or iii) on compelling grounds relating to their particular situation. The request shall be granted unless there are overriding vital interests, beneficiary interests, legal obligations or other legitimate interests. Automated decision-making:

Data subjects shall be entitled not to be subject to a decision based solely on automated processing, which produces adverse legal or significant material effects on them, unless the processing is carried out with consent, is necessary for entering into or performance of a contract between the data subject and UNICEF, or is necessary for beneficiary interests or other legitimate interests (and provided that appropriate safeguards are in place).

Personal data transfers:

Transfers may only occur when there is a legitimate basis for both personal data transfer and data processing. What constitutes a legitimate basis has been set out in paragraph above, and these legitimate bases apply equally to data processing and data transfers.

Each of the data protection principles and sections of this Policy applies equally to data processing and data transfers. In particular, transfers shall only occur where the conditions set out in paragraph 13 are met.

Policy Implementation: Awareness-raising:

UNICEF shall provide training and take appropriate action to raise awareness so as to ensure the effective implementation of this Policy by its personnel, considering resource and logistics constraints.

Planning:

In acting as a controller and determining the means of processing personal data (including when creating databases), UNICEF shall incorporate "data protection by design and by default" into planning, development and decision making, and implement appropriate technical and organizational measures, such as data minimization and pseudonymization.

When UNICEF acts as a controller and the processing of personal data is likely to involve high risks to the rights and freedoms of the data subjects, in particular where new technologies are involved, a data protection impact assessment (DPIA) shall (and in other cases may) be conducted prior to the processing to identify the risks, any corresponding mitigating measures, and inform whether the processing shall proceed.

Monitoring:

UNICEF shall take practical measures to monitor compliance with this Policy, including the development and maintenance of centralized registers of: Key measures taken by offices to implement this Policy.

Personal data breach: A personal data breach regulation shall be established, addressing, among other things, appropriate reporting channels, review or investigations of incidents, technical responsive measures, and notifications to data subjects and others.

WHO Data Security and Protection

Security classification of information is fundamental for its adequate protection. The purpose of the information classification policy is to ensure that WHO information is classified and protected in a manner appropriate to its value and sensitivity.

Classification

WHO information assets shall be classified in terms of their confidentiality, integrity and availability in order to determine the adequate information security controls for the data protection.

I. Confidentiality

WHO's information and data shall be classified in the three following ways:

a) Confidential
b) Internal Use Only
c) Public

a) *Confidential:* the security classification "Confidential" is assigned to the information that is highly sensitive. It is information where unauthorized disclosure, modification, inaccuracy or incompleteness would be expected to cause damage to the organization and its reputation and credibility. Adequate information security controls must be always in place to protect such information.

Examples of "Confidential" information shall include without limitation:

- Information that could result in failure of operations including loss of life or serious injury; negative impact on public safety; cessation of functioning in all or part of the organization; significant monetary loss; loss of productivity; serious legal ramifications prejudicial to the Organization; significant damage to or destruction of partnerships.
- Selected HR records (e.g. disciplinary files, administrative review documents, appeal documentation, personal information on staff or family members).
- Information related to mediation process.
- Selected financial records (e.g. e-banking access details, bank accounts details, salary information).
- Sensitive information on dealings with the member states, donors and partners.
- Information on security vulnerabilities and incidents reports.
- IT technical and security audits, assessments and reviews.
- Staff medical records.
- Information on Internal Audit or fraud and security investigations.
- Selected Director General Office (DGO), Regional Director Office (RDO) or Director of the International Agency for Research on Cancer (IARC) records and documents.
- Selected Office of the Legal Counsel (LEG) records and documents.

- Records and documents (e.g., contracts) containing information which WHO is legally obliged to retain on a confidential basis.
- Passwords and PIN codes for access to WHO systems.

b) *Internal Use Only:* The security classification "Internal Use Only" is assigned to the information that is somewhat sensitive. It is information where unauthorized disclosure, modification, inaccuracy or incompleteness may cause inconvenience to the organization and its staff.

Examples of "Internal Use Only" information shall include without limitation:

- Selected financial records (e.g. audit reports, statistics and tracking, working procedures).
- Selected HR records (e.g. employment history in WHO, travel claims, vacancy notices before publication).
- Internal telephone directories.
- Information on WHO Head Quarter (HQ) and regional office Intranets.
- E-mail correspondence of a non-confidential nature, administrative exchanges.
- Internal procedures.

c) *Public:* information that is not sensitive and which is freely available to anyone is classified as "Public". Security requirements for "Public" information are minimal. Such documents may be freely accessible but not modifiable by the public.

Examples of "Public" information shall include without limitation:

- Information published on the WHO public website and the public websites of the regional and country offices.
- Annual reports of WHO governing bodies.
- Publications and other materials that are made available to the public.
- Standard information issued by the Organization.

II. Integrity:

In terms of requirements for integrity, the following categories will be used in WHO:

a) Low - no impact or very minor inconvenience if data is accidentally corrupted, modified or lost.
b) Medium - some inconvenience would be caused if data is accidentally corrupted or modified, but data can be restored from other sources.
c) High - the accidental corruption or modification of data would result in a major embarrassment or outage for WHO and partners and recovery would be laborious and difficult or not possible at all.

III. Availability:

Regarding the requirements for availability, the following categories will be used:

a) Low - long periods of unavailability are acceptable.
b) Medium - unavailability for more than 24 hours would cause inconvenience.
c) High - unavailability of information for more than a couple of hours would result in a serious service outage for WHO or partners.

Roles and responsibilities

Three categories of roles have been defined: Owner, Custodian and User.

1. Owner - are those in WHO charged with the ownership of the information or systems utilized by their respective unit. Owners include managers or their representatives who bear responsibility for the acquisition, development and maintenance of data and systems processing that data. Owners are responsible for determining access rights and access authorization, information security classification and requirements for information under their control.
2. Custodian - are those with physical or logical possession of WHO information or any other data that has been entrusted to WHO. IT and Records and Archives staff are examples of custodians. When information is stored only on a personal computer or laptop, the individual user is the custodian. Custodians implement the access rights and security controls approved by the Owners.
3. User - are those individuals or entities who use and/or process information in their day-to-day work that is owned or under the custody of others. Users are responsible for complying with the security rules (policies, standards, procedures, etc.) established by the Owners. In the event of questions regarding access or data classification, the Users must refer to the Owners. Users may be staff members, consultants, contractors, or third parties with whom special arrangements have been made.

Table 21: Personal Data Related Definitions

Personal Data Related Definitions
Data Subject *means an identified or identifiable natural person***.**
Personal Data *means any information relating to a Data Subject.*
Processing *means collecting, recording, organizing, structuring, storing, adapting or altering, retrieving, consulting, using, disclosing, sharing or otherwise making available to third parties, erasing or destroying Personal Data collected under the Project.*

Examples of data that might be considered personal data:

- General patient data of a data subject including name, contact information, date infected, nationality, gender, age, persons with whom the data subject had contact.
- Other information related to a data subject (if applicable):
- Medical and health symptoms.
- Specific information about diagnosis or treatment.
- Travel data, particularly to "hot zones" (date, time, and duration).
- Mobile location data.
- Biometric data such as facial recognition technology.

Table 22: Personal and Non-personal Data

Distinguishing between Personal and Non-personal Data
Not Personal Data: *body temperatures collected randomly or en masse as individuals enter a building.* ***Personal Data:*** *body temperatures tied to personal identification numbers as individuals enter a building.*

Data collected under the YEHCP will be processed only for purposes defined in the project. To meet these requirements, WHO will or will cause its agents or contractors acting on its behalf to:

- Process personal data only for purposes defined in and only for performing and achieving the PDO under the Project (legitimate purpose).
- To the extent practical in the circumstances, inform data subjects about the personal data being processed using the following form of notice, and keep a log of data subjects who are so informed and where it keeps its register of other data collected in connection with this project.

Example Form of Notice
"You are hereby informed that data about you is being collected for public health reasons, all information that you give us will remain strictly private and confidential and it will not be linked with your private medical/ employment records. It will not be possible to identify you from any information we release or use. We may share or otherwise automatically process this data for the mentioned purpose only."

- Process only the amount and type of personal data necessary for the legitimate purpose.
- Take due care to ensure that personal data collected is accurate, complete, and up-to-date.
- Take due care to secure collected personal data.
- Afford Data Subjects with the ability to inspect Personal Data collected about them and correct any errors in such data.
- Share anonymized or aggregated data, rather than Personal Data, wherever possible.

Global Cybersecurity Policy

The Global Cybersecurity policy serves as the highest-level statement on Cybersecurity in WHO. The security of information and associated systems and networks is a critical business requirement of WHO. Cybersecurity is the protection of information assets from threats to WHO's operations, reputation, business continuity, and user identity data. This policy establishes the ongoing preservation of best practices security for safeguarding accuracy and completeness of information and processing methods and granting access to authorized users.

Incident Management

An "event" *is an observed or observable occurrence in a system, a network, application or daily operations. Events are not necessarily adverse. When first observed, an event could appear to be an incident but after analysis, turn out to be an explainable anomaly in the environment.*

An "incident" *is an adverse event where a WHO asset (examples include, but are not limited to: personnel, information, hardware, software) is attacked or threatened with attack, accessed without authorization, used in a manner inconsistent with established WHO policies and which results in the real or possible loss of confidentiality, integrity, availability or potential damage to the WHO asset.*

The WHO Chief Information Security Officer (CISO) is responsible for the coordination of the Cybersecurity program throughout the Organization, the implementation of Cybersecurity policy, and reporting noncompliance issues to WHO senior leadership. Cybersecurity Incident Management allows timely and accurate identification, containment, and remediation of Cybersecurity incidents.

All suspected Cybersecurity events are reported through the correct and established channel and cybersecurity@who.int. In case confidential information is lost or disclosed to unauthorized parties, the Owner and the WHO CISO shall be notified immediately. Cybersecurity events will be assessed to identify impact and severity, actions performed during each incident response will be documented, and the post-incident review will be carried out and lessons learned documented.

UNOPS Data Security and Protection

UNOPS holds significant assets in the form of information and physical property. Information includes human resources and personnel records, administrative processes, procurement-related data, field operations and location information, legal (including contracts and investigations), third-party data, and politically sensitive information, among others. During the course of carrying out their activities, UNOPS collects, processes, stores, transfers and manages a wide range of Information, some of which may be confidential and/or sensitive.

Such Information shall therefore be managed carefully by UNOPS and in a coherent manner across the organization, particularly ensuring respect for human rights and fundamental freedoms of individuals, in particular the right to privacy. Regulatory frameworks, industry standards and best practices may be used by

the organization as guidance for managing certain information, such as information relating to personnel, suppliers, partners and other stakeholders.

In this context, UNOPS has issued the following Executive Directive and Instructions relevant to data security and protection.

I. **Privacy and Information Security:** Executive Office Directive (EOD) Ref. EOD.ED.2019.01 (4 November 2019)

The purpose of this EOD is to define the key principles, roles and responsibilities for the development and management of UNOPS' Information Security Management System (ISMS) and personal data privacy (PDP) program to address the critical needs of the organization to protect all of these assets, including written and oral information transmitted and stored in magnetic media, computing devices, documents, applications, systems, databases and networks.

Key Privacy Principles

The following key privacy principles apply to personal data, contained in any form, and processed in any manner. Where appropriate, they may also be used as a benchmark for the processing of non-personal data, in a sensitive context that may put certain individuals or groups of individuals at risk of harm. UNOPS personnel need to respect and apply the following principles when processing personal data:

- **Fair and legitimate processing:** UNOPS will process personal data in a fair and legitimate manner with the consent of the data subject; in the best interests of the data subject; consistent with the mandate and objectives of UNOPS; consistent with any other legal basis identified by UNOPS.
- **Purpose specification:** Personal data must only be processed for specified purposes which are consistent with the mandate and objectives of UNOPS, taking into account the balancing of relevant rights, freedoms and interests. Personal data must not be processed in ways that are incompatible with such purposes.
- **Proportionality and necessity:** The processing of personal data must be relevant, limited and adequate to what is necessary in relation to the specified purposes of personal data processing.
- **Retention:** Personal data will only be retained for the time that is necessary for the specific purpose, and in accordance with the Operational Instruction on Document Retention (Ref: OI.LG.2018.03).
- **Accuracy:** Personal data must be accurate and, where necessary, up to date to fulfil the specified purposes.
- **Confidentiality:** Personal data must be processed with due regard to confidentiality.
- **Security:** Appropriate organizational, administrative, physical and technical safeguards and procedures must be implemented to protect the security of personal data, including against or from unauthorized or accidental access, damage, loss or other risks presented by data processing.
- **Transparency:** Processing of personal data must be carried out with transparency to the data subjects as appropriate and whenever possible. This must include, for example, provision for information about the processing of their personal data as well as information on how to request access, verification, rectification, and/or deletion of that personal data, insofar as the specified purpose for which personal data is processed is not frustrated.
- **Transfers:** In carrying out its activities, UNOPS may transfer personal data to a third party, provided that, under the circumstances, UNOPS satisfies itself that the third party affords appropriate protection for the personal data.

- **Consent:** Where processing is based on consent, UNOPS shall be able to demonstrate that the data subject has consented to the processing of their personal data. The data subject shall have the right to withdraw their consent at any time. The withdrawal of consent shall not affect the lawfulness of processing based on consent before its withdrawal. Prior to giving consent, the data subject shall be informed thereof. It shall be as easy to withdraw as to give consent.
- **Accountability:** UNOPS must have adequate policies and mechanisms in place to adhere to these Principles.

Key Information Security Principles

The following key information security principles shall underpin the UNOPS ISMS to be developed and overseen by the Chief Information Security Officer (CISO):

- **Not all information shall be treated the same way:** The way any given information is to be managed, and the degree of protection needed for such information, shall be based on the nature of the information and its intended use.
- **Confidentiality:** Confidentiality refers to ownership of the information that is only to be made available or disclosed to authorized individuals, organizations or processes. Access to information, to an extent, is reserved for those who require it on a clearly identified need-to-know basis.
- **Integrity:** Information integrity relates to the accuracy and completeness of information resources. This means it involves protecting the accuracy and consistency of the information, as well as the methods used to process this information.
- **Availability:** This is the property (for an information system) of being accessible and of fulfilling the functions envisaged at the time of the application to an authorized entity, under the expected conditions of time-scales and performance. This means protecting the capacity of an information system to perform a function under defined schedule, time-scale and performance conditions.

II. Privacy and Information Security Governance: Executive Office Instruction (EOI) Ref. EOI.IAIG.2019.01 (4 November 2019)

The purpose of this EOI is to provide instructions on the governance and management of personal data privacy and information security across the operational footprint of the organization.

In order to deliver effective oversight for all activities related to the governance, risk management, and overall control of privacy and information security arrangements within the organization, the Executive Director (ED) has authorized the Chief Information Security Officer (CISO) to develop the organization's privacy governance framework, addressing key areas such as leadership & governance, planning & strategy, program delivery, incident management, and evaluation & reporting. The CISO is also authorized to develop a system by which the organization directs and controls information security, including key areas such as policy development, information security investment, coordination across departments, and risk management.

The Privacy and Security Incident Response Team (PSIRT) will serve as the first responder to privacy and computer security incidents and perform vital functions in identifying, mitigating, reviewing, documenting, and reporting findings to the ED and the Senior Leadership Team (SLT).

The CISO will engage, collaborate and coordinate with individuals across the organization to ensure that collective intelligence is at the core of key activities. Key thought partners will include representatives from

safety & security, ICT, internal audit, legal, human resources, enterprise risk management (ERM), etc. Inputs from these functions will ensure that the ED and SLT receives the expert advice required to implement privacy and information security controls and policy requirements that are strong, appropriate and in alignment with the organization's mission.

The PSIRT will include the CISO and the individuals responsible for storage and other data repositories, computer networks, data centre operations, and other organizational stakeholders. The PSIRT defines privacy and security emergency situations, determines when such situations exist and initiates appropriate countermeasures according to incident response procedures.

Incident Definition

For the purposes of this EOI, an incident is defined as an event that has actual or potential adverse effects on individual privacy or computer and network resources resulting in misuse or abuse, compromise of information, or loss or damage of property or information. Any such events that originate from, are directed towards, or transit UNOPS controlled facilities, systems or network resources will fall under the purview of PSIRT.

This definition is purposely made inclusive, however it is foreseen that many events classified with a "limited" severity rating may be handled by semi-automated means and not require any further escalation. Incident types include, but are not limited to: Compromised Machine, Laptop Lost or Stolen, Denial of Service, Hoax, Malicious Code, Policy Violation, Probe, Unauthorized Access, Unauthorized Use.

Incident Reporting

All UNOPS employees shall report any potential event that adversely impacts the Confidentiality, Integrity, or Availability of Institutional Information, regardless of form (paper or electronic), Infrastructure Technology, or Information Systems by email (ciso@unops.org). An incident shall also be immediately reported through the Privacy and Security Incident Reporting Form (online form). In addition, the PSIRT Chair will coordinate with all relevant departments to ensure that PSIRT is notified of any reported problem that may reflect a security incident. The individual reporting the incident will be asked to provide date, time, time zone, user contact information, brief description of the incident, and other pertinent information. Acknowledgement of a reported incident by the PSIRT shall occur via an auto-generated response to email. A telephone-reported incident will be acknowledged with a telephone call or email message from the PSIRT. All user reports will be analyzed, classified by severity rating, and an appropriate response will be generated. The scope of PSIRT response will be determined by the incident severity rating, or as directed by the ED and SLT . If the nature of the incident cannot be reported via non-confidential methods, the incident may be directly reported to the CISO.

III. Information Classification: Executive Office Instruction (EOI) Ref.EOI.IAIG.2019.02 (4 November 2019)

The purpose of this EOI is to provide instructions on classifying UNOPS data based on its sensitivity and quantifying the amount of data protection required. UNOPS data is defined as information generated by or for, owned by, or otherwise in the possession of UNOPS that is related to the organization's activities. UNOPS data may exist in any format (i.e. electronic, paper) and includes, but is not limited to, all strategic, tactical,

operational, administrative, and research data, as well as the computing infrastructure and program code that supports the business of UNOPS.

In order to effectively secure this data, it is necessary to have a vocabulary that can be use to describe the data and quantify the amount of protection required. This EOI defines four categories into which all UNOPS data can be divided:

1. Public
2. Unclassified
3. Confidential
4. Strictly Confidential

UNOPS is committed to openness in research – freedom of access by all interested persons to the underlying data, to the processes, and to the final results of research. Research at UNOPS generally should be widely and openly published and made available through broad dissemination or publication of the research results. Research data is generally considered as Public data unless there are specific requirements to maintain the confidentiality of research data, such as when a researcher is bound to protect the confidential information of a collaborating government, partner organization or when the data relates to human subjects.

Classification Levels

Public. Public data is information that may be disclosed to any person regardless of their affiliation with UNOPS. The Public classification is not limited to data that is of public interest or intended to be distributed to the public; the classification applies to data that do not require any level of protection from disclosure. While it may be necessary to protect original (source) documents from unauthorized modification, Public data may be shared with a broad audience both within and outside the community and no steps need be taken to prevent its distribution.

Examples of Public data include: press releases, directory information, application forms, and other general information that is openly shared. The type of information a department the organization chooses to post on its website is a good example of Public data.

Unclassified. Unclassified data is information that is potentially sensitive and is not intended to be shared with the public. Internal data generally should not be disclosed outside of UNOPS without the permission of the person or group that created the data. It is the responsibility of the data owner to designate information as Unclassified where appropriate. If you have questions about whether the information is Unclassified or how to treat Unclassified data, you should talk to Information Security or your department head.

Examples of Unclassified data include: some memos, correspondence, and meeting minutes; contact lists that contain information that is not publicly available; and procedural documentation that should remain private.

Confidential. Confidential data is information that, if made available to unauthorized parties, may adversely affect individuals or the business of the UNOPS. This classification also includes data that UNOPS is required to keep confidential, either by law or under a confidentiality agreement with a third party, such as a vendor. This information should be protected against unauthorized disclosure or modification. Confidential data should be used only when necessary for business purposes and should be protected both when it is in use and when it is being stored or in transit.

Any unauthorized disclosure or loss of Confidential data must be reported to the appropriate department head. The department head should determine whether to report the unauthorized disclosure or loss of Confidential data to the Chief Information Security Officer (CISO) at ciso@unops.org.

Examples of Confidential data include:

- Information covered by privacy and data protection legal frameworks across
- UNOPS operations and other jurisdictions (e.g. EU GDPR, HIPAA, etc.).
- Personally identifiable information (PII) entrusted to our care that is not Strictly
- Confidential data, such as information regarding government officials, existing donors, potential donors, or children of current or former employees.
- The UNOPS ID (CSID), when stored with other identifiable information such as name or email address.
- Financial records.
- Individual employment information, including salary, benefits and performance appraisals for current, former, and prospective employees.
- Legally privileged information.
- Information that is the subject of a confidentiality agreement.

Strictly Confidential. Strictly Confidential data includes any information that UNOPS has a contractual or fiduciary obligation to safeguard in the most stringent manner. In some cases, unauthorized disclosure or loss of this data would require UNOPS to notify the affected individual and state or federal authorities. In some cases, modification of the data would require informing the affected individual.

UNOPS's obligations will depend on the particular data and the relevant contract or laws. The Minimum Security Standards sets a baseline for all Strictly Confidential data. Systems and processes to protect the following types of data need to meet that baseline:

- Personally identifiable health information.
- Personally Identifiable Information (PII), including an individual's name plus the individual's national identification number, driver's license number, passport information, or bank account number.
- Unencrypted data used to authenticate or authorize individuals to use electronic resources, such as passwords, keys, and other electronic tokens.
- "Criminal Background Data" that might be collected as part of an application form or a background check.

More stringent requirements exist for some types of Strictly Confidential data. Individuals working with the following types of data must follow UNOPS's policies governing those types of data and consult with Information Security to ensure they meet all of the requirements of their data type:

- Protected health information (PHI). Protected health information includes all individually identifiable health information, including demographic data, medical histories, test results, insurance information, and other information used to identify a patient or provide healthcare services or healthcare coverage.
- Financial account numbers covered by the Payment Card Industry Data Security Standard (PCI-DSS), which controls how credit card information is accepted, used, and stored.
- European Union (EU) and the countries of the African, Caribbean and Pacific Group of States (ACP) partnership information.
- U.S. Government Classified Data.

Strictly Confidential data should be used only when no alternative exists and must be carefully protected. Any unauthorized disclosure, unauthorized modification, or loss of Strictly Confidential data must be reported to the Chief Information Security Officer at ciso@unops.org.

Resolving Conflicts between the EOI and other Regulations

Some data may be subject to specific protection requirements under a contract or grant, or according to a law or regulation not described here. In those circumstances, the most restrictive protection requirements should apply. If you have questions, please contact the CISO at ciso@unops.org.

Knowledge Management

The project will support operational knowledge management not only to measure the results, but also to extract lessons and draw recommendations for future World Bank interventions in similar contexts on aspects such as operational effectiveness, availability of and accessibility to health services, responsiveness of the system, and sustainability. Accordingly, knowledge management focal points will be identified from WB, WHO, UNICEF and UNOPS to develop knowledge management and analytical plan. In order to create multi-organizational task force and practical knowledge packages based on research, literature reviews, and data deep analysis to support project operations, a discussion with the WB was held during the EHNP to establish the Knowledge Management Hub in Amman aimed to ensure that the project data is used to its full potential, to prevent knowledge loss, to understand what works, avoid repeating mistakes, having strong structures, data repository and approaches to manage the project knowledge.

Operational research could potentially be conducted and published within the Yemen context through the YEHCP based upon each internal agency's official channels. However, as all data is ultimately the property of the MoPHP, thus it is critical that all approvals for use of data must be sought accordingly. Other approvals are needed according to each internal rules and guidelines of each agency.

UNICEF Knowledge Management

Knowledge Management (KM)has been practiced in UNICEF for a long time and the benefits of effective KM are identified as the following:

1. Improved organizational effectiveness; by helping ensure that programs are designed using the latest knowledge, capitalizing on the experience and expertise of its staff.
2. Improve organizational efficiency and reduced cost; through strengthening UNICEF ability to respond quickly to emerging issues on the ground, through rapid mobilization of organizational expertise and experience, avoidance of past mistakes and duplication of efforts.
3. Strengthened UNICEF capacity to engage partners as a knowledge leader; they need to be effective advisors and advocates on children's issues.
4. Improved operational effectiveness; through promoting a culture of continual learning from experience and refining of policies, procedures, and practices based on this learning.

UNICEF embeds learning from experience and use of knowledge and evidence in UNICEF's programming and business. Additionally, KM is a connector that runs across the evidence functions in UNICEF and connects with other knowledge work (program content in guidelines, knowledge products, and tacit knowledge sharing) so

that the evidence and knowledge that we capture and generate is well-organized, easily shared, and –most importantly –used in our programs and partnerships. UNICEF will continue to strengthen health and nutrition sectors data collection and analysis under YEHCP by using different data sources: administrative data and TPM data.

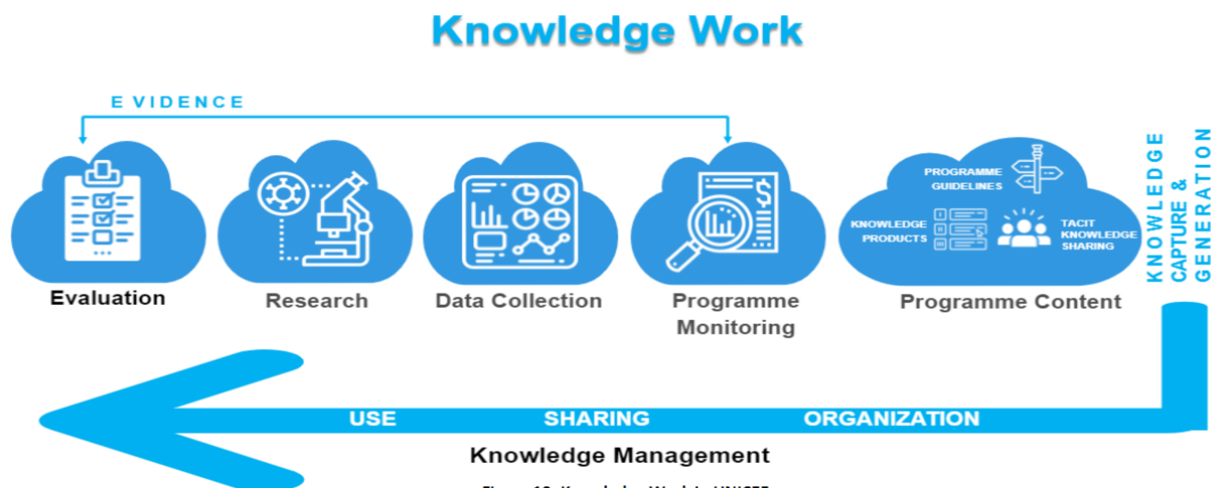

Figure 10: Knowledge Work in UNICEF

UNICEF build a Medium-Term Strategy (2021-2022) as the first step in a longer path towards achieving the vision for knowledge management (KM), please check annex 22.

WHO Knowledge Management

Knowledge and its effective management play a critical role to ensure high-quality interventions and impact the project generates through its operations. Knowledge Management allows the organization to realize and understand how the operations will evolve over time, and the results it will produce. WHO and through the Health and Knowledge Management officer (HKM) will enhance its strong data infrastructure and analytical capacity, with the ability to get granular and streamline data collection from different sources within WHO or other partners (as much as possible).

Knowledge Management enriches data analytics through navigating and utilizing the amounts of data and documentation collected by TPM during their field visits across the project cycle.
HKM with the collaboration of the WHO Information Management Unit will explore the possibility to utilize multiple data sources, different methods, and different observations such as DHIS2, Health Cluster, HeRAMS, etc. as a one strategy for increasing confidence in the findings and addressing the shortcomings of any single approach.

The analytical plan concentrates on the inputs themselves and how it converters the inputs into outcomes. For example, looking at utilization of main services such as an obstetrician consultation, deliveries, caesarian section, minor and major surgeries, inpatient and outpatient.

WHO knowledge Management plan includes the best estimates for the population catchment hospital using the three following methods:

1- Geospatial technology by distance.
2- Geospatial technology by time.
3- TPM data.

WHO open-access policy: The policy applies to all articles or chapters published in non-WHO publications that are authored or co-authored by WHO staff or produced by individuals or institutions funded in whole or in part by WHO.

The requirements of the policy are that the articles must be published in one of the following ways:

1. In an open access journal.
2. In a subscription journal that offers an open-access option (a hybrid open-access journal);
3. In a subscription journal that allows authors to deposit the accepted author manuscript in Europe PubMed Central (Europe PMC) within 12 months of the date of publication.

Knowledge Management in UNOPS

The mission of the United Nations Office for Project Services (UNOPS) is to help people build better lives and countries achieve peace and sustainable development. UNOPS focuses on the implementation of projects, supporting our partners to achieve the sustainable development goals. UNOPS has ongoing projects and programmes taking place across five regions - Africa, Asia, Europe and Central Asia, Latin America and the Caribbean, and the Middle East - including 19 country offices and a headquarters in Copenhagen. However, this global presence presents both benefits and challenges, as being global means there are more opportunities to learn from the experiences, successes, innovations and failures of projects, and to apply these lessons learned[20] in similar projects within or across regions.
UNOPS has adopted two working definitions of knowledge management to frame the corporate approach for this strategy.

1. “the deliberate and systematic coordination of an organization’s people, technology, processes and organizational structure in order to add value through reuse and innovation […] achieved through creating, sharing and applying knowledge as well as through feeding the valuable lessons learned and best practices into corporate memory in order to foster continued organizational learning”

2. "Knowledge management is a business process that formalizes the management and use of an enterprise’s intellectual assets. KM promotes a collaborative and integrative approach to the creation, capture, organization, access and use of information assets, including the tacit, uncaptured knowledge of people".

As part of the United Nations family, UNOPS has the responsibility to formally address knowledge management both internally and externally[21]. UNOPS' role in sustainable development through the efficient and sustainable

[20] *Knowledge management is one of the six dimensions of UNOPS projects success criteria, which centers around that projects lessons must be documented, acted upon, and shared in line with the UNOPS Project Management Manual (PMM).*
[21] *98% of partner agreements are signed in compliance with its cost recovery policy, and UNOPS invests 1% of indirect costs in knowledge management.*

implementation of projects requires a corporate approach on knowledge management, as detailed in the UNOPS Strategic Plan 2018-2021:

> "support(s) the ambition to focus knowledge management on efforts to harness expertise for integrated service offerings, and specialized solutions, based on realized or anticipated demand towards specific goals and operational contexts".

Knowledge Management process, initiative, and efforts at UNOPS is governed by six principles:

- **People-centered -** focus on the usability of system capabilities to manage both explicit and tacit knowledge
- **Field-driven -** based on the needs that arise from the work done on the ground
- **Aligned to the UNOPS Strategic Plan -** its aim is to assist the organization deliver on its management and organizational goals
- **Focused -** recognize the importance of defining thematic knowledge areas relevant to our business needs
- **Integrated -** knowledge sharing and management embedded in our existing processes and procedures
- **Present and Future Needs -** it will help address our operational excellence ambitions in improving business as usual to ensure best practices are embedded in UNOPS operations, as well as innovation, to ensure UNOPS has the capability to adapt to changing environments.

UNOPS Knowledge Management Strategy, Objectives, and Tools

UNOPS has a knowledge management[22] Strategy based on the premise that knowledge is a valuable core asset of UN organizations and their best comparative advantage. The main goal of the Knowledge Management Strategy is to learn from UNOPS past project experiences, replicate the successes and avoid the mistakes or failures.

The UNOPS Knowledge Management strategy relies on the collaboration and knowledge sharing among HQ units, regional offices and country offices using different tools and mechanisms, including the standardization of UNOPS project management practice through the Project Management Manual (PMM), OneUNOPS Project (OUP) which is an online project management system that provides a wealth of knowledge in lessons learned which are also available and searchable in the Global Lessons library), the Communities of Practice (CoPs), UNOPS Intranet, and UNOPS knowledge Share Fair Sessions.

UNOPS' approach to Knowledge Management includes both the explicit and tacit knowledge categories, which can be further detailed as follows:

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[22] More details on UNOPS Knowledge Management Strategy can obtained through: https://docs.google.com/document/d/1HEnqyXrAN89I3oHvKcvvXa2bwzJqegUbdOD-4GKmGnI/edit#
UNOPS Management Strategy Annex: https://docs.google.com/document/d/1nC1aZ3G4Q2tAoAf_uoL4tIYa8FUhUhxBf8GthYJeuxg/edit

Table 23: Explicit Knowledge vs Tacit Knowledge

Explicit knowledge	Tacit knowledge
• Codifiable • Objective, consciously exercised • Impersonal • Easy to share (through repositories and documents) • Easy to communicate and transfer • Exists independently of how people create or use it.	• Almost impossible to codify • Subjective, exercised intuitively • Personal • Difficult to share • Difficult to communicate and transfer • Tied to the specific experience, culture and activities of the person who uses it.

Both knowledge categories are relevant in an organizational approach to Knowledge. In the case of tacit knowledge, which resides within people, it is theoretically more applicable to refer to *knowledge sharing* (KS) rather than *knowledge management*, but for the purpose of this strategy, UNOPS' approach to *Knowledge Management* will include both the explicit and tacit categories.

Knowledge Management Objectives

Based on the results obtained from the knowledge assessment exercise, on UNOPS Strategic Plan, on knowledge management theory and research, and on best practices from organizations with a proven track record in Knowledge Management, the following Knowledge Management objectives have been outlined:

- **Objective 1:** Create a strong organizational knowledge sharing culture which is continuously measured and improved
- **Objective 2:** Implement effective mechanisms and systems for the development and use of information, creation of knowledge and access to experts
- **Objective 3:** Reduce risk through integration of lessons learned and best practices into project development, "business as usual" operations and decision-making
- **Objective 4:** Enable growth through impact-focused organizational learning for strategic positioning
- **Objective 5:** Improve the efficiency and impact of operating units and business processes, and enable promotion of innovation

Measurable results and enablers were defined for each objective by applying the UNOPS Excellence Model framework.

Conflict of Interest

Declaration of Interest in UNICEF

Declarations of Interest (DOI) for UNICEF staff members

A conflict of interest occurs when, by act or omission, a staff member's personal interests interfere with the performance of his or her official duties and responsibilities or with the integrity, independence and impartiality required by the staff member's status as an international civil servant. When an actual or possible conflict of interest does arise, the conflict shall be disclosed by staff members to their head of office, mitigated by the Organization and resolved in favour of the interests of the Organization.

Conflict of Interest and Financial Disclosure (CIFD) Programme:

The UNICEF CIFD Programme is intended to mitigate the risks to the Organization by enabling staff members to understand, identify and avoid situations where there is an actual or potential conflict of interest between the staff member and the organization. Hence, the program aims to ensure that the assets, economic activities, and outside engagements of staff members and their close family members do not pose a conflict of interest with their official duties or with the interests of the United Nations and of UNICEF.
In line with Financial Disclosure and Declaration of Interest Statements policy, CIFD statements of staff members are confidential and will be accessible only to the Executive Director, the Ethics Office and to staff members specifically authorized in writing by the Executive Director.
The verification process is an exercise undertaken by the Ethics Office to verify the accuracy and completeness of the CIFD Statements filed by staff members. A randomly selected staff member participating in the CIFD will be requested to provide verification documentation supporting their CIFD statements. When any staff selected for verification, he will receive a separate communication from the Ethics Office informing him that he has been selected for verification and need to provide verification documentation backing his CIFD statement.

Ethics advice may be provided for the following conflict of interest situations:

- Outside activities
- Employment-related questions
- Financial interests
- Pre-appointment reviews for senior appointments
- Honors, decorations and gifts
- Institutional integrity matters
- Procurement ethics
- Due diligence and risk assessment process
- Other conflicts of interest

TPM and conflict of interest

As part of the selection process, UNICEF ensures that the proposed TPM service provider for any intervention does not have any conflict of interest. Conflict of interest may arise from the following scenarios:

1. The selected TPM service provider is at the same time an implementing partner of UNICEF. A community based organization that has an active program document for program implementation cannot undertake TPM in the same geographic or programmatic area due to conflict of interest.
2. The selected TPM service provider is conducting financial assurance activities and TPM programmatic visits for the same implementing partner

UNICEF expects that the service providers will declare in advance any potential conflicts of interest which may affect their ability to conduct neutral and independent monitoring on behalf of UNICEF. If such a scenario occurs, the TPM service provider will be expected to declare the conflict of interest to UNICEF. Declaration of a conflict of interest will not be considered negatively but is taken into account in the deployment of TPM service providers, and where possible UNICEF deploys other Third-Party Monitoring service providers which do not have a conflict of interest to the specific location or implementing partner. Failure to declare a conflict of interest may lead to termination of contract of the Third-Party Monitoring Service Provider. As a requirement the TPM service providers sign a code of conduct which includes declaration of no conflict of interest, do no harm and data security among others.

Declaration of Interest in WHO

Declarations of Interest (DOI) for WHO staff members

A conflict of interest occurs when private interests (financial, personal, or other non-WHO interest or commitment) interfere—or appear to interfere—with the ability of a WHO staff to act impartially, to discharge their functions and to regulate their conduct with the interests of WHO.

In compliance with staff rule 110.7 and WHO e-manual III.1.2, staff members in designated employment categories are required to submit a Declaration of Interest (DOI) form (see annex 23) The declaration will include any interest in (including association with) any entity with which they may be required, directly or indirectly, to have official dealings on behalf of the Organization, or which has a commercial interest in the work of WHO, or a common area of activity with WHO. All new staff members are requested to submit a DOI form upon recruitment, as are all WHO collaborators.

Declarations of interest when WHO interacting with external experts and consultants

The term "conflict of interest" means any interest declared by an external expert that may affect or reasonably be perceived to (1) affect the expert's objectivity and independence in providing advice to WHO, and/or (2) create an unfair competitive advantage for the expert or persons or institutions with whom the expert has financial or business interests. To ensure the highest integrity and public confidence in its activities, WHO requires that external experts serving in an advisory role disclose any circumstances that could give rise to a potential conflict of interest related to the subject of the activity in which they will be involved. All experts serving in an advisory role need to disclose any circumstances that could represent a potential conflict of interest.

Expert DOI form (see annex 24) declares any financial, professional or other interest relevant to the subject of the work or meeting in which expert have been asked to participate in or contribute towards and any interest that could be affected by the outcome of the meeting or work.

WHO ensures that the proposed TPM service provider should sign and stamp two forms: Declaration of interest and confidentiality form. This is to ensure there is no conflict of interest in the work in of TPM and staff with WHO. This is also to protect the confidentiality of data that will be collected from the field.

Declaration of Interest in UNOPS

UNOPS Personnel engaged on a retainer contract shall not be required to file unless the relevant Regional Director or HQ Director determines that the risks for UNOPS in the event of a conflict of interest by such personnel warrant the completion of a FDCOI. UNOPS Personnel who are required to file a FDCOI Statement shall report the following in respect of (i) themselves, (ii) their spouse and/or Domestic Partner (if any), and (iii) dependent children (if any):

a. details of any financial interest or other interest in or association with or liability or money owed to any UNOPS Vendor or UNOPS partner;
b. any lease of real property (house, apartment, other premises or land) to or from the filer's supervisor at UNOPS or any UNOPS colleague supervised by the filer or his/her supervisor.

UNOPS Personnel who are required to file a FDCOI Statement shall also report the following:

a. any leadership or policymaking role held by him/her in any non-United Nations entity (including membership on any corporate board);
b. details of any outside employment or occupation;
c. details of any political activity going beyond the exercise of his/her right to vote and belong to a political party;
d. receipt in the course of his/her duties of any gift or hospitality or other benefit from an outside source; e. any spouse/Domestic Partner, father, mother, son, daughter, brother or sister employed in the United Nations system;
e. any other relatives or close friends working for any Vendor or UNOPS partner;
f. any other activity or relationship or other aspect of the filer's past or present situation which could have an impact on his/her objectivity or independence in the specific performance of the functions for which he/she has been contracted by the United Nations, or which could otherwise affect the image of UNOPS.

The filing of a FDCOI Statement will lead to a review and follow-up process by the External Reviewer and/or the Ethics Office during which additional information, which may include supporting documents, may be requested. UNOPS Personnel will be informed by the Ethics Officer if they are to be contacted by an External Reviewer in respect of their submission.

In order to validate the information disclosed and ensure its accuracy and completeness, the Ethics Officer may conduct a verification process among a representative sample of all individuals having submitted a FDCOI Statement. UNOPS Personnel who have been selected to provide verification must, within the time specified by the Ethics Office, provide a copy of supporting documentation including, but not limited to, statements from third parties as well as bank statements, mortgage statements, certificates of title, loan agreements, tax returns and credit card statements. UNOPS Personnel selected for verification will be given no less than 30 calendar days by the Ethics Office to provide the documentation requested. Verification documents will be provided to the Ethics Office or the External Reviewer, as directed by the Ethics Office.

Disciplinary measures or administrative remedies may be taken against UNOPS Personnel who knowingly make false statements or provide inaccurate information under this OI. Failure by staff members or other personnel to file a FDCOI Statement or, if required, an Asset Disclosure Statement, or to respond to follow-up or verification inquiries could lead to disciplinary action or administrative remedies respectively. Failure to submit an initial statement may result in a withdrawal of the offer or termination of the appointment.

All UNOPS personnel have the obligation to disclose actual or potential conflicts of interest. Certain categories of UNOPS personnel are required in addition to file a financial disclosure and conflict of interest statement ("FDCOI Statement") within 30 calendar days after taking up their functions and thereafter as part of UNOPS annual filing programme. The obligation on the part of a specific group of personnel of UNOPS to file statements under this OI (Operational Instruction) does not eliminate or limit in any way the obligation on the part of all UNOPS personnel to comply with regulations/rules concerning conflicts of interest and related duties and obligations. Compliance by a UNOPS personnel with filing obligations under this OI does not excuse him/her from proactively disclosing any actual or potential conflict of interest which arises in between filing cycles.

The following UNOPS Personnel are required to file a FDCOI Statement:

a. All internationally recruited staff members at the P-5 to D-2 levels. (Personnel at the Assistant Secretary-General level and above, as well as those serving in the Ethics Office are subject to the UN Secretariat financial disclosure policy);
b. All personnel retained under individual contractor agreements (ICAs) at level International ICA 4 and above;
c. All UNOPS personnel who are procurement specialists, or whose principal occupational duties are the procurement of goods and services. 'Principal occupational duties' include those individuals for whom expected procurement activities exceed 40% of their normal prescribed duties;
d. All UNOPS personnel whose principal occupational duties relate to the investment of the assets of UNOPS or of any accounts for which UNOPS has fiduciary or custodial responsibility. 'Principal occupational duties' include those individuals for whom expected investment activities exceed 40% of their normal prescribed duties;
e. All HQ Directors, Regional Directors, Hub Directors, OC Directors, PC Managers, Cluster Managers and the executive head of each Hosted Initiative (and, in the Peace and Security Cluster, all Programme Managers);

f. All project/portfolio managers, all Heads of Support Services and all Heads of Programme (and, in the Peace and Security Cluster, all Chiefs of Operations);
g. UNOPS internal auditors;
h. All Headquarters Contracts and Property Committee (HQCPC) and Local Contracts and Property Committee (LCPC) members and secretaries;
i. All UNOPS personnel who hold a Finance Delegation of Authority (DOA) of level 3 or above;
j. Other UNOPS Personnel designated by a Regional Director or HQ Director where he/she determines that such person is exercising duties akin to those of a position referred to above or that such person has direct access to confidential procurement or investment information or whose engagement in procurement activity for a limited duration or under specific exceptional circumstances warrants the completion of a FDCOI Statement.

Component 4: Contingent Emergency Response Component (CERC)

The CERC will be in place to provide an expedited response in case of emergency. There is a probability that an epidemic or outbreak of public health importance or other emergencies may occur during the life of the project, causing major adverse economic and/or social impacts. An Emergency Response Operational Manual will be prepared jointly and agreed upon with the World Bank to be used if this component is triggered.

3. ENVIRONMENT AND SOCIAL SAFEGUARDS

The World Bank has classified the environmental and social risks of YEHCP as substantial. This classification takes into account relevant issues, such as the type, location, sensitivity, and scale of the project; the nature and magnitude of the potential environmental and social risks and impacts; and the capacity and commitment of the recipient (including any other entity responsible for the implementation of the project) to manage the environmental and social risks and impacts in a manner consistent with the Environmental and Social Standards (ESSs). The risk classification will be reviewed on a regular basis during implementation, and will change the classification where necessary, to ensure that it continues to be appropriate.

Prior to the negotiation for the YEHCP AF, UNICEF, WHO and UNOPS jointly formulated, updated and disclosed the Environmental and Social Commitment Plan (ESCP). The ESCP contains material measures and actions, to be carried out or caused to be carried out during the project life period. Setout the timeframes of the actions and measures, institutional, staffing, training, monitoring and reporting arrangements, grievance management and the environmental and social assessments and instruments to be prepared or updated, disclosed, consulted, adopted and implemented under the ESCP and the ESSs, during the project lifetime period.

The ESCP forms part of the legal agreement. It outlines the material measures and actions required to avoid, minimize, reduce or otherwise mitigate the potential environmental and social risks and impacts of the project. In order to comply with the ESSs and to implement these measures and actions identified in the ESCP, UNICEF, WHO and UNOPS formulated a group of ES instruments that includes the appropriate measures to identify and

manage the potential environmental and social risks and impacts associated with the project activities. These environmental and social measures will be implemented to do no harm to the environment and surrounding communities during the course of activities implementation. These instruments will be reviewed and updated by the implementing agencies as required in a manner acceptable for the WB.

Project Environmental Risks and Impacts

Detailed identification of the Project risks and impacts is available in the YEHCP Environmental Social Review Summary. The environmental risks and impacts are expected to be generated from activities to be financed under Component 1: 'Improving Access to Health, Nutrition and Public Health Services' which will finance, inter alia, medical and non-medical supplies, essential drugs and vaccines, specifically under subcomponent 1.1 which will support cholera preparedness and prevention activities such as, but not limited to, supporting the rapid response teams, and cholera case management as well as routine delivery of selected public health programs and immunizations. Also, under subcomponent 1.4 which will finance nationwide public health campaigns, including vaccination and neglected tropical diseases, to prevent disease outbreaks; and system strengthening and resilience-building measures to support the epidemiological and diagnostic laboratory capacity of the local institutions particularly the reference labs at the governorate level. The main environmental risks associated with such interventions are: (i) medical waste management and community health and safety issues related to the handling, transportation, and disposal of vaccines, labs materials and tests, medical consumables and associated healthcare waste; and (ii) the OHS issues related to vaccination, lab testing, handling of medical supplies, blood transfusions and the possibility that they are not safely used by medical crews. Furthermore, potential environmental impacts might result from supporting component 2, particularly, subcomponent 2.1 which will finance rehabilitation and scaling up of medium to large scale water and sanitation facilities including rehabilitation of water and sanitation infrastructure, main water and sewerage pipelines and networks, WTPs, WWTPs, water wells, pumping and booster stations. Potential environmental impacts of such interventions include dust emissions, debris and other solid waste generation and management, ground/surface water contamination, social annoyance and community safety due to traffic increase, blocked streets, noise, dust and unsafe construction sites as well as workers safety including occupational health and safety. Nonetheless, such risks and impacts are expected to be site-specific, reversible and of low magnitude that can be mitigated following appropriate measures. Furthermore, the application of adequate occupational and community safety precautions following the World Bank Environmental, Health and Safety Guidelines is expected to be sufficient to prevent any associated impacts (Please refer to Annex 19,23,24).

The project activities may entail social impacts and risks. These risks are mainly related to possible inequality and discriminatory practices, particularly due to gender, vulnerability, and other social and economic factors, in the provision of healthcare and nutrition services, and in the access to water supply and sanitation services under the project. There could also be risks of SEA/SH in the provision and access to project services. The ESMF will include a gender and GBV action plan to address potential risk of sexual exploitation and abuse and/or sexual harassment (SEA/SH) during Project implementation. Labor influx due to the project could also lead to conflicts between IDPs and hosting communities, discriminatory practices in employment as well as possible use of child labor in the project. COVID-19 infection is a serious risk to stakeholders in the project implementation process, including both project workers as well as targeted beneficiaries. The civil works that are likely to be supported under the WASH component may impose temporary restrictions on land use, thus affecting communities and owner persons. But these restriction impacts are expected to be insignificant due to the rehabilitation and temporary nature.

For adequate management of projects risks and impacts, Environmental and Social Instruments package as detailed in the below sections have been prepared for the Project in addition to operational GM for receiving the stakeholder's feedback on the Project implementation activities.

The implementation of the Environmental and Social requirements will be monitored during the project lifetime and regular reporting will be maintained. The Safeguards team supported by the PMU of each agency will oversee monitoring and evaluating safeguard compliance of the Project as guided by the ESMF. The PMU will include a section on safeguards compliance in each progress report which will be submitted to the World Bank.

Key objectives of the monitoring include:

- Tracking environmental and social performance of the project activities.
- Verify that all requirements of ESMF, ESMP are addressed and implemented.
- Ensure the capacity building of personnel, provide any required support.
- Ensure adequate stakeholders' engagement, proper feedback, and communication.
- Including the list and response to the Project related grievances.
- Ensure proper implementation of the Project instruments and to report any deviation.

On the other hand, another level of monitoring will be performed by Third Party Monitoring (TPM). TPM will assess the status and performance of the project implementation phases, compliance status, or emerging issues through a specialized party and to provide an unbiased perspective on the issue and status, and to make recommendations for improvement, where relevant.

Environmental and Social Management Framework (ESMF)

WHO ESMF Link UNICEF ESMF Link - UNOPS ESMF Link

Each implementing agency has prepared, updated and disclosed its own ESMF to meet the requirements of the World Bank's Environmental and Social Framework (ESF), most particularly the Environmental and Social Standard on the Assessment and Management of Environmental and Social Risks, including the World Bank Group Environment, Health and Safety (ESHS) Guidelines. The updated ESMF will apply to both YEHCP parent and AF projects. The ESMF will guide the implementing agencies to ensure that all interventions meet the requirements of the ESF, including the preparation of interventions/sub-projects or activities specific Environmental and Social Management instruments as relevant to the activity (especially those of the civil work nature) type and in accordance with the ESF. The ESMF details how implementing agencies will assess the environmental and social risks and impacts, identify the necessary mitigation measures, and monitor the ES measures implementation, most particularly the environmental and social performance of project contractors/activities implementers. With support of the team the environmental and social specialist will prepare the required environmental and social assessment, screening, and relevant ES instruments/plans are prepared on consistent with the risk, impact level and magnitude and set mitigation measures appropriate to mitigate and/or reduce the risks associated with the project activities implantation. The environmental and social specialist will ensure that proper implementation of the mitigation measures and regular monitoring

and reporting procedures during project lifecycle. Close follow-up and field visits will be conducted, meeting with stakeholders, communities on the project activities, its impact (positive and negative) and training would be provided to workers and contractors on the ES risks, impacts and measures related to the activities and ESHS applicable for the nature of the work.

The **ESMF** is developed to:

1. Ensure that environmental and social management is integrated into the development cycle of individual subprojects.
2. Serve as a practical tool to guide identification and mitigation of potential negative environmental and social impacts of proposed investments and serve as a platform for consultations with stakeholders and potential project beneficiaries.
3. Propose high-level principles, rules, guidelines, and procedures to screen, assess, manage and monitor the mitigation measures of environmental and social impacts of the project activities /subprojects.

Screening Form for Potential Environmental and Social Issues is included in the ESMF, the form should be used by the implementing agencies to screen (as per Annex 22 and 26) for the potential environmental and social risks and impacts of specific activities. Screening will allow the project to identify the relevant Environmental and Social Standards (ESS), establish an appropriate environmental and social risk rating, and specify the type of environmental and social risk management measures required, including specific instruments, if needed. Each implementing agency has its own screening form as part of each ESMF, screening form for WHO, UNICEF and UNOPS are available in annex 25.

Based on the screening process, subproject risks will be categorized as based on the following criteria, in which the relevant environmental and social instruments shall be prepared by each agency. All subprojects' instruments (Environmental and Social Impact Assessment ESIA or Environmental and Social Management Plan ESMP) need to be reviewed and cleared by the World Bank prior the implementation of any site activities.

High Risk subprojects are likely to generate a wide range of significant adverse risks and impacts on human populations or the environment, because of the complex nature of the Project, their large to very large scale, or the sensitivity of the subproject locations. Impacts are likely to be long term, permanent, irreversible, and impossible to avoid entirely due to the nature of the Project. Subprojects with High-Risk rating needs to be excluded and alternative lower risk rating activities shall be determined.

Substantial Risk subprojects are likely to generate some significant adverse risks and impacts on human populations or the environment, because of their large to medium scale. They are not located in a highly sensitive area. Impacts are likely to be mostly temporary, predictable and reversible. ESIA or ESMP shall be prepared for subprojects with substantial risk rating.

Moderate Risk subprojects have adverse risks and impacts on human populations and/or the environment that are not likely to be significant, because the subproject is not complex or large, do not involve activities

that have a high potential for harming people or the environment, and are located away from environmentally or socially sensitive areas. ESIA or ESMP shall be prepared for subprojects with Moderate risk rating.

Low Risk subprojects have potential adverse risks to and impacts on human populations or the environment that are likely to be minimal or negligible. These subprojects do not require further ES assessment following the initial screening.

In addition to the ESMF the below Environmental and Social instruments have been prepared for the Project to meet the requirements stated in the Project ESCP and to help in implementing the necessary mitigation measures.

- Medical Waste Management Plan (MWMP)**:** WHO MWMP Link - UNICEF MWMP Link

UNICEF and WHO each prepared, updated and disclosed their own MWMP which focuses on medical waste management practices during the Project implementation stages. The updated MWMP will apply to both YEHCP parent and AF projects. MWMPs detailed the procedures and measures for managing different types of medical wastes and handing medical consumables starting from distribution, use while applying infection prevention and control measures- collection, temporary storage, transportation, and final safe disposal. Furthermore, the MWMP will include infection control measures to limit the spread of COVID-19 during the project activities. As part of the MWMP, the Medical Waste Management Survey form (annex 26) is available to monitor the status of waste management at the supported facilities and can be used to determine the need and estimate the necessary support.

- Labor Management Procedures (LMP): WHO LMP Link -UNICEF LMP Link UNICEF LMP LinkUNOPS LMP Link

Each implementing agency prepared, updated and disclosed its own LMP that details the applicable labor rules, regulations, and the associated risks, impacts and mitigations as well as occupational health and safety risks for the project. The updated LMP will apply to both YEHCP parent and AF projects. The Project will include the use of: (i) Direct workers who will be engaged directly by each implementing agency, (ii) Contracted workers (people employed or engaged by third party contractors), (iii) the primary supply workers (staff employed by suppliers providing goods and supplies to the implementing agencies). The Management of such workers in addition the applicable legislations and requirements are detailed within the LMP of each implementing agency

- Stakeholders Engagement Plan (SEP) **X**

The implementing agencies have developed, updated and disclosed a joint SEP that details the stakeholders' categories, engagement methods, and Grievance Mechanism (GM). The updated SEP will apply to both YEHCP parent and AF projects. To ensure adequate consultations, considering the World Bank advisory note on public consultations and stakeholder engagement in the current COVID-19 pandemic situation. The SEP will be updated on a regular basis during the project life cycle.

- Gender Based Violence (GBV) Action Plan

Each implementing agency prepared and updated its own GBV action plan that the necessary actions should be taken during the various implementation stages in addition to the timeframe of each action. The updated GBV action plan will apply to both YEHCP parent and AF projects. Any case or suspicion of sexual exploitation and abuse can be reported to the Project GM system. This GM will be in place for the project and will also be used for addressing GBV-related issues exacerbated by project activities and will have in place mechanisms for confidential reporting with safe and ethical documentation of GBV issues.

A GBV focal point is included within each agency's PMU and will be responsible for the implementation of this action plan, responding to related grievances as well as performing the necessary consultations as guided by the Project GBV action Plan.

- Security Management Plan (SMP)

Each implementing agency has prepared and updated a security management plan (SMP) in accordance with the requirements of ESS1 and ESS4. The updated SMP will apply to both YEHCP parent and AF projects. The objective of this SMP is to provide and maintain a safe physical environment and manage staff activities to reduce the risk of personal injury and property loss during the implementation of YEHCP.

Environmental and Social Management Plan (ESMP)

To address risk and impact associated with activities implemented under the project including the civil work or rehabilitation, environmental and social instruments may require to be prepared. However, environmental and social screening should be conducted first and based on the results of the screening level of the anticipated risk will be identified and accordingly, environmental and social instruments most likely activity/site-specific Environmental and Social Management (ESMP) will be prepared. The key content of the ESMP will be in addition to the sup-project/activities description, and the environmental and social baseline data, consultation with stakeholders/beneficiaries, GM details, and requirements for contractors. It will mainly include the following:

1. A mitigation plan that identifies and summarizes potential environmental and social impacts as a result of project activities/subprojects; describes mitigation measures including the type of impact to which it relates and the condition under which mitigation is required.
2. A monitoring plan including description of monitoring measures (corresponds to mitigation measures proposed in the mitigation plan) with the parameters to be measured, methods to be used, sampling locations, frequency of measurements; description of institutional arrangements and responsibility, and the reporting procedures The monitoring forms and plans will be included in each ESMP considering the nature, scale and size of each subproject.
3. An implementation schedule for mitigation and monitoring measures proposed in the above plans, cost estimates and responsibility for implementing the ESMP.

Grievance Redress Service

Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org

UNICEF Grievance Mechanism (GM)

The engagement of community members and beneficiaries (including service providers supported under this project) in all aspects of the project is critical. One way of to ensure that the communities and service providers are involved is through establishing a Grievance Mechanism (GM) where complaints, queries or feedback on the project will be received and addressed. The GM helps to address issues related to the project. Complaints or issues relating to other projects or interventions may also be referred to the appropriate project personnel or sister agencies. All communications received through the GM will be treated confidentially. Complainants will not be punished for submitting complaints. Communication through the GM is free of charge, the UNICEF free call center No. is 8004090.

Through the GM, community members and service providers may make complaints on issues such as the following:

- Adverse social or environmental situations caused by the project.
- Access to project services – (for example if an intended project beneficiary has not been reached by the project.).
- Deviation in implementation or use of project inputs – (if implementing partners deliver services or pay to beneficiaries an amount less than the standard set by UNICEF for the project);
- Complaints GBV/SEA related issues with ensuring complete confidentiality to protect impacted survivors due to culture norms in the country; and
- Any other concerns

The YEHCP GM will:

- Be responsive to beneficiaries, address and resolve their grievances.
- Serve as a channel to receive suggestions, and to increase community participation;
- Collect information to enhance management and improve implementation performance.
- Promote transparency and accountability on the modality and performance of the project.
- Deter fraud and corruption.
- Include referral pathways to refer GBV survivors to appropriate support services.
- Mitigate environmental and social risks; and
- Build trust between citizens and YEHCP management.

GM Principles:

- Protect beneficiaries' and stakeholders' rights: beneficiaries and stakeholders have the right to make their voices heard. No retribution will be exacted for participation/use of the GM system.
- Transparency and Accountability: All complainants will be heard, taken seriously, and treated fairly.
- Timeliness: All complaints will be addressed – ideally - within two to three weeks. Complainants will be informed if their issue requires more time than this.
- Neutrality, Equity, and Non-Discrimination: All complaints will be treated with respect and equally regardless of the community groups and individuals, types, ages and gender.
- Accessibility: The GM will be clear and accessible to all segments of affected communities.
- Confidentiality: Information communicated through the GM is restricted to a limited number of people and is not disseminated more widely, offering protection and security to the complainant.

GM communication channels:

The only channel that is maintained currently, is the toll-free number to ensure the centralization of the entire grievance collection and process in the MIS. PMU is planning to explore the possibility of having grievances submitted through SMS, WhatsApp, Telegram and Facebook messenger leveraging on the integration of the MIS with RabidPro. In addition, trying to have an android GM application with online and offline capability and also integrated MIS with KOBO, PMU can publish a KOBO form that can be public to anyone who has a smartphone to submit a grievance or inquiry.

UNICEF GM Call Center is managed by UNICEF's PMU. The PMU is an entity internal to the UNICEF Yemen

Country Office that was originally established for the management of World Bank-funded Emergency Cash Transfer (ECT) Project, but due to its expertise in risk management, has now expanded to take on components of other UNICEF Yemen projects. This is a separate unit from the YEHCP PMU. The process is as follows:

Table 24: UNICEF Complaints Management Process

No	Action	Responsibility	Time frame
1.	Complaint is submitted to the CC	Complainant	Any time
2.	Complaint logged into the CC registration system with index number	CC Agent	Day 1
3.	Confirm receipt of complaint and notify complainant whether complaint is related to the YEHCP project or not (see table 24 and 25 below).	CC Agent	Day 1
4.	Gather evidence on the complaint and conduct interviews as necessary, analyze the information and develop resolutions on grievance (correction actions)	YEHCP appointed staff (FP)/team (at central level and local focal points)	Day 2 to 7
5	Include GBV referral pathway	GBV specialist	Day 1
6.	Inform the complainant on the resolutions (correction actions)	CC Agent	Day 7-8
7.	Review and Close the complaint	YEHCP -GM central FP	Day 8 to 11
8.	Produce grievance summary report	YEHCP -GM central FP	Quarterly

Please find UNICEF Health and Nutrition Grievance Categories and Types attached in annex 27.

WHO Grievance Mechanism (GM)

Communities and individuals who believe that they are adversely affected by the project could submit complaints to the project grievance mechanism. The engagement of community members, beneficiaries including employees and service providers supported under this project in all Project aspects is critical. The GM will help to address issues related to the project. All communications received through the GM will be

treated confidentially. Complainants will not be punished for submitting complaints. Communication through the GM is free of charge. The GM is also applied to the additional financing activities.

Through the GM, community members and service providers may make complaints on issues such as the following:

- Adverse social or environmental situation caused by the project.
- Access to project services – (for example if an intended project beneficiary has not been reached by the project.)
- Deviation in implementation or use of project inputs – (if implementing partners deliver services or pay to beneficiaries an amount less than the standard set by the Project for the project)
- Any other concerns.

The GM will:

- Be responsive to beneficiaries, address and resolve their grievances.
- ·Serve as a channel to receive suggestions, and to increase community participation.
- Collect information to enhance management and improve implementation performance.
- Promote transparency and accountability on the modality and performance of the project.
- Mitigate environmental and social risks.
- Build trust between citizens and YEHCP management.

GM Principles:

- Protect beneficiaries' and stakeholders' rights: beneficiaries and stakeholders have the right to make their voices heard. No retribution will be exacted for participation/use of the GM system.
- Transparency and Accountability: All complainants will be heard, taken seriously, and treated fairly.
- Timeliness: Ideally for emergency complaints, acknowledgment should be within three days max. Complaints should be addressed within a possible timeframe as demonstrated Complainants will be informed if their issue requires more time than this.
- Neutrality, Equity, and Non-Discrimination: All complaints will be treated with respect and equally regardless of the community groups and individuals, types, ages and gender.
- Accessibility: The GM will be clear and accessible to all segments of affected communities.
- Confidentiality: Information communicated through the GM is restricted to a limited number of people and is not disseminated more widely, offering protection and security to the complainant.

Additionally, the channels mentioned in table below have been dedicated to receiving any grievances related to the project implementation activities through GM joint call center.

Table 25: WHO GM channels

YEHCP- GM channels	
Toll free number	**8004090**
Email	**YEMGRMehnp@who.int**

WHO Health and Nutrition Grievance Categories and Types attached in annex 28 and GM log template in annex 29.

UNOPS Grievance Mechanism (GM)

UNOPS will apply the Project Grievance Mechanism detailed in Section 5 of the Project Stakeholder Engagement Plan and as per Annex 25, to all subprojects. Each ESMP will include a subproject specific Grievance Mechanism, with procedures relevant to its specific context. Subproject related grievances can be brought up by affected people in case of: (i) non-fulfillment of contracts or agreements; (ii) compensation entitlements; (iii) types and levels of compensation; (iv) disputes related to destruction of assets or livelihoods; or (v) disturbances caused by construction activities, such as noise, vibration, dust or smell. Anonymous complaints will be admissible.

The UNOPS Program Manager based in the Sana'a Office will have the overall responsibility to address Project activity-related complaints and inquiries from Project affected communities or individuals regarding any environmental or social impacts due to subproject activities. The UNOPS ESSO in its Sana'a Office will handle Project activity-related complaints, who will be assisted by UNOPS' City Engineers in the target cities. The ESSO in each of the Implementing Partners will handle complaints related to their activities. UNOPS will coordinate with the local Implementing Partners and will set a unified timeframe for reporting grievances. UNOPS and the Implementing Partners will present and explain the mechanism to all subproject affected persons subproject preparation.

UNOPS is providing multiple access points to the ESSO for beneficiaries to voice their concerns. These access points will be advertised at subproject level, and include: complaint box at Project activity sites, at UNOPS' offices in Sana'a by directly contacting Project affiliated staff, and by mail, telephone, email, and UNOPS 'website:

Address	Haddah Street, former European Union Office Building, Sana'a
Telephone	8000-190 (Toll-free number)
Email	gm-yemen@unops.org
Website	www.unops.org

UNOPS and its local implementing partners are responsible for implementing the necessary mitigation measures that are beyond the control of contractors. In addition, subprojects should regularly consult with project affected persons and communities throughout subproject implementation, as indicated in the Project's Stakeholder Engagement Plan.

4. Communications, Visibility and Social mobilization

The World Bank, UNICEF, WHO and UNOPS adopted a coordinated and strategic communication approach that is in line with the SEP. This will ensure the timely coordination and agreement on the content, sequence, and

frequency of the communication materials shared with the different audiences. An action plan is regularly developed with an indicator matrix to measure the effect and outcome of the communication activities under the project, with particular attention to the awareness and utilization of health, nutrition and WASH services provided with YEHCP. A dedicated communication task force consists of the Communications specialists from the three partners working in a closely coordinated approach. Findings are presented to the project teams upon submission of the semi-annual progress report separately by each agency.

UNICEF Communication and Visibility

UNICEF will ensure an effective visibility of the EHCP by implementing a comprehensive visibility and communication plan that is prepared in coordination with the World Bank Communication focal point. This will be building on lessons learned from the EHNP and aimed at ensuring key stakeholders are well informed about the EHCP. The plan will be developed with input from programmes team by the Communication Specialist with oversight from the Chief of Communication and Advocacy Section. The EHCP visibility and communication plan will outline objectives, key messages, required resources, specific actions and activities and the products and the target audience and the dissemination and monitoring and evaluation plan.
Communication and Visibility Goal:
To ensure effectiveness of EHCP communication and visibility through development of complementary plans, documentation of project's activities, collection and publishing of multimedia content, conducting timely monitoring and evaluation of activities to ensure communication objectives are met.
Objectives:

- Ensure a clear visibility of YEHCP is in place at all sites supported by the project.
- Promote YEHCP objectives and services to the public.
- Identify, produce, and distribute branded materials highlighting the YEHCP donor and implementing partners.
- Promote the project's achievements and successes on different communication and social media platforms.
- Enhance quality and consistency of joint communication and visibility materials by collaboratively working with partners through leading the Communication Task Force.
- Ensure rapid and accurate information sharing with beneficiaries and stakeholders; and promote the Grievance Redress Mechanism (GRM) for regular flow of feedback, suggestions, and complaints.

Communication Task Force Lead:
In order to enhance the quality and consistency of communication and visibility outcomes, UNICEF will lead on establishing, reviewing and refining the process of working collaboratively with partners including maintaining regular contact and meetings with communication focal points, joint projects, information sharing, etc.
Deliverables:

- Develop quarterly communication and visibility plans - in coordination with the World Bank focal point- to ensure proper coverage of the project's activities in target locations.
- Prepare semi-annual, and annual reports to showcase the results of the effectiveness of used media materials, and other updates.
- Collect different multimedia content from field and provide proper documentation of project's activities in various areas.
- Ensure regular publishing of final media products on UNICEF social media platforms, such as:
  - Videos of project's interventions and beneficiaries' stories.

  - Written human interest stories.
  - GRM animation video and posters.
  - Infographics, general information, and project's achievements posts.
- Design and supervise the production of various branded printable materials such as (vests, caps, lab coats, stickers, flyers, banners, brochures, etc.).
- Share Communication Task Force's joint plans, reports, and updates with the World Bank Communication Focal Point.

Grievance Redress Mechanism (GRM) Visibility

Unicef has developed a visibility plan targeting public audience to raise awareness and introduce the Grievance Redress Mechanism (GRM). The plan will include:

- Design, print, and distribute printable materials, such as:
  - Flyer/one pager describes the package of support the World Bank and UNICEF are providing to health centers and health units, as well as the complaints and grievances hotline number.
  - GRM brochure that gives a brief about the project, explain what the GRM is, its process, and highlights the hotline number.
  - GRM one pager which focuses more on the GRM principles and steps.

GRM animation video which explains all about the project and its components and services, as well as the GRM and how, when, why to call the hotline number.

UNICEF Social and Behaviour Change (SBC)

Communication for Development (C4D) Social and Behaviour Change (SBC) is a UNICEF cross-sectoral strategy for delivery on program sector results. SBC engages communities and decision-makers at local and national levels in dialogue toward promoting, developing, and implementing policies and programs that enhance the quality of life for children, families and whole communities. In the context of the YEHCP, SBC supported community-based interventions that;

- Generated demand for Health, Nutrition, Child Protection and WASH Services
- Promoted preventive practices for disease, outbreaks and for early care seeking
- Strengthened community level engagement, participation and decision-making
- Promoted equitable access to health services by supporting the most vulnerable and marginalized people to access the services provided
- Supported capacity development of partners – governmental, NGO and community level frontline volunteers for social mobilization and engagement
- Facilitated community dialogue to address the underlying causes of health disparities and non-utilization of services (gender and culture-related power structures, stigma, harmful cultural beliefs, discrimination)
- Empowered households and communities and support resilience-building for preventing and responding to outbreaks.

Social and behavior change programs are facilitated by community owned resource people including

Community Volunteers, Teachers, School Health Facilitators and Religious Leaders – Imams and Female Religious Leaders (Morshydat) working in collaboration with Community Health Workers and other community-level frontline resources. To facilitate high impact programming at scale, the SBC team is guiding implementation of an integrated package of five core essential family care practices – the *5 plus 1* Communication Initiative, which prioritizes five essential family care practices, mainly: handwashing with soap at critical times, exclusive breastfeeding followed by age-appropriate complementary feeding, immunization for eligible children up to age two years; safe motherhood and newborn care practices including at least four ANC visits during pregnancy and skilled birth attendance; and seeking early care for illness for children, pregnant women and all household members. The package also promotes adoption of critical life-saving preventive behaviors for outbreak-prone diseases such as COVID-19, diphtheria, measles and AWD/Cholera, ensuring that affected populations have the accurate and relevant information they need to effectively reduce the impact of outbreaks and emergencies. The roll-out includes orientation for C4D community-based workforce; and Community Volunteers (CVs). The community workforce plays an important role in the community ensuring equitable coverage of health services at the community level.

A community is defined as the lowest administrative structure - usually a village - with a population sharing a common culture and social norms. In Yemen there are 333 Districts, 2,210 sub-districts and 38,284 villages. The estimated population per sub-district varies significantly from 1,000 to 500,000, due to ongoing conflict which has resulted in population movement from frontline areas to safer locations.

C4D interventions use a mix of participatory community-based approaches in engaging communities for social and behavioral change, often reinforced by mass media.

The approaches used in EHNP and will be used in YEHCP, which include:

- Community engagement and Social Mobilization
- Interpersonal communication - Home Visits and Peer-to-Peer Communication
- Group-based - engagement of Social Support groups/Networks
- Mass and social media engagement

Social listening and assessments

Community Engagement and Social Mobilization: Community-based interventions are focused on mobilizing communities broadly to generate demand and strengthen utilization of health interventions. In Yemen this approach supports vaccination campaigns including the OCV campaigns, and the cholera and disease outbreak prevention and response which requires reaching a critical mass of the population with timely and accurate information. Social mobilization is a collective action of a community team which includes the support of Religious Leaders who have credibility and are highly respected in the community. In collaboration with key government partners, the SBC Section has created a network of over 22,000 registered Community Engagement Mobilizers (of which approximately 9,000 are actively engaged in regular community engagement and mobilization interventions). SBC Community engagement volunteers are identified, trained, and engaged for specific communities to support risk communication and community engagement interventions.

Interpersonal communication – The approach includes home visits and counselling sessions at HFs carried out by CVs and CHWs. The home visits are conducted by community volunteers - mostly female - who are living in the same area including the female religious leaders (Morshydat). In the Yemeni cultural context and due to security concerns, females are the most socially accepted to enter households. The current plan is that two

CVs are allocated 200 households which they visit at least once per quarter. In some areas CHWs who were trained on the integrated package of core essential family practices are conducting health education sessions in Primary Health Care Facilities. They are using the waiting time during ANC visits to engage pregnant and lactating mothers on child health care practices.

Other community engagement volunteers are managed by NGO implementing partners, the Ministry of religious guidance (religious leaders) and the School Health Education Program (school health facilitators).

The Community Engagement volunteers are distinct from Community Health Workers who are attached to a HF, whereas the engagement volunteers are community-based and work directly in the community, referring clients to the HFs and for vaccination outreach services.

Group-based Engagement of Social Support Groups/Networks. A social and behavior change initiative to address social norms by empowering social networks and the reference groups of women is being implemented as Mother-to-Mother clubs which target pregnant and lactating women and mothers of children under five years. The initiative enrolls women in targeted communities, organizes them in groups and facilitates comprehensive engagement to promote adoption of key essential family care practices, promoting basic health and nutrition services and strengthening linkages with existing Primary Health Care Facilities for service delivery. The Mother-to-Mother Clubs initiative, premised on the Social Network and Care Group models, adopts a peer-to-peer behavior change approach based on the principle that individual decision is facilitated by social reference groups and the social environment. The clubs provide a forum for women to support each other in adopting and sustaining positive practices as well as a platform where their concerns can be addressed. The clubs are becoming important forums for engagement not only on essential family care practices, but also on disease outbreaks and the household response as well as building the resilience of women and their communities to prevent and/or withstand future outbreaks and other humanitarian emergencies.

Each of the 15 members of fully functioning Mother-to-Mother (Jadati) Clubs are mandated to reach out and engage with five neighbors after each twice-monthly group session to share learnings and to take back feedback and questions for redress. This initiative is currently partially funded by FCDO while around 25% of the cost has been supported through the YEHCP.

Mass and social media engagement: Mass media complements and reinforces communication messages carried through community engagement interventions. UNICEF Yemen's mass media partnerships include more than 30 local radio stations and 12 Television stations, in addition to the use of Public Address Systems (PAS) mounted vehicles. Other mass communication channels include megaphones, mobile cinema, print media and social media outlets particularly WhatsApp groups created by community volunteers, members of Mother-to-Mother clubs, and religious leaders for engagement with their communities, which combined have a capacity to reach about 75% of the population. UNICEF facilitates the use of mixed media approaches during vaccination campaigns, responding to outbreaks and to address rumors or misinformation related to health services.

UNICEF covers the production costs of mass media interventions and part-funds the cost of broadcasting the products. In addition, the cost for using mobile vehicles for social mobilization are covered as part of the operational cost for vaccination and outbreak response campaigns.

Evidence Generation: The generation of evidence to understand the drivers of key behaviors and barriers to

adoption of positive practices to inform strategies and response plans is key for SBCand program interventions. interventions. Three rounds of the Cholera Behavior Indicators Monitoring (BIM) study have been conducted between 2018 – 2019 in 9,800 households across 98 high-risk cholera districts in 14 governorates providing rich information to inform the cholera response and to strengthen context-specific messaging and engagement on key prevention behaviors. In addition, qualitative evidence is generated through Ad hoc Focus Group Discussions (FGDs) facilitated by UNICEF SBC and implementing partner teams in specific communities to identify the root causes and drivers of negative practices.

A behavioral Rapid Assessment on COVID-19 is regularly conducted to assess knowledge, attitudes, risk perception and adoption of COVID-19 prevention practices and vaccination uptake behaviors in Yemen. In the last round, questions on COVID-19 vaccine were included in the assessment to measure the acceptance of the vaccine and to inform development of the COVID-19 vaccine demand communication strategy. The assessment studies utilize both quantitative and qualitative methodologies and are administered by the main implementing partners across 22 governorates of Yemen. The results of the assessments help to enhance the COVID-19 messages and strategies as well as focus the response interventions.

Social and Behavioral Changes Deliverables in YEHCP:

1. Support implementation of the revised COVID-19 Vaccine Demand and Risk Communication and Community Engagement (VDRCCE) approaches and strategy updated in May 2022, and implement community engagement and mass and social media interventions to address gaps identified in RCCE and vaccine demand reviews and findings from the last COVID-19 Knowledge, Attitudes and Practices Survey conducted in September 2021 and March 2022.
2. Support Advocacy, Communication and Social Mobilization activities in outbreak responses. During the YEHCP, support will be provided to promote uptake of immunization services during COVID-19, Polio, oral cholera vaccine (OCV), and Measles and Rubella vaccination campaigns planned in the country. In addition to supporting uptake of the services, preventive behaviours including sanitation and hygiene promotion will be promoted to prevent diseases.
3. Support qualitative and quantitative research and social listening to track shifts and understand behaviours related to access to health services, nutrition practices, COVID-19 and cholera prevention to inform programmatic shifts and communication messaging.
4. Develop a comprehensive package, and conduct community engagement and mass and social media campaigns promoting positive parental, family and community practices related to mental and psychosocial support and gender-based violence.
5. Support community engagement and accountability to affected populations by coordinating the system-wide Community Engagement and Accountability to Affected Populations Working Group, and coordination of a system-wide complaints and beneficiary complaints and grievance redressal mechanism.

WHO Communication and Visibility

The plan for the YEHCP will be reflecting the lessons learned from the EHNP to ensure improved implementation and overcome similar challenges.

The WHO will set the activities, initial relations with related stakeholders and involved parties, supervise the implementation and measure the impact on a regular basis.

Led by the project's communication officer and supervised by the project's management, the delivery and reporting of the activities will be through the semi-annual project progress reports, which will echo the visibility implementation, social media activity, next action points and any matter related to the C&V application.

Communication and Visibility Objectives
The objects focus on spreading the word about the project, and the different services that people should expect as beneficiaries of the project:

1. Promote the YEHCP services and raise the public awareness of the project.
2. Promote and communicate the results of the project.
3. Promote the cooperation of the project and national/local partners to deliver on the project goals.
4. Ensure visibility of World Bank support to the Project.
5. Promote the Grievance Mechanism (GM) and its contacting channels as an important tool that beneficiaries can use to directly address their complaints/suggestions about the project.

Communication and Visibility Deliverables:
1. Cover and document the project's main supported areas (healthcare, nutrition, public health services), and reflect them on the different publishing platforms, such as (Facebook, Twitter, YouTube, Instagram) through:
    a. Videos
    b. Human interest stories
    c. Infographs
    d. Maps
2. Design and supervise the printing of the project's visibility material, such as: banners, stickers, brochures, storybooks, etc., and ensure the project's visibility in the field.
3. Include a communications section on the semi-annual progress report on the C&V activities progress, social media activity, challenges and next action points.
4. Conduct a KAP survey every six months to measure the progress that has been achieved in regards to the beneficiaries knowledge of the project and the services that the project provides.

Targeted Audience:
- The national and local government counterparts
- The communities and civil society
- The global development partners

Table 26 Communication and Visibility Objectives-based Indicators

Objective	Application	Indicator	Tools	Focal Point	Timeline

Promote the YEHCP services and raise the public awareness of the project.	Social media posts (photos, videos, Infographs, etc.) Poster on the field Awareness sessions Mass media	Percentage (%) of beneficiaries' recognition & knowledge of the project	KAP survey	YEHCP Communication Officer YEHCP M&E Officer	Every 6 months
Promote and communicate the results of the project.	Social media platforms	# of reached and # of users engagement on social media (Facebook, Twitter, Instagram, YouTube)	Social media analysis	YEHCP Communication Officer	Monthly basis through the C&V monthly report
Promote the cooperation of the project & national/local partners to deliver on the project goals.	Social media posts (photos, videos, Infographs, etc.)	# of reached and # of users engagement on social media (Facebook, Twitter, Instagram, YouTube)	Social media posts	YEHCP Communication Officer	Monthly basis through the C&V monthly report
Ensure visibility of World Bank support to the Project.	Social media posts (photos, videos, Infographs, etc.) Printed logos on visibility material such as: stickers, poster, banners, etc.	# of reached and # of users engagement on social media (Facebook, Twitter, Instagram, YouTube) Sufficient & efficient distribution of visibility material on the field. This will be measured through: · the # of visibility installed (banners, posters, etc.) in supported HFs · % of visibility-covered HFs compared to the whole targeted HFs of the project · # of visibility installed per supported HF	Social media posts Printed material	YEHCP Communication Officer Contracted supplier for the installation process	Upon requirement

Also, it's important to hire a media analysis company to provide critical and comprehensive analysis reports via professional media analysis platforms (software), which will be used on quarterly/annual reports and during the implementation mission presentations.

Risk Communication

Risk communications are the activities that take place on the ground, directly interacting with beneficiaries to help fulfilling implementation goals and objectives. Risk communication implementation is led by UNICEF as one of the main project's partners and a lead for this part of the communication and visibility for the project.

All activities under this section will be planned to integrate with the main objectives of the project and reflect the awareness messages tailored for this project in coordination with UNICEF.

The main goal of the Risk Communication activities is to ensure effective and impactful community engagement and mobilization, through speaking directly with the beneficiaries and communicating awareness messages as well as encouraging positive sustainable behavioral-change practices that echo the main objectives of the project.

Identifying Strategic Behavioral Objectives (SBOs) will help isolating the action that would allow the team to make the desired change they're seeking through the community:

SBO1: To ensure reached communities have acceptable health perception related to infective and spreading diseases and adopt protective health behavior
SBO2: To ensure that the targeted communities are fully aware of the essential healthcare and nutrition services that the project is providing.

Grievance Mechanism (GM) communication activities

The GM will serve a platform for beneficiaries to express their perceptions and file any grievances and suggestions about the services they receive, which helps in return in increasing accountability towards beneficiaries, and assist in addressing potential problems.
Effectiveness for the GM system will arise from the awareness of the beneficiaries of the system and that they own the platform to share their perceptions and suggestions of the services provided under YEHCP. Towards this end, communications and visibility activities falling under this component require specific tailoring to ensure a wider audience reach with a profound and comprehensive understanding of the mechanism of the system towards serving its purpose.

Figure 3 Example of GM Social Media Poster

This mechanism will be advocated during the project's implementation through promoting the contacting channels on social media every once then, and highlight the importance of using this system, and to make suggestions that may improve the project's performance, which will benefit them in return.
Visibility material will also be used to clarify the Grievance Mechanism for the targeted beneficiaries and how to effectively reach out to the specified channels of the system by printing posters and banners that include the info related to this system, when, why and how to use it. Moreover, the GM will be introduced to the

targeted community through the Risk Communication activities as part of their awareness and goal messages.

UNOPS Communication

UNOPS and the World Bank will develop a project communication plan jointly, in order to reflect the collaborative nature of Component 2 of the project. In addition, UNOPS and the Bank will establish a joint communications task force, to ensure that the messaging is agreed upon by both sides, and that the messaging is synchronized. The objective of the project communications will be to reflect the nature of Component 2 of the project as that of supporting the target beneficiaries, the local institutions and local service providers.

The branding will be joint and will follow the practice employed by previous and ongoing projects implemented by UNOPS and funded by WB including YIUSEPI, YIUSEP-II +AF etc, whereby the World Bank Group logo will be followed by "implemented by UNOPS". IDA branding will be emphasized when the communication products will be aimed at IDA donors. Although branding will be considered for project sites, it will not be placed on the equipment procured for the sub-projects, due to the risk of misuse.

The project will also make use of the different social media platforms (Facebook, Twitter, etc.) to communicate project messaging on a more frequent basis. The press releases, websites, statements, and interviews will be a part of the communication outreach beyond the direct stakeholders of the project, and those will be agreed upon by both sides. Visual communication material, such as before and after pictures, videos, and other presentations will be actively shared and communicated, including possibly at the World Bank annual meetings. The project will undertake proactive efforts to showcase successes to a wide audience internally and externally. The project will undertake specific efforts to elaborate messaging that would mitigate negative communication, such as explaining why certain projects have been prioritized over others.

5. Implementation Arrangements

A. Institutional and Implementation Arrangements

Throughout the implementation of YEHNP and YIUSEP since 2017, the agencies have further strengthened and expanded their operational capacities and presence in the country to address the health, nutrition, and WASH issues at different levels. Since the three agencies will be relying on and enhancing PMUs that are already in place, the level of readiness for implementation is very high. Similar to what has been done for the YEHNP, YCRP, YIUSEP I and II, the WB and the three implementing agencies will keep the Government of Yemen appraised on implementation progress through periodic consultative meetings where the relevant ministries will be represented.

WHO leads the Health Cluster with UNICEF as a key partner and UNICEF leads the Nutrition Cluster with WHO as a key partner. The Clusters are the main sectoral coordination mechanisms across UN agencies, multilateral and bilateral donors as well as international and local NGOs and civil society organizations. Through their network of providers, contractors, GHOs, DHOs, and INGOs/local non-governmental organizations (LNGOs), both organizations have existing institutional and implementation channels for the delivery of essential services and ensuring the availability of critical medicines nationwide. For WASH interventions under the ongoing YEHNP and YIUSEP I, two levels of coordination have been ensured, at the WASH cluster level and the

regular coordination meetings that used to be held between the WHO, UNICEF and UNOPS and led by the UW-PMU. These implementation arrangements, which proved successful under the past health and WASH projects, are context-specific and flexible, based on the population needs and local capacity (DHOs or NGOs, WSLCs) to provide the identified package of healthcare and WASH services. Therefore, both organizations (WHO and UNICEF) will work with the existing local health system structures at the central,[23] governorate, district, and community levels to preserve the national capacity and maintain the core functions of the health system. Under YEHCP, UNOPS will also join the regular weekly meeting of WHO and UNICEF as well as WASH cluster meetings. Focused attention to coordination will be given during implementation to coordination mechanisms among the UN agencies and stakeholders are especially given that there is no legally binding mechanism for coordination. UNOPS will continue working with the autonomous national and local water and sanitation institutions at a local decentralized level to strengthen their capacity and resiliency and maintain the delivery of water and sanitation services.

At the PHC level, UNICEF will work closely with the staff hired at the facility level (doctors, nurses, technicians, etc.). Outreach and mobile teams will be formed from NGOs, local facilities and communities. GHO and DHO staff networks will be used in their supervisory, support, and monitoring roles. Community-Based Organizations (CBOs) will be utilized to directly provide services as needed. UNICEF will also be responsible for the training of CHNVs, CMWs and CHWs; as well as for monitoring the implementation of the integrated community-based program.

At the secondary care level, WHO will provide direct logistical, operational and capacity support to the teams working in public hospitals at various targeted units (maternal wards, neonatal wards and nutrition therapeutic feeding centers/stabilization centers), while UNICEF will provide the nutrition therapeutic supplies. Contracting for the needed services in deprived hospitals will also be considered to cover some of those service gaps. WHO will also work closely with vendors and suppliers to maintain an adequate flow of basic supplies (water and fuel) and essential medicines for all levels of care. WHO will be responsible for operationalizing the sites under eIDEWS which are staffed by public health workers in terms of logistics and capacity readiness. Finally, WHO will oversee the logistical preparation and execution of the nationally targeted campaigns for the various infectious agents by working closely with implementing teams following the same modalities as, and in close collaboration with, UNICEF.

UNOPS will be responsible for WASH activities under component 2 and will coordinate with UNICEF and WHO on community engagement aspects, behavioral elements (i.e. hygiene practices) of WASH. UNOPS will work with the autonomous national and local institutions (UW-PMU and PWP), WSLCs, their branches, AUs and branches of GARWSP that are key implementing partners based on signed project partnership agreements (following satisfactory detailed capacity micro-assessment carried out by UNOPS). UNOPS' main responsibilities are: (i) implementing Component 2 to achieve its objectives; (ii) coordinating and collaborating with national implementing partners (UW-PMU and PWP) and local institutions as mentioned above; (iii) enhancing the institutional capacity of local WSS providers and local implementing partners; and (iv) contracting private sector to implement interventions. UNOPS will work with qualified contractors / private sector with an established track record in the implementation of WSS interventions under YIUSEP-I. Having UNOPS as the implementing agency for the two WASH component under the new projects (YEHCP and YIUSEP-II) will ensure solid integration of WASH interventions in 35 urban and rural areas.

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[23] While no IDA funds will be channeled to central institutions, the central MoPHP plays a central role in at the policy level. UNICEF coordinate with, receive approvals from and indirectly build the capacity of the MoPHP through training and technical assistance.

SPECIFIC TASKS UNDERTAKEN BY national and local institutions (UW-PMUs and LCs etc): (to be filled by UNOPS based on the signed PCA)

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…………………………………

8.

B. Fiduciary Arrangement

Financial Management

WHO, UNICEF and UNOPS will maintain separate accounts for the project and ensure that original supporting documents of expenditures are retained. The project will use Interim Unaudited Financial Reports (IFRs) for disbursements and will submit the reports on a quarterly basis to the Bank. Funds will flow from the Bank to the recipients' corporate accounts before flowing to their local bank account or the bank accounts of their implementing partners and onward to the ultimate recipients/beneficiaries. The project will follow the audit arrangements agreed between the Bank and UN agencies as per the FMFA. In case the Association and the Recipient agree that additional due diligence measures are needed, the Recipients shall ensure that any additional due diligence measures of its Respective Part of the Project are carried out exclusively in accordance with its Financial Regulations and Rules, and in conformity with the single audit principle observed by the United Nations system as a whole.

Progress Made and Applied to the YEHCP on Strengthening Fiduciary Performance

Additional controls over the use of DFC and DCT modalities where advances are provided to UN agencies implementing partners:

a. Replacing the reliance on such modalities, as deemed appropriate, with the direct disbursement and reimbursement modalities.
b. Limiting the use of such modalities to 30 percent of the total financing provided to each recipient.
c. An initial financial assessment of implementing partners (IPs) will be carried out to assess the FM arrangements of the potential IP under the DFC/DCT modalities. Based on the assessment results and the risk rating provided through the assessment recipients will decide on whether the IP maintains the required level of FM arrangements to receive funds through such modality.
d. On a quarterly basis, advances provided to IPs will be reviewed by the recipients'' financial team and/or the TPM. A full financial review of the IP will be carried out by the TPMA after the settlement of the advance in a period that will not exceed 6 months from receiving the advance.
e. All UNOPS advances are covered by bank guarantees, except for operational advances to implementing units that are monitored on quarterly basis and do not exceed USD250K to meet operational expenses.
f. IPs that will receive more than US$300,000 in one financial year will be subject to financial audit.
g. WHO and UNICEF maintain systems in place to timely follow up and address findings of financial reviews of IPs.
h. Invoices are stamped to show the source of financing and avoid double-dipping.

- Use of the market exchange rate in both the north and the south: Stemming from concerns related to the difference in the Yemeni Rial (YER) - US Dollar (US$) exchange rate between the southern and northern governorates and the associated risks related to possible lack of transparency on how the project funding would be converted from US$ into YER, the following arrangements have been agreed:
    a. A streamlined mechanism has been developed for the use of market rate in the south, similar to the one applied in the north by UN agencies. The new mechanism uses the daily published market rate by the Currency Traders Association and maintaining the funds in USD accounts in the north and the south while conversion to YER is made at the time of payment.
    b. UN agencies and their implementing partners will apply the new mechanism.
    c. The spot checks and annual audits of implementing partners will ensure compliance with the new mechanism.
    d. In addition to project-specific audits, on an annual basis or according to other frequency agreed, UNOPS Carry out spot checks of specific transactions reported in the IFRs and selected by the bank. The spot checks will be conducted by UNOPS auditors on behalf of the UNOPS Internal Audit and Investigation Group (IAIG).

Flow of Funds and Disbursement Arrangements:

The project will use the IFR method for the flow of funds to WHO, UNICEF and UNOPS. For this project, recipients will use the Direct Implementation modality as much as possible, to mitigate any risk associated with advances to implementing partners, by which funds will flow from the Bank to their corporate accounts and then to the ultimate beneficiaries/recipients without going through intermediary accounts.

Funds will flow from the Bank to the UN agencies' corporate accounts. Transfer from the UN corporate accounts to UNICEF, WHO and UNOPS in Yemen will be based on semi-annual forecasts. UN agencies disburse in US$ and the Implementing Partners obtain market rates based on the Yemeni association for money exchangers. Implementing Partners follow the market rates and ensure that the commercial banks they are dealing with apply the same rate.

The use of advances to implementing partners should be limited. In cases when advances are used, recipients (the UN Agencies) will ensure proper controls are in place, such as: (i) the advances should not exceed certain thresholds; (ii) no new advances are released to implementing agencies unless previous advances are fully settled (in cases of partial settlement, additional funds can be provided within the limit of the partial settlements made); (iii) all supporting documents for expenditures incurred under the project are maintained; and (iv) all advances have proper audit trails.

Recipients (the UN Agencies) will exert all efforts to ensure that funds reach the ultimate beneficiaries with sufficient evidence provided. This includes ensuring that no funds are transferred to the central government or personal accounts of individuals unless those individuals are the legitimate recipients of cash for work or services rendered.

Internal Controls:

To ensure proper controls are applied over the use of funds, the recipients will ensure the following:

a. The finance teams located in the field is comprised of sufficient qualified staff to review and properly maintain and file all original supporting documents of the project. The finance team will also ensure that proper controls are in place over the use of funds and that payments are made for eligible expenditures with consideration to economy and efficiency.

b. The compliance team or its equivalent will assist their finance teams to ensure arrangements are in place for funds to reach the legitimate beneficiaries.

c. Finance and compliance (or its equivalent) teams will ensure proper controls are in place for the management and recording of inventory. In addition, they will ensure that proper measures are in place to prevent double-dipping of activities.

d. Adequate financial and technical reviews are conducted regularly by the TPMAs and recipients' finance and/or M&E teams.

e. In case of payments to individuals in return for goods or services rendered, recipients will use mobile banking, payment agencies or other methods that can provide a high level of assurance that funds reached the intended beneficiaries.

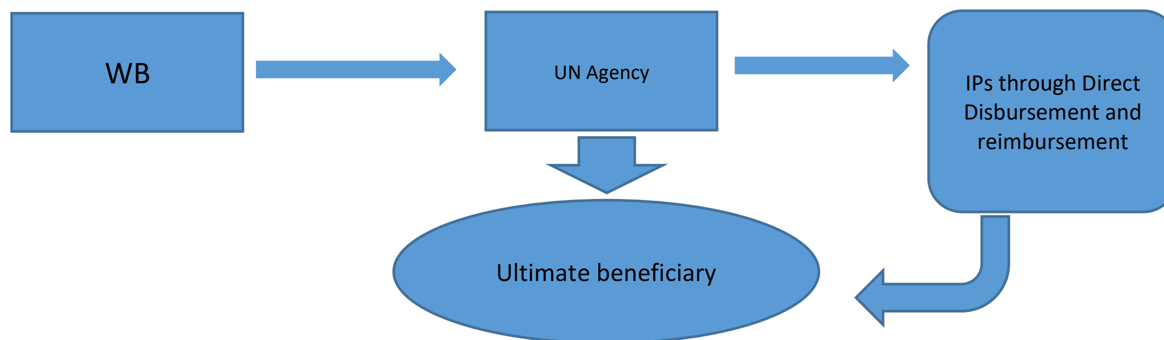

Figure 4: Flow of Funds to Ultimate Individual Beneficiary

f. Recipients will ensure that IFRs are properly reviewed and approved before submission to the Bank. In addition, IFR-reported expenditures will include no advances other than those agreed with the Bank and disclosed in the IFR.

g. Adequate controls over the use of DFC and DCT modalities which will include the following items agreed with the Bank:

h. Replacing the reliance on such modalities, as deemed appropriate, with the direct disbursement and reimbursement modalities.

i. Limiting the use of such modalities to 30 percent of the total financing provided to each recipient.

j. An initial financial assessment of IPs will be carried out to assess the FM arrangements of the potential IP under the DFC/DCT modalities. Based on the assessment results and the risk rating provided through the assessment recipients will decide on whether the IP maintains the required level of FM arrangements to receive funds through such modality.

k. On a quarterly basis, advances provided to IPs will be reviewed by the recipients'' financial team and/or the TPM. A full financial review of the IP will be carried out after the settlement of the advance in a period that will not exceed 6 months from receiving the advance.

l. IPs that will receive more than USD300K in one financial year will be subject to financial audit.

m. WHO, UNICEF and UNOPS maintain systems in place to timely follow-up and address findings of financial reviews of IPs.

Fraud and corruption:

The following provisions apply to the UNICEF Office of Internal Audit and Investigations ("OIAI"), the UNOPS Internal Audit and Investigations Group ("UNOPS IG"), and the WHO Office of Internal Oversight Services ("WHO IOS") (the "UN Investigative Offices"), each for their Respective Parts of the Project, as defined in their respective organization's Financing Agreement.

The UN Investigative Offices shall be responsible for, in a manner consistent with their accountability and oversight frameworks, including their regulations, rules, policies, procedures, and administrative instructions:

(*i*) carrying out any investigations of non-frivolous (credible) allegations of corrupt, fraudulent, collusive, or coercive practices under their Respective Parts of the Project, as defined in their Financing Agreement (collectively, "Non-Frivolous Allegations"); and (*ii*) notifying the World Bank of any Non-Frivolous Allegations of which they become aware and providing updates, as defined below. This responsibility does not extend to government officials, or officials or consultants of the World Bank.

Each UN Investigative Office shall provide the World Bank Group Integrity Vice Presidency ("INT"), on a confidential basis every six months, with a report on Non-Frivolous Allegations of which it becomes aware, as well as any related investigations and any actions taken. This process applies to all such Non-Frivolous Allegations, regardless of whether the UN Investigative Office intends to act on the allegation, or of any actions taken by the UN Investigative Office to address the allegation. Should the UN Investigative Office not become aware of any Non-Frivolous Allegations during the reporting period, the UN Investigative Office will inform INT of this fact in the report.

A template for this report is provided on the page that follows. Alternatively to using this template, the UN Investigative Office may provide the details of any Non-Frivolous Allegations to INT through the disclosure of pertinent documentation, *e.g.*, through the referral of an investigative report, or a summary of the Non-Frivolous Allegations and/or the results of any investigation or assessment, provided the disclosure includes the minimum information listed in the template. The report or alternative disclosure should be sent to a contact point to be designated by INT.

In addition to this reporting, if INT informs the UN Investigative Office that a Non-Frivolous Allegation falls under the World Bank Group's sanctions jurisdiction, the UN Investigative Office shall continue to work in close collaboration with INT—in accordance with its accountability and oversight framework, including its regulations, rules, policies, procedures, and administrative instructions—to: (*i*) cooperate with INT's investigation of the allegation; or (*ii*) if the UN Investigative Office takes action and completes an investigation of an allegation of that matter itself, cooperate with INT in bringing a sanctions case against any implicated entities and individuals, as appropriate. The specific terms of this collaboration will be agreed-upon by INT and the UN Investigative Office on a case-by-case basis. The entities and individuals potentially subject to INT investigation, or to a World Bank sanctions case initiated by INT, do not include UNICEF, UNOPS, WHO, or their personnel.

Template for Reporting on Non-Frivolous Allegations

Date: _______________

☐	During the prior six months, [UN Investigative Office Name] has not become aware of any Non-Frivolous Allegations in connection with any World Bank-financed projects under which [UN Organization] has received funding.
☐	During the prior six months, [UN Investigative Office Name] has either: (*i*) become aware of one or more new Non-Frivolous Allegations in connection with a World Bank-financed

	projects under which [UN Organization] has received funding; or (*ii*) progressed in actions that it has chosen to take in relation to a previously-reported Non-Frivolous Allegation. The details of those Non-Frivolous Allegations are as follows:

Allegation Reference Number	Date of Allegation	If Possible given Allegation-specific Context, the Source of Allegation (*E.g., Internal or External Party to [the UN Organization], Anonymous or Unknown Complainant etc.)*	Country	Name(s) of World Bank-Financed Project(s) Potentially Affected	Description of Allegation (*Including the nature of the allegation and, if possible in that matter, information about the alleged perpetrator(s), e.g. Project Official or Competitor)*	Description of Status or, if Applicable, Outcome

Note: The above information is being provided to INT by [UN Investigative Office Name] on a confidential basis, in a manner consistent with the [UN Organization's] accountability and oversight frameworks, including its regulations, rules, policies, procedures, and administrative instructions, and giving due consideration to the safety, security and privacy of any involved individual(s) [*IF APPLICABLE: including pursuant to the confidentiality procedures outlined in the Memorandum of Understanding between [UN Investigative Office Name] and INT dated [DATE]*]. INT will only disseminate it within the World Bank on a strict 'need to know' basis. In the event that INT decides to share the above information, on an allegation-specific level or in any way that could permit an external party to identify an involved individual, with another party external to INT, regardless of whether that party is also part of the World Bank, or decides to use the above information in furtherance of its own investigations, it will notify [UN Investigative Office Name] in advance and, consult with [UN Investigative Office Name] before doing so.

C. Procurement

Alternative Procurement Arrangements (APA) will be applied given that the procurement procedures of UNICEF, WHO and UNOPS (the UN Agencies) have been assessed to be consistent with the Bank's Core

Procurement Principles at the corporate level by OPCS and at the local level they have been assessed as satisfactory both in terms of staffing and practices under other agreements in Yemen (Emergency Health and Nutrition Project -P161809, COVID-19 Response Project -P173862, Integrated Urban Services Emergency Project II, Yemen Emergency Crisis Response Project -P159053) as allowed by the Procurement Framework Policy Section III. F. Thus, WHO, UNICEF and UNOPS will follow their own procurement procedures to procure the required supplies, including storage and distribution to the destination.

As most of the project activities will be a continuation or similar to those of the current Yemen Emergency Health and Nutrition Project, the risk of the project can be rated Substantial due mainly to the security situation in Yemen, the composition of the marketplace (limited competition and availability of service delivery), and the situation on the ground in conflict or post-conflict zones having an impact on the project activities.

UN Agencies will be responsible for: (i) implementing the procurement plan as agreed with the World Bank; (ii) hiring the Third-Party Monitoring Agents (TPMAs); (iii) preparing a semi-annual report on the progress of procurement and distribution; (iv) reporting on the indicators in the results framework; and (v) providing other relevant performance information to the World Bank as requested.

As part of the procurement process, contractors will be pre-screened against the World Bank's list of sanctioned or temporarily suspended companies/individuals (https://www.worldbank.org/en/projects-operations/procurement/debarred-firms) prior to awarding any contract financed by the EHCP. The main objective is to be sure that no contract will be awarded to a firm or individual debarred and thus ineligible to participate in World Bank-financed contracts for the period indicated.

Implementing agencies will report on the implementation progress of the procurement plan as part of the Progress Report, including any procurement complaint received and how it was addressed. The following information will be provided (date of complaint filing, date of response to complaint (if any), type of complaint (bidding documents, pre-bid conference, award). This does not include complaints related to the shipment or delivery of equipment/products (e.g. differing specifications, breakages etc). Such complaints will continue to be reported through the GRM and TPM key findings. The reporting of complaints should not in any way delay or slow down the procurement process, given the level 3 emergency context of Yemen.

Procurement Activities: The procurement activities under this project will include component 1: procurement of basic supplies, equipment, maintenance, medical and non-medical supplies, essential drugs, vaccines, micronutrients, fortified nutritious supplements, and minor rehabilitation of existing facilities. From component 2, the project will procure basic supplies (water and fuel), equipment and maintenance for WSS facilities, WASH consumables and kits and rehabilitation of existing medium and large water and sanitation facilities. The main procurement activity under component 3 is the hiring of TPMAs.

Organization Procurement Policy

UNICEF Procurement Policy

The procurement methodology within UNICEF is carried out based on specific policies and procedures which are set by UNICEF Headquarters and compliant with international procurement and financial standards.

The sourcing of supplies depends upon the type of material to be procured and the financial value of the order to be placed thus competitive bidding can be global, regional or local.
To differentiate, the procurement within UNICEF is carried as per below:

1. Local procurement (Carried by Country Office)
2. Offshore Procurement (Carried by Supply Division – HQ)
3. Direct Order using Global LTA`s (Long Term Agreement set by Supply Division while the order is placed directly by Country Office against the Long-Term Agreement with global vendors)

The procurement within UNICEF is directed by solicitation processes which is aligned with financial regulations ensuring purchases are based on fair competitive bidding which ensures best value for money.

The solicitation processes are categorized as follow:

1. Request for Quotation (RFQ): Written solicitation sent to a number of suppliers sufficient to obtain preferably three acceptable quotations, if possible, for requirements between USD 2,500 and USD 30,000. The RFQ incorporates UNICEF General Terms and Conditions. No formal bid receiving, or opening is required.
2. Invitation to Bid (ITB): Written solicitation sent to a number of suppliers sufficient to obtain preferably three valid and acceptable bids if possible, for requirements of USD 30,000 and over. The ITB incorporates UNICEF General Terms and Conditions. A formal bid receiving and bid opening are required.
3. Request for Proposal (RFP): Written solicitation sent to a number of suppliers sufficient to obtain preferably three valid and acceptable proposals if possible. The RFP typically requests a solution to a complex problem. A RFP is used to satisfy requirements that cannot be described in a complete or definitive manner, where the selection will not be made on compliance and price alone, but rather on the best value for money*. This is achieved by assessing value-adding factors, which are pre-defined in the RFP which incorporates the evaluation criteria. The RFP also includes UNICEF General Terms and Conditions. A formal bid receiving and bid opening is required, irrespective of the value of the order.

Solicitation Methods:
The solicitation process starts by issuing a RFQ, ITB or a RFP. This document is prepared in VISION (ERP System – SAP) by the supply staff and sent to the potential suppliers on the invitee list.

Bidding:
UNICEF follows various methods for bidding, this is described below:

1. Public bidding using local newspapers, websites
2. 2. Publishing bid on UNGM (United Nation Global Market)
3. Circulation of bids to pre-qualified suppliers based on market assessment

Receipt and Opening Of Submissions

RFQ: Responses are submitted directly to the Supply section by hand, mail, fax or e-mail as per instruction in the RFQ document.

ITB and RFPs: Responses are submitted in sealed envelopes (UNICEF Yemen is in process as per 2020 Supply strategy in applying online tendering) clearly marked on the outside with the solicitation number and other details as per the instructions sent to the invitees. All submissions are kept sealed and secured in a tender box until the date and time specified for the opening. (Secure process is adoptable using secure fax and/or email).

Bids or proposals are opened at the specified time by the Supply Manager, or the designated staff in the presence of a witness from another UNICEF Section as designated by the Head of Office. The designated witness should be neutral, i.e. not directly involved with the requisition for which the opening of the bids or proposals is being conducted. The Supply Manager, or the designated staff, and the witness initial each page of each bid. A record detailing all responses received and the names of the two staff members responsible for the bid opening should be prepared and signed.

Bids are tabulated as soon as possible after the bid opening using a tabulation sheet.

Bid evaluation
The bid evaluation is done in two phases:

Technical evaluation is conducted by program unit/technical team and accordingly the result is shared with supply unit staff highlighting approved and unapproved companies/vendors
Financial evaluation is conducted by supply unit staff members; this is initiated based on the receipt of the technical evaluation report were only accepted companies offers are considered (financial envelopes for companies that are not approved remains sealed).

In general, the recommendation on selection is based on factors such as the lowest price for an acceptable bid and delivery lead time.

Based on the total value of the purchase order to be issued, an approval process is followed (e.g. if the value is above $100,000 a CRC (Contracts Review Committee) recommendation should be obtained which entail a review based on the value to be done by Chairperson of CRC, convene a CRC full meetings and eventually approval by the Representative.

On completion of the adjudication and award recommendation a purchase order or a contract is prepared for the bid accepted. As soon as the PO has been authorized and signed it is forwarded to the supplier, with the PO Acknowledgement copy for the supplier’s signature.

Upon receipt of confirmation from the vendor on Goods readiness, the supply unit would advise the inspection company (LTAs exist for this service) for conducting a pre delivery inspection and share the report for UNICEF endorsement. If the predelivery inspection is cleared, the supplier will deliver the items as per agreed incoterm and submit his invoice accordingly to UNICEF along with a signed/stamped waybill which confirm completion of delivery.

Every PO item will be defaulted with “GR based IR” (Goods Receipt based Invoice Receipt). This implies that the vendor invoice can be paid only after proof of delivery is obtained. The proof of delivery and valuated goods receipt for all local and Country-offshore documents are processed in the system.

For offshore supplies, the payment to the vendor, is made when the GR (Goods Receipt) is produced with the vendor invoice, while for local supplies, the payment to the vendor is based on the submission of the proof of delivery signed by the Implementing Partner (IP). If supplies are not delivered directly by the supplier, but through a third- party transporter / freight provider, the third party will sign the vendor receipt / proof of delivery against which payment can be made.

Local procurement vs international procurement

UNICEF procurement at country level is guided by global policies, and the supply manual defines the list of materials which are not allowed to be procured locally at country level and may only be procured through UNICEF Supply Division (Exceptions may be granted on a case by case through supply division).

Table 27: Materials not allowed under local procurement, UNICEF Procurement Policy

Materials not allowed under local procurement		
Human Vaccines	antitoxins/globulins	anti-venom
Tuberculin/sensitins	auto-disable syringes	re-use prevention featured (RUP) syringes
Safety boxes	pharmaceuticals	therapeutic food
Supplementary food	salt iodization supplies	food fortification supplies
Drill rigs and associated high value equipment	ground water survey measuring equipment, e.g. resistivity meters	HIV-AIDS diagnostic and monitoring equipment
Long Lasting Insecticidal Nets (LLINs) and insecticides	Rapid Diagnostic Test Kits, including for HIV/AIDS, Hepatitis, Malaria, etc	Cold chain equipment, including solar powered refrigeration systems, cold and freezer rooms, cold boxes, vaccine carriers, ice packs, refrigerators and freezers
Household water treatment and purification products. This includes products such as filters, chlorine and non-chlorine-based additives, water treatment chemicals, etc. Products for bulk water treatment do not require local procurement authorization.		

In addition to the above, country offices are required to obtain a Local Procurement Authorization (LPA) for construction or rehabilitation projects exceeding $100,000 annually with the exception of sanitation facilities in schools and to water treatment facilities where the ceiling is $500,000.

WHO procurement policy

WHO follows the WCO procurement policy, and types of an agreement to use, for the acquisition of services, whatever the source of funds or the use for which they are intended. Service agreements may be provided by individuals, companies (firms), institutions or other non-profit organizations.

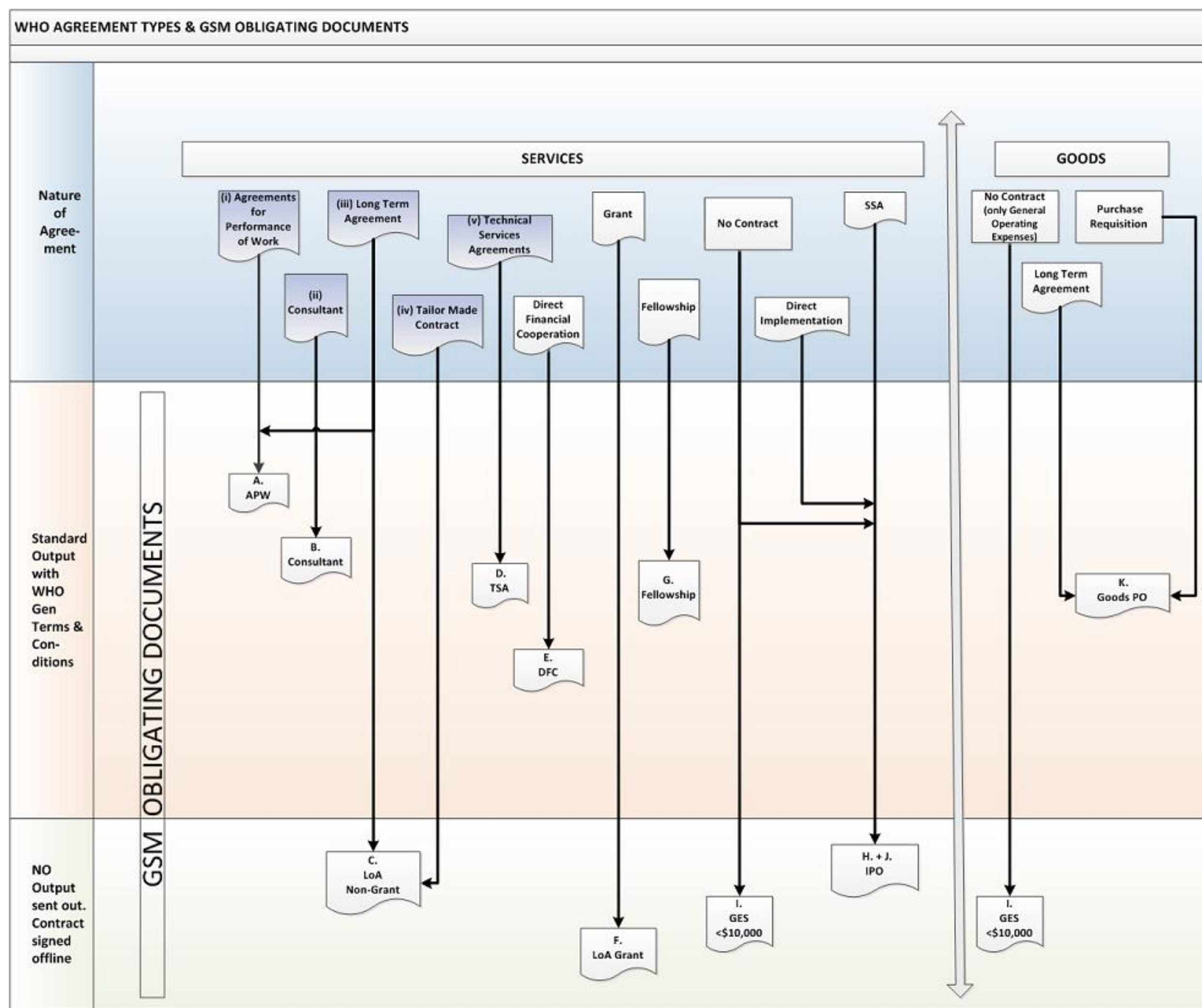

Figure 5 A Schematic Overview of All Agreement Types and GSM Obligating Documents (WHO)

An adjudication report is required for all services procurement in excess of US$ 2,500. An adjudication report must justify the selection of a contractor in relation to other available alternatives in the market. Offers should normally be sought from at least three prospective suppliers or, in the case of procurement expected to exceed US$ 200,000, from as many prospective suppliers as possible. Cost, quality, reliability and availability to meet deadlines are important criteria to address and compare. Experience with WHO is not in itself a factor, unless it specifically contributes to the quality or cost of the work.

Any proposed procurement of services expected to exceed US$ 200,000 and any proposed procurement of services for which a waiver of the normal competitive bidding requirements is requested, should be submitted

to the Contract Review Committee. The Contract Review Committee should also be consulted where it can reasonably be expected that the work to be contracted is part of a larger piece of work to be performed by the same contractor, which will require a total contractual expenditure that may exceed US$ 200,000.

The types of agreements that can be used for the acquisition of services as described in this are: the Agreement for Performance of Work (APW), Consultant Contract, Long Term Agreement (LTA), Tailor Made Agreement (TMA) and in certain cases (as further explained below), the Technical Services Agreements (TSA).

If there is doubt about the appropriate agreement type to use, CPC (at HQ) or the Regional Procurement Officer are consulted. The Office of the Legal Counsel (LEG) or the Director of Administration and Finance (DAF) in the regions may be asked to provide further guidance if needed.

Any request by a contractor to amend any of the general conditions applicable to WHO's standard contracts (APW, Consultant Contract, TSA) must be referred to LEG. LEG should be consulted with regard to all Tailor-Made Agreements. LEG should also be consulted with regard to Long Term Agreements when standard contracting clauses in the approved LTA templates need to be amended.

The Agreement for Performance of Work (APW) is used for arrangements whereby a specific product such as a report, an article, or translation and editing of a document is prepared and delivered; or technical services such as organization of a seminar is arranged by an individual or a firm, at the request of WHO, without direct supervision by an officer of the Organization. Normally, the individual contractor or firm will not carry out the work on WHO premises.

Agreements for Performance of Work should not be concluded for work which would typically be carried out under a Consultant Contract, i.e. work requiring direct supervision by a WHO staff member and possibly also presence on WHO premises for more than an occasional visit. In case of doubt, clearance should be sought from Director, Human Resources Management (or Regional Personnel Officer) before an agreement is concluded.

An individual or employee of a company hired under an APW shall not be related to a staff member who is responsible for reviewing and/or approving the commissioned work.

APWs may not be issued to WHO staff members. In signing the APW in his/her personal capacity, the contractor certifies that he/she does not (and will not during the term of the APW), hold any form of contractual relationship with WHO (including any WHO regional, country or project office, as well as any program, center or other entity, where staff is subject to WHO Staff Regulations and Rules) that confers upon the contractor the status of a WHO staff member.

An individual contractor should not hold concurrent contracts with WHO unless the contracting unit or units can show that the overall work required of the contractor under the various contracts is less than 40 hours per week.

The General Conditions applicable to the APW are set out on the APW form generated automatically through the GSM procurement module. All parts of the APW form relevant to the particular service to be performed should be completed, including the project period, summary of the work, payment terms, and deliverables. If more detailed terms of reference or a separate budget are prepared, they must be attached as an annex to

the Purchase Requisition at the time of submission and filed electronically in the Records Management System (ECM).

Consultants. A consultant is an individual who is a recognized authority or specialist in a specific field, engaged under a temporary contract in a technical advisory or consultative capacity. A consultant must have special skills or knowledge not normally possessed by the staff of the Organization and performs functions for which there is no continuing need in WHO.

- The consultant is engaged for the purpose of performing a specific time-limited piece of work for WHO in a technical advisory or consultative capacity and normally:
  nature of the work requires the presence of the individual on WHO premises for more than an occasional visit; and/or
  The work to be performed requires close WHO technical guidance; and/or
- The work requires the individual to undertake travel for WHO, including to areas affected by disease outbreak or areas where a public health problem is prevalent.

Examples of the type of work for which a consultant contract should normally be issued are: the analysis of medical, scientific or other technical issues in countries; the evaluation of national health programmes; the assessment of disease outbreaks; the performance of disease outbreak activities; the assessment of compliance by third parties with WHO recommended standards (through site-visits); the provision of specialized health-related training in countries, the filming of WHO activities in countries; and the performance of specialized IT-related work on WHO premises. This list of examples is not exhaustive.

Long Term Agreement (LTA) for the provision of services (also referred to as "umbrella" or "framework" agreement) is an agreement between the Organization and a supplier for the provision of certain defined services at a fixed price during a defined period of time (e.g. 2 or 3 years). An LTA does not constitute an obligation on the part of WHO to procure any (minimum quantity of) services from the company, nor does it prevent WHO from purchasing similar services from other sources.
LTAs are used to maintain one or more reliable sources of supply for services at a competitive price, in accordance with pre-defined terms and conditions. As noted above, the price for the services is fixed for the duration of the LTA. Each LTA includes the procedures for WHO to place specific orders for the services at the agreed price and the terms to which such orders will be subject.
LTAs may be raised with a single supplier or (in order to have multiple sources of supply for the same type of services) with several suppliers and may include one or several services. The supplier shall offer the same prices and terms as those agreed with WHO to other interested UN system agencies and to organizations eligible to purchase through WHO (it being understood that each agency and organization will be responsible for independently entering into and administering its own contract with the supplier); and the supplier shall take into account the additional quantities of services purchased by all UN system agencies and other organizations as aforesaid to further reduce the priced for WHO and such other agencies and organizations.

Tailor-Made Agreements (TMA) is the general term used to describe an agreement with an external party, which is not a standard WHO agreement. It is used for the procurement of services where it is not appropriate to use an APW, Consultant Contract, TSA or LTA (for example, where a significant number of special requirements need to be included because of the type of work to be performed).
Tailor-Made Agreements need to be drafted separately each time to fit the particular circumstances and requirements of the proposed activity. Therefore, it is important to consult with LEG at an early stage. As Tailor Made Agreements are non-standard, they always require clearance by LEG before signature.

Technical Services Agreements (TSA) is an agreement for research or other technical projects/investigations. Technical Services Agreements (TSAs) which have been reviewed and recommended for funding by an established steering committee or similar established scientific or technical review body are exempt from WHO's rules on competitive procurement and Contract Review Committee (CRC) review. Those TSA contracts which have not been reviewed by an established steering committee, scientific or technical review body shall be subject to WHO's rules on competitive procurement and review by the Contract Review Committee (CRC).
TSAs should not be confused with Agreements for Performance of Work (APWs), which are intended for use in arrangements whereby a specific product such as a report, an article, or technical services such as organization of a seminar, or translation and editing, is prepared and delivered by an individual or a firm, without direct supervision by an officer of the Organization. In case of any uncertainty about whether the APW or TSA should be used in a particular case, LEG should be consulted.
The General Conditions applicable to the TSA are set out on the TSA form generated automatically through the GSM procurement module. All parts of the TSA form relevant to the particular research or other technical project/investigation to be performed should be completed, including the project period, a summary of the work, payment terms, and deliverables. If more detailed terms of reference or a separate budget are prepared, they must be attached as an annex to the Purchase Requisition at the time of submission and filed electronically in the Records Management System (ECM).

Direct Financial Cooperation (DFC) is both a contractual agreement document and a GSM obligating document. The DFC contract generated by the GSM system is sent to the supplier for countersignature. The countersigned DFC agreement must be uploaded into ECM.

Direct Implementation (DI) Imprest Purchase Order (IPO) should only be initiated once it has been determined that other types of standard contracts (e.g. DFC, APW, GES) are not possible. The GSM obligating document is internal only and it does not generate an output to be signed or uploaded.

General External Services (GES) is an internal commitment that does not generate a contract to be sent to the supplier for countersignature. Its purpose is to create an encumbrance in a WHO work plan, and an internal commitment against which the supplier's invoice(s) can be paid.
A GES can only be used to create an encumbrance for the payment of a service for which no written agreement exists and for which the supplier simply invoices WHO. Where a contractor refers in its quotation to its own general terms and conditions, LEG should be consulted prior to issuing a GES.

Imprest Purchase Order (IPO) provides a means to procure from local suppliers and pay directly from the Imprest account when it is impractical, not feasible, or not possible to use the regular procure-to-pay process. The IPO is mainly used in Regional Offices and Country Offices. The IPO is an internal commitment that does not create a contract to be sent to the supplier for countersignature. Its purpose is to create an encumbrance in a WHO workplan mainly in-country offices against which payments can be made. The IPO is also used for processing payments to individuals holding a Special Services Agreement (SSA) contract.

Goods Purchase Order (Goods PO) is used for the procurement of goods. It is also used for the processing of Long Term Agreements (LTA) for goods. The Goods PO serves both as a contractual agreement document and as an internal commitment in GSM. The Goods PO which is generated by the GSM system is sent to the supplier for countersignature. The countersigned Goods PO must be uploaded into ECM.

UNOPS Procurement Policy

UNOPS will have a procurement team within its office in Sana'a. It will be led by an experienced international procurement specialist who will oversee 3 national procurement staff to carry out day-to-day implementation of procurement activities. Procurement decision authority is vested with the country-based program manager. The UNOPS Regional Director approves awards of contracts above US$ 250,000 equivalent. The Procurement Committee at UNOPS Headquarters will review awards decisions above US$1 million equivalent. The Committee has virtual reviews twice a week. The Regional Director can request an ad-hoc meeting in the case of critical, time-sensitive procurement. If purchase orders are placed against the existing Long-Term Agreements with UNOPS' suppliers, no reviews by the Committee are required.

UNOPS procedures require its regional committee's review for contracts above US$250,000 even under emergency situations – a process that could take from ten to fourteen working days which may have an effect of delaying the procurement process. This risk will be mitigated by delegation of authority to the Yemen Country Office as needed, and also by invoking emergency procurement procedures within UNOPS which allows to have only one person from CPC to review and approve related procurement process with less than 10 working days. UNOPS will need to remain abreast of the local market response and the complexity of the banking system in Yemen, where local bidders must submit a bid and performance security from reliable local commercial banks. To that end, UNOPS has already carried out an initial market assessment. UNOPS will also take the necessary pre- arrangements to assess the possibility of signing agreements with local commercial banks to accept their securities and include the list of acceptable banks in the bidding documents. UNOPS will also assess the possibility of waiving the requirement for bid security for low-value contracts or may accept certified cheques from credible banks in Yemen.

In respect of UNOPS PROCUREMENT PRINCIPLES they are based on:

Best value for money: in order to obtain high quality goods, services or civil works at the right price competitive processes provided for in the guidelines are important. In addition, technical specifications, TOR or Scope of Work (SOW) should be thoroughly researched and developed for value addition and the Evaluation Committee should be composed of members who understand what is being procured and guidelines for objective evaluation

Fairness, integrity and transparency: Integrity, fairness and transparency and professionalism should be maintained by staff involved with the procurement process at all times.

Effective competition: Ensure equal access of bidding documents and information through any clarifications. UNOPS fosters competition in all procurement processes, as a means of ensuring fairness, integrity and transparency. There may be, however, exceptional circumstances when competition is not feasible and this shall be justified in line the exceptional guidelines. As competition is the basis for fair and transparent procurement, no restrictions should be placed on the competitive process by limiting the pool of potential suppliers unless explicitly mentioned in the legal agreements.

The best interests of UNOPS and its clients: Undertaking procurement in the interest of UNOPS and its partners shall refer to focusing on the achievement of the objectives set out in project agreements while maintaining the image and reputation of the organization. In doing so, UNOPS shall carry out background checks/due diligence of vendors prior to contract award.

In respect of ROLES AND RESPONSIBILITIES, there are four key roles within a procurement process: project manager/requisitioner, procurement official, procurement reviewer, committing officers with procurement

authority (PA). The responsibilities of these roles, as well as the essential segregation of duties measures among these roles, are set out in the Procurement Manual. See below figure.

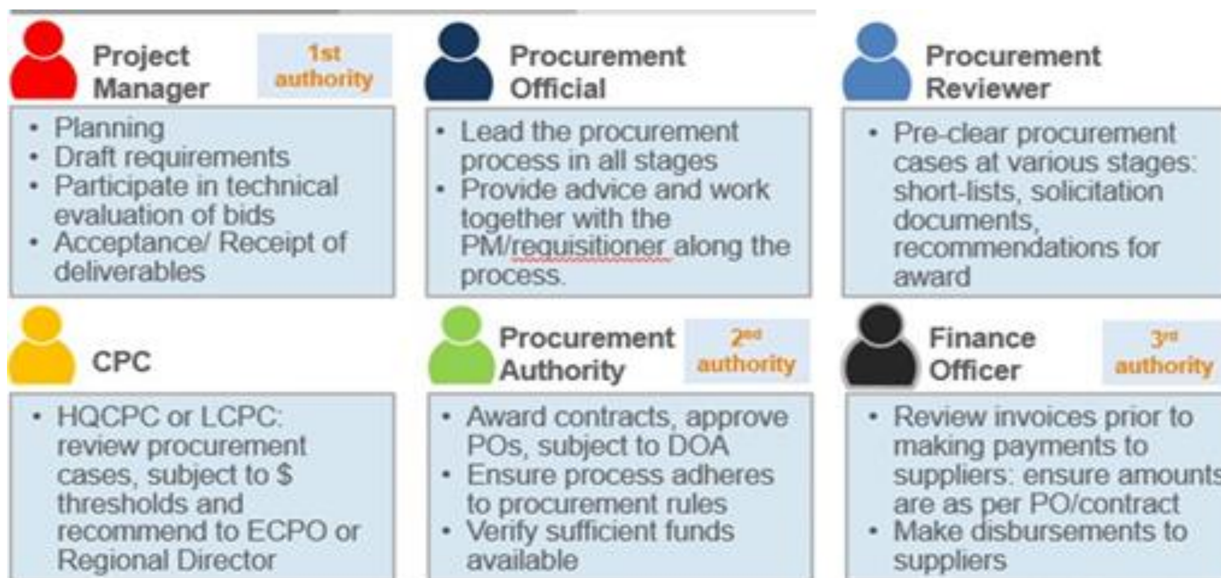

Figure 6: Procurement Roles and Responsibilities in UNOPS

In respect of E-SOURCING, all procurement processes for a value of USD 5,000 or above must be carried out in the UNOPS eSourcing system. This excludes cases done under Emergency Procurement Procedures (EPP) and any other applicable exceptions set out in the Procurement Manual. All procurement activities related to this project will be advertised in the UNGM, and Local Newspaper (when needed) for the aim of attracting more local suppliers.

Figure 7: UNOPS eSourcing Interface Page

In respect of SUPPLIER REGISTRATION AND ELIGIBILITY, UNOPS contracts shall only be awarded to vendors that are registered with the United Nations Global Marketplace (UNGM), except for processes under advisory services projects where UNOPS does not sign the contract with the vendor. Furthermore, for procurement processes carried out through the UNOPS eSourcing system, it is mandatory for vendors to register in UNGM (www.ungm.org) to access the full tender details, request clarifications and submit an offer more details are included in the Procurement Manual.

In respect of PROCUREMENT STRATEGY AND PLANNING, developing a strategic approach to procurement is a key element for successful acquisition of goods, services and works and necessary for timely implementation of projects or operations. Procurement planning for an individual procurement activity includes setting up the timelines required to perform each step of the procurement process per the identified solicitation method, contract type and type of competition.

In respect of REQUIREMENTS DEFINITION, requirements definition is a systematic approach aimed at defining the procurement with the purpose to identify the precise needs of the requisitioner and to determine the best solution to meet those needs. Requirements definition for goods and services can take the form of technical specifications, terms of reference or statement of work. For works requirements, these can be: terms of reference for design and other technical consultancy services for works, design document for works, Employer's Requirements for Design and Build Construction Contracts. Requirements must be generic and defined with the aim of engendering competition; no specific brands, or other unnecessary restrictions can be requested unless for justified standardization purposes.

In respect of PROCUREMENT METHODS, UNOPS Procurement Manual provides a detailed account on procurement methods. Table 3 below summarizes the different solicitation methods and respective procurement thresholds.

Table 28: UNOPS Procurement Methods

Solicitation method	Contract estimated value	Requirements	Evaluation method	Envelope system
Shopping	< US$5,000	Off-the-shelf goods, standard specification, simple services and works	Lowest priced most technically acceptable	No requirement for sealed offers
RFQ	US$5,000 < US$50,000	Requirement for goods, services or works is clear and specific.	Lowest priced most technically acceptable	No requirement for sealed offers
ITB	≥ US$50,000	Requirements for goods, services or works are clearly and completely specified	Lowest priced substantially compliant	

RFP	≥ US$50,000	Requirements for goods, services or works that cannot be expressed quantitatively and qualitatively or complex requirements that may be met in a variety of ways	Cumulative analysis	

The UNOPS PROCUREMENT PROCESS is as follows:

In respect of SOURCING, sourcing is carried out by two main methodologies:

a) Market research, including through internal and external sources; and

b) Advertisement of business opportunities, through either open competition solicitation, or through sourcing methods (RFI, EOI, pre-qualification). All UNOPS business opportunities must be advertised on UNGM and on any website/media specified as mandatory in the project agreement. In addition, it should be advertised or distributed in a manner that, according to the nature and circumstances of the requirements, would lead to the most beneficial responses. If the sourcing process is used to create a short list of suppliers to be invited to a limited competition tender, supplier selection must follow the provisions set out in the Procurement Manual, and the short list must be approved by the relevant PA.

In respect of SOLICITATION, solicitation is done either through formal methods of solicitation or exceptions to formal methods of solicitation. Unless exceptions to the use of formal methods of solicitation are justified, procurement contracts shall be awarded on the basis of effective competition which include:

A. Acquisition planning for developing an overall procurement strategy and methodology;
B. Market research for identifying potential contractors;
C. Competition on as wide a geographic basis as is practicable and suited to market circumstances; and,
D. Consideration of prudent commercial practices (Fin. Rule 118.03).

Open international or national/regional competition is the default method of competition. In the event of a valid reason (as set out in the Procurement Manual) for not holding an open competition and if approved by the PA, a limited competition tender may be issued where only selected vendors are invited to participate in a solicitation.

Limited international and national/regional competition is restricted to a short list of suppliers selected in a non-discriminatory manner from rosters, pre-qualifications, expressions of interest, market research, etc. There are four solicitation methods: Shopping, Request for Quotation (RFQ), Invitation to Bid (ITB) and Request

for Proposal (RFP). The first two are considered non-formal methods (to be used for procurements up to USD 5,000 in the case of shopping, and up to USD 50,000 for RFQ) and the latter two as formal methods of solicitation to be used for values equal or above USD 50,000. For procurement of works, the specific solicitation documents for works must be used.

For the procurement of works, to ensure that the necessary standards for design of UNOPS projects are followed, it is mandatory that prior to commencing the tender process, all infrastructure designs and technical specifications have been reviewed and assessed for design risks according to UNOPS applicable design planning manual and that IPMG has issued a Certificate of Design Review Compliance.

Contracts must be awarded in accordance with the evaluation methodology that corresponds to the selected solicitation method: 'lowest priced, most technically acceptable offer' methodology for RFQs and shopping; 'lowest priced substantially compliant offer' for ITBs, and 'cumulative analysis of technical and financial proposals for RFPs as per definitions included in the Procurement Manual. The evaluation criteria should include as applicable: formal and eligibility criteria, qualification criteria, technical criteria, and financial criteria.

The solicitation documents must be approved by the relevant PA prior to issuing with prior pre- clearance by a Procurement Reviewer if applicable. The deadline for submission should allow vendors a sufficient number of days to prepare and submit an offer. Unless otherwise approved by the PA, the following minimum solicitation period 9 applies: 5 calendar days (RFQ), 15 calendar days (ITB for goods and works), 21 calendar days (ITB for services and RFPs).

Pursuant to the project agreement and subject to review by a contracts and property committee(s) where necessary in accordance with the FRRs, the ECPO or authorized personnel may authorize the issuance of contracts in reliance on the pre-selection of a contractor or implementing partner by the funding source, per further provisions detailed in the Procurement Manual.

In respect of MANAGEMENT OF SUBMISSION, it is the responsibility of suppliers to ensure that offers are submitted to UNOPS in accordance with the stipulations in the solicitation documents. Bidders may modify or withdraw their offers only prior to the submission deadline. For procurement values equal or exceeding USD 50,000 (except for RFQs under secondary bidding under a LTA, RFQs under Emergency Procurement Procedures and processes done with the eSourcing system) an individual not directly concerned with the procurement function must be appointed to receive all offers. For ITBs and RFPs, a bid opening panel must be appointed by the PA and consist of a minimum of two individuals, where at least one individual has no involvement in the subsequent stages of the procurement process, except for processes carried out with the eSourcing system, and documented waivers of segregation of duties in small offices. The bid opening report shall be available for viewing by bidders who submitted bids and may be made available electronically if the bidder requests a copy.

In respect of EVALUATION, evaluation is the process of assessing offers in accordance with the evaluation methodology and criteria stated in the solicitation document. Prior to starting the evaluation, the PA must approve the composition of an evaluation team comprised of minimum two members per provisions in the Procurement Manual. As part of the evaluation, it is recommended to always undertake an assessment of the reasonableness of price to establish value for money, and such justification is mandatory when less than three substantially compliant offers have been received.

The results of the evaluation shall be documented in an evaluation report to be signed by the evaluation team members. After completion of the evaluation but prior to award, UNOPS shall conduct background checks/due diligence on the bidder recommended for award to verify that the bidder meets the criteria set forth in the solicitation document or as appropriate to the nature of the procurement process and may reject a bidder on the basis of these findings, which shall be documented. Further provisions including the tiered risk approach to be followed for background checks are included in the Procurement Manual.

In respect of REVIEW AND AWARD, all procurement activities are subject to a review process prior to award. The review process should ensure that that appropriate authority has been obtained for the commitment of funds; that the best interests of UNOPS and its clients are protected; and that the procurement activities are carried out in conformity with UNOPS FRRs, relevant policies and procedures and are in accordance with generally recognized leading business practices. Procurement review shall be done by either: (a) the PA directly, (b) a Procurement Reviewer, or (c) a contracts and property committee (CPC), subject to the applicable thresholds. Award is, as per UNOPS FRRs, the authorization given by authorized personnel to establish a commitment. Contracts are awarded by the relevant authorized PA, and when applicable, based on recommendations from a CPC. Requests for award for any works contract must include a contingency sum of between 6 percent and 12 percent in the procurement submission except in situations identified in the Procurement Manual. UNOPS posts on its website (http://data.unops.org/) information about all awarded purchase orders, upon approval in the ERP system (oneUNOPS). Furthermore, when a tender process has been carried out using the UNOPS eSourcing system, information on the contracts awarded will be posted on the UNGM website.

In respect of CONTRACT FINALIZATION AND ISSUANCE, written procurement contracts shall be used to formalize every procurement activity with a monetary value of USD 2,500 or above. All contracts must be signed by a PA on behalf of UNOPS except when the purchase order generated in the UNOPS ERP system (oneUNOPS) is used as the contract itself and it has been approved electronically by an appropriate PA in the ERP system.

Contract management and administration is the responsibility of the project manager/requisitioner as supported by the procurement official in charge of the procurement process. Contracts may be amended further to the provisions set out in the Procurement Manual and may require a prior review by a CPC subject to applicable thresholds.

In respect of COMPLAINT HANDLING PROCEDURES, procurement protest procedures are provided for in the UNOPS Procurement Manual. Suppliers perceiving that they have been unjustly treated in connection with the solicitation or award of a contract may lodge a complaint directly with the UNOPS General Counsel. All bidders must be informed of UNOPS independent bid protest procedure in the solicitation documents as well as in subsequent contracts.

Under no circumstances will the personnel involved in the procurement activity under complaint be allowed to participate in the review of the protest.

The General Counsel will make an initial assessment of the complaint and may, at the Counsel’s discretion, seek clarification from the PA responsible for the procurement process or any other personnel. The General Counsel will issue a response to the supplier. This response will reflect the final formal position of UNOPS on the matter. Suppliers filing complaints may be granted clarification meetings with the General Counsel in order to better understand the rationale for UNOPS‟ final decision on the subject.

Any further appeals by the supplier must be dealt with through arbitration, in line with the provisions in the solicitation documents. The solicitation documents shall contain a paragraph informing potential suppliers of the independent protest mechanism in UNOPS.

In respect of EMERGENCY PROCUREMENT, the UNOPS Financial Regulations and Rules (FRR) provide for exception to the use of formal methods of solicitation in clearly defined emergency situations (FRR 118.05 (b)). UNOPS has a set of formal procedures in place to be able to rapidly respond in emergency situations without waiving competition. EPP are based on the informal solicitation method of Request for Quotation (RFQ) for all requirements, irrespective of procurement value, and they come with a set of other processes which help make procurement easier and faster during emergencies. At UNOPS, special situations which justify the use of EPP are limited with the underlying principle being that the emergency situation is defined as "where there is clear evidence that an event or a series of events has occurred which imminently threatens human life/lives or livelihoods, and where the event or a series of events produces disruption in the life of a community on an exceptional scale". The other consideration is that use of the EPP is subject to the prior written approval by the UNOPS Executive Chief Procurement Officer (ECPO).

Pursuant to Fin. Rule 118.05(b), the ECPO has authorized the Director, PG, to establish the following emergency procurement procedures:

a) Definition of emergency situation: "urgent situations in which there is clear evidence that an event or a series of events has occurred which imminently threatens human life/lives or livelihoods, and where the event or a series of events produces disruption in the life of a community on an exceptional scale."

b) Based on the definition mentioned above, the ECPO determines when there is an emergency situation justifying use of the emergency procurement procedures. Therefore, requests for approval of the use of the emergency procurement procedures must be presented to the ECPO using the standard corporate template.

c) Upon approval by the ECPO of the use of the emergency procurement procedures, Request for Quotations (RFQs) may be used for solicitation of offers regardless of the value of the procurement. Notwithstanding section (b) above, where such ECPO approval has been granted, the solicitation of offers using an RFQ shall be deemed to be a formal method of solicitation.

d) Save as stated in the following paragraph, the PA for awards made under emergency procurement procedures is the same as for normal awards.

e) At his/her discretion, the ECPO may decide that only the Headquarters Contracts and Property Committee (HQCPC) and not a Local Contracts and Property Committee (LCPC) can review submissions under emergency procurement procedure requiring committee review. The committee designated to review emergency procurement submissions will be indicated by the ECPO at the time of his/her approval. If a CPC review is required according to the OI establishing CPC scope and thresholds, the following simplified review process is established for emergencies:

f) Procurement undertaken following the approval of the ECPO to use emergency procedures can be submitted to the relevant PA for award through the chairperson of the relevant contracts and property committee.

g) There is no requirement for a full committee review, but the chairperson reviews and provides written advice to the relevant PA. Alternatively, an ad hoc meeting of the relevant CPC can be called at the discretion of the chairperson.

h) The approval for use of EPP is time- bound, limited to a specific operation and may also be limited to the procurement of defined products in relation to a specific operation. Contract awards can only be done outside the approved EPP period provided the solicitation process for that procurement activity was initiated within the EPP period.

i) Additional instructions on emergency procurement procedures are set out in the Procurement Manual.

In respect of PROCUREMENT CONDUCTED BY LOCAL PARTNERS, for procurements conducted by the local partners, the Third Party Monitoring (TPM) agent will review the implementation of procurement activities as per the agreed upon procedures, and report on any deviation. Given that project activities will be implemented with the local implementing partners as per the respective agreement between UNOPS and the local implementing entity. For procurements to be conducted by the local implementing partners, each entity will follow their established procurement procedures that were reviewed and approved by UNOPS. Each entity's obligations vis- à-vis UNOPS are spelled out in the bilateral legal agreements.

In general, prior to commencing their procurement processes, the local implementing partners will prepare the technical specifications which will be reviewed and agreed with UNOPS. Following the completion of the bidding process and technical review, the local implementing partners will share the full procurement package with UNOPS for review and no objection before awarding the contract.

The supervision of installation of equipment or construction/ works contracts will be done by the implementing entity with additional monitoring for quality assurance by UNOPS.

Once the goods are received/ construction is completed, the local implementing partner will submit the receiving and inspection report (RIR) certification to UNOPS Project Manager, following which the payment would be released by the Project finance section as per the previously described procedures. While the local implementing partner will support UNOPS in the supervision, certification of payments will be only done by authorized UNOPS personnel.

Procurement activities directly implemented by UNOPS will fully adhere to UNOPS procurement principles, rules and regulations. In such occasions, local entities will prepare necessary technical specifications; requirements and submit to UNOPS PM.

In respect of MAINSTREAMING GENDER IN PROCUREMENT, UNOPS shall undertake steps to mainstream gender through procurement activities, these shall include:

a) Identify Women Owned Business in Yemen that UNOPS can work with

b) Identify and reserve some procurement of small-medium financial value for Women Owned Businesses; as this will increase participation of women in doing business with UNOPS. The lots to be reserved shall be carefully selected in line with capacity and expertise of the business activities owned by women.

c) Run training and capacity building sessions for Women Owned Businesses on UNOPS procurement processes, requirements, registration on UNGM that will enable them to participate in any tenders that may arise.

d) All bidders must adhere to the minimum percentage (5%) of females in their workforce. The below shall be included under the qualification criteria in all tenders. The bidder must hire or have in place female employees, that should constitute at minimum 5% of the company's overall workforce, bidders are encouraged to include female employees among the proposed key personnel for this contract and/ contract representatives. Bidders must submit the company organogram with clear indication of the job titles/portfolio that the female employees hold in the company. The job description and CVs for the female employees shall be submitted along with the bid, these employees must be in place at the time of submitting the offers and preferably have permanent employment with the company.

In respect of CAPACITY BUILDING, UNOPS Procurement department shall organize and run periodic capacity building sessions with its:

A. Contractors/Suppliers on UNOPS procurement guidelines, requirements, esourcing, registration in UNGM; and,
B. Local implementing partners on Procurement best practices, procurement guidelines and requirements, contract management.

6. Reporting

- **Narrative Reporting***:* The three agencies will provide narrative progress reports as well as financial reports and financial statements to the World Bank every six months. The narrative report will include: a summary of the progress and the context within which the project is implemented; the activities carried out during the reporting period; any challenges encountered, and measures taken; changes introduced in implementation, including changes in the budget; achievements and results of the project with reference to identified indicators; and the work plan for the following period. The report will also include red-flagged issues raised by TPMs that have not yet been closed during the reporting period, as well as actions taken to address the issues, and the estimated financial implications of those issues.

- **Accounting and financial reporting:** The implementing partners will: (i) maintain an FM system, including records and accounts, adequate to reflect the transactions related to the activities, in accordance with the requirements of the UN Financial Regulations; (ii) maintain a separate ledger account (Grant Control Account) in their books to record the financial transactions of this project; (iii) prepare, on a quarterly basis, unaudited IFRs, in accordance with accounting standards established pursuant to the UN Financial Regulations and in the format agreed with the Bank during negotiation of this project, adequate to reflect the expenditures related to the project. The IFRs will be provided to the World Bank no later than 45 days after the end of the quarter.

- **Incident Reporting:** Incident or Accident is defined as any significant event which has or is likely to have a significant adverse effect on the environment, the affected communities, the public or workers including without limitation, explosions, spills, and any workplace accidents that result in

death or serious injuries, any violent and exceptional labor incident or dispute involving the Recipients or security forces in the Project area, and local communities or any gender-based violence (GBV), sexual exploitation and abuse and sexual harassment (SEA/SH) suffered by beneficiaries receiving support under Respective Parts of the Project or Project workers.

UNICEF, WHO, and UNOPS shall notify the World Bank within 48 hours after learning of the incident or accident, once confirmed, and provide an initial report within 10 days of that notification indicating possible root causes and proposing possible corrective actions, as requested by the Bank. Incident Report Template has been developed and is attached to this manual as annex 31.

Incident Reports as per the existing reporting template shall provide sufficient detail regarding the incident or accident, indicating immediate measures taken or that are planned to be taken to address it, and any information provided by any contractor and supervising entity, as appropriate. It should include any measures to prevent its recurrence to the extent that the cause of Significant Event is within the scope of the Recipient's control

7. Sustainability

The project contributes to sustainability in three ways. First, the project aims to support and preserve the national and local implementation capacity by investing in the existing, local structure of health, nutrition and water and sanitation service delivery, which will help maintain the main foundations of the system for a speedy post-conflict recovery of the health and water and sanitation systems. This also includes focusing on retaining available human resources and the core functions of the system. Second, continuing to strengthen the core public health and water and sanitation capabilities will help the country to be more responsive to emerging diseases and more resilient to public health threats. Third, the project will support the community-based approach through its community health services provided by the CHNVs, CMWs CHWs, DLAs/ WUAs. Evidence indicates that CHNVs/CHWs continue to provide some services such as health promotion and awareness even when funding stops. By protecting the human capital of the population through the provision of essential health, nutrition and WASH services with a special focus on children, the project will help preserve the future of Yemen during the ongoing crisis.

A key element of the YEHCP is the community engagement and outreach element of the overall framework and implementation plan underpinned by facility-based outreach and community-based service delivery models in close collaboration with public health institutions. The engagement of communities is critical to build community knowledge and confidence, establish trust, ensure that the government responds to community needs and thus to optimize the provision of essential health, nutrition, water and sanitation services to the population of Yemen. The project will also be responsible for the training of CHNVs and for monitoring their implementation of the integrated community-based program. Lessons from implementation indicate that CHNVs/CHWs can play a pivotal role in sustaining the provision of services such as health promotion and awareness even when other funding ceases.

More specifically, the project aims to reduce gender gaps endemic in all aspects of a woman's life in Yemen by removing gender-related constraints with regards to their access to essential services like maternal health services and water and sanitation, educational information to help them make informed decisions, and

opportunities for professional development. The project will deploy interventions that target women and girls in very specific ways to address and close the gender gaps in health and WASH service delivery. Skilled female healthcare workers will be a critical part of the outreach and mobile teams at the primary level care for the population in remote areas and IDPs.

The project intends to increase adaptation of vulnerable populations to climate change through all project components. Components 1 and 2 include climate-related and climate-informed activities to help mitigate negative effects of adverse weather and other natural disasters and build resilience to withstand future shocks. Climate adaptation activities are integrated within all elements of Components 1 and 2 to the extent possible within the design and form part of the project's response approach. The activities from which adaptation co-benefits are expected under this project include: (i) training and capacity building for disaster risk management/response to ensure beneficiaries' access to health and nutrition services in case of extreme weather events or other climate induced disruptions to health service delivery; (ii) rehabilitation and construction of rainwater systems, rehabilitation of water sources to access safe drinking water, the rehabilitation of sewage networks and WWTPs, and the inclusion of solar PV solution to WASH activities; (iii) ensuring access to safe water and basic sanitation at the health facilities and for service continuity, during sudden-onset or protracted natural disasters, in areas where climate change is expected to impact water availability; and (iv) medical waste management capacity in health facilities to ensure proper treatment of medical equipment, protective gear, and other medical waste, especially in flood-prone areas. Finally, mitigation co-benefits may be expected as solarization of selected PHCFs and cold store will be explored to ensure steady access to electricity and minimize the use of fuel.

8. Complementarity and Coordination

The Bank’s effective collaboration with partners is critical for mobilizing a successful and technically sound crisis response on the ground.

a. Complementarity between the three organizations

This project has been specifically designed to ensure that the population of Yemen continues to have access to critical health, nutrition, and WASH services. The design reflects important lessons learned from previous Bank experience in the country, notably the EHNP, YCRP, and YIUSEP-I, as well as from previous Bank engagements in emergency health, nutrition and WASH operations in countries with similar fragile, conflict and violence situations. The project also builds on the balanced concept of using the flexibility provided by working with partner UN agencies such as UNICEF, WHO, and UNOPS for project stewardship and implementation oversight, while using the experienced and trained capacities available at central, GHO and DHO levels. It will cover all governorates in Yemen on a need basis using a transparent, evidence based and pre-agreed set of criteria for each type of activity.

UNICEF and WHO will engage the decentralized organizational and technical structure of the MoPHP, in coordination with central authorities to: (i) achieve basic service delivery to the population of Yemen in general and the disadvantaged groups in particular; (ii) maintain, revive and retain the Yemeni health operational capacities, especially at the central, GHO and DHO levels; and (iii) prevent the collapse of the Yemeni HFs and maintain the basic foundations and institutions for the post-conflict recovery phase.

UNOPS will implement the WASH component, which will focus in infrastructure rehabilitation for optimum

utilization of existing systems by restoring services and rehabilitating damaged and old water and sanitation facilities, through: (i) rehabilitation of water and sanitation medium to large facilities including networks, WTPs, WWTPs, etc.; (ii) provision of spare parts, fuel, water trucking for IDP camps, health facilities, WASH non-food items, PPE and equipment etc.; and (iii) supporting the capacity of local water and sanitation institutions including staff at decentralized level to ensure continuity of services and improve water quality and wastewater treatment. For water and sanitation interventions, activities will focus on priority sanitation interventions to be implemented in selected urban, peri-urban, and rural areas at decentralized level based on transparent and clear criteria.

b. Coordination with other funds/support:

WHO, UNICEF and UNOPS will be the managing and implementing agencies. The three organizations have set up robust implementation arrangements under the YEHNP, YCRP and YIUSEP-I. These implementation arrangements, which proved successful under the past health and WASH projects, are context specific and flexible, based on the population's needs and local capacity to provide the identified package of services and interventions. For this project, the organizations will further strengthen these implementation arrangements and will continue to partner with and build the capacity of local implementing partners (providers, contractors, GHOs, DHOs, autonomous national and local water and sanitation institutions, and local and international NGOs) to deliver results on the ground. Since the three agencies will be relying on PMUs that are already in place, the level of readiness for implementation is very high. As in the cases of YEHNP, YCRP, YIUSEP-I and II, the World Bank and the three implementing agencies will keep the Government of Yemen appraised on implementation progress through periodic consultative meetings where the relevant ministries will be represented.

WHO leads the Health Cluster in Yemen, with UNICEF as a key partner, while UNICEF leads the Nutrition Cluster with WHO as a key partner. UNICEF also leads the WASH cluster, with UNOPS as a key partner. The Clusters are the main sectoral coordination mechanisms across UN agencies, multilateral and bilateral donors, as well as international and local NGOs and civil society organizations. For WASH interventions under the ongoing YEHNP and YIUSEP-I, there are two levels of coordination. One is at the WASH cluster level and the other through regular coordination meetings between the WHO, UNICEF and UNOPS, led by the UW-PMU. To strengthen coordination under EHCP, UNOPS will also join the regular weekly meetings of WHO and UNICEF, as well as regular WASH cluster meetings. Focused attention will be given during implementation to coordination mechanisms among the UN agencies and stakeholders, especially as there is no legally binding mechanism for coordination.