



Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 24-Dec-2016 | Report No: PIDISDSA20172



BASIC INFORMATION

A. Basic Project Data

Country Yemen, Republic of	Project ID P161809	Project Name Emergency Health and Nutrition Project	Parent Project ID (if any)
Region MIDDLE EAST AND NORTH AFRICA	Estimated Appraisal Date 04-Oct-2016	Estimated Board Date 17-Jan-2017	Practice Area (Lead) Health, Nutrition & Population
Lending Instrument Investment Project Financing	Borrower(s) United Nations Children's Fund, World Health Organization	Implementing Agency United Nations Children's Fund, World Health Organization	

Proposed Development Objective(s)

To contribute to the provision of basic health and essential nutrition services for the benefit of the population of the Republic of Yemen.

Components

Improving Access to Health, Nutrition, and Public Health Services
Project Support, Management, Evaluation and Administration
Contingent Emergency Response

The processing of this project is applying the policy requirements exceptions for situations of urgent need of assistance or capacity constraints that are outlined in OP 10.00, paragraph 12.

Yes

Financing (in USD Million)

Financing Source	Amount
IDA Grant	200.00
Total Project Cost	200.00

Environmental Assessment Category

B - Partial Assessment

Decision



Other Decision (as needed)

N/A

B. Introduction and Context

Country Context

- The ongoing conflict in Yemen has resulted in a national catastrophe.** The escalation of conflict in March 2015 amplified an already existing protracted crisis. According to UN agencies, by November 2016, health facilities reported nearly 7,070 people killed and more than 36,818 injured. About half of the Republic of Yemen's population of about 26.8 million lives in areas directly affected by the conflict. Over 3 million Yemenis have been forcibly internally displaced (IDPs). Severe food insecurity affects 14 million people, and an estimated 3.3 million are malnourished, including 1.4 million children, of whom 462,000 are suffering from acute malnutrition. Basic services across the country are on the verge of collapse.¹ Chronic drug shortages and conflict-related destruction constrain access to health care services for around 14 million Yemenis, including 8.3 million children. Since the start of the cholera outbreak on October 6, 2016, the number of suspected cholera cases in Yemen has soared to 6,119 and WHO reported 68 deaths associated with cholera in 10 governorates as of November 24, 2016.²
- Poverty, already high before the conflict, further deteriorated.** Before 2014, Yemen was already profoundly challenged on several fronts – high population growth, severe urban-rural imbalances, food and water scarcity, female illiteracy, widespread poverty, and economic stagnation. The ongoing conflict is likely to have fundamentally altered the social and economic landscape of the country and further increased poverty levels. Initial simulations of the impact of the conflict show that the poverty incidence may have almost doubled nationally from 34.1 percent in 2014 to 62 percent in 2016.³
- Economic distress is mounting.** Aside from physical destruction of infrastructure, the conflict and the associated deterioration in conditions have deepened the economic crisis and further worsened living conditions in the country. A preliminary multiagency assessment estimates conflict-related infrastructure damages and economic losses incurred across a range of sectors and urban locations at around US\$19 billion as of end 2015. However, these estimates remain partial and preliminary and will need reassessment in a post-conflict situation. In 2015, the economy contracted by about 28 percent. Oil production and exports, the mainstay of the pre-conflict Yemeni economy, came to a halt. Inflation is assessed to have reached about 40 percent in 2015. The fiscal expenditure program had to shrink by about a third in 2015, reducing the state's share in the economy to around 20 percent, essentially being able to finance only salaries of public employees but having no resources for maintaining public services such as health and education. The situation in 2016 has worsened, with salary payments outstanding for a vast majority of public employees since August 2016.
- The proposed project is being processed under OP 10.00 paragraph 12 (Projects in Situations of Urgent Need of Assistance and Capacity Constraints), given that instability and violence affect the whole

¹ <http://reliefweb.int/report/yemen/2017-humanitarian-needs-overview>

² Figures are updated as of November 25, 2016

³ The poverty headcount is based on a national poverty line of YER 10,913 (or about US\$50) per capita per month in 2014 prices. In terms of 2011 Purchasing Power Parity, about US\$3.52 per person per day, or about US\$105.6 per person per month.



country. Of Yemen's 22 governorates, 21 are affected directly by airstrikes, armed clashes, and shelling, with thousands killed and injured. The ongoing armed conflict, service delivery breakdown, collapsing health system, deteriorating infrastructure, and inaccessibility to safe drinking water and food have turned the health status of the country from a crisis into a disaster.

Sectoral and Institutional Context

5. **With the start of the current crisis, a new set of challenges emerged that jeopardized the very core foundations of the Yemeni health system and its ability to meet the most basic health and nutrition needs of the population.** Essential inputs to the health facilities (HFs) and outreach teams have become scarcer and, in many places, non-existent. This is most evident in: (a) severe shortages of essential medicines and medical supplies required at all levels of care with huge disruptions in procurement, transport and supply-chain capabilities; (b) diminished, and sometimes non-existing, safe potable water from the public domain and lack of essential fuel, power, maintenance, water pumps, among others; (c) insufficient operational and logistical resources for essential health and nutrition programs at first level referral centers, especially for emergency obstetric and maternal care as well as referral nutrition services, further risking the lives of hundreds of thousands. Consequently, the Expanded Program for Immunization (EPI) and national vaccination campaigns have been interrupted, threatening the re-emergence of some vaccine preventable diseases and risking the lives of millions of the Yemeni children. Also, pockets of new diseases that are usually associated with conflict-stricken countries (for example, cholera and trachoma) are emerging under a health system lacking adequate surveillance and rapid response systems for early detection and treatment.

6. **The service availability and health status were greatly hampered by the conflict, and malnutrition among children has worsened.** Only 45 percent of HFs are fully functional and the availability of maternal and newborn health (MNH) services, as well as child health and nutrition services stand at 35 percent and 42 percent,⁴ respectively. Malnutrition rates are rising in Yemen with children under the age of five and pregnant and lactating women being the most affected. Within these groups, IDPs are most at risk. Around 3.3 million are currently estimated to be malnourished, including 1 million children affected by Moderate Acute Malnutrition (MAM) and 460,000 children suffering from Severe Acute Malnutrition (SAM). Children suffering from MAM are three times more likely to die than their healthy peers; children with SAM are nine times more likely to die. Around 45 percent of deaths among children under five in Yemen are attributable to malnutrition.

7. **The World Bank partnerships with the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) under the ongoing Health and Population Project (HPP) and the Schistosomiasis Project (SCP) have proved successful.** In December 2015, the World Bank management endorsed the resumption of activities under these projects through UNICEF and WHO acting as the implementing entities. Both agencies managed to set implementation mechanisms in place, through existing local delivery networks, and achieved results on the ground during the ongoing conflict in Yemen for the two projects. Under HPP and over the last year, WHO reached 1.5 million children under five with polio vaccination for more than one round, and 190,000 beneficiaries have been treated for malnutrition, deworming, and maternal and child illnesses through UNICEF-supported outreach rounds. In addition, around 400,000 doses of Penta-3, MR, and BCG were given to infants under one year of age, and around 1,000 health workers have been trained. Under SCP, the planned tenth drug distribution campaign was

⁴ Health Resources Availability Mapping System June 2016



successfully completed with an estimated 0.4 million school-aged children in 20 districts having been treated. The Implementation capacity has relied on a heavy presence of an expanded UN teams composing of technical staff, consultants and contractors based mainly in Sanaa with multiple satellite offices in the regions.

8. **WHO and UNICEF have maintained a steady presence, scaled up their operations, and strengthened their policy coordination during the conflict.** The Health Cluster of Partners, led by WHO and UNICEF, developed and is currently implementing a Health Engagement Plan with a focus on the provision of an essential package of services to address the dire needs of the population and to maintain the operational capacity of the existing health system at the governorate health offices (GHOs) and district health offices (DHOs). The Health Engagement Plan, having representation from the local level players and is agreed upon among development partners, including the World Bank, identified the urgent needs of the country where the funding gap for essential health and nutrition services for 2016 stood at an estimated US\$300 million as of July 2016.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

To contribute to the provision of basic health and essential nutrition services for the benefit of the Yemeni population.

Key Results

9. The following is the PDO-level results indicator:
- (a) People who have received essential health, nutrition, and population services (cumulative number disaggregated by gender, children and IDPs).⁵

D. Project Description

10. The project financing is an IDA grant in an amount equivalent to US\$200 million, and will build on the evidence-based outreach model of the HPP, but with a wider scope of services, service delivery models, and geographical targeting. As part of cleaning up the Yemen portfolio, the undisbursed balances of 11 IDA grants under suspension were cancelled to free up resources for recommitment to priority activities that meet the current needs of Yemen in view of the ongoing crisis. Of the US\$200 million equivalent for this project, US\$142 million equivalent is being recommitted from cancelled IDA grants for Yemen, and US\$58 million equivalent is allocated from Yemen IDA17 resources.

11. The project will finance health and nutrition services as well as help maintain the capacity of the existing health system, i.e. public HFs and community level engagement. The project will include the following three components.

⁵ A composite indicator with the sum of: (a) children immunized; (b) women and children who have received basic nutrition services; and (c) deliveries attended by skilled health personnel.



Component 1: Improving Access to Health, Nutrition, and Public Health Services (US\$191.0 million)

12. This component will support the coverage of the population of Yemen with well-defined packages of health and nutrition services at both primary health care (PHC) level and first level of referral centers/secondary care. The services are intended to cater to the essential and most urgent needs of the population through integrating the PHC model with the first level referral services, and thus ensuring a continuum of care for the population. In addition, it will support the integration of some mental health services into the package provided. The component will also emphasize and prioritize the targeting of the most disadvantaged groups on a needs basis within the context of conflict, namely, women of reproductive age, children, and IDPs. This component includes three subcomponents:

Subcomponent 1.1: Strengthening the Integration of Primary Health Care Model (implemented by UNICEF)

13. This subcomponent will ensure continued service delivery at the PHC level to provide the essential health and nutrition services for the population.

14. **PHC facility health and nutrition services.** This subcomponent will support the operations and services offered inside fixed PHC facilities, including provision of medical and non-medical equipment, required nutrients and medicines, training of staff, and costs associated with clinical and administrative supervision.

15. **Integrated outreach health and nutrition services.** Given the significant service gap, this subcomponent will complement the fixed facility and community-based services described below through an integrated outreach model. This model will cater to the needs of the population in remote areas and IDPs through outreach rounds, and in areas without functioning fixed facilities, through mobile teams.⁶ Outreach rounds and mobile teams offer similar packages of PHC services and will be flexible to accommodate additional services based on the identified needs of target areas.

16. The integrated outreach model will include the following services and related activities: (a) MNH services; (b) child nutrition; (c) Integrated Management of Childhood Illness (IMCI); (d) mental health services; (e) routine delivery of selected public health programs such as, but not limited to, routine immunization and malaria; and (f) water chlorination, sanitation and hygiene, and social mobilization.

17. **Community-based health services.** The services provided at the PHC facilities and through the integrated outreach model will be complemented by a basic package of services delivered at the household level through a nationwide network of community health volunteers (CHVs) and midwives. This network of community volunteers will also be trained to provide psychosocial support for women and children.

18. This subcomponent will cover the basic equipment, medical and non-medical supplies, required nutrients and medicines, vaccines, training, and implementation expenses required for the aforementioned services through the facilities, integrated outreach, mobile teams and community-based services.

Subcomponent 1.2. Supporting Health and Nutrition Services at the First Level Referral Centers (implemented by WHO)

⁶ Mobile teams will be targeting those areas without functioning fixed facilities and thus, those teams work on a biweekly basis. Outreach rounds operate in remote areas (zone 2 and 3) where there are fixed facilities (zone 1). More details are in annex 1.



19. This subcomponent will complement the PHC model through ensuring the continuum of care. Therefore, it will support the following activities: (a) management of SAM cases with complications and for patients who failed Outpatient Therapeutic Program (OTP) at Therapeutic Feeding Centers (TFCs) and/or Stabilization Centers (SCs); (b) provision of Basic Emergency Obstetric and Neonatal Care (BEmONC) and Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) services in targeted referral centers; and (c) provision of equipment, maintenance, medical and non-medical supplies, essential drugs, vaccines, training, and implementation expenses required for the first level referral centers. This subcomponent will also support the provision of basic supplies (water and fuel) and essential medicines to PHC facilities within an integrated supply chain system serving the referral centers in coordination with UNICEF's targeted PHC facilities.

Subcomponent 1.3. Sustaining the National Health System Preparedness and Public Health Programs (implemented by WHO)

20. **Disease surveillance and outbreak response.** This will include the roll-out of the current electronic Disease Early Warning System (eDEWS) nationwide through improving the core functions of the system, including data collection from HFs, field investigation, implementation of preparedness plans as well as stock piling, vector control, and field activities to respond to outbreaks such as cholera, dengue fever, malaria, and so on.

21. **National public health campaigns.** The project will support the implementation of the nationwide immunization and treatment campaigns for diseases such as polio, measles, trachoma, and schistosomiasis. Funds will be made available to support the implementation expenses of the campaigns as well as the procurement of vaccines and drugs, if needed.

22. **Cholera management.** A multifaceted approach will be supported to prevent and control cholera, and to reduce deaths. A combination of surveillance (through eDEWS), case management, and treatment interventions will be used. This will complement UNICEF's ongoing water chlorination, sanitation and hygiene and social mobilization efforts. Therefore, the project will finance the WHO-developed cholera kits for the prevention and control of cholera outbreak.

Component 2: Project Support, Management, Evaluation and Administration (US\$ 9.00 million)

23. This component will support project administration and monitoring and evaluation activities (M&E) to ensure smooth and satisfactory project implementation. The component will finance: (a) general management support for both WHO and UNICEF; and (b) hiring of a TPM agency for which the terms of reference (TOR) will be agreed upon with the World Bank, and will complement the current TPM arrangements for both agencies. Both UNICEF and WHO 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. Specifically, the two organizations will: (a) monitor the project targets, and evaluate the program results in coordination with the existing local health workforce; (b) handle procurement, financial, and disbursement management, including the preparation of withdrawal applications under the project; (c) ensure that independent audits of the project activities are carried out; and (d) ensure that all reporting requirements for IDA are met according to the Project Financing Agreements. This component will support the monitoring, supervision and evaluation activities undertaken by the two organizations under the project. The project monitoring and evaluation arrangements emphasize not only measuring the results, but also extracting lessons and recommendations for future interventions.



Component 3: Contingent Emergency Response (US\$0)

24. The objective of this component is to improve the country's response capacity in the event of an emergency, following the procedures governed by OP/BP 10.00 paragraph 12 (Rapid Response to Crisis and Emergencies). There is a probability that during the life of the project an epidemic or outbreak of public health importance or other health emergency may occur, which causes a major adverse economic and/or social impact. In anticipation of such an event, this contingent emergency response component (CERC) allows UNICEF and/or WHO to request the World Bank for support by re-allocating funds from other project components or serving as a conduit to process additional financing from the Pandemic Emergency Facility (PEF) or other funding sources for eligible emergencies to mitigate, respond and recover from the potential harmful consequences arising from the emergency situation. Disbursements under this component will be subject to the declaration of emergency and the preparation of an "Emergency Response Operational Manual" (EROM) by UNICEF and WHO, agreed upon by the Bank.

E. Implementation

Institutional and Implementation Arrangements

25. Under the proposed Emergency Health and Nutrition Project (EHNP), UNICEF and WHO will be the grant recipients as well as the managing and implementing entities on an exceptional basis, where each organization is responsible for a number of activities based on the project design and the implementation experience under the HPP and SCP. Both organizations managed to set implementation mechanisms in place for these projects, through the existing local public system structures, to deliver various results on the ground during the ongoing conflict in Yemen. Since March 2015, these agencies further strengthened and expanded their operational capacities and presence in the country to address the health issues at different levels.

26. WHO and UNICEF are key players of the Yemen Health and Nutrition Clusters of Partners, who are contributing to the Health Engagement Plan in Yemen. Through their own network of providers, contractors, GHOs, DHOs, and international/local nongovernmental organizations (INGOs/LNGOs), both organizations have existing institutional and implementation channels for the delivery of essential services and ensuring the availability of critical medicines nationwide. These implementation arrangements, which proved successful under the HPP and SCP, are context specific and flexible based on the population needs and local capacity (DHOs or NGOs) to provide the identified package of healthcare services. Therefore, both organizations will work with the existing local health system structures at the governorate, district and community levels to preserve the national capacity and maintain the core functions of the health system.

27. On the PHC level, UNICEF will work closely with the public health facility staff hired at the facility level (doctors, nurses, technicians, etc.). Outreach and mobile teams will be mainly formed up from the local facility and community levels, only to be augmented by external capacities if the need arises. GHO and DHO staff networks will be used in their supervisory, support, and monitoring roles. However, Community Based Organizations (CBOs) will be utilized to directly provide the needed services in areas where health staff number is limited or in areas with large concentrations of IDPs. UNICEF will also be responsible for the training of CHVs and for monitoring their implementation of integrated community based program.



28. On 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 TFC/SCs), while UNICEF provides the nutrition therapeutic supplies at this level. 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 eDEWS 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 national targeted campaigns for the various infectious agents by working closely with implementing teams following the same modalities as, and in close collaboration with, UNICEF.

29. The proposed project would be financed by an IDA grant to WHO and UNICEF, co-signatories of the Financial Management Framework Agreement (FMFA). The project's financial management (FM) arrangements will be governed by the FMFA between the World Bank and the UN agencies, which provides for the use of the UN's Financial Regulations.

30. The project is designed to fit within the current activities that have been implemented by both UN organizations. No additional or external capacity would be required to undertake procurement under the proposed project. The procurement arrangement under this project is that the UNICEF and WHO will use their own procurement procedures as Alternative Procurement Arrangements allowed by the New Procurement Framework Policy Section III. F. This implementation arrangement is recommended by the Project Procurement Strategy for Development (PPSD) based on the fact that the procurement procedures of both agencies were assessed and found acceptable to the World Bank under other agreements. This procurement arrangement is considered a fit-for-purpose arrangement.

31. **Closing date and implementation schedule.** Given the critical health situation in Yemen, the planned activities under the proposed emergency operation will be implemented over a period of two years (February 1, 2017 to January 31, 2019 - see the disbursement profile). A third year is proposed to be added to the project duration to allow for the financial closure undertaken by the implementing agencies.⁷ Therefore, it is envisaged that the proposed US\$200 million IDA grant will be disbursed during the first two years.

F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

While the project activities have no specific geographical targeting, activities financed by the project aims at delivery of service nationwide. With the ongoing conflict, the locations' selection will draw on the health need targeting while considering Yemen's security map and the security situation of each governorate.

G. Environmental and Social Safeguards Specialists on the Team

Amer Abdulwahab Ali Al-Ghorbany, Ibrahim Ismail Mohammed Basalamah

⁷ Under UNICEF rules, there is a financial closure period of 12 months during which the ongoing activities need to be wrapped up (that is, goods delivered to the country, consultants' reports submitted, all invoices to subcontractors paid, and so on).



SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The policy is triggered as the project includes interventions with potential site-specific, limited and mitigatable environmental impacts as they might involve the disposal of the medical consumables (vaccination kits, vials, syringes, etc.). A safeguards action plan has been prepared due to its emergency nature, and a medical waste management plan will be prepared before effectiveness and implemented by the implementing agencies. The project is categorized as B because of the potential small-scale and site-specific impacts associated with the disposal of medical consumables.
Natural Habitats OP/BP 4.04	No	
Forests OP/BP 4.36	No	
Pest Management OP 4.09	No	
Physical Cultural Resources OP/BP 4.11	No	
Indigenous Peoples OP/BP 4.10	No	
Involuntary Resettlement OP/BP 4.12	No	This policy is not triggered due to the fact that the project activities will not entail land acquisition, restriction to access and/or impact on livelihood of beneficiaries.
Safety of Dams OP/BP 4.37	No	
Projects on International Waterways OP/BP 7.50	No	
Projects in Disputed Areas OP/BP 7.60	No	

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

Activities supported by this project are expected to have limited environmental impacts. The project will finance several interventions including, among other things, outreach and facility-based services and nationwide campaigns which have potential site-specific, limited and mitigatable environmental impacts as they might involve the disposal of



the medical consumables such as, but not limited, vaccination kits, vials and possible syringes. To avoid/mitigate any potential adverse environmental impacts under this intervention, a Medical Waste Management Plan (MWMP) – under the OP/BP 4.01 - is to be prepared and implemented by the implementing agencies to be applied once the implementation begins. The safeguards action plan is included in the project appraisal document. Both the safeguards action plan and the MWMP will also address safe handling and storage of medicines, vaccines, and other medical consumables.

The project will have broad social benefits because it supports the provision of the essential package of health and nutrition services to the Yemeni population nationwide. The emphasis will be to target the most needed groups namely mothers, newborns and children. The health and nutrition services will also cater to the needs of population in remote areas and the areas without functioning fixed facilities through mobile teams.

The proposed project will not cause any safeguard impacts because OP 4.12 is not triggered. However, there are non-safeguard elements (social impacts) that may negatively impede the successful implementation of the project. The first social impact would be the difficulty to reach the severely affected women and children at areas under conflict by the ongoing war which could hinder the supply of the health and nutrition services. The second social impact would be the difficulty to access the areas under the control of religious factions where the vulnerable groups are residing and could lead to inadequate delivery of health services. The mitigation measures for social risks are addressed under #4 below.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:

None

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.

None

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

The implementing agencies (WHO & UNICEF) in collaboration with the appropriate Yemeni authorities will implement the MWMP (prepared by WHO and UNICEF and reviewed and cleared by the Bank before effectiveness) for proper management and safe disposal of any medical wastes and used vaccination kits generated during the implementation of the project.

In terms of capacity, both agencies have institutional and implementation mechanisms in place to ensure the delivery of essential services on the ground during the ongoing conflict in Yemen, particularly since March 2015. The existing mechanism comprises their own networks of providers, contractors, Governorate Health Offices (GHOs), District Health Offices (DHOs), and international and local NGOs. Both organizations have long standing experience in the preparation and implementation of the proposed interventions including the immunization campaigns in Yemen, including proper arrangements for the management and safe disposal of medical waste. Arrangements for monitoring the application of safeguards measures will include field visits by officers from the central, governorate and district levels. Monitoring tools - such as checklists - have been previously developed, adopted and already in use by the implementing agencies for monitoring and reporting on the implementation, including of safeguards measures.

The mitigation measure for the first social impact is to adopt UNICEF and WHO modalities through their network of service providers (local offices all over the country which proved to be successful in reaching remote areas). The



mitigation measure for the second social impact would be to cooperate with the neutral communities on the local level and NGOs.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

The project key stakeholders include the Ministry of Public Health, Governorate Health Offices (GHOs), District Health Offices (DHOs), and International and local NGOs. This MWMP will be publicly disclosed and will be shared with the relevant government agencies, concerned governmental and nongovernmental organizations. The safeguards instrument will be disclosed both in-country (in the appropriate communication channels) as well as at the World Bank InfoShop.

Given the nature of the project, consultations with relevant stakeholders and the intended beneficiaries would be critical under the current circumstances of the country. The alternative mechanism for consultation would be to adopt the implementing agencies' "Beneficiaries' Satisfaction Checklist". This checklist can be used to measure the satisfaction of providing the essential package of health and nutrition services to the Yemeni population nationwide, especially the most vulnerable group here (mothers and children). This checklist will be carried out by the teams of UNICEF and WHO located in their offices in Sana'a and all over Yemen and the hired Third Party Monitoring (TPM) agency. The checklist could include a scale such as (1. Very good; 2. Good; 3. Moderate; 4. Poor; 5. Very poor). This satisfaction checklist shall be disseminated at all target areas during implementation to ensure it is accessible and available in Arabic language to all beneficiaries. The staff of both UNICEF and WHO should read the checklist to beneficiaries to ensure that they can provide complaints if not satisfied by the services. This satisfaction checklist can be used in lieu of the grievance redress mechanism and would be more workable in unstable settings like Yemen.

The terms of reference for the TPM agency will include monitoring of safeguards issues, and it will be ensured that the agency will have the capacity to conduct such monitoring activities.

B. Disclosure Requirements

The review of this Safeguards has been Deferred.

Comments

As an emergency operation, the requirement to prepare the safeguards instrument will be deferred to the project implementation period under paragraph 12 of OP 10.00, allowing for condensed procedures and deferral of the safeguards instruments in situations of urgent need for assistance.

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?



Yes

If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?

No

Are the cost and the accountabilities for the EMP incorporated in the credit/loan?

Yes

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank's Infoshop?

NA

Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?

NA

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?

Yes

Have costs related to safeguard policy measures been included in the project cost?

Yes

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?

Yes

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?

Yes

CONTACT POINT

World Bank

Moustafa Mohamed ElSayed Mohamed Abdalla
Health Specialist

Borrower/Client/Recipient

United Nations Children's Fund



World Health Organization

Implementing Agencies

United Nations Children's Fund

Fouzia Shafique

Chief - Health

fshafique@unicef.org

World Health Organization

Akjema Magtymova

Deputy Representative

magtymova@who.int

FOR MORE INFORMATION CONTACT

The World Bank

1818 H Street, NW

Washington, D.C. 20433

Telephone: (202) 473-1000

Web: <http://www.worldbank.org/projects>

APPROVAL

Task Team Leader(s):	Moustafa Mohamed ElSayed Mohamed Abdalla
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Approved By

Safeguards Advisor:	Nina Chee	15-Dec-2016
Practice Manager/Manager:	Ernest E. Massiah	19-Dec-2016
Country Director:	Asad Alam	28-Dec-2016

