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The World Bank

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Report No: PAD2160

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED GRANT

IN THE AMOUNT OF SDR147.8 MILLION
(US$200.0 MILLION EQUIVALENT)

TO THE

UNITED NATIONS CHILDREN'S FUND

AND

WORLD HEALTH ORGANIZATION

FOR A

YEMEN EMERGENCY HEALTH AND NUTRITION PROJECT

DECEMBER 29, 2016

Health, Nutrition and Population
Middle East and North Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective November 30, 2016)

Currency Unit =	Yemen Rials (YER)
YER 250.50 =	US$1
US$ 1 =	SDR 0.74

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Hafez M. H. Ghanem
Country Director:	Asad Alam
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Ernest E. Massiah
Task Team Leader(s):	Moustafa Abdalla

ABBREVIATIONS AND ACRONYMS

ADM	Accountability and Decision Making
ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Newborn Care
CBO	Community-based Organization
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHV	Community Health Volunteer
CHW	Community Health Worker
CMAM	Community-based Management of Acute Malnutrition
CMW	Community Midwife
DHO	District Health Office
ECRP	Emergency Crisis Response Project
eDEWS	Electronic Disease Early Warning System
EHNP	Emergency Health and Nutrition Project
EmONC	Emergency Obstetric and Newborn Care
EPI	Expanded Program on Immunization
FMFA	Financial Management Framework Agreement
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GHO	Governorate Health Office
GRM	Grievance Redress Mechanism
HACT	Harmonized Approach to Cash Transfers
HF	Health Facility
HPP	Health and Population Project
IDP	Internally Displaced Persons
IMCI	Integrated Management of Childhood Illness
INGO	International Nongovernmental Organization
IYCF	Infant and Young Child Feeding
LNGO	Local Non-governmental Organization
M&E	Monitoring and Evaluation
MAM	Moderate Acute Malnutrition
MNH	Maternal and Newborn Health
MOPHP	Ministry of Public Health and Population
MUAC	Mid-Upper Arm Circumference
MWMP	Medical Waste Management Plan
NGO	Nongovernmental Organization
OTP	Outpatient Therapeutic Program
PDO	Project Development Objective
PHC	Primary Health Care
PNC	Postnatal Care
RH	Reproductive Health
SAM	Severe Acute Malnutrition
SAP	Safeguards Action Plan
SC	Stabilization Center
SCP	Schistosomiasis Project

SFD	Social Fund for Development
SFP	Supplementary Feeding Program
TFC	Therapeutic Feeding Center
TPM	Third-party Monitoring
UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organization

BASIC INFORMATION

Is this a regionally tagged project?	Country(ies)	Lending Instrument
No		Investment Project Financing

[✓] Situations of Urgent Need of Assistance or Capacity Constraints

[ ] Financial Intermediaries

[ ] Series of Projects

Approval Date	Closing Date	Environmental Assessment Category
17-Jan-2017	31-Jan-2020	B - Partial Assessment

Bank/IFC Collaboration
No

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

Component Name	Cost (USD Million)
Improving Access to Health, Nutrition, and Public Health Services	191.00
Project Support, Management, Evaluation and Administration	9.00
Contingent Emergency Response	0.00

Organizations

Borrower :	United Nations Children's Fund World Health Organization
Implementing Agency :	United Nations Children's Fund World Health Organization

Safeguards Deferral

Will the review of safeguards be deferred?

[✓] Yes [ ] No

PROJECT FINANCING DATA (IN USD MILLION)

[ ] Counterpart Funding	[ ] IBRD	[ ] IDA Credit [ ] Crisis Response Window [ ] Regional Projects Window	[✓] IDA Grant [ ] Crisis Response Window [ ] Regional Projects Window	[ ] Trust Funds	[ ] Parallel Financing

Total Project Cost:	Total Financing:	Financing Gap:
200.00	200.00	0.00
	Of Which Bank Financing (IBRD/IDA): 200.00	

Financing (in USD Million)

Financing Source	Amount
IDA-D1640	200.00
Total	**200.00**

Expected Disbursements (in USD Million)

Fiscal Year	2017	2018	2019	2020
Annual	60.00	110.00	30.00	0.00
Cumulative	60.00	170.00	200.00	200.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the project plan to undertake any of the following?

a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF

Yes

b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment

Yes

c. Include Indicators in results framework to monitor outcomes from actions identified in (b)

Yes

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	High
2. Macroeconomic	High
3. Sector Strategies and Policies	High
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	High
7. Environment and Social	High

8. Stakeholders	● High
9. Other	● High
10. Overall	● High

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[✓] Yes [ ] No

Have these been approved by Bank management?

[✓] Yes [ ] No

Is approval for any policy waiver sought from the Board?

[✓] Yes [ ] No

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	✓	
Natural Habitats OP/BP 4.04		✓
Forests OP/BP 4.36		✓
Pest Management OP 4.09		✓
Physical Cultural Resources OP/BP 4.11		✓
Indigenous Peoples OP/BP 4.10		✓
Involuntary Resettlement OP/BP 4.12		✓
Safety of Dams OP/BP 4.37		✓
Projects on International Waterways OP/BP 7.50		✓
Projects in Disputed Areas OP/BP 7.60		✓

Legal Covenants

Conditions

Type	Description
Effectiveness	Preparation, adoption and disclosure of the Medical Waste Management Plan before project effectiveness.
Disbursement	Disbursement under component 3: (1) declaration of an emergency; and (2) an agreed Emergency Response Operational Manual.

PROJECT TEAM

Bank Staff

Name	Role	Specialization	Unit
Moustafa Mohamed ElSayed Mohamed Abdalla	Team Leader(ADM Responsible)	Health Specialist	GHN05
Jamal Abdulla Abdulaziz	Procurement Specialist(ADM Responsible)	Procurement	GGO05
Moad M. Alrubaidi	Financial Management Specialist	Financial Management	GGO23
Alex Woodhouse Turingan	Team Member	Legal	LEGAM
Amer Abdulwahab Ali Al-Ghorbany	Environmental Specialist	Environmental Safeguards	GEN05
Amr Elshalakani	Team Member	Health Specialist	GHN05
Andrianirina Michel Eric Ranjeva	Team Member	Disbursement	WFALN
Claire Louise Greer	Team Member	Operations	GHN05
Edith Ruguru Mwenda	Counsel	Legal	LEGAM
Ibrahim Ismail Mohammed Basalamah	Safeguards Specialist	Social Safeguards	GSU05
Miyuki T. Parris	Team Member	Operations	GHNGE
Mohammed Mahmoud Duban	Team Member	Monitoring and Evaluation	GHN05
Raghada Mohammed Abdelhady Abdelhamied	Team Member	Administration	MNCEG

Souraya Mahmoud Moustafa Elassiouty	Team Member	Operations	GPV05

Extended Team

Name	Title	Organization	Location

YEMEN, REPUBLIC OF
EMERGENCY HEALTH AND NUTRITION PROJECT

TABLE OF CONTENTS

I. STRATEGIC CONTEXT

A. Country Context

1. **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. 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. 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 7,700, of which 120 cases were confirmed and WHO reported 82 deaths associated with cholera in 12 governorates as of December 14, 2016.

2. **Poverty, already high before the conflict, further deteriorated.** Before 2014, Yemen was already 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.[2]

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 multi-agency 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.

4. **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 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

[1] http://reliefweb.int/report/yemen/2017-humanitarian-needs-overview

[2] 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.

turned the health status of the country from a crisis into a disaster.

B. 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 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 availability of health services has been 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,[3] 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, internally displaced persons (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 462,000 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. An estimated 45 percent of deaths among children under five in Yemen are attributable to malnutrition.

7. **The supply-demand equilibrium of health services has further worsened by the ongoing conflict.** Many HFs were rendered non-operational because of the destruction of some or all of the infrastructure. Other facilities were left deserted by staff owing to security risks associated with working at those facilities. This has created a "service vacuum" in areas that were previously considered being stable. The conflict has also generated a new wave of IDPs in certain geographic areas that were straining the already limited resources of existing HFs. Further, the conflict has deepened the economic pressures on most citizens with increasing poverty and unemployment rates, shifting many of those who previously were used to buying health services from the private or NGO sectors to utilize the public system. Those factors have remarkably increased the demand on an already over-strained system.

8. **The World Bank partnerships with the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) under the ongoing IDA Health and Population Project (HPP) and the Schistosomiasis Project (SCP) have proved to be successful.** In December 2015, the World Bank resumed activities under these projects through UNICEF and WHO acting as the implementing entities. Both

[3] Health Resources Availability Mapping System June 2016

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. Under HPP 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 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 expanded UN teams in Yemen composing of technical staff, consultants and contractors based mainly in Sanaa with multiple satellite offices in the regions.

9. **The ongoing IDA-financed HPP with both UN organizations has illustrated some very important lessons that this proposed operation has taken into consideration,** notably: (a) a design that is flexible enough to accommodate the urgent needs of the population wherever and whenever they arise; (b) the prudence of preserving and supporting the technical capacity of Ministry of Public Health and Population (MOPHP) staff as the core element of sustaining the integrity and future prospects of the health system; (c) partnering with leading health and nutrition UN agencies in their capacity as implementing agencies providing the required level of responsiveness in operational matters and handling fiduciary issues; (d) the possibility of providing national public health interventions reaching vast geographic locations and showing positive results on a national scale; and (e) the need for sound operational and technical experience during implementation provided by UN agencies in fragile context.

10. **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, which includes 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. Higher Level Objectives to which the Project Contributes

11. **The IDA support to Yemen at this stage of conflict to the health and nutrition sectors is central to addressing the development challenges faced by the country.** The project will complement the ongoing interventions offered by the Bank, namely, the Emergency Crisis Response Project (ECRP) on demand- and supply-side nutrition interventions, as well as the ongoing efforts by other international and local partners. This will be achieved through a design that strongly emphasizes the following: (i) addressing development needs of the population, building on the successful pre-conflict IDA engagement in the health sector (as explained below in details) and a need to hasten and scale up in response to the exacerbated needs resulting from conflict; (ii) enforcing IDA's role in partner coordination, monitoring and learning through well-structured third party monitoring (TPM) activities that will contribute to planning of the post-conflict and recovery phases; (iii) supporting the health system components represented by the local public institutions (GHOs, DHOs, community and outreach teams) and NGOs involved in the health service provision to preserve functionality and operability of the health system, an approach that

has been well tested and utilized by IDA in Afghanistan and in the Horn of Africa; and (iv) adopting a multi-sectoral approach with the ongoing IDA interventions, namely, the ECRP.

12. The project will contribute to the ongoing efforts by the World Bank and the international community to deliver critically needed services to the Yemeni population most affected by the conflict. The project will also seek to maintain the national capacity of the health system delivery. It will aim to support and preserve the national implementation capacity by investing in the existing, local structure of health and nutrition service delivery, which will help maintain the main foundations of the system for a speedy post-conflict recovery of the health system. The project contributes to the fourth Sustainable Development Goal, "ensuring healthy lives and promoting well-being for all at all ages".

13. **Linkage to the World Bank Group goals and regional strategy**. This project contributes to the achievement of the World Bank Group (WBG) twin goals of ending extreme poverty and boosting shared prosperity in a sustainable manner as it aims for social inclusion and achieving progress in non-monetary dimensions of welfare, including health, with a particular emphasis on underserved and vulnerable groups.

14. The WBG has articulated a new framework for engagement in the Middle East and North Africa (MENA) Region, shifting Bank Group's engagement from working around conflict and instability to supporting peace and stability through social and economic inclusion. The proposed project supports the MENA strategy pillars including: (a) renewal of the social contract by preserving inclusive service delivery resilience and improving emergency services to conflict-affected poor; and (b) resilience to IDP/refugee shocks by strengthening existing public health service delivery mechanisms and improving health and nutrition service delivery to IDP-affected areas. In addition, the inclusion of early warning surveillance and public awareness campaigns will contribute to both renewal of the social contract and community resilience to the shocks.

15. **Linkage to the Yemen Country Engagement Note (CEN)**. The CEN (Report 106118-YE), discussed by the World Bank Board in July 2016, sets out the WBG's engagement with Yemen during the conflict. The CEN's objectives are to: (i) provide emergency support to preserve local service delivery capacity to support conflict-affected families and communities, in close collaboration with UN institutions; and (ii) prepare for post-conflict recovery, laying the foundation for a more inclusive and resilient development framework in the future. The proposed Emergency Health and Nutrition Project is fully aligned with these two objectives, as it will be implemented by UNICEF and WHO in close partnership with local health delivery actors, supporting vulnerable communities' access to an essential package of health and nutrition nation-wide.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

16. The project development objective (PDO) is to contribute to the provision of basic health and essential nutrition services for the benefit of the population of the Republic of Yemen.

B. Project Beneficiaries

17. The project is a nationwide intervention and thus the project activities have no specific geographical targeting. All activities will be guided by the security situation of each governorate. 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 needs and the implementation capacity of the existing local providers. The World Bank has worked closely with WHO and UNICEF to identify and agree upon the selection criteria to develop a priority list of governorates. These selection criteria will be periodically reviewed by the three organizations to ensure the appropriate responsiveness to the emerging health development needs.

18. Based on the proposed activities, the project is expected to: (a) reach 7 million Yemenis with essential health, nutrition and population services; (b) cover 100,000 beneficiaries with essential drugs for non-communicable diseases; (c) train 4,000 health personnel; and (d) establish Disease Surveillance and early warning system for cholera and other outbreaks in 600 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 which will be integrated within the package to sustain the service delivery.

19. **Selection of target population**. The proposed project activities will be carried out nationwide and the support provided therein will be used in any district or governorate of the country based on a set of criteria. At the initiation of the program implementation and every 3-6 months thereafter, the World Bank, WHO and UNICEF will review the criteria and the situation on the ground and identify additional or new governorates. The agreed upon criteria for the first six months of the project implementation are provided in Annex 1.

C. PDO-Level Results Indicators

20. The PDO-level results indicator:

- People who have received essential health, nutrition, and population services (cumulative number disaggregated by gender, children and IDPs).[4]

III. PROJECT DESCRIPTION

A. Project Components

21. The project financing is an IDA grant of SDR 147.8 million, 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 the restructuring of the Yemen portfolio, the undisbursed balances of 11 IDA grants under suspension were cancelled. 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's IDA17 resources.

[4] 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.

22. 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.

Component 1: Improving Access to Health, Nutrition, and Public Health Services (US$191 million)

23. 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)

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

25. **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.

26. **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.[5] 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.

27. 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.

28. **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.

29. This subcomponent will cover 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

[5] Mobile teams will be targeting those areas without functioning fixed facilities and thus, those teams will 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.

services.

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

30. 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)

31. **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.

32. **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.

33. **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. 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 million)

34. 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; (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; and (c) technical assistance.[6] 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 results in coordination with the existing local health workforce; (b) handle

[6] Technical assistance means the cost associated with the agencies' advisory services other than consultants' services on account of monitoring, evaluation and supervision of activities under Component 1, 2 and 3 of the project, including charge of direct staff time for the agencies' staff assigned from time to time to perform such services under the project.

procurement, financial management, 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 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)

35. 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 Crises 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 receive support by reallocating 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[7] and the preparation of an "Emergency Response Operational Manual" (EROM) by UNICEF and WHO, agreed upon by the Bank.

B. Project Cost and Financing

36. The financing instrument of the proposed project is an Investment Project Financing with an operational life of three years. The project will be financed by a US$200 million equivalent IDA grant to the UNICEF (US$123.75 million) and WHO (US$76.25 million), as recipients and implementing agencies of the proposed project.

Project Components	Project cost	IDA Financing	Trust Funds	Counterpart Funding
Component 1: Improving Access to Health, Nutrition, and Public Health Services	**191.00**	**191.00**	0	0
Subcomponent 1.1: Strengthening the Integration of Primary Health Care Model (UNICEF)	118.54	118.54		
Subcomponent 1.2. Supporting Health and Nutrition Services at the First Level Referral Centers (WHO)	52.46	52.46		
Subcomponent 1.3. Sustaining the National Health System Preparedness and Public Health Programs (WHO)	20.00	20.00		

[7] Either the Republic of Yemen, the international community, or the United Nations has issued an Emergency Declaration

Component 2: Project Support, Management, Evaluation and Administration	**9.00**	**9.00**	0	0
- UNICEF Indirect Cost **3%**	3.60	3.60		
- WHO Indirect Cost **3%**	2.22	2.22		
- TPM and Evaluation	1.50	1.50		
- Technical Assistance	1.68	1.68		
Component 3: Contingent Emergency Response	**0.00**	**0.00**	0	0
Total Costs	**200.00**	**200.00**	0	0
Total Financing Required	**200.00**	**200.00**		

C. Lessons Learned and Reflected in the Project Design

37. **Integration of lessons learned from previous country and/or from World Bank-wide experience with emergency response operations:** The proposed project design was informed by lessons learned from previous operations in Yemen, as well as from global disaster risk management and emergency recovery and reconstruction experience. The key lessons considered in the project design include the following:

(a) **Promote resilience through strengthening inclusive institutions**. Bank experience in various countries indicates that relying on local-level resilience and recovery mechanisms existing on the ground can pay dividends by contributing to service delivery restoration and expansion, and serve as a spring board for larger scale restructuring programs, where these remain the most cost effective and efficient way of delivering services. Past Bank engagement in Yemen has recognized the importance of inclusiveness in all of its elements. However, given the weaknesses in local capacity and the importance of maintaining service delivery, helping develop resilient state institutions and strengthen local capacity is essential to maintain service delivery.

(b) **Ensuring a quick disbursing mechanism and working through specialized existing partner agencies for an effective emergency response.** Lessons learned from Yemen reflect the critical importance of the World Bank's partnerships with the existing UN agencies and others for ensuring basic service delivery during periods of conflict. As mentioned above, under the ongoing UN partnership of the HPP and SCP in Yemen, both WHO and UNICEF managed to set implementation arrangements in place to successfully reach 1.5 million children under five with vaccination through WHO, and 150,000 women and children with medical treatments through UNICEF.

(c) **Focusing on quick wins and flexibility when responding to an emergency context.** Experience in emergency context indicates the crucial need for design flexibility to ensure adequate response to the various and emerging needs on the ground. The experience from Yemen and other countries stresses the importance of focusing on quick wins to ensure a positive impact on the affected population during conflict.

(d) **Simple design and preserving national capacity.** The experience from the ongoing HPP and SCP provide strong evidence that simple design and feasible implementation arrangements are prerequisites for any interventions during conflict. Both projects support the implementation of simple, yet high impact activities for the mass population. In addition, such a simple design allowed the projects to rely on the existing local delivery networks at the governorate and district levels to provide timely essential services. Such arrangements significantly contributed toward maintaining the operational capacity of the local institutions to deliver health services as the main foundation for the post-conflict recovery of the health system.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

38. 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.

39. WHO and UNICEF are key players of the Yemen Health Cluster 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.

40. At 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 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.

41. 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 TFC/SCs), while UNICEF provides 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 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.

42. 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.

43. The project is designed to fit within the current activities that have been implemented by both UN organizations under the ongoing IDA-financed projects. The procurement arrangement under this project is that UNICEF and WHO will follow their own procurement procedures as Alternative Procurement Arrangements allowed by the World Bank 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.

44. **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.[8] Therefore, it is envisaged that the proposed US$200 million IDA grant will be disbursed over the period of two years.

B. Results Monitoring and Evaluation

45. For their respective activities, UNICEF and WHO will use data collected by the GHOs and other implementing partners (LNGOs/INGOs) according to the standard reporting formats for levels/workers including those for mobile team reporting, integrated outreach reporting on all interventions, monthly reports by CHVs and quarterly reports by Community Health Workers (CHWs), and monthly reporting by HFs on services and supplies. Databases for each service are maintained at national, governorate, and lower levels. At each UNICEF or WHO zonal office, data will be collected and reviewed before it is consolidated at the central level by focal points from the GHO and NGO partners. The information management officers at zonal and country offices of UNICEF and WHO will support this process. As the security situation allows, UNICEF and WHO Health and Nutrition Officers at zonal field offices will conduct regular field visits to implementation sites to monitor and report on the progress of project activities. In addition to their regular M&E activities, UNICEF and WHO have an independent TPM mechanism in place to undertake quarterly performance verification and field monitoring of their program activities. The TPM agency will provide reports on the outputs as well as the delivery of services to the intended beneficiaries. In addition, UNICEF and WHO will submit to the Bank technical and financial progress reports on the

[8] Under UNICEF rules, there is a financial closure period of twelve 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).

project activities every six months with an agreed upon template.

46. The World Bank will conduct regular "reverse" implementation support missions with UNICEF and WHO to discuss the progress, implementation arrangements, governorate selection and prioritization criteria for each service, and action plans. These missions will be conducted biannually to: (a) review implementation progress and achievement of the PDO and intermediate indicators; (b) provide support for any implementation issues that may arise; (c) provide technical support related to implementation, achievement of results, and capacity building; (d) discuss relevant risks and mitigation measures; and (e) monitor the health system's performance through progress reports, audit reports and field visits, if and when they become possible. In addition, the project will support expanding the scope of the TPM mechanisms in place. The TORs for this TPM will be developed and agreed upon with UNICEF and WHO. The TPM reports will be shared with the World Bank, and will include the actions taken to address the implementation issues identified by the TPM agency.

47. Given the unique implementation arrangements of the project and the associated high risks, the Bank's role in monitoring and evaluation will be not only to measure the project results, but also to extract lessons and draw recommendations for future World Bank interventions in similar contexts on aspects such as effectiveness and sustainability.

C. Sustainability

48. The proposed project contributes to sustainability in three ways. First, the project aims to support and preserve the national implementation capacity by investing in the existing, local structure of health and nutrition service delivery, which will help maintain the main foundations of the system for a speedy post-conflict recovery of the health system. This also includes focusing on retaining available human resources and the core functions of the system. Second, building the eDEWs will allow the system to be more responsive to the 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 CHVs and CHWs. Evidence indicates that CHVs/CHWs continue to provide some services such as health promotion and awareness even when funding stops. In addition, the project's main focus on children and women at reproductive age will contribute to preserving the future of Yemen during the ongoing crisis.

D. Link to other WBG Emergency Programs and Role of Partners

49. Implemented by United Nations Development Programme in partnership with the Social Fund for Development (SFD) and Public Work Project (PWP), the ongoing World Bank-funded Emergency Crisis Response Project (ECRP) supports community-based nutrition activities through short-term employment for CHWs. Under the proposed project, UNICEF will coordinate with SFD to streamline the training program, priority districts with highest malnutrition, and scope of nutrition services provided through the community based services. In addition, ECRP, through the CHWs, will identify poor women and children suffering from malnutrition and will facilitate their reach to facility based nutrition services that are provided under EHNP. Targeted poor women and children will receive transport compensation and follow up from the CHW which will support the accessibility to and utilization of health services by these groups. Accordingly, EHNP and scaled-up ECRP will together support some supply and demand sides' interventions for malnutrition, respectively.

50. The existing local structure of the health system at the governorate and district levels is currently working, and will continue to act as the service providers and the frontline entry point for service delivery. LNGOs also play an important role in bridging some of the service gap in remote and underserved areas

with no functional facilities. The project will support the interagency coordination and complementarities between local existing public providers and NGOs as well as train community health volunteers. In addition, it will complement other health and nutrition interventions supported by other development partners.

51. Several partners are currently involved or stepping up their engagement in the Yemeni health sector. For instance, the EU is supporting a CHW network for building community resilience with an amount of almost US$15 million. In addition, DfID is supporting a package of nutrition and sanitation interventions amounting to US$50 million. The Islamic Development Bank (IsDB) is supporting the health system through a US$50 million project. GAVI is also providing technical and health system strengthening support with a focus on immunization for an amount of US$20 million. Furthermore, several bilateral donors, including Saudi, USA, and UAE governments have pledged and/or committed financial support to the Yemeni health system. However, by large, WHO and UNICEF remain the two leading agencies in the sector having the most extensive field presence in terms of planning and direct implementation capacities through their strategic partnerships and coordination with the majority of donors.

V. KEY RISKS

A. Overall Risk Rating and Explanation of Key Risks

52. Given the context of this emergency project and the difficult circumstances under which it will be implemented, the overall risk to the achievement of the project's objective is "High". The key risks that may negatively impact the successful implementation of the project are as follows: political and governance risks; macroeconomic risks; technical design and institutional capacity risks; and fiduciary, stakeholders and other risks.

53. **Political and governance risks.** The ongoing conflict in Yemen, prevalent at various degrees of intensity throughout the country, can significantly impede the implementation of this project. The situation may make project supervision difficult, which could result in resource diversion or funds only benefiting population residing in areas linked to political interests. Additionally, control of geographical areas by different political or armed factions could lead to interference and inadequate targeting of truly vulnerable people. Maintaining a strong focus on lower level collaboration with communities and primary HFs and working with politically neutral implementing partners are key mitigation measures. This mitigation strategy has proven effective in delivering services during times of instability. In addition, the project will put in place a TPM mechanism, which will not only verify services rendered under the project, but also reflect the beneficiaries' perceptions regarding these services through beneficiary checklists.

54. **Macroeconomic risks.** The economic impact of the crisis has been devastating for Yemen, aggravating an already weak pre-conflict economic performance. In 2015, the economy contracted by about 28 percent of Gross Domestic Product (GDP), while inflation has been estimated to have reached about 40 percent. The resulting fiscal pressures led to a sharp reduction of expenditures (from about 28 percent of GDP in 2014 to 21 percent in 2015) while revenues suffered an even larger shock from about 24 percent of GDP to 10 percent, in 2015. The government is no longer able to fund the operational costs of the health facilities, and there is a likely risk of salaries not being paid to health personnel due to the acute shortage of public resources. While these risks cannot be mitigated through this project, the project

is nonetheless a contribution to maintain urgently needed public services and local capacities. The Yemeni government in exile has made a public announcement that it is committed to pay all outstanding salaries to public officials, and not just those in areas under its control. The government has already begun to pay salaries to a part of the workforce. It is in the process to arrange resources to meet its outstanding salary payment obligations, expected to become available by the beginning of 2017.

55. **Technical design and institutional capacity risks.** The project design builds on the recently achieved success under the IDA funded HPP and SCP and aims to expand currently offered services nationwide, which can pose significant risks with regard to the capacity of local service providers. Risks will be mitigated by the diversity of interventions and implementation modalities currently adopted by UNICEF and WHO through their network of service delivery providers; strong focus on the communities as well as services that have proven effective will provide reasonable mitigation measures. The security challenge and frequent mobility of the population fleeing heavily conflict-affected areas may compromise the ability of UNICEF and WHO and their implementing partners to adequately identify eligible potential beneficiaries. This will be mitigated by the strong field presence and knowledge of the agencies and their implementation partners. The UN system has a track record in identifying IDPs in conflict-affected settings, has standing partnerships with LNGOs and CBOs and extensive experience in reaching out to the most affected communities. In addition, the project will cover all governorates in Yemen on a needs basis that will follow a transparent, evidence based and pre-agreed upon set of criteria for each type of activity.

56. **Fiduciary, stakeholder, and other risks.** Risks arising from implementation issues related to fiduciary, stakeholders, and the lack of official government counterpart still remain. If the ongoing conflict escalates and, as a result, UNICEF and/or WHO offices shut down at least temporarily, implementation will be significantly affected. A mitigation measure for such a situation would be for UNICEF and WHO to follow the business continuity plan and continue project implementation with remaining local staff on the ground, within the scope of what is possible. Risks related to procurement may include delay in responding to unexpected events such as disease outbreaks or mass injuries due to difficulties in importation and transportation. This risk will be mitigated by allowing for retroactive financing for advance planning using UNICEF's and WHO's own available resources to make the goods available in their stores in Yemen, Amman, Dubai, and Djibouti, through procurement and supply of vaccines, medicine and medical equipment and for implementation expenses for activities including capacity building and operational support. Another risk is the lengthy procurement process and approvals needed for low-value purchase orders. WHO procedures require the regional committee's approval for purchase orders above US$200,000 even under emergency situations; the process normally takes from 2–4 weeks. This risk will be mitigated by advance planning and delegation of authority as needed to the WHO regional procurement adviser. Finally, there is a risk related to weak fiduciary oversight and grievances mechanism at the governorate and locality levels. This will be mitigated by hiring a TPM Agent and by including fiduciary reviews on a sample basis in its TOR.

VI. APPRAISAL SUMMARY

A. Technical Summary

57. The health sector in Yemen is on the verge of collapse with many essential health services either ceasing to exist in some geographic locations or severely affected by the ongoing conflict. This operation

has been specifically designed to ensure that the Yemeni population continues to have access to critical healthcare services. Furthermore, the design reflects the important lessons learned from previous Bank experience in the country, notably the HPP, and from previous Bank engagements in emergency health and nutrition operations in countries with similar sociopolitical situations. This relates to: (a) using the existing, on the ground, technical capacity of MOPHP staff located all over the country at the GHO and DHO levels; (b) partnering with leading health organizations (WHO and UNICEF); and (c) providing the main elements of health system sustainability delivering the essential health services of the population, especially the disadvantaged groups.

58. To guide the design of the operation, two major principles were used in formulating the project activities:

(a) Achieve a balanced approach on two fronts: (i) providing a package of essential health and nutrition services based on the principle of continuum of care throughout the lifecycle (childhood, adolescence/adulthood, pregnancy, childbirth, postnatal period), and among models of service delivery (including clinical care settings, outreach, and household and communities); and (ii) supporting the PHC facilities and first level referral centers with the basic inputs for maintaining their operational capacity, and keeping the design flexible enough to respond to the fast-paced changing context during the conflict.

(b) Support the delivery of an integrated package of services building on the experience of the two ongoing IDA funded health operations. There are predefined guidelines and protocols for integrated service delivery and facility-based health planning that are suited to Yemen, and are consistent with the current capacities in the country. These standards ensure that: (i) delivery through fixed facilities is based on realistic distribution of services that ensure efficiency and optimum use of the limited resources; (ii) routine outreach and community based services are planned to complement delivery through fixed services, where appropriate; and (iii) mobile teams respond to the needs of disadvantaged groups in areas lacking functional fixed facility or overwhelmed by IDPs.

59. The project also builds on the balanced concept of using the flexibility provided by working with partner UN agencies for project stewardship and implementation oversight, while using the experienced and trained capacities working at decentralized GHO and DHO levels. The project will cover all governorates in Yemen on a needs basis that will follow a transparent, evidence based and pre-agreed upon set of criteria for each type of activity. Governorate prioritization will be revisited periodically to appropriately respond to the changing security considerations, as described above in paragraph 17.

60. UNICEF and WHO will engage the decentralized organizational and technical structure of the MOPHP to: (a) achieve basic service delivery to the Yemeni population in general and the disadvantaged groups in particular; (b) maintain, revive and retain the Yemeni health operational capacities especially at the central, GHO and DHO levels; and (c) prevent the collapse of the Yemeni HFs and maintain the basic foundations and institutions for the post-conflict recovery phase. The project will also engage, where appropriate and according to the changing situation in the field, a wide network of non-state partners, including CBOs and NGOs. This will contribute to a more inclusive future for Yemen where all parties are engaged in the rebuilding process on equal footing for the welfare of all Yemeni people.

B. Economic Analysis

61. Stemming from a pre-conflict state of an already deteriorated health system, different types of

inequities are evident in the Yemeni health system particularly with respect to: (i) access and utilization of health services; (ii) a high out-of-pocket expenditure incurred by households for health care services; and (iii) irrelevance and low accessibility of the services to the population. An estimated 40 percent of the population had no access to health services due to their disadvantaged locations in the rural and poor areas, and the utilization of health and nutrition services was severely in favor of the wealthiest quintile when compared to the poorest population prior to the conflict.

62. With the effective coverage of the target population, the project is expected to directly address the aforementioned issues in the target areas through the package of relevant maternal, childhood and nutrition services. The periodic re-prioritization of the target areas will ensure that this focus is persistent and sustained. Utilization rates are expected to match those among higher income groups. Additionally, the target population and their families will be protected against health expenditure shocks. This situation has worsened during the conflict where the utilization rates dropped to below 10-20 percent in some areas.

63. A simple cost-benefit analysis for project activities has been conducted. The impact of free and targeted maternal programs on the utilization of health services is evident. It ranges from as low as 50 percent to 200 percent increase in some cases. The positive association between utilization and improvement of health status is established. Most of maternal mortality in the developing world is avoidable and preventable. Assuming that the project in Yemen will directly prevent maternal mortality of the target population over a ten-year societal perspective, the project would be expected to save around 1,050 mothers' lives in total. This number is based on conservative estimates given that the average maternal mortality ratio in Yemen (210 per 100,000 live births prior to the war) is far better than that of the poorest countries. Assuming that these lives are saved over a period of two years starting at the end of the first year of implementation, the total number of life years saved thanks to the project would be 8,925 years [(525*9) + (525*8)].

64. Given the income elasticity (0.5-0.9) of statistical value of life (VL = VLY * LY where VLY=Value of Life year and LY=Life expectancy in Years), Viscusi and Aldy (2003) assume US$10,000-20,000 for each life-year saved in India (comparable to the socioeconomic status of Yemen) compared to US$160,000 in the US and US$50,000 per year of quality life internationally. Adopting a very conservative assumption (US$10,000 for each life-year saved) for the Yemeni context will yield a total annual economic benefit of (8,925*10,000) = US$89 million.

65. The average Infant mortality rate stood at 44 per 1,000 births in Yemen prior to the conflict. Thus, if the average infant mortality rate is applied to this project's target population, around 8,800 infant mortalities could be estimated. This is a conservative assumption given the low socioeconomic indicators of the target population. Assuming a mere 25 percent project effectiveness with respect to the preventable infant mortality (70 percent of the total infant mortalities), around 1,540 life-years would be saved by the project (70 percent of 8,800*25 percent=1,540 life-years). Adopting the same estimates of the statistical value of lives, the project would save around US$88 million. In addition, the project is expected to target 100,000 beneficiaries with essential and critical medicines. Assuming the project is effective in saving 2 percent of those beneficiaries, EHNP would be expected to save 17,000 years of life and thus saving US$170 million.

66. These estimated benefits totaling US$350 million do not include potential benefits on the economic productivity and welfare. The internal rate of return is expected to be around 75 percent, and the benefit-cost ratio is 1.5. This means that for each dollar spent under this project, an expected US$1.5

will be gained (as a benefit) or saved (as a cost).

C. Financial Management

67. The proposed project is an IDA grant to UNICEF and WHO (co-signatories of FMFA). The project's financial management arrangements will be governed by the FMFA between the World Bank and the UN agencies, which provides for use of UN Financial Regulations. An FM assessment was carried out to ensure adequate capacity, fiduciary and accountability oversight, consistent with the Operational Policy/Bank Procedures (OP/BP 10.00) for Investment Project Financing. Overall, the FM policies and requirements of the World Bank and the UN are aligned, except for the requirement of external audit as the UN's Financial Regulations give the UN's external auditors, the UN Board of Auditors, the exclusive right to audit the accounts and statements of UN organizations. At the same time, the World Bank audit policies provide for an exemption from its normal requirements if the recipient has more cost-effective mechanisms that provide the World Bank with "equivalent assurance" that the World Bank proceeds have been used appropriately. In all cases, the World Bank retains the right to request an audit.

68. UNICEF and WHO have strong presence in Yemen and have successfully implemented health and nutrition programs for the past several years, including during the ongoing conflict. Both agencies have proven their ability to carry out procurement of drugs and provide health services in close collaboration with the MOPHP and GHOs. They have successfully implemented similar activities under IDA-financed operations, for example, HPP in partnership with UNICEF and WHO, and SCP in partnership with WHO.

69. The Grant Control Account will be subject exclusively to the internal and external audit arrangements applicable to UNICEF and WHO as set out in the UN Financial Regulations. The two UN agencies will make their externally audited financial statements and accompanying reports of their external auditors on their financial statements available to the World Bank. The UN agencies will retain all records evidencing all expenditures in respect of which withdrawals from the Grant Control Account were made, in accordance with its regulations, rules, policies, and procedures relating to retention of records.

70. Accounts and Audits: Both UNICEF and WHO will: (i) maintain a financial management 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 six-month basis, interim unaudited financial reports (IFRs), in accordance with accounting standards established pursuant to the UN Financial Regulations and in the format agreed with the World Bank, adequate to reflect the expenditures related to the grant. The IFRs will be provided to the World Bank no later than 45 days after the end of the six-month period; (iv) ensure that the audit of the project activities is governed by the UN Financial Regulations and the FMFA; and (v) retain, until at least one year after the World Bank has received the final interim unaudited financial report in which the last withdrawal from the Grant Account was made, all records (contracts, orders, invoices, bills, receipts, and other documents) evidencing all expenditures in respect of which withdrawals from the Grant Account were made.

71. Retroactive Financing: The project will finance an amount of US$15 million (US$10 million for UNICEF-related activities, and US$5 million for WHO-related activities) starting from October 1, 2016 for procurement and supply of vaccines, medicine and medical equipment and for implementation expenses for activities, including capacity building and operational support under the project.

Flow of Funds and Disbursement Arrangements

72. These arrangements are simplified to ensure timely availability of funds to implement the proposed emergency operation. Disbursement to WHO and UNICEF shall be made on the basis of the interim unaudited financial reports and notices of withdrawal submitted by each UN agency to the World Bank. Each UN agency is required to prepare and submit the IFRs in accordance with the format and periodicity agreed with the World Bank. The grant proceeds will be transferred into the UN agencies' official bank accounts based on a written notice of withdrawal submitted to the World Bank by the designated officials for each agency. The first notice of withdrawal will cover projected expenditures for the activities for the first nine months of implementation. Subsequently, UN agencies should submit notices of withdrawal each six months thereafter, and each such notice will cover an amount representing the UN agencies' good faith projection of the expenditures for the following six months, up to the project's closing date, reconciling against amounts previously withdrawn against the project budget.

D. Procurement

73. The procurement activities under this project will include procurement of basic drugs, vaccines, medical equipment (laboratory and related general equipment for referral centers and PHC facilities), training of CHVs, CHWs, and community midwives (CMWs) and other health facility based workers and their supervisors and managers, and different kinds of medical kits for the CHVs, CHWs, CMWs, and for different uses such as diarrheal disease kits, emergency health kits, midwifery kits. It will also include procurement of medical equipment and training of CHVs and CHWs and supplies for community-based services and home-based delivery. The procurement plan has been finalized by UNICEF and WHO and reviewed by the Bank. The procurement plan will be attached to the implementation plan and operations manual of the project.

74. The ongoing conflict and restrictions on imports have led to severe shortages in fuel products, and a significant increase in their cost. This may not encourage enough suppliers to be engaged. The estimated increase in cost of similar items purchased locally is about 50 percent compared with the international market according to the information provided by UNICEF and WHO in Yemen.

75. The project is designed to fit within the current activities that have been implemented by both UN organizations. Both organizations will also aim to support the supply chain capacity in the health system, where appropriate. 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 World Bank 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 for several reasons:

(a) The two agencies have strong presence on the ground and have proven their capacity to work in conflict and post conflict areas in Yemen.

(b) The procurement activities proposed under this project are within the mandate of both UNICEF and WHO and already in their existing strategy using the same implementation mechanism.

(c) The implementation arrangement is flexible and relying on branch offices of the MOPHP at

the governorates, qualified local staff, NGOs and health volunteers.

(d) The two agencies have a preparedness mechanism, which enables optimal emergency procurement response. UNICEF has already assessed the needs, and the goods are available in their warehouses in three governorates. In addition, they have an emergency plan with the possibility of renting private warehouses in case of losing access to the existing warehouses or if these warehouses are damaged as a result of the conflict in the area. WHO has a strategic warehouse in Dubai to serve the whole region using their own air charter for transportation of goods to Yemen.

(e) The agencies' procurement arrangements provide reasonable assurance that the World Bank's financing will be used for the intended purpose.

(f) UNICEF and WHO are very much informed about the market response locally and internationally using their own criteria to register qualified suppliers considering the suppliers' performance and their responses in emergency situations.

(g) Cost effectiveness is achieved by prior planning and flexibility in delegating the decision to their local offices to buy the goods from the local market, though prices are up to 50 percent higher compared to the international prices. However, this is equal to the cost of transporting the goods to Yemen.

E. Social (including Safeguards)

76. The project is not expected to pose social safeguard risks. There are non-safeguard (social) risks that may negatively affect implementation of the project. The Involuntary Resettlement OP/BP 4.12 is not triggered. The first risk will be the difficulty to reach the severely affected women and children in conflict areas which could hinder the supply of the health and nutrition services. The mitigation measure 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). In addition, the ongoing ECRP will also support the transportation and uptake of basic services by these groups. The second social risk will be the difficulty to access areas under the control of armed factions where the vulnerable groups are residing and could lead to inadequate delivery of health services. This will be mitigated by the collaboration with neutral communities at the local level and with NGOs.

77. Given the nature of the project, consultation with the relevant stakeholders and intended beneficiaries will be critical under the current circumstances of the country. The project will adopt the implementing agencies' (UNICEF and WHO) "Beneficiaries' Satisfaction Checklist". This checklist will 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.

F. Environment (including Safeguards)

78. According to the OP 4.01 on Environmental Assessment, this project is classified as Environmental Category "B". 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 to, vaccination kits, vials and syringes.

79. A Safeguards Action Plan (SAP) with the required safeguards instrument has been prepared and cleared (Annex 2). A Medical Waste Management Plan (MWMP) will be prepared by the grant recipients, adopted, and disclosed before effectiveness. The implementing agencies (WHO and UNICEF) in collaboration with the appropriate Yemeni authorities will implement the MWMP to ensure proper management and safe disposal of any medical wastes. The MWMP will be disclosed both in-country as well as at the World Bank's InfoShop.

80. The implementing organizations have institutional arrangements and implementation mechanisms in place and long-standing experience in Yemen. The existing mechanism comprises WHO and UNICEF's own networks of providers, GHOs, DHOs, INGOs, LNGOs, and contractors. 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 a checklist—have been previously developed, adopted and already in use for monitoring and reporting on the project implementation, including on safeguards measures.

G. Waiver of Specific Operational Policies

81. **Waiver of Application of the Anti-Corruption Guidelines to UN Agencies and Waiver of IDA Commitment Charge.** The project will comply with Bank operational policies and procedures for Investment Project Financing. To facilitate implementation of the project by UNICEF and WHO as respective recipients and implementing agencies of the project, the Board is requested to approve two policy waivers:

(a) Waiver of paragraph 20 of BP10.00 on application of the World Bank's Anti-Corruption Guidelines to UN Agencies. To facilitate the implementation of the project by UNICEF and WHO, specifically in terms of the due diligence and monitoring of fraud and corruption, it is proposed to allow both UNICEF and WHO to use the respective UN agency's procedures for fraud and corruption, instead of the Bank's Anti-Corruption Guidelines, under alternative arrangements modeled on the integrity provisions of the Fiduciary Principles Accord (FPA). The two agencies are also uniquely placed to carry out the activities of the project within Yemen at this time, and there is no practical alternative in view of the project's design and focus. The Bank would consequently not have jurisdiction to sanction parties that engage in fraud and corruption in connection with the project, although the Bank would apply its suspension and debarment list to the project for eligibility purposes. The Bank will reserve its right to investigate parties other than the UN agencies (e.g., suppliers), but the Bank would not benefit from formal "third party audit rights" embedded in downstream contracts with suppliers and other third parties.

(b) Waiver of any application of the IDA Commitment Charge to the UN agencies implementing this project during the life of the project. In accordance with Section 3.01 of the IDA General Conditions for Credits and Grants, the Board reviews and sets the Commitment Charge on unwithdrawn financing balances on an annual basis. The IDA Policy, *IDA Commitment Charge for FY2017*, issued and effective July 1, 2016, sets the Commitment Charge for FY17 at zero percent. Given that the current Commitment Charge is zero percent, the financial impact of this proposed waiver is expected to be negligible.

H. World Bank Grievance Redress

82. 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.

VII. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY : Yemen, Republic of
Emergency Health and Nutrition Project

Project Development Objectives

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

Project Development Objective Indicators

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: People who have received essential health, nutrition and population services		Number	0.00	7000000.00	Every 6 months	Service reports coming from providers at different levels	UNICEF and WHO
People who have received essential health, nutrition and population services (% female)		Percentage	0.00	60.00	Every 6 months	Service reports coming from providers at different levels	UNICEF and WHO

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
People who have received essential health, nutrition and population services (% IDPs)		Percentage	0.00	10.00	Every 6 months	Service reports coming from providers at different levels	UNICEF and WHO
People who have received essential health, nutrition and population services (% children under 5)		Percentage	0.00	50.00	Every 6 months	Service reports coming from providers at different levels	UNICEF and WHO

Description: The indicator measures the actual utilization of the services. This would be reflected through the number of the project beneficiaries, who have received services supported by the project, i.e. number of direct project beneficiaries.

Intermediate Results Indicators

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Number of outreach rounds conducted		Number	0.00	3000.00	Every 6 months	GHOs and DHOs reports	UNICEF

Description: The project is expected to cover around 300 districts across Yemen, with 5 outreach rounds each year. The coverage per district for once is calculated as a round (300 districts x 5 rounds x 2 years).

Name: Number of mobile		Number	0.00	1500.00	Every 6 months	NGOs, GHOs and DHOs	UNICEF

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
team rounds						reports	
Description: The mobile teams are expected to cover the areas where there is no fixed facility, twice a week across the project's life cycle.							
Name: Health facilities provided with equipment and medical/non-medical supplies (number)		Number	0.00	300.00	Every 6 months	GHOs and DHOs reports	UNICEF and WHO
Description: This indicator measures the operational capacity sustained by the project. This includes all primary and referral health care facilities supported by the project.							
Name: Women who have received basic nutrition services (number)		Number	0.00	200000.00	Every 6 months	GHOs and DHOs reports	UNICEF
Description:							
Name: Children U5 who have received basic nutrition services (number)		Number	0.00	600000.00	Every 6 months	GHOs and DHOs reports	UNICEF
Description:							

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Children immunized (number)		Number	0.00	5500000.00	Every 6 months	GHOs and DHOs reports	UNICEF and WHO
Description: This indicator measures the cumulative number of children receiving vaccines purchased through a Bank-financed project, as well as the cumulative number of children immunized with vaccines purchased with other resources (i.e. GAVI or government funds) that are delivered through a Bank-supported project. It captures the number of children immunized and not the number of vaccinations.							
Name: Pregnant women receiving antenatal care during a visit to a health provider (number)	✓	Number	0.00	200000.00	Every 6 months	GHOs and DHOs reports	UNICEF and WHO
Description: This indicator measures the cumulative number of pregnant women receiving at least one antenatal care visit to a health provider as a result of Bank-financed activities.							
Name: Births (deliveries) attended by skilled health personnel (number)	✓	Number	0.00	40000.00	Every 6 months	GHOs and DHOs reports	UNICEF and WHO
Description: This indicator measures the cumulative number of women who delivered with the assistance of a health provider as a result of Bank-financed activities.							
Name: New electronic disease early warning system (eDEWS) data collection sites (number)		Number	0.00	600.00	Every 6 months	GHOs and DHOs reports	WHO

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Description: These are the additional sites that will be established under the project.							
Name: Health personnel receiving training (number)	✓	Number	0.00	4000.00	Every 6 months	GHOs and DHOs reports	UNICEF and WHO
Description: This indicator measures the cumulative number of health personnel receiving training through a Bank-financed project.							
Name: Local NGOs involved in service provision (number)		Number	0.00	15.00	Every 6 months	UNICEF data	UNICEF
Description: This reflects the NGOs and CBOs taking part in implementation of the project activities.							
Name: Beneficiaries satisfied with services provided		Percentage	0.00	30.00	Every 6 months	TPM agency, UNICEF and WHO	WHO and UNICEF
Description: This satisfaction survey is part of the Third Party Monitoring activities.							

Target Values

Project Development Objective Indicators

Indicator Name	Baseline	YR1	YR2	YR3	End Target
People who have received essential health, nutrition and population services	0.00	3500000.00	7000000.00	7000000.00	7000000.00
People who have received essential health, nutrition and population services (% female)	0.00	50.00	60.00	60.00	60.00
People who have received essential health, nutrition and population services (% IDPs)	0.00	5.00	10.00	10.00	10.00
People who have received essential health, nutrition and population services (% children under 5)	0.00	40.00	50.00	50.00	50.00

Intermediate Results Indicators

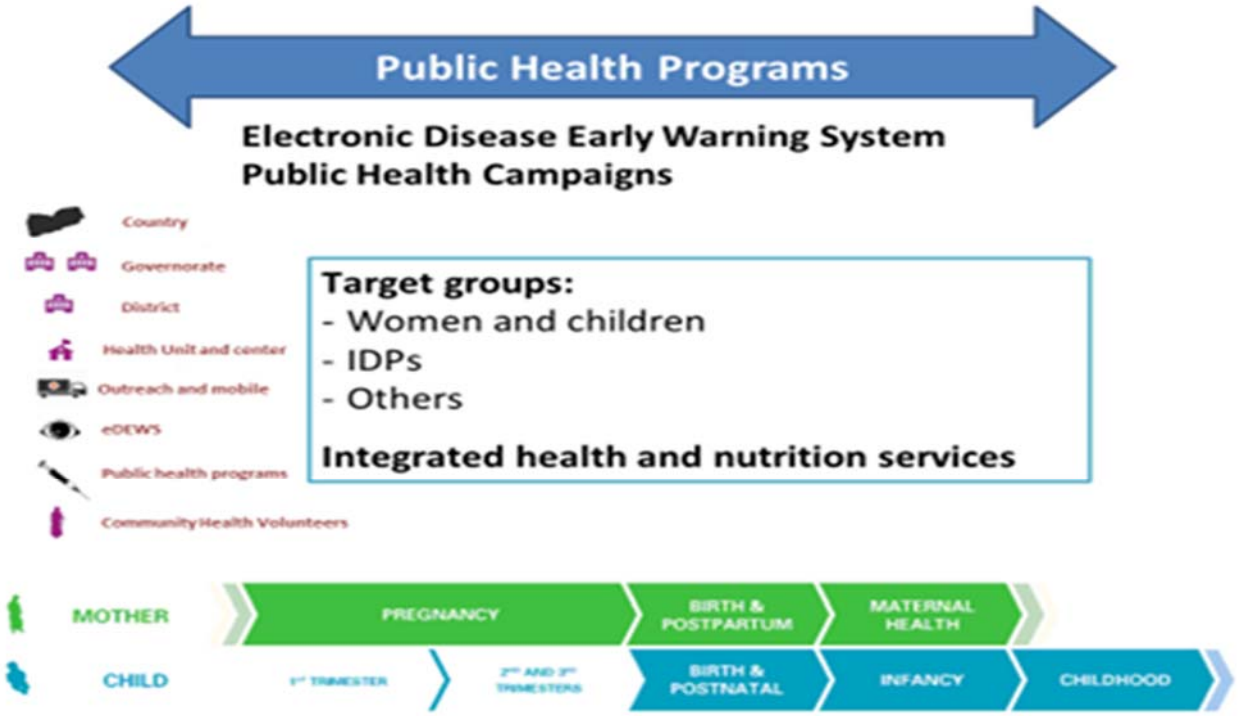
Indicator Name	Baseline	YR1	YR2	YR3	End Target
Number of outreach rounds conducted	0.00	1500.00	3000.00	3000.00	3000.00
Number of mobile team rounds	0.00	750.00	1500.00	1500.00	1500.00
Health facilities provided with equipment and medical/non-medical supplies (number)	0.00	150.00	300.00	300.00	300.00
Women who have received basic nutrition services (number)	0.00	100000.00	200000.00	200000.00	200000.00

Indicator Name	Baseline	YR1	YR2	YR3	End Target
Children U5 who have received basic nutrition services (number)	0.00	300000.00	600000.00	600000.00	600000.00
Children immunized (number)	0.00	5000000.00	5500000.00	5500000.00	5500000.00
Pregnant women receiving antenatal care during a visit to a health provider (number)	0.00	100000.00	200000.00	200000.00	200000.00
Births (deliveries) attended by skilled health personnel (number)	0.00	20000.00	40000.00	40000.00	40000.00
New electronic disease early warning system (eDEWS) data collection sites (number)	0.00	300.00	600.00	600.00	600.00
Health personnel receiving training (number)	0.00	2000.00	4000.00	4000.00	4000.00
Local NGOs involved in service provision (number)	0.00	7.00	15.00	15.00	15.00
Beneficiaries satisfied with services provided	0.00	20.00	25.00	30.00	30.00

ANNEX 1: DETAILED PROJECT DESCRIPTION

COUNTRY : Yemen, Republic of
Emergency Health and Nutrition Project

Figure 1.1. Conceptual Framework of Project Design



I. Detailed Component Description:

Component 1: Improving Access to Health, Nutrition, and Public Health Services (US$191 million)

83. The component will support the coverage of the population of Yemen with well-defined packages of health and nutrition services at both levels of care (PHC and 1st level referral centers/secondary care). The services are intended to cater to the essential and most urgent needs of the population with their complementary applicable referral level services, 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 a context of conflict, namely, reproductive age women, children and IDPs. This component includes three subcomponents:

Subcomponent 1.1: Strengthening the Integration of Primary Health Care Model

84. This subcomponent will ensure the continued service delivery of the PHC facilities to provide the essential health and nutrition services for the population within their catchment areas. It will also support providing services to other locations outside of their catchment areas to bring needed services in localities that lack operational facilities as well as have high concentrations of IDP's. The subcomponent mainly

addresses the lack of an operating budget for the PHC facilities and outreach model along with the significant shortage of pharmaceuticals and supplies. Therefore, this subcomponent will address this service gap nationwide through supporting the main inputs for service provision at the PHC level. Through outreach and community-based services, the project aims to reach directly to the beneficiaries – especially women of reproductive age and children – with the essential health services.

85. **PHC facility health and nutrition services.** The services offered under this subcomponent will support the operations and services offered inside fixed PHC facilities. Therefore, it aims to sustain and strengthen the operations of the existing functional facilities and to resume services in the non-functional ones[9]. It will also maintain the basic preventive and clinical curative health and nutrition services offered at the facilities. This subcomponent will include provision of basic supplies (fuel and water supply), medical and non-medical equipment, essential medicines, training of staff, and costs associated with clinical and administrative supervision.

86. **Integrated outreach health and nutrition services.** Given the significant service gap, this subcomponent will complement the fixed facility and community based services through an integrated outreach model. This model will cater to the needs of population in remote areas through outreach rounds, and in areas without functioning fixed facilities, through mobile teams[10]. The package of PHC services under outreach rounds and mobile teams is similar and will be flexible to accommodate additional services based on the identified needs of each area.

87. The integrated outreach model will include the following services and related activities: (a) MNH services; (b) child nutrition; (c) IMCI; (d) mental health services; and (e) routine delivery of selected public health programs such as, but not limited to, routine immunization and prevention and treatment of malaria, schistosomiasis, and trachoma.

88. **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 CHVs and CMWs. This network of community volunteers will be also trained to provide some mental health services to the population such as psychosocial support for women and children. In addition, these services will include chlorination campaigns and hygiene awareness sessions at the household level.

89. This subcomponent will cover the basic equipment, medical supplies, required nutrients and drugs, vaccines, training, and implementation expenses required for the aforementioned services at the facilities, integrated outreach, and community based services.

90. The Integrated outreach will strive to do the following:

(a) Provide/expand access to a basic health and nutrition package of services to populations with no or limited access to health services, using a service delivery model of regular outreach health services to areas far away from the fixed facilities and mobile teams to serve disadvantaged communities and locations with IDPs wherever they are. This model will complement service delivery in fixed facilities as well as community/household based services provided through MOPHP and partner organizations. This will help in increasing the demand and utilization of fixed HFs through referring cases in need of more slightly

[9] This does not include any works for rehabilitation or construction for the said primary health facilities

[10] Mobile teams will target 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 areas are directly served by the fixed facilities.

advanced services.

(b) Support the integration of health and nutrition services in the outreach and mobile teams' activities.

(c) Cover the costs associated with integrating some vertical programs' activities within the outreach and mobile teams' delivery mechanisms, for example, schistosomiasis, malaria, and so on.

(d) Support the supply of outreach and mobile teams with the needed essential medicines, supplies, and equipment. Support will also be given to the logistical supply chain for supplying the field teams with the needed medicines and commodities in proper quantities, quality and timing.

(e) Strengthen health management information systems and quality assurance that will ensure the proper functioning and monitoring of outreach services.

(f) Provide for program implementation costs associated with outreach and mobile teams' activities.

91. **The mobile teams** will deliver a package of health and nutrition services to targeted populations (IDPs, remote population, population with very high SAM rates) once every week or every two weeks. They are a short to medium term strategy to provide services in the absence of functional HFs. This component will support the deployment of mobile teams providing integrated health and nutrition interventions to the targeted beneficiaries.

92. The integrated package of services that mobile teams are providing includes vaccination, community-based management of acute malnutrition (CMAM), IMCI, RH care (antenatal care [ANC], postnatal care [PNC], and safe delivery services if needed), vitamin A and micro-nutrients supplementation and de-worming for targeted children, iron folate supplementation for pregnant and lactating women, and counselling on infant and young child feeding (IYCF) practices, on hygienic and healthy family practices.

93. CMAM is a program focusing on prevention and management of malnutrition among children and improving the nutrition status and general well-being for children under five and pregnant or lactating women. Wasting includes two components: SAM and MAM. Severely acute malnourished child is at risk of death ten times more than a non-malnourished child, while moderately acute malnourished child has risk of death three times more than a non-malnourished child. CMAM includes both preventive and curative elements that are implemented by community and HF levels of interventions.

94. The CMAM program includes four main components: (i) treatment of severe acute malnourished children without complication by outpatient therapeutic feeding centres (OTPs); (ii) treatment of moderate acute malnourished children by supplementary feeding program (SFP); (iii) treatment of acute malnourished children with complication by TFCs/SCs; and (iv) community mobilization component, including sensitization for community members and CHVs' role in active case finding (screening and referral of malnourished children and women at reproductive age), raising awareness on key messages (for example: IYCF practices counselling).

95. Both WHO and UNICEF will work closely in CMAM through supporting: (i) capacity development of health workers, CHVs, CHWs and community health monitors at the central, governorate, and district levels; (ii) monitoring and reporting (field monitoring visits and regular reports submission); and (iii)

supplies (planning based on the case load, procurement, supplies delivery till end user).

Subcomponent 1.2. Supporting Health and Nutrition Services at the First Level Referral Centers

96. This subcomponent will complement the PHC model through ensuring continuum of care. Therefore, it will support the following activities: a) Management of SAM cases with complications and OTP-failed patients with TFC/SC; b) provision of CEmONC/EmONC services in targeted referral centers; and c) coverage of equipment, maintenance, medical supplies, essential drugs, vaccines, training, and Implementation expenses required for the smooth operations at first level referral centers.

97. This project will also fill shortages in medicines and basic supplies (water and electricity) procured and supplied for use at the PHC and first level referral levels. Medicines falling under the Essential Drug List for Yemen (an interagency approved list) will be eligible for financing. The supply will be needs-based for the selected UNICEF-supported health centers that will receive essential drugs for adults, procured and distributed by the WHO. WHO will procure and distribute essential drug kits (Integrated Emergency Health Kit) to a number of pre-selected referral hospitals based on a pre-identified needs list. Medicines will be procured through UN systems to ensure timely procurement and meeting the WHO quality standards.

WHO work plan in SAM treatment at TFCs and BEmONC/CEmONC

98. As a response to the continuous state of crisis in Yemen since 2009, 20 TFCs were opened in the priority governorates on the coastal region. The available funding for the nutrition activities is barely enough for maintenance of the old functioning TFCs (16 TFCs) and upgrade of the quality of the services by conducting refresher and on the job trainings as well as more supervision and monitoring visits. There is an urgent need to open new ones as the situation is deteriorating and the turnover from MAM to SAM is alarmingly high especially in the already vulnerable and conflict affected governorates. The WHO strategy to manage the TFCs is mainly composed of: (i) Integration with other nutrition partners in the field; (ii) Supporting the referral pathway; and (iii) Establishment and running cost.

99. On the other hand, BEmONC/CEmONC services will be offered in first level referral hospitals at governorate or district levels. The services are delivered within the settings of Obstetric wards and will include: (i) parenteral administration of antibiotics; (ii) treatments for eclampsia (provision of anticonvulsants); (iii) parenteral administration of Oxytoxics; (iv) assisted vaginal delivery (vacuum extraction); (v) manual removal of placenta; and (vi) removal of retained products of conception (MVA). CEmONC includes all the above six services along with the availability of blood transfusion facility and the facility for Caesarian section.

Subcomponent 1.3. Sustaining the National Health System Preparedness and Public Health Programs

100. **Disease Surveillance and outbreak response:** This will include the roll-out of the current eDEWS nationwide through adding new sites in the health facilities identified by WHO, and improving the core functions of the system including, data collection from HFs, field investigation, and 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.

101. **Support national public health campaigns:** The project will support implementation of the nation-wide immunization and treatment campaigns for diseases such as, but not limited to, polio, measles, 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 administration activities of the campaign.

102. **Cholera management**. A multifaceted approach will be supported to prevent and control cholera, and to reduce deaths. A combination of surveillance (through eDEWS), water chlorination, sanitation and hygiene, social mobilization, treatment, and oral cholera vaccines will be used. Therefore, the project will support the WHO-developed cholera kits for the prevention and control of cholera outbreak.

II. Selection of Target Population:

103. The operation will be nationwide and support provided therein will be used in any district or governorate of the country based on a set of criteria. At the initiation of the program implementation and every 3-6 months thereafter, the World Bank, WHO and UNICEF will review the criteria and the situation on the ground and identify additional or new governorates. For the first six months of the project implementation, the following criteria are proposed.

1- Smallest proportion of the HFs functional (Score 3)	Proportion of the functional HFs—preference will be given to those that have higher levels of non-functional HFs
2- High General Acute Malnutrition and SAM rates (Score 1)	General Acute Malnutrition of more than 10 percent and SAM of more than 3 percent
3- Low immunization coverage rates (Score 1)	Penta coverage of less than 70 percent
4- Outbreaks of diseases (Score 1)	At least one outbreak in the last 6 months
5- High proportion of the IDPs in the governorate (Score 1)	Proportion of IDPs to the host governorate population
6- Presence of other partner support (Score 1)	Absence of any partners in health and nutrition
7- Non-availability of specific services (Score 1)	Percentage of non-availability of specific service domains
8- Degree of impact of conflict (Score 2)	Destroyed/ damaged key HFs

Table 1.1. Examples of Supported Health and Nutrition Interventions

Partner	Areas of Support	Activities
WHO	Water Supply	o Provision for HC o Goods o Implementation expenses o Capacity building
	Disease Surveillance	o Scaling up of eDEWS o Outbreak response o Goods o Implementation expenses o Capacity building
	Supplies (essential drugs)	o Procurement and distribution (to selected/ UNICEF-operated HCs) o Goods o Implementation expenses o Capacity building
	Polio Campaigns	o Four national campaigns o Goods o Implementation expenses o Capacity building
	Provision of EmONC services in targeted referral centers / hospitals	o Standards and training of staff o Goods o Implementation expenses o Capacity building

Partner	Areas of Support	Activities
	Management of SAM cases with complications and OTP-failed patients with TFC / SC services in 16 health facilities	o Coordination with nutrition partners in the field, monitoring and active surveillance o Supporting the referral pathway o Support therapeutic feeding center's establishment and running cost, patients' needs and care taker accommodation o Goods o Implementation expenses o Capacity building
	Supply of essential medicines	o Procurement and logistics o Goods o Implementation expenses
	Emergency operations and maintenance cost of the facility	o Provision of fuel o Water Supply o Emergency allowance o Maintenance o Goods o Implementation expenses o Capacity building
	Management of cholera cases	o Procurement of cholera kits o Investigation and treatment
UNICEF	Provision of vaccination at fixed HFs/EPI sites	1. Vaccine and cold chain procurement: o Procurement of BCG, bOPV, MR & TT o Procurement of Pentavalent, PCV-13 and Rota vaccines (Govt. share under co-financing) 2. Operational support for EPI service delivery (fuel/ gas, in-country transportation etc.) o Fuel for cold rooms at central, governorate and district vaccine stores o Provision of gas to EPI centers (3500)
	Provision of Integrated Management of Childhood Illnesses (IMCI) services at the Health facilities	1. Capacity building for IMCI 2. Operational support to HFs for IMCI service delivery (supervision and monitoring, reporting and reviews) o Supportive supervision and monitoring o Data collection o Quarterly review meetings 3. IMCI supplies
	Provision of Basic Emergency Obstetric and Newborn Care (BEmONC) at Health facilities	Provision of BEmONC at the PHC facility
	Provision of integrated Nutrition Package (IYCF, CMAM)	1. Capacity building for CMAM and IYCF at PHC Facilities 2. Operational support to HFs for Nutrition service delivery (supervision and monitoring, reporting and reviews) 3. Nutrition supplies including micronutrient supplements, anthropometric measurements, RUTF and printed material
	Support maintaining health system at primary care level	1. Supervision & Monitoring 2. Fuel/ gas and other operational supplies 3. Health promotion activities
	Other vaccination campaigns support (MR, TT, others)	1. Prevent measles cases and outbreaks in areas of low immunity, internally displaced populations, etc. 2. TT vaccination of the women of reproductive age for prevention of neonatal tetanus
	Integrated Outreach	Provision of package of health and nutrition interventions to women and children in areas beyond the reach of health facilities and IDPs

Partner	Areas of Support	Activities
	Support to management of cholera outbreak	1. Support to the chlorination campaigns and hygiene awareness sessions at household levels 2.Support the case management and follow up on the suspected and confirmed cases
	Provision of a H&N package at community level (mobile teams)	Support development of new 20 H&N mobile teams in hard to reach areas & areas with IDPs gatherings
	Provision of maternal and newborn care at household (CBMNC)	1. Capacity Building and ensuring the provision of High Impact - evidence based interventions by conducting training courses on CBMNC for the CMW 2. Ensuring the quality of services through conducting Supportive Supervision Visits
	Provision of an H&N package at household level (CHWs & CHVs)	1. Capacity development for CHVs and CHWs 2. Provision of the needed supplies/kits for CHVs and CHWs
	Supply of essential medicines for maternal, newborn and child health and nutrition	o Procurement and logistics o Goods o Implementation expenses
	Management of cholera cases	o Procurement of cholera vaccines

104. UNICEF will primarily implement activities related to PHC including procurement and delivery of vaccines, nutrition supplements packages, and supplies for HFs, as well as in areas beyond the HFs through the integrated outreach campaigns and mobile teams. Expenditures will mainly consist of: (a) procurement of health and nutrition packages, vaccines, and supplies, (b) implementation support for delivery of health and nutrition services (transportation allowances, per diem, fuel, and so on), and (c) capacity building activities for service providers.

105. WHO will implement activities at PHC and secondary levels; at the PHC level, WHO will implement national health campaigns, procure and provide essential drugs to selected health centers (drugs and implementation support), provide HFs with water supply (goods and operation cost), and scale up the outbreak response (goods, operational cost, and training). At the secondary level, WHO will implement emergency services in selected health centers (goods, operational cost and capacity building), support nutrition in selected HFs (goods, operational cost, and training), procurement and delivery of essential medicines (goods and implementation support cost), and maintenance of HFs (implementation expenses).

Component 2: Project Support, Management, Evaluation and Administration (US$9 million)

106. 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; (b) monitoring and evaluation related activities, and 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 at both agencies; and (c) technical assistance.[11] Both UNICEF and WHO will perform project core management and implementation support activities through

[11] Technical assistance means the cost associated with the agencies' advisory services other than consultants' services on account of monitoring, evaluation and supervision of activities under Component 1, 2 and 3 of the project, including charge of direct staff time for the agencies' staff assigned from time to time to perform such services under the project.

their multidisciplinary teams located in their offices in Sana'a and satellite offices all over Yemen. Specifically, the two organizations will: (a) monitor and 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.

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

107. 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 moderate 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 CERC allows UNICEF and WHO to request the World Bank to support by re-allocating funds from other components or serving as a conduit to process an additional financing to mitigate, respond and recover from the potential harmful consequences arising from the emergency situation.

108. Disbursements under this component will be subject to the declaration of emergency[12] and the preparation of an "Emergency Response Operational Manual" (EROM) by UNICEF and/or WHO and agreed upon by the Bank.

[12] Either the Republic of Yemen, the international community, or the United Nations has issued an Emergency Declaration

ANNEX 2: IMPLEMENTATION ARRANGEMENTS

COUNTRY : Yemen, Republic of
Emergency Health and Nutrition Project

Project Institutional and Implementation Arrangements

1. In view of the ongoing conflict and crisis situation in Yemen, the World Bank operational policy (OP) 2.30 (Development Cooperation and Conflict) applies to the project. In light of that status the request to provide the IDA grant to WHO and UNICEF proceeds under paragraph 3 of OP 2.30, which stipulates that "if there is no government in power, Bank assistance may be initiated by requests from the international community, as properly represented (for example, UN agencies), and subject in each case to the prior approval of the executive directors."

2. The proposed EHNP will be implemented by UNICEF and WHO as implementing agencies. UNICEF and WHO representation in Yemen will be responsible for the implementation of the project. Each of the two UN agencies will be fully responsible for a number of activities based on the project design and specialization of each agency. There is in place a strong partnership between the World Bank and the two UN agencies, which has enabled successful implementation of two IDA-financed projects for Yemen in the health sector during the conflict situation. In December 2015, the World Bank on an exceptional basis lifted suspension of disbursements for the HPP and SCP in order for UNICEF and WHO to implement the two projects through an existing contractual arrangement with Yemen's MOPHP under technical and operational assistance agreements. In view of the implementation experience under HPP and SCP, the two UN agencies will also use their local implementing partners (including government technical teams, LNGOs, CBOs, and private sector providers) through relevant agreements and contracts with the implementation partners. The implementation arrangement will be described in detail in the Project Operational Manual for the project, which will be in place before effectiveness

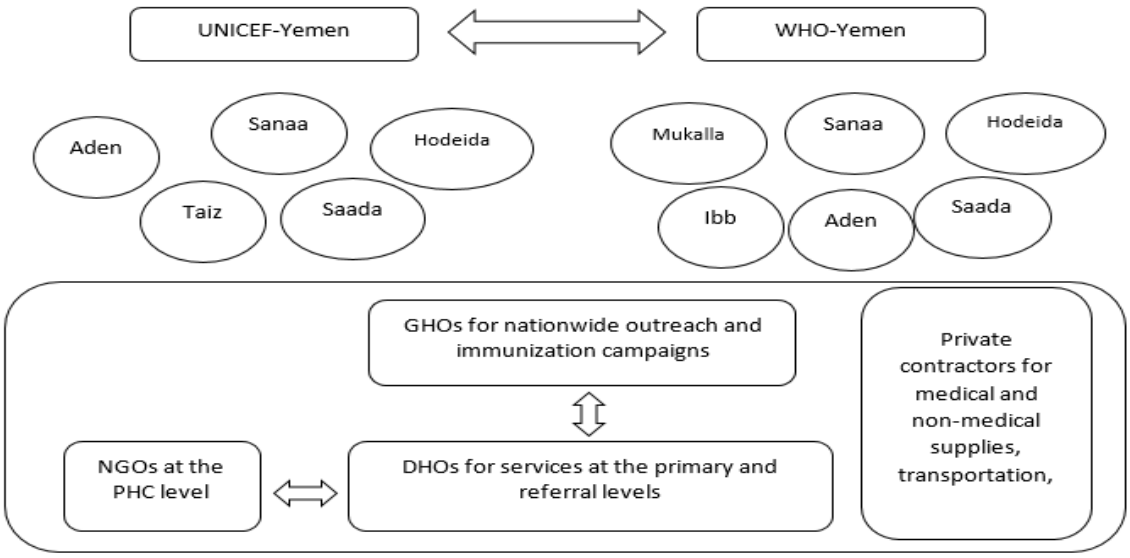
3. The two agencies have established implementation mechanisms in place to deliver various results on the ground during the ongoing conflict in Yemen. Since March 2015, both organizations further strengthened and expanded their operational capacities and presence in the country to address the health issues at different levels. **UNICEF-Yemen** has 52 international and 146 national staff distributed among the country office in Sana'a, and four other offices in Hodeida, Aden, Sa'ada, and Taiz.[13] **WHO-Yemen** similarly expanded their presence in the field and scaled up their operations in the country over the last year through the recruitment of other national and international positions to reach a total of 85 staff (69 nationals, 16 international) distributed among the country office in Sana'a and other offices in Aden, Sa'ada, Hodeida, Ibb, and Mukalla. All offices of both organizations have been operational and maintained supply chains to most service delivery points through their own contractors or partners.

4. Both WHO and UNICEF are key players of the Yemen Health Cluster of Partners, which is guided by the Health Engagement Plan. Through their own network of providers, contractors, GHOs, DHOs, and INGOs/LNGOs, both organizations have institutional and implementation mechanisms in place to ensure the delivery of essential services and availability of critical medicines nationwide. These implementation

[13] Staff in Sa'ada office have worked from home for some weeks during the conflict, while Taiz office was temporarily moved to Ibb due to the intense fight in Taiz.

arrangements, which were proved successful under 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 health care services. At the PHC level, for instance, UNICEF has its own network of contracted NGOs which provide mobile health teams in districts where fixed facilities are non-functional. Both organizations also work with the existing local health system structures at the governorate and district levels to preserve the national capacity and maintain the core functions of the health system. Due to limited resources, the current health engagement program is only reaching 35 percent of its target beneficiaries nationwide, and thus, the EHNP will narrow this funding gap and expand the program to additional beneficiaries.

Figure 2.1. The Institutional Coordination Framework for the Project



5. **Implementation approach.** While the project activities have no specific geographical targeting, they will be guided by the security situation of each governorate. Therefore, areas with ongoing conflicts will be reached once the security situation improves and the service delivery can be resumed. Similarly, the package of services will vary among governorates based on the population's health needs and the local implementation capacity of the existing providers. Therefore, the World Bank team will work closely with WHO and UNICEF to identify and agree upon the selection criteria for each health and nutrition service to develop a priority list of governorates for each service. These selection criteria will be periodically reviewed by the three organizations to ensure the appropriate responsiveness to the emerging health needs.

Governance and Management Framework of the Project

6. In line with the Yemen Health Engagement Plan, both UNICEF and WHO country offices in Yemen have their existing structures for the policy and institutional coordination, strategic planning and guidance, day-to-day program management at central and local levels, field supervision and monitoring, regular data collection and reporting, international and national supply chain management for medical and non-medical supplies, and program evaluation. As a complementary intervention to the existing Health Engagement Plan, the EHNP will fall under the current structures of both organizations.

7. The current Health Engagement program of both organizations have the directions discussed as

follows;

A commitment to development/resilience building in various geographic areas based on the needs and the situation:

8. Both organizations will scale up the preventive and curative health and nutrition activities through HFs, integrated outreach services and mobile teams to reach IDPs and people living in conflict-affected and needy areas identified by the respective clusters. This will increase the coverage of both preventive and basic interventions to address both mortality and morbidity as well as wasting and stunting. It will also improve the resilience of the individuals, households and communities against childhood morbidities and mortalities, including those due to malnutrition.

A commitment to an integrated approach to programming and service delivery:

9. The integrated outreach and community-based approaches will only be successful if the community platform has strong linkages with first level PHC facilities and the referral linkages exist to ensure continuation of services for referred cases at these facilities. In addition, the outreach model integrates a package of vertical programs to minimize system fragmentation.

Focus on promoting decentralization:

10. The escalation of conflict in 2015 has increased the need for decentralized program implementation as the country has become further fragmented with the de-facto authorities in the capital having limited authority over significant portions of the country. Therefore, UNICEF and WHO strengthened their decentralized program through the following measures:

- Continued decentralization of planning and implementation related processes;
- Decentralization of funds to field offices and GHOs;
- Decentralization of capacity development for planning, implementation and monitoring; and
- Decentralization of accountability including responsibility for field monitoring and spot checks.

Emphasis on quality improvements and preserving the national capacity

11. In order to ensure the provision of quality services to the target population, building the capacity of the government to monitor at governorate and district levels is at the center of WHO and UNICEF interventions. In addition, UNICEF and WHO staff are responsible for the day-to-day field monitoring and supervision visits as well as the deployment of a TPM provider in locations the staff may not have access due to security restrictions.

M&E Mechanisms

12. For their respective activities, UNICEF and WHO will use data collected by the GHOs and other implementing partners (international and local NGOs) as per the standard reporting formats for different levels/workers including formats for mobile team reporting, integrated outreach reporting on all interventions, monthly reports by CHVs and quarterly reports by CHWs, and monthly reporting by HFs on services and supplies. Databases for each are maintained at national, governorate, and lower levels. At each UNICEF or WHO zonal office, data will be collected and reviewed before it is consolidated at the central level by focal points from the GHOs and NGO partners. The information management officers at zonal and country offices of UNICEF and WHO will support this process. Regular data verification is

undertaken by UNICEF and WHO staff, TPM, as well as zonal and district governmental monitors who have been trained on integrated monitoring and provided with the essential tools. In addition, as the security situation allows, UNICEF and WHO health and nutrition officers at zonal field offices will conduct regular field visits to implementation sites to monitor, supervise and report on the implementation progress of the project activities.

Bank Supervision

13. The World Bank will be conducting regular reverse implementation missions to discuss the project progress, implementation arrangements, governorate selection/prioritization criteria for each service, and action plans. Additionally, the Bank will rely on a TPM mechanism being in place to complement the current TPMs in place by UNICEF and WHO. The TORs for this TPM will be developed and agreed upon with UNICEF and WHO.

Financial Management

14. The proposed project is an IDA grant to both WHO and UNICEF (co-signatories to the FMFA). The project's FM arrangements will be governed by the FMFA between the World Bank and the UN agencies, which provides for the use of UN's Financial Regulations. An FM assessment is carried out to ensure adequate capacity, fiduciary and accountability oversight, consistent with OP/BP 10.00 Investment Project Financing. Overall, the FM policies and requirements of the World Bank and the UN are aligned, except for the requirement of external audits as the UN Financial Regulations give the UN external auditors, the UN Board of Auditors, the exclusive right to audit the accounts and statements of the UN organizations. At the same time, the World Bank audit policies provide for an exemption from its normal requirements if the recipient has more cost-effective mechanisms that provide the World Bank with "equivalent assurance" that the World Bank proceeds have been used appropriately. In all cases, the World Bank retains the right to request an audit.

15. To conduct the FM assessment, the World Bank considered the World Bank-wide assessment of UN agencies including reviewing prior external and internal audit reports, project design, implementation arrangements, and associated risks and mitigating measures.

16. Both agencies have a strong presence in Yemen and have successfully implemented health and nutrition programs for the past several years, including during the ongoing conflict. Both agencies have proven their ability to carry out procurement of drugs and provide health services in close collaboration with the MOPHP and GHOs. Both agencies have successfully implemented similar activities under IDA-financed operations, HPP in partnership with UNICEF and WHO, and SCP in partnership with WHO. However, there was a delay in sending reports to the MOPHP and the World Bank on funds utilization. This issue was discussed with both UN agencies during the preparation of the project and it was agreed to strengthen the internal control mechanism on monitoring of project reports to ensure all reports are submitted on time.

17. To provide reasonable assurance that project funds are spent for the intended purposes, the following arrangements will be in place: (i) reliance on established UN internal control mechanisms for the process of disbursement, documentation of expenditures, and reporting; (ii) contracting of independent monitors by the UN agencies to supervise the implementation of health campaigns and the compliance with the implementation arrangements; (iii) use of a TPM agent to verify the physical implementation of the health and nutrition services, and the compliance with the internal controls and

financial management arrangements; and (iv) preparation of timely financial and progress reports submitted on a semiannual basis.

Accounts and Audits

18. Both UNICEF and WHO will: (i) maintain a financial management system, including records and accounts, adequate to reflect the transactions related to the activities, in accordance with the requirements of the UN Financial Regulations and Rules; (ii) maintain a separate ledger account (Grant Control Account) in their books to record the financial transactions of this project; (iii) prepare, on a six-monthly basis, interim unaudited financial reports (IFRs), in accordance with accounting standards established pursuant to the UNICEF and WHO Financial Regulations and in the format agreed with the World Bank, adequate to reflect the expenditures related to the grant. The IFRs will be provided to the World Bank no later than 45 days after the end of the six-month period; (iv) ensure that the audit of the Project Activities is governed by the UN Financial Regulations and the FMFA; and (v) retain, until at least one year after the World Bank has received the final interim unaudited financial report in which the last withdrawal from the Grant Account was made, all records (contracts, orders, invoices, bills, receipts, and other documents) evidencing all expenditures in respect of which withdrawals from the Grant Account were made.

19. The Grant Control Account will be subject exclusively to the internal and external audit arrangements applicable to the UNICEF and WHO as set out in the UN's Financial Regulations. The two UN agencies will make their externally audited financial statements and accompanying reports of their external auditors on their financial statements available to the World Bank. The UN agencies will retain all records evidencing all expenditures in respect of which withdrawals from the Grant Control Account were made, in accordance with its regulations, rules, policies, and procedures relating to retention of records.

Flow of Funds and Disbursement Arrangements

20. Flow of funds and disbursement arrangements are designed to be simplified to ensure timely availability of funds to implement the proposed emergency operation. Disbursement to WHO and UNICEF shall be made on the basis of the interim unaudited financial reports and notices of withdrawal submitted by each UN agency to the World Bank. Each UN agency is required to prepare and submit the IFRs in accordance with the format and periodicity agreed with the World Bank. The grant proceeds will be transferred into the UN implementing agencies' official bank accounts based on a written notice of withdrawal submitted to the World Bank by the designated officials for each agency. The first notice of withdrawal will cover projected expenditures for the activities for the first nine months of implementation. Subsequently, they should submit notices of withdrawal each six months thereafter, and each such notice will cover an amount representing the UN agencies' good faith projection of the expenditures for the following six months, up to the project's closing date, reconciling against amounts previously withdrawn against the project budget.

21. Both WHO and UNICEF have bank accounts in commercial banks in Yemen in US dollars and Yemeni rials. Steps have been taken by both agencies to deal with the currency crisis due to the lack of Yemeni rials and they have signed agreements with commercial banks to facilitate payments through direct transfers into the implementing partners' bank accounts, checks to beneficiaries, cash delivery, and so on.

Implementation Arrangements

22. The planning process for each of UNICEF and WHO is done jointly with the MOPHP and the health cluster to identify priority programs for the collaboration. Plans are then translated into a rolling work plan.

23. WHO implements an independent monitoring system of national health campaigns through trained independent monitors who visit all targeted districts. In preparation for health campaigns, vaccines and supplies are distributed to the GHOs along with their respective allocated budgets for implementation of the campaigns. The independent monitors visit all targeted districts during and after the health campaigns to ensure compliance with WHO implementation instructions and internal control procedures.

24. UNICEF follows the Harmonized Approach to Cash Transfers (HACT) which is a simplified set of principles and processes to request, disburse, provide assurance, and report on funds. There are four key elements: (a) capacity assessments (macro and micro); (b) disbursement and reporting (FACE form); (c) assurance activities (programmatic visits, spot checks, and audits); and (d) capacity development. Risk assessment is achieved through the capacity assessments carried out by UNICEF prior to engagement with the MOPHP or NGOs, and so on. Risk management and risk reduction are done during program implementation following UNICEF's assurance plan.

25. HACT was rolled out in UNICEF's Yemen country office in 2014/2015. In preparation for the adoption of HACT, UNICEF conducted training of 300 participants from 95 partners. In 2015, the Yemen country office prepared a HACT assurance plan which showed the number of micro assessments, programmatic visits, spot checks and audits that would be carried out in line with the HACT Framework. In 2015, UNICEF Yemen country office started using the FACE form for all cash disbursement and reporting. Micro assessments include a review of the partner's financial management capacities. The results of the micro assessments will be used to develop capacity building plans for the weak areas that will be addressed by UNICEF.

26. The objective of the annual HACT assurance plan activities is to provide the appropriate level of assurance that funds are being used for the intended purpose. The following are the planned activities:

- **Programmatic visits.** The objective of a programmatic visit is to obtain evidence on the status of the implementation of the program as well as to review progress toward achievement of planned results, challenges and constraints in implementation, and ways to address them. Programmatic visits focus on programmatic issues, including attention to alignment of actual implementation and utilization of resources.
- **Spot checks.** Spot checks are a review of financial records to obtain reasonable assurance that amounts reported by implementation partners on the FACE form are accurate. Spot checks are performed to assess the accuracy of the financial records for cash transfers to implementation partners, and the status of program implementation (through a review of financial information), and to determine whether there have been any significant changes to internal controls. A spot check is conducted on the actual project expenditures reported on the FACE form.
- **Scheduled audits.** Audits are conducted for all partners that receive US$500,000 during the program cycle.
- **Special audits.** These are carried out when significant issues and concerns are identified during the program cycle.

Procurement

27. The procurement activities under this project will include procurement of basic drugs, vaccines, medical equipment (laboratory and related general equipment for hospitals and health centers), training of midwives, and different kinds of kits for the CMWs. It would also include procurement of medical equipment and training of CHVs and CHWs and supplies for community-based services and home-based delivery. A draft procurement plan prepared by UNICEF and WHO will be attached to the implementation plan of the project.

28. The ongoing conflict and restrictions on imports have led to severe shortages in fuel products, and a significant increase in their cost. This may not encourage enough suppliers to be engaged. The estimated increase in cost of similar items purchased locally is between 50 percent compared with the international market as per the information provided by the UN agencies UNICEF and WHO in Yemen.

29. 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 for several reasons:

(a) The two agencies have strong presence on the ground, have proven that they are very well equipped to work in conflict and post conflict areas in Yemen, and have the capacity to reach out to the most affected women and children.

(b) The procurement activities proposed under this project are within the mandates of UNICEF and WHO and already in their existing strategy using the same implementation mechanism.

(c) The implementation arrangement relies on branch offices of the MOPHP at the governorates, qualified local staff, NGOs and health volunteers.

(d) The two agencies have a preparedness mechanism, which enables optimal emergency procurement response. In fact, UNICEF has already assessed the needs and the goods are available using their warehouses in three governorates. In addition, they have an emergency plan with the possibility of renting private warehouses in case of losing access to the existing warehouses or if these warehouses are damaged as a result of the conflict in the area. WHO has a strategic warehouse in Dubai to serve the whole region using their own air charter for transportation of goods to Yemen.

(e) The agencies' procurement arrangements provide reasonable assurance that the World Bank's financing will be used for the intended purpose.

(f) UNICEF and WHO are very much informed about the market response locally and internationally using their own criteria to register qualified suppliers considering the suppliers' performance and their responses in emergency situations.

(g) Cost effectiveness and value for money is achieved by prior planning and flexibility in

delegating the decision to their local offices to buy the goods from the local market with prices up to 50 percent higher compared to the international prices. This is equal to the cost of transporting the goods to Yemen.

Environmental and Social (including safeguards)

Safeguards Action Plan

I. Objectives

30. **The Safeguards Action Plan (SAP)** provides a time-bound plan for the environmental safeguards instrument. This SAP provides general requirement and guidelines to be integrated into the implementation of the IDA-financed Yemen EHNP.

31. The objective of the SAP is to ensure that the planned project activities and related environmental requirements and instruments will be compliant with the national legislation of Yemen as well as the World Bank's operational safeguards policies, and are duly and diligently implemented. This means that, as a general principle, any required environmental instrument should be completed, and disclosed before project-funded activities with relevant environmental footprints may commence.

32. This SAP complies with the World Bank safeguards policies, specifically OP 10.00 (paragraph 12) and OP 4.01 (paragraph 12).

II. Project Scope and Context

33. **The project scope** is described in detail in Section III. In summary, the proposed project will support the delivery of essential health and nutrition services to the most vulnerable populations through: (a) mobile service delivery to reach IDPs, overburdened host communities and populations in areas with no functional HFs; (b) outreach activities from functional HFs and DHOs to provide services in areas in zone 3 and zone 2 areas which are far from the HFs (see Figure 4.1); (c) nationwide immunization and treatment campaigns to maintain the polio free status and to support prevention and treatment of cholera and other diseases; and (d) community-based health and nutrition services for acutely malnourished children under five, and women of reproductive age through screening, detection and referral, and treatment of SAM cases.

III. Compliance with World Bank Safeguards Policies

34. Considering the nature, magnitude, and interventions of this project, particularly under the nationwide immunization campaigns, **the proposed operation is classified as category 'B'**. Activities supported by the proposed operation are expected to have minimal environmental impacts. This SAP has been developed specifically to ensure due diligence, avoid causing harm, and ensure consistent treatment of environmental impact by the implementing agencies which are WHO and UNICEF. The World Bank's policy on Environmental Assessment (OP/BP 4.01) is triggered for this Project.

35. The safeguards instrument, that is an MWMP, will be prepared before the project effectiveness.

36. **OP 4.01 Environmental Assessment** The proposed project will include several interventions including, among other things, outreach and facility-based services and nationwide campaigns which have potential site-specific, limited and mitigable environmental impacts as they might involve the disposal of the medical consumables such as, but not limited to, vaccination kits, vials and possible syringes. These interventions will be implemented under OP 4.01 and it is not anticipated that any other safeguards policy will be triggered.

IV. Social Safeguards

37. OP/BP 4.12 Involuntary Resettlement 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. The project will have broad social benefits given the scope of services provided and the target population.

38. The project will not entail social safeguard risks because OP 4.12 is not triggered. However, there are non-safeguard (social) risks that may negatively impact the successful implementation of the project. The first risk will be the difficulty to reach the severely affected women and children in areas under conflict by the ongoing war, which could hinder the supply of the health and nutrition services. The mitigation measure 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 second social risk will be the difficulty to access areas under the control of armed factions where the vulnerable groups are residing and could lead to inadequate delivery of health services. This will be mitigated by the collaboration with the neutral communities at the local level and NGOs.

39. Given the nature of the project, consultation with the relevant stakeholders and intended beneficiaries will be critical under the current circumstances of the country. The alternative mechanism of consultation will be to adopt the implementing agencies' (UNICEF and WHO) "Beneficiaries' Satisfaction Checklist". This checklist will 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. This checklist will be used by the teams of the two implementing agencies located in their offices in Sana'a and all over the country and the hired TPM agency. The checklist could include a scale like 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 UNICEF, WHO, or contracted TPM will read the checklist to beneficiaries to ensure that they can file complaints if not satisfied by the services. This satisfaction checklist can be used in lieu of the GRM and would be more workable in unstable settings like Yemen.

V. Roles and Responsibilities, including Supervision Arrangement for Safeguards Preparation, Implementation, and Monitoring

40. WHO and UNICEF will be responsible for the implementation of the MWMP and for complying with national environmental regulations, as well as the World Bank's environmental safeguards policy. The World Bank will ensure the timely commencement of the preparation of the MWMP and that activities with potential limited impacts will not start without the required safeguards instrument in place. The MWMP will be reviewed to ensure that its scope and quality are satisfactory to the World Bank. In addition, the World Bank will monitor the implementation of the prepared MWMP through the abovementioned monitoring and reporting arrangements by the implementing agencies and TPM.

VI. Sequencing and Tentative Implementation Schedule for Safeguards Processing

41. The following time-bound steps describe the schedule for preparing, reviewing, clearing and implementing the MWMP which is anticipated to help manage and mitigate the potential limited impact which might result from the proposed interventions.

42. The MWMP will be developed by the project effectiveness and will be the safeguards document, covering the following topics: (i) scope of activities under the project that might result in generating medical waste; (ii) typologies of expected wastes, as well as magnitude and duration of these activities;

and (iii) good practices and options for dealing with medical wastes. Once prepared, the draft MWMP will be submitted to the Bank for clearance.

VII. Disclosure

43. This SAP is subject to public disclosure as part of the Project Appraisal Document. The SAP will be shared with the relevant government agencies, concerned NGOs and development partners of Yemen. In addition, the SAP will be disclosed both in-country (in the appropriate communication channels) as well as at the World Bank InfoShop.

ANNEX 3: IMPLEMENTATION SUPPORT PLAN

COUNTRY : Yemen, Republic of
Emergency Health and Nutrition Project

Strategy and Approach for Implementation Support

1. The proposed project is an emergency operation processed under OP 10.00 paragraph 12 and OP 2.30 and uses UN agencies as recipients of IDA funds and alternative implementing agencies. The project will be subject to UNICEF's and WHO's fiduciary policies and procedures, while the World Bank safeguard policies and procedures will apply. With regard to fraud and corruption, the Board decision is sought for a waiver of paragraph 20 of BP10.00 on application of the World Bank's Anticorruption Guidelines to the UN agencies, (see section G. under Implementation arrangements). The World Bank will support UNICEF's and WHO's implementation efforts and help manage key risks to attain the PDO.

2. UNICEF and WHO are responsible for the implementation of the project activities in close coordination with the GHOs and DHOs at the MOPHP which provides oversight and guidance to health workers at various levels. UNICEF and WHO 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. Both agencies have already expanded their presence in Yemen given that the project is supporting the already ongoing interventions under the health engagement program. The project, however, will support the TPM, and the organizations' monitoring and evaluation activities of the project.

Bank Supervision

3. The World Bank will conduct "reverse" implementation support missions at least biannually to: (a) review implementation progress and achievement of PDO and intermediate indicators; (b) provide support for any implementation issues that may arise; (c) provide technical support related to project implementation, achievement of results, and capacity building; (d) discuss relevant risks and mitigation measures; and (e) monitor the health system's performance through progress reports, audit reports and field visits, if and when they become possible.

4. The World Bank team comprises specialists in the areas of health, nutrition, operations, financial management, procurement, social and environment safeguards, legal, and administration. Bank operational and fiduciary staff are based in the World Bank's Country Office in Cairo which will facilitate implementation support and ad hoc problem solving as needed. With regard to specific technical support, experts may be recruited as deemed necessary during project implementation.

Implementation Support Plan and Resource Requirements

Time	Focus	Skills Needed	Resource Estimate	Partner Role
First twelve months	Operational readiness	Technical and operational support for addressing early implementation bottlenecks. Fiduciary (procurement, financial management, safeguards) and implementation planning and start-up.	US$250,000	Joint supervision, technical support and data sharing.
12-48 months	Implementation, technical and operational support	Specialists as needed.	US$80,000	Joint supervision, technical support and data sharing.
Other				

Skills Mix Required

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
Team leadership – technical and operational	12	At least 2 trips per year	Country office based
Technical expertise	6	At least one trip per year	Country office based
Legal counsel	1	As needed	HQ based
Procurement expertise	4	As needed	Country office based
FM expertise	4	As needed	HQ based
Environmental expertise	2	As needed	Country office based
Social development expertise	2	As needed	Country office based

M&E expertise	4	At least one trip a year	Country office based
Operations support	4	At least one trip a year	HQ based

Partners

Name	Institution/Country	Role
UNICEF	Yemen, Rep. of	-Grant recipient and implementing agency -Joint missions and technical cooperation -Data sharing -Operational coordination
WHO	Yemen, Rep. of	-Grant recipient and implementing agency -Joint missions and technical cooperation -Data sharing -Operational coordination

ANNEX 4: PROPOSED SERVICE DELIVERY MODEL

COUNTRY : Yemen, Republic of
Emergency Health and Nutrition Project

I. General Context of the Design

1. Historically, the Yemeni health delivery system depended mainly on fixed facilities to provide health services to populations living in the vicinity of the facilities as well as vertical programs to address priority public health problems. During the 90's and 2000's, evidence showed that overdependence on fixed public HFs was not offering the population the required health and nutrition services because of their inability to reach the entire population and meet their health needs. Further analysis has demonstrated that the system delivery model was suffering from: (a) low outpatient utilization rates; (b) underutilization of public HFs due to issues of access and quality; and (c) lack of provision of health services and essential drugs in public HFs leading to a high bypass rate.

2. For two decades, the World Bank and development partners supported interventions in the country that started introducing outreach health services to those with no or poor accesses to health services as well as making efficient use of resources spent on national vaccination campaigns. The strategy considered providing low cost essential drugs and packaging of health services through outreach interventions. It aimed to ensure coverage of the entire population, including the poor and the near-poor as an approach for poverty alleviation. It recommended payment of lower transportation and direct service provision costs. The new strategy also stressed the importance of integration of services and considered it as one of the main basic principles of decentralizing the provision of basic health and nutrition services and aimed to integrate resources and activities of the different vertical programs, for example, transportation and supervision visits. Service integration as well as operational cost support were identified as key areas where donor support is most needed.

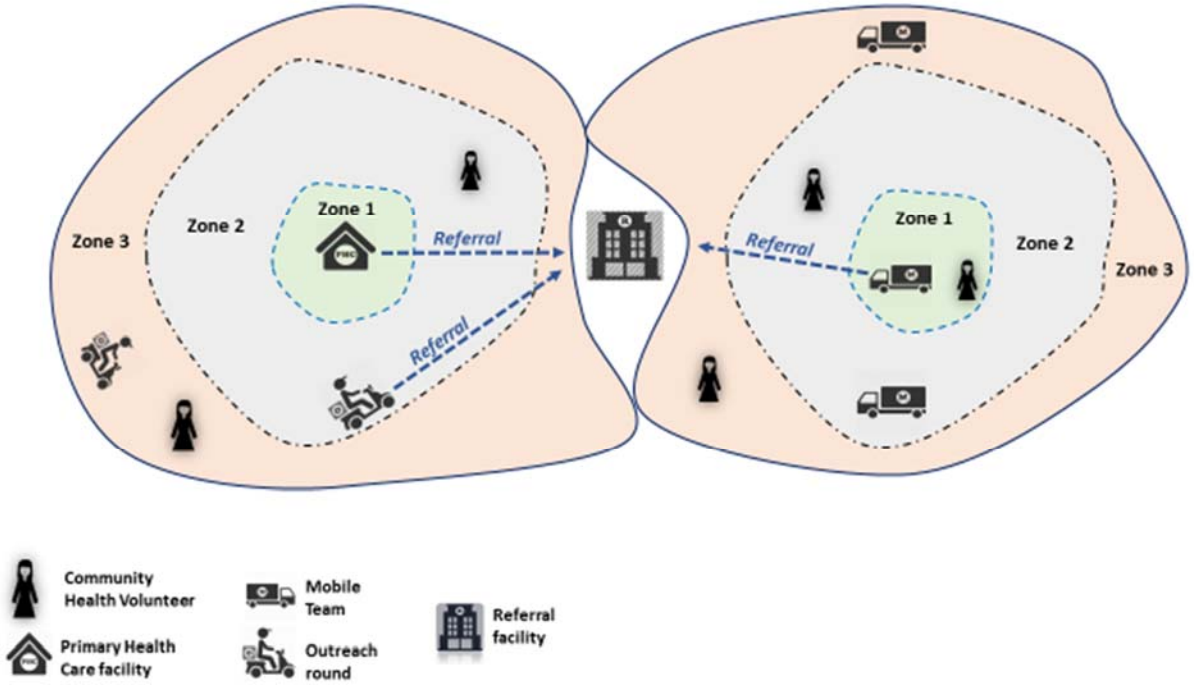
3. The ongoing World Bank HPP has illustrated some very important lessons that this proposed operation has taken into consideration, notably: (a) a design that is flexible enough to accommodate for the urgent needs of the population wherever and whenever they arise; (b) the prudence of preserving and supporting the technical capacity of MOPHP staff as the core element of sustaining the integrity and future prospects of the health system; (c) partnering with leading health and nutrition UN agencies in their capacity as implementing agencies providing the required level of responsiveness and flexibility in handling fiduciary issues; and (d) the possibility of providing national public health interventions reaching vast geographic locations and showing positive results on a national scale.

4. The current crisis has generated a new set of challenges to the Yemeni health system that was not of major concern before the conflict. Many HFs were rendered non-operational because of the destruction of some or all of the infrastructure falling geographically in the front-lines. Other facilities were left deserted by staff owing to security risks associated with working at those facilities. This has created a "service vacuum" in areas that were previously considered being stable. The conflict has also generated a new wave of IDPs in certain geographic areas that were straining the already limited resources of existing HFs. Further, the conflict has deepened the economic pressures on most citizens with increasing poverty and unemployment rates, shifting many of those who previously used to buy health services from the private or NGO sectors to utilize the public system. Those factors have remarkably increased the demand on an already over-strained system.

II. The Proposed EHNP Service Delivery Model

5. The delivery of services will be based on protocols and guidelines adopted by WHO and UNICEF for integrated service delivery and facility-based, outreach, mobile and referral systems that are suited to the geography, and the emerging needs of the population in Yemen. The model will strive to achieve a balance among the delivery of health and nutrition services based on the principle of continuum of care throughout the lifecycle (childhood, adolescence/adulthood, pregnancy, childbirth, postnatal period), and between models of service delivery (including clinical care settings, outreach, and household and communities). The model will complement service delivery between the different service delivery levels: (a) fixed facilities (primary and secondary); (b) integrated outreach services; (c) household level; and (d) mobile teams for distant and unserved localities. This approach shall aim to preserve the main foundations of the national health system for the post-conflict recovery phase. The model will also contribute towards the prevention of the health system collapse through: (a) re-establishing basic services at first level care facilities closed/non-functional due to conflict; (b) provision of minimum operational cost to selected HFs; (c) support to human resources at community and first level care facilities in the form of per-diems; and (d) continued move towards decentralization to district and governorate levels.

Figure 4. 1. Model of Services Used under EHNP for Areas with Functional HFs (Left) and Areas with No Fixed HF (Right)



III. The Service Delivery Package

6. The model of service adopted for the operation builds on previous experiences with the GAVI-funded Health Sector Strengthening project and the World Bank-funded HPP and will comprise provision

of services at four levels: (a) PHC facilities catering to patients that live in the vicinity or are referred by the outreach and mobile teams for further interventions; (b) complementary community-based services focusing on health education, active case finding, and referral by CHVs in addition to home-based delivery by midwives; (c) outreach services to deliver a defined core package of maternal and child health and nutritional services at temporary sites using outreach teams on a periodic basis or mobile teams to serve the disadvantaged communities; and (d) referral facilities for management of complicated cases that cannot be treated at a PHC facility.

7. **The PHC facility Level.** PHC focuses on preventive and promotive health programs such as immunization, maternal and child health, family planning, health education, and nutrition and serves as a referral base for community and outreach teams. It also refers cases in need of advanced secondary care to first level referral centers. The PHC facilities also provide first level curative care.

8. **Team Skill Mix:** At the village level where PHC units are run by paramedical staff in the form of technicians and nurses, the units are backed up by PHC centers, most of which are managed by at least one physician as per availability and have laboratory and X-ray facilities.

HFs Type	Population Coverage	Services
Health unit	From 5,000 to 10,000	PHC services (Vaccination, IMCI, treatment of malnutrition, IYCF counseling, Reproductive Health (RH) services including family planning, ANC and PNC
Health center	From 10,000 to 15,000	PHC services (vaccination, IMCI, treatment of malnutrition, IYCF counseling, RH services including family planning, ANC and PNC, delivery)
Rural Hospital	More than 15,000	PHC services, acceptable level of curative care (based on the staffing and equipment)
Referral hospital	More than 20,000	PHC services, more advance level of curative care, BEmONC and CEmONC

9. **Community level.** The community team will be responsible for the following: (a) active case finding and referral of sick and/or malnourished children or pregnant or lactating women; (b) complement the management of malnourished children; (c) provision of health and nutrition education and provision of counseling on selected preventive/ curative services such as IYCF, home based care for diarrhea and fever, and so on; (d) registration and recording of cases; (e) home based delivery and care by CMWs; and (f) social mobilization for outreach rounds and public health campaigns.

10. **Team Skill Mix.** The community team would be comprised of: (a) CMW to provide RH services; and/or (b) CHV to provide child health services including nutrition. The composition of the team will differ based on the availability of CMWs. Each level is detailed below.

The Outreach Level

11. Outreach-level services, provided through outreach and mobile teams, will include teams of specified health and nutrition workers originating from fixed HFs to provide the PHC services to children under five and women of reproductive age (including pregnant and lactating women) for outreach teams,

and a more advanced package of medical and basic surgical services for the mobile teams. CHVs will join outreach rounds to provide health education activities and identify cases that need follow up services at the community level between outreach rounds. The outreach team is structured to cover the catchment population unable to reach a HF easily or residing within 5 km or one-hour walking distance. Services are provided by walking or simple transport method (for example, bicycle or light vehicle). Mobile teams on the other hand, cover the remote catchment population, areas with no current health and nutrition services and/or areas overwhelmed with IDPs. This is usually translated as being unable to reach a HF at all beyond 5 km or one-hour walking distance. However, the mobile team will have a higher frequency of visiting its intended sites owing to the nature of their target population. Its coverage needs a transport vehicle.

12. **Outreach team skill mix.** The outreach team will deliver the services in the form of mobile teams at selected community sites. Each outreach site will have one or more teams depending on the population of the catchment area. The team would be comprised of: (a) one medical doctor/medical assistant to provide child health services (IMCI including child nutrition and malaria) and provide children ages 6 years and above and adults with drugs for schistosomiasis; (b) one trained midwife to provide RH services; (c) one health staff (primary health care worker) to provide vaccination; and (d) one health worker responsible for management of outreach logistics and registration of patients. The outreach team that will implement outreach rounds is based in the nearest facility.

13. The Mobile team will have all of the duties of the Outreach team in addition to providing the simple clinical and surgical procedures, roles equivalent to the clinical privileges of a General Practitioner level medical doctor. Further, some treatment interventions for SAM cases will be offered as well. The mobile teams will have the same composition of the outreach teams except for the following differences: (a) the team may comprise of additional number of the specified staff categories according to the volume of work required and as stipulated by the population of the coverage area; and (b) the team composition must have at least one certified medical doctor.

14. **Referral level** services provided through fixed first level of referral secondary health care facilities will include at least one referral facility to provide secondary care services at the governorate and/or district level**.** It will include BEmONC as well as CEmONC. In addition, therapeutic feeding programs will provide advanced clinical nutrition services to children under five who are suffering from SAM, and MAM cases not responding to OTP either walking in or referred from the primary care level.

15. **Staff Pattern of the Referral Level.** The obstetric wards will depend mainly on the current, retained and committed clinical and administrative capacities to cope with the volume of work. As for the therapeutic feeding programs, a dedicated optimal team of 3 physicians, 9 nurses and 1–2 administrative workers will be supported by the project.

ANNEX 5: NUTRITION SERVICES SUPPORTED BY THE PROJECT

COUNTRY: Yemen, Republic of
Emergency Health and Nutrition Project

Table 5.1. Examples of Nutrition Services under the project

Level	Location of Service	Services
PHC Level	PHC Facilities	• Folic Acid and Iron for pregnant and lactating women, vitamin A after delivery • Nutrition education pregnant women • Malnutrition component of IMCI • MUAC screening • Management of SAM children • Refer the complicated malnourished child (MAM and SAM) to referral centers (CMAM services) • Vitamin A for children • Screen pregnant and lactating women for malnutrition • Promotion of iodized salt
	Household/Community	• Nutrition education for pregnant women • Breast-feeding education • Preparation of commercial oral rehydration solution • Nutrition education by CHVs to household
	Outreach and Mobile Teams	• Nutrition education for pregnant women • Folic acid and iron for pregnant and lactating women, vitamin A after delivery • Malnutrition component of IMCI • MUAC screening and start case management • SAM (provide the first dose of RTUF for two weeks and standard medicines). • Refer the uncomplicated malnourished child (MAM and SAM) to OTP/SFP for follow-up and complicated malnourished child to TFC • Vitamin A for children • Screen pregnant and lactating women on MUAC • Promotion of iodized salt • Nutrition education by CHVs to community
Secondary Level (First level Referral Services)	First level referral centers	• Management of referred complicated under 5 malnourished children (SAM) at the TFCs/SCs