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IDA/R2017-0147/1

May 10, 2017

Closing Date: Friday, May 19, 2017 at 6 p.m.

FROM: Vice President and Corporate Secretary

UNICEF and WHO - Yemen Emergency Health and Nutrition Project

Additional Financing

Project Paper

Attached is the Project Paper regarding a proposed additional grant to the United Nations Children's Fund (UNICEF) and World Health Organization (WHO) for the Yemen Emergency Health and Nutrition Project – Additional Financing (IDA/R2017-0147), which is being processed on an absence-of-objection basis.

Distribution:
Executive Directors and Alternates
President
Bank Group Senior Management
Vice Presidents, Bank, IFC and MIGA
Directors and Department Heads, Bank, IFC and MIGA

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The World Bank

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Report No: PAD2412

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT PAPER

ON A

PROPOSED ADDITIONAL GRANT

IN THE AMOUNT OF SDR 60.7 MILLION
(US$83 MILLION EQUIVALENT)

TO THE

UNITED NATIONS CHILDREN'S FUND

AND THE

WORLD HEALTH ORGANIZATION

FOR A

YEMEN EMERGENCY HEALTH AND NUTRITION PROJECT

MAY 7, 2017

Health, Nutrition and Population
Middle East and North Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective April 30, 2017)

Currency Unit	=	Yemeni Rials (YER)
YER 250.05	=	US$1
US$1	=	SDR 0.73

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
BCR	Benefit Cost Ratio
BSFP	Blanket Supplementary Feeding Program
CERC	Contingency Emergency Response Component
CMAM	Community-based Management of Acute Malnutrition
CHV	Community Health Volunteer
CHW	Community Health Worker
CNS	Community Nutrition Sensitive Site
DHO	District Health Office
EFSNA	Emergency Food Security and Nutrition Assessment
ECRP	Emergency Crisis Response Project
EHNP	Emergency Health and Nutrition Project
FAO	Food and Agriculture Organization
FBF	Fortified Blended Food
GAM	Global Acute Malnutrition
GHO	Governorate Health Office
GRS	Grievance Redress Service
IASC	Inter-agency Standing Committee
IDP	Internally Displaced Person
INSS	Integrated Nutrition Surveillance System
IPC	Integrated Food Security Phase Classification
IYCF	Infant and Young Child Feeding
LNS	Lipid Nutrient Supplement
MAM	Moderate Acute Malnutrition
MOPHP	Ministry of Public Health and Population
MUAC	Mid-upper Arm Circumference
NGO	Non-governmental Organization
OP	Operational Policy
OTP	Outpatient Therapeutic Program
PLW	Pregnant and Lactating Women

RUSF	Ready to Use Supplementary Food
RUTF	Ready to Use Therapeutic Food
SAM	Severe Acute Malnutrition
SC	Stabilization Center
TFC	Therapeutic Feeding Center
TSFP	Therapeutic Supplementary Feeding Program
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WFH	Weight-for-Height
WFP	World Food Programme
WHO	World Health Organization

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

REPUBLIC OF YEMEN
EMERGENCY HEALTH AND NUTRITION PROJECT ADDITIONAL FINANCING

CONTENTS

ADDITIONAL FINANCING DATA SHEET

Yemen, Republic of

Emergency Health and Nutrition Project Additional Financing (P163741)

MIDDLE EAST AND NORTH AFRICA

HEALTH, NUTRITION AND POPULATION

Basic Information – Parent			
Parent Project ID:	P161809	Original EA Category:	B - Partial Assessment
Current Closing Date:	31-Jan-2020		

Basic Information – Additional Financing (AF)			
Project ID:	P163741	Additional Financing Type (from AUS):	Scale Up
Regional Vice President:	Hafez M. H. Ghanem	Proposed EA Category:	B
Country Director:	Asad Alam	Expected Effectiveness Date:	30-Jun-2017
Senior Global Practice Director:	Timothy Grant Evans	Expected Closing Date:	31-Jan-2020
Practice Manager/Manager:	Ernest E. Massiah	Report No:	PAD2412
Team Leader(s):	Moustafa Abdalla		

Borrower				
Organization Name	Contact	Title	Telephone	Email
United Nations Children's Fund	Meritxell Relaño	Representative UNICEF Yemen	00967 712223363	mrelano@unicef.org
World Health Organization	Nevio Zagaria	Representative WHO Yemen	00967 734348384	Zagarian@who.int

Project Financing Data - Parent (Emergency Health and Nutrition Project-P161809) (in XDR Million)

Key Dates

Project	Ln/Cr/TF	Status	Approval Date	Signing Date	Effectiveness Date	Original Closing Date	Revised Closing Date
P161809	IDA-D1630	Effective	17-Jan-2017	04-Feb-2017	06-Feb-2017	31-Jan-2020	31-Jan-2020
P161809	IDA-D1640	Effective	17-Jan-2017	04-Feb-2017	06-Feb-2017	31-Jan-2020	31-Jan-2020

Disbursements

Project	Ln/Cr/TF	Status	Currency	Original	Revised	Cancelled	Disbursed	Undisbursed	% Disbursed
P161809	IDA-D1630	Effective	XDR	56.35	56.35	0.00	22.42	33.93	39.78
P161809	IDA-D1640	Effective	XDR	91.45	91.45	0.00	36.53	54.92	39.95

Project Financing Data - Additional Financing Yemen Emergency Health and Nutrition Project Additional Financing (P163741) (in USD Million)

[ ] Loan [ ] Grant [X] IDA Grant
[ ] Credit [ ] Guarantee [ ] Other

Total Project Cost:	83.00	Total Bank Financing:	83.00
Financing Gap:	0.00		

Financing Source – Additional Financing (AF)	Amount
IDA Grant	83.00
Total	83.00

Policy Waivers

Does the project depart from the CAS in content or in other significant respects?	No
Explanation	
Does the project require any policy waiver(s)?	Yes
Explanation	
(1) Waiver of Application of the Anti-Corruption Guidelines to UN Agencies; and (2) waiver of IDA Commitment Charge.	
Has the waiver(s) been endorsed or approved by Bank Management?	Yes
Explanation	
The decision to seek the Board approval for the waiver was endorsed by the Senior Vice President for Operations as well as Managing Director and Chief Finance Officer.	

Team Composition

Bank Staff

Name	Role	Title	Specialization	Unit
Moustafa Abdalla	Team Leader (ADM Responsible)	Health Specialist	Team Lead, Health Specialist	GHN05
Jamal Abdulla Abdulaziz	Procurement Specialist (ADM Responsible)	Senior Procurement Specialist	Procurement	GGO05
Moad M. Alrubaidi	Financial Management Specialist	Senior Financial Management Specialist	Financial Management	GGO23

Alex Turingan	Team Member	Program Assistant	Legal Support	LEGAM
Amer Abdulwahab Ali Al-Ghorbany	Team Member	Environmental Specialist	Environmental Specialist	GEN05
Amr Elshalakani	Team Member	Health Specialist	Health Specialist	GHN05
Andrianirina Michel Eric Ranjeva	Team Member	Finance Officer	Disbursement	WFALN
Edith Ruguru Mwenda	Team Member	Senior Counsel	Legal Support	LEGAM
Ibrahim Ismail Mohammed Basalamah	Team Member	Social Development Specialist	Social Safeguards	GSU05
Mariam William Guirguis	Team Member	Program Assistant	Administrative Support	GHN05
Miyuki T. Parris	Team Member	Operations Analyst	Operational Support	GHNGE
Raghada Mohammed Abdelhady Abdelhamied	Team Member	Team Assistant	Administrative Support	MNCEG

Extended Team

Name	Title	Location

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments

Institutional Data

Parent (Emergency Health and Nutrition Project-P161809)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Additional Financing Yemen Emergency Health and Nutrition Project Additional Financing (P163741)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Consultants (Will be disclosed in the Monthly Operational Summary)

Consultants Required? - Consulting services to be determined

I. Introduction

1. This Project Paper seeks the approval of the Executive Directors to provide an additional grant in an amount of SDR 60.7 million (US$83 million equivalent) to the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO), in support of the Yemen Emergency Health and Nutrition Project (EHNP) (P161809) for the benefit of the Republic of Yemen. The proposed grant will help scale up delivery of essential health and nutrition services in response to the unprecedented malnutrition situation in Yemen caused by the ongoing conflict and food security crisis. The amount of US$83 million equivalent is raised through recommitment of cancelled IDA grants for Yemen resulting from portfolio restructuring.

2. The parent project with a total commitment of SDR 147.8 million (US$200 million equivalent) was approved by the World Bank's Board of Executive Directors on January 17, 2017. EHNP is implemented by UN agencies together with the local institutions, and has rapidly achieved significant implementation progress since its effectiveness on February 6, 2017.

3. This proposed AF is prepared using condensed procedures under OP 10.00 paragraph 12 (*Projects in Situations of Urgent Need of Assistance and Capacity Constraints*) and in line with the Operational Policy (OP) 2.30, Development Cooperation and Conflict. In accordance with paragraph 3(b) of OP 2.30, if there is no government in power, Bank assistance may be initiated by requests from the international community, as properly represented (e.g. by UN agencies), and subject in each case to the prior approval of the Executive Directors.

4. In order to facilitate the implementation of the proposed AF by UNICEF and WHO as recipients and implementing agencies, the Board is requested to approve the following two waivers: (i) waiver of paragraph 20 of BP 10.00, which would otherwise require application of the Bank's Anti-Corruption Guidelines, in favor of relying on the fraud and corruption procedures of WHO and UNICEF for the project; and (ii) waiver of any application of the IDA Commitment Charge to WHO and UNICEF during the life of the project.

5. Yemen currently has one of the greatest levels of needs in the world. The current conflict threatens household food security and the nutrition status of the population as a result of widespread food shortages and rising food costs. The March 2017 Integrated Food Security Phase Classification (IPC) report shows an overall deterioration in the food security and nutrition situation, with an increase in the total number of food insecure people in Yemen from 14 to 17 million people between June and December 2016.[1] Seven governorates are currently in IPC Phase 4 (Emergency) while 13 are in Phase 3 (Crisis). Four governorates exceed the WHO threshold for a critical nutrition situation with global acute malnutrition (GAM) rates among children of 6 to 59 months ranging from 16 to 25 percent. In all these governorates, over 20 percent of the people have poor food consumption. Several UN agencies and non-governmental organizations (NGOs) have issued warnings about impending famine.

6. To alleviate the impact of the looming catastrophe in Yemen, especially for women and children, the EHNP and the proposed AF will provide an integrated package of nutrition interventions with complementary activities in the health sector. The areas with the highest risk

[1] Integrated Food Security Phase Classification, March 2017. IPC analysis is an interagency exercise undertaken by various partners including, among others, FAO, WFP, OCHA, UNICEF, CARE, Mercy corps, NRC, OXFAM, Scaling up Nutrition.

of famine and malnutrition in the country will be prioritized based on the 2017 IPC analysis, the 2016 Emergency Food Security and Nutrition Assessment (EFSNA) and joint UNICEF, WHO, World Food Programme (WFP) and Food and Agriculture Organization (FAO) analysis supported by the relevant Inter-Agency Standing Committee (IASC) clusters for Nutrition, Health, and Food Security Agriculture.

7. This proposed AF will complement the parent project in scaling up the delivery of a comprehensive package of nutrition services, which not only meets the immediate needs of the most vulnerable, but also expands the prevention of acute malnutrition nation-wide at all levels of care. The AF will aim to build the capacity of existing health facilities, link the curative services with preventive ones, bring complementarity between the community and health facility-based services to address acute malnutrition, and significantly expand the coverage over a short span of time.

II. Background and Rationale for the Proposed Additional Financing

8. Political upheaval, severe security threats, port blockades for most imports, chronic market shortages for all basic commodities and severe fiscal disruptions have been the unfolding reality of the continuous conflict situation in Yemen. The economic and social fabric is under severe pressure and the economy has contracted sharply since the conflict erupted. Gross Domestic Product (GDP) is reported to have plunged by 40 percent, underpinned by widespread disruptions of economic activities, with enterprises operating at half the capacity compared to pre-war era. Unemployment rates are on the rise. An estimated 8 million Yemenis have lost their livelihoods or are living in communities with minimal to no basic services. Fiscal revenues are falling, deficit financing is increasingly resorting to arrears build-up, and undermining state functions and impairing the situation for the private sector. The financial sector is facing enormous difficulties with a rising share of non-performing loans. Moreover, oil and gas exports, a major source of fiscal revenues, have largely come to a halt.

9. Yemen imports more than 90 percent of its medicines and food. Foreign reserves are down to less than one month of imports. Aside from the lack of foreign reserves, there is a significant challenge in accessing the lines of credit which makes trade financing and importation of medicines and food difficult. Only private sector operators as well as international organizations still operating within the country have active access to import channels. However, import markets are small and private actors shy away from assuming the responsibility of handling major imports owing to the security and economic risks involved.

10. The latest figures[2] show that an estimated 17 million people, or 60 percent of the total population, are now food insecure, of which 6.8 million are facing emergency crisis level, only one level before famine. Acute malnutrition is at alarming levels; four governorates (Abyan, Taiz, Al Hodaidah, and Hadramout) have GAM prevalence above the WHO critical threshold (≥15 percent), while seven and eight governorates have GAM prevalence at serious levels (10-14.9 percent) and poor levels (5-9.9 percent), respectively. This is further deterioration from an already critical situation a few months ago at the time of the parent project approval, when severe food insecurity already affected 14 million people, including 2.2 million children

[2] As of March 2017

affected by acute malnutrition, of whom 462,000 were suffering from severe acute malnutrition and required immediate assistance. Basic services across the country are on the verge of collapse. Chronic drug shortages and conflict-related destruction constrained access to health care services for around 14 million Yemenis, including 8.3 million children. Children under five years of age represent 18 percent of the total population in Yemen, and 44 percent of them are acutely malnourished.

11. In order to treat severe acute malnutrition (SAM), coordinated efforts at different levels of care are required. Globally, from 5 to 10 percent (8 percent on average) of children affected by SAM are suffering from life threatening complications and thus are in urgent need of 24-hour care in hospital units known as Therapeutic Feeding Centers/Stabilization Centers (TFCs/SCs) for 2 to 3 weeks. Once stabilized, they are referred to the Outpatient Therapeutic Program (OTP) clinic to continue the SAM treatment course. Malnutrition is responsible for nearly half of all deaths of children under 5, and, together with poor diet, is the number one driver of the global burden of disease. More than half of early child deaths are due to conditions that are preventable and curable with access to simple, affordable interventions.

12. Significant implementation progress has been achieved since the parent project became effective on February 6, 2017. As of April 30, 2017, about $80 million has been disbursed, and the initial implementation status and results report recorded the "satisfactory" rating for all categories for the parent project. The month-long nationwide polio vaccination campaign concluded on March 28, 2017, and managed to reach around five million children in all governorates with EHNP support. Both the cost of vaccines and the distribution expenses were fully covered by the project. In addition, 375,000 Yemeni children between 6-24 months and 132,000 pregnant and lactating women received micronutrients under the project. In addition, more than 10 tons of essential medicines arrived at the country in late March 2017 for the activities implemented by WHO under the project.

13. The Contingency Emergency Response Component (CERC, component 3 of the EHNP) has been triggered to better respond to the food security situation and potential risk of famine. The pace of deterioration of nutrition status and food security in Yemen has prompted UN to declare emergency - a condition for triggering CERC. About US$30 million was reallocated from Subcomponent 1.1 to Component 3 in order to allow a significant scale up, including procurement of certain health and nutrition activities at a much faster pace than initially planned.

14. The overall design of the project will remain the same with some changes in the component design, implementation arrangements, and PDO indicators. The Project Development Objective (PDO) remains unchanged: "to contribute to the provision of basic health and essential nutrition services for the benefit of the population of the Republic of Yemen". Changes are introduced to Component 1 to reflect additional nutrition services provided under the integrated package. Whereas the IDA grant recipients are WHO and UNICEF, WFP is expected to have a bilateral joint program agreement with UNICEF under the project to undertake complementary nutrition activities, particularly with regard to prevention and management of Moderate Acute Malnutrition (MAM) along with the provision of fortified nutritious supplements/food.[3] Finally, the proposed AF is expected to result in increased targets

[3] The World Bank management has authorized financing food expenditures under the proposed AF.

for the following indicators: (i) number of people who have received essential health, nutrition and population services; (ii) number of women who have received basic nutrition services; (iii) number of children under 5 who have received basic nutrition services (treatment and prevention); and (iv) health personnel receiving training. Furthermore, a new indicator is introduced to monitor coverage of the Integrated Nutrition Surveillance System.

15. The proposed AF will support the prevention and treatment of MAM and SAM, widening the scope of the parent project. The additional support will mainly address moderate and severe acute malnutrition among children and women at all levels of care, and sustain a basic calorie intake of the identified malnourished people through fortified nutritious supplements/food. This involvement would ensure an integrated nutrition package through different models of service delivery and thus, mitigate the risk of malnutrition and famine in Yemen among the vulnerable population. With the AF, the Bank's support would better address the prevention and management of malnutrition which would have lasting socio-economic effects on the future development of Yemen at the individual, community, and national levels.

16. Added to the scope of the EHNP, the AF will support a myriad of interlinked nutritional services. These include, but are not limited to: (a) scaling up of Community-based Management of Acute Malnutrition (CMAM) which is an approach that focuses on saving the lives of acutely malnourished children under five and acutely malnourished pregnant and lactating women (PLW) by providing curative treatments and preventing deterioration; (b) integration of fortified nutritious supplements to support families of acutely malnourished children, as well as Blanket Supplementary Feeding Program (BSFP) for PLW and children of 6 to 23 months; and (c) scaling up and ensuring the national coverage of the Integrated Nutrition Surveillance System (INSS).

17. The AF will enable WHO and UNICEF to deliver, through a network of local health institutions and partners including WFP, urgently needed nutrition services. Similar to the parent project, this AF will seek to strengthen the institutional capacity of the local health and nutrition providers. This would entail integration of service delivery models, including fixed facilities, outreach, mobile teams, and community-based care. In addition, and given the implementation capacity of local institutions, WHO and UNICEF shall seek to partner with international and local NGOs to undertake some of the planned activities. WFP, through a planned joint program agreement with UNICEF, will work on MAM and related interventions, including provision of fortified nutritious supplements to the target group.

18. Under **Component 1**, the scope of interventions will be scaled up and expanded. For Subcomponent 1.1, which focuses on primary level of care and is implemented by UNICEF, the integration of the prevention and management of MAM along with the supply of fortified nutritious supplements will be introduced together with the management of SAM. This will cover, but will not be limited to: i) community-based Targeted Supplementary Feeding Programs (TSFP) with specialized nutrition foods, Ready-to-Use Supplementary Food (RUSF) that can be used at home; ii) BSFP targeting all vulnerable groups in the community regardless of nutrition status with a preventive Lipid-based Nutrient Supplement (LNS) for the children of 6 to 23 months and fortified blended flour for the PLW; and iii) general distribution of fortified nutritious supplements or food to the identified families with malnourished children or women.

(a) **Community-based TSFP**. These services will be provided through a blend of delivery models employed to fill in service gaps where possible at the fixed facility level. Community-based model using health volunteers will seek to mobilize and sensitize the local community. Children will be screened for malnutrition and referred to the closest available SAM or MAM treatment services. Awareness will be raised on key lifesaving messages, such as infant and young children feeding (IYCF) practices, safe drinking water, hygienic practices like hand washing, latrine use, and the safe disposal of waste. Identified SAM or MAM cases without medical complications will be referred to the OTP and TSFP either at primary care facilities or through outreach rounds and the mobile team.

(b) **BSFP will be provided regardless of nutrition status[4].** A monthly take home ration will be provided to all children (LNS) and PLW (fortified blended flour) in the community. Each child of 6 to 23 months will receive a monthly 1.5 kg ration of LNS, Plumpy'Doz, which provides daily 281 kcal of energy and essential micronutrients, including iron. Pregnant and lactating women, on the other hand, will receive a monthly 6 kg ration of Super Cereal per capita, starting from the second trimester through six months of lactation to prevent malnutrition and micronutrient deficiencies.

(c) **General distribution of fortified nutritious supplements or food.** The fortified blended food (FBF) are blends of partially precooked and milled cereals, soya beans, and pulses fortified with micronutrients (vitamins and minerals). Other fortified formulas, which may contain flour, cereals, iodized salt and vegetable oil or milk powder, will aim to cover the recommended daily mean nutrient intake.[5] The FBF will be provided to households with malnourished children or PLW to ensure a minimum calorie intake and prevent the onset of malnutrition.

19. Under **Subcomponent 1.2** of the EHNP, implemented by WHO, in-patient secondary level services will be provided for SAM children with medical complications. The health and nutrition services under this Subcomponent will be scaled up and further strengthened through better coordination between TFCs/SCs and both OTPs and TSFPs. Therefore, acutely malnourished children, who might develop any complications, will be referred to TFCs/SCs till they stabilize. The same Subcomponent will continue to provide: (a) Basic Emergency Obstetric and Neonatal Care and Comprehensive Emergency Obstetric and Neonatal Care services in targeted referral centers; and (b) equipment, maintenance, medical and non-medical supplies, essential drugs, vaccines, training, and implementation expenses required for the first level referral centers.

20. Under **Subcomponent 1.3**, which is implemented by WHO, an integrated Nutrition Surveillance System (INSS) will be established. Currently, there is no surveillance system in the country that captures multi-dimensional regular data on malnutrition at the health facility level. This INSS will integrate multi-sectorial sources of data to initiate a timely and comprehensive response linked to the surveillance indicators. INSS is meant to provide ongoing nutrition, health, water, sanitation and hygiene (WASH), and food security information to inform

[4] To be managed by WFP through a planned joint program agreement with UNICEF.
[5] Recommended by WHO, 1995

decisions to ensure a greater focus on nutrition and food security. This, in turn, would lead to a better allocation of resources to improve the nutritional and food security status of the population, particularly children under 5 and PLW. It is estimated that Yemen urgently needs 3,574 community nutrition sentinel sites (CNS) nationwide to generate an ongoing, systematic and representative national report. Currently, only 45 percent of health facilities are functional, thus the AF will support the establishment of the nutrition surveillance sentinel sites at these facilities.

21. Under **Component 2** of the EHNP, the proposed AF will also support administration, and monitoring and evaluation (M&E) activities to ensure smooth and satisfactory project implementation. The Component will finance: (a) general management support for both WHO and UNICEF; (b) hiring of a Third Party Monitoring (TPM) agency, with terms of reference (TOR)[6] satisfactory to the World Bank, that will complement the existing TPM arrangements for both agencies; and (c) technical assistance.[7]

22. This AF fits within a scaled up and complementary IDA-financed support package to the Yemeni people to address their urgent social, health and nutrition needs in times of crisis. The parent project and the AF will complement the ongoing Yemen Emergency Crisis Response Project (ECRP) and its planned AF for cash transfers. EHNP and this proposed AF will support the supply side of an integrated nutrition and food security package in the face of an imminent famine. This package includes provision of vitamins and minerals, micronutrients, therapeutic nutritious interventions, Fortified food, health awareness and promotions, and training of health staff. The ECRP will, however, focus on accessibility to the aforementioned services through identifying the hard-to-reach affected women and children, provide the poorest families with cash assistance, assign community health promoters for case management and provide general cash transfer assistance to the needy families to help them purchase food. As the implementing agency for both EHNP-AF and the proposed ECRP-AF for cash transfer, UNICEF will ensure operational complementarities among the two operations through coordinating geographical data on CTs beneficiary households and nutrition services.

23. The AF is aligned with the World Bank twin goals and the strategy for Yemen. 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. The AF directly supports implementation of the MENA strategy pillars on: (a) renewal of the social contract by preserving inclusive service delivery resilience and improving emergency services to conflict-affected poor; and (b) resilience to internally displaced persons (IDPs)/refugee shocks by strengthening existing public health service delivery mechanisms and improving health and nutrition service delivery to IDP-affected areas. It also directly supports the objective of the Yemen Country Engagement Note (CEN): to provide emergency support to preserve local

[6] The TOR of the TPM agency hired for the parent project will be adjusted to include the activities supported by the AF.

[7] 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 components 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.

service delivery capacity to support conflict-affected families and communities. The AF is also well aligned with the main principles of the CEN to maintain simple project design and relying on existing mechanisms to scale up support to well performing projects. Finally, the AF enables the delivery of free critical health and nutrition services to the vulnerable population in an extremely fragile context, which directly contributes to the World Bank Health Nutrition and Population Global Practice goals of supporting progress towards universal health care and ensuring financial protection and service delivery.

24. Table 1 below illustrates the changes in the project's results framework.

Table 1: Changes in the Results Framework

Indicator	Targets for the Parent Project	Revised Cumulative Targets with AF
People who have received essential health, nutrition and population services • Female • IDP • Children under 5	7,000,000 • 60% • 10% • 50%	8,000,000 • 60% • 10% • 50%
Women who have received basic nutrition services	200,000	660,000
Children under 5 who have received basic nutrition services (number)	600,000	1,050,000
Health personnel receiving training	4,000	4,500
Number of community nutrition sites covered by a new integrated Nutrition Surveillance System (new indicator)	0	1,100

Policy Exceptions and Proposed Waivers

25. **Waivers.** The project will comply with the Bank's 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, Executive Directors are requested to approve two policy waivers for the proposed AF. Similar waivers were approved by the Executive Directors in January 2017 with respect to the parent project.

(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. 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.

III. Proposed Changes

Summary of Proposed Changes The following changes are proposed: (a) scaling up support for prevention and treatment of moderate acute malnutrition in the Republic of Yemen given the deteriorating food insecurity; and (b) modification of the PDO-level and intermediate results indicators, to better capture the expected increase in project results.	
Change in Implementing Agency	Yes [ ] No [X]
Change in Project's Development Objectives	Yes [ ] No [X]
Change in Results Framework	Yes [X] No [ ]
Change in Safeguard Policies Triggered	Yes [ ] No [X]
Change of EA category	Yes [ ] No [X]
Other Changes to Safeguards	Yes [ ] No [X]
Change in Legal Covenants	Yes [ ] No [X]
Change in Loan Closing Date(s)	Yes [ ] No [X]
Cancellations Proposed	Yes [ ] No [X]
Change in Disbursement Arrangements	Yes [ ] No [X]
Reallocation between Disbursement Categories	Yes [ ] No [X]
Change in Disbursement Estimates	Yes [X] No [ ]
Change to Components and Cost	Yes [X] No [ ]
Change in Institutional Arrangements	Yes [ ] No [X]
Change in Financial Management	Yes [ ] No [X]
Change in Procurement	Yes [ ] No [X]
Change in Implementation Schedule	Yes [ ] No [X]
Other Change(s)	Yes [ ] No [X]

Development Objective/Results

Project's Development Objectives

Original PDO

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

Change in Results Framework

Explanation:

End targets of the indicators will be increased to reflect the scaled-up project activities, and a new indicator will be introduced (see Table 1).

Compliance

Covenants - Additional Financing (Yemen Emergency Health and Nutrition Project Additional Financing - P163741)

Source of Funds	Finance Agreement Reference	Description of Covenants	Date Due	Recurrent	Frequency	Action
				☐		

Conditions

Source of Fund	Name	Type

Description of Condition

Risk

Risk Category	Rating (H, S, M, L)
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: lack of official government counterpart	High
OVERALL	High

Finance

Loan Closing Date - Additional Financing (Yemen Emergency Health and Nutrition Project Additional Financing - P163741)

Source of Funds	Proposed Additional Financing Loan Closing Date

Change in Disbursement Estimates (including all sources of Financing)

Explanation:

Expected Disbursements (in USD Million) (including all Sources of Financing)

Fiscal Year	2017	2018	2019	2020	0000	0000	0000	0000	0000	0000
Annual	140.00	143.00	00.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Cumulative	140.00	283.00	283.00	283.00	0.00	0.00	0.00	0.00	0.00	0.00

Allocations - Additional Financing (Yemen Emergency Health and Nutrition Project Additional Financing - P163741)

Source of Fund	Currency	Category of Expenditure	Allocation	Disbursement %(Type Total)
			Proposed	Proposed
IDA	USD		83.00	0.00
		Total:	83.00	

Components

Change to Components and Cost

Explanation:

As part of the integrated nutrition package of services in response to the food security and malnutrition crisis, this AF will scale up and add new nutrition services to the EHNP scope of interventions.

Component 1:

Subcomponent 1.1: The AF will scale up the services of the parent project and add the following interventions: i) community-based TSFP with specialized nutritious foods and RUSF, that can be used at home; ii) BSFP targeting all vulnerable groups in the community regardless of nutrition status with a preventive LNS for the children of 6 to 23 months and fortified blended flour for the PLW; and iii) general distribution of fortified nutritious supplements or food to the identified families with malnourished children or women. This subcomponent will cover basic equipment, medical and non-medical supplies, required nutrients and medicines, fortified nutritious food, vaccines, training, and implementation expenses required for the aforementioned services through the facilities, integrated outreach, mobile teams and community-based services.

Subcomponent 1.2: The AF will expand the services of the parent project to cover the provision of equipment, maintenance, medical and non-medical supplies, essential drugs, vaccines, training, and implementation expenses required for the first level referral center and hospitals. There are no new activities introduced under this Subcomponent.

Subcomponent 1.3: In addition to scaling up the activities of the parent project, the AF will finance the establishment of the INSS at health facilities. This will cover the costs of equipment, maintenance, training and implementation expenses.

Component 2: The AF will continue to support the administration, and monitoring and evaluation (M&E) activities to ensure smooth and satisfactory project implementation.

Component 3: The CERC will continue to be in place to provide expedited response in case of emergency (US$0): 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. An Emergency Response Operational Manual has been prepared by and agreed upon by the Bank to be used when this component is triggered.

The table below demonstrates the revised cost allocation by component.

Current Component Name	Proposed Component Name	Current Cost (US$M)	Proposed Cost (US$M)	Action
Improving Access to Health, Nutrition, and Public Health Services	Improving Access to Health, Nutrition, and Public Health Services	191.00	78.49	Revised
Project Support, Management, Evaluation and Administration	Project Support, Management, Evaluation and Administration	9.00	4.51	Revised
Contingent Emergency Response	Contingent Emergency Response	0.00	0.00	No Change
	Total:	200.00	83.00	

Financial Management and Disbursement Arrangements

The financial management (FM) and disbursement arrangements for the AF are consistent with those of the parent project and subject to the Financial Management Framework Agreement FMFA. Disbursement and flow of funds under the parent project for both UNICEF and WHO have been processed efficiently and in a timely manner. UNICEF and WHO will continue to maintain their FM systems and separate ledger accounts to record transactions of the project, and prepare and submit to the Bank six-monthly IFRs showing receipts and expenditures. Overall, the FM and disbursement arrangements have worked well and remain adequate for the proposed AF. 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 help provide health services in close collaboration with national partners including local health offices. Both UNICEF and WHO will continue with their independent monitoring systems through programmatic visits focusing on implementation issues and utilization of resources by national and local partners, as well as spot checks, and financial audits. A third party monitoring agency will verify implementation progress and carry out spot checks to assess partners' FM and internal controls in line with the UN Harmonized Approach to Cash Transfers. The results of these assessments and TPM reports will be shared with the Bank and contribute to the Bank's supervision of the project.

Procurement Arrangements:

The procurement arrangements for the AF are consistent with those of the parent project. There is no procurement activity that would need additional or external capacity. The procurement arrangement under this project is that the UNICEF and WHO will follow their own procurement procedures. As in the parent project, given that OP 2.30 was triggered for Yemen, the procurement rules of the two UN implementing agencies - as a "Recipient agency" are acceptable and can be used. No waivers on procurement matters are required to enact this scenario. In addition, the team would not need to carry out a separate assessment of UNICEF and WHO as this is already covered by the other arrangements that the Bank has in place with the UN agencies. Since UNICEF and WHO will follow their own procurement rules and procedures, no contract would be subject to prior or post review. Third Party Monitoring (TPM) agency will be hired as part of the monitoring activities to follow up on the implementation of the program and ensure that the agreed upon procedures are followed and to report on any deviations. The TORs for TPM will be developed and agreed upon with the Bank. The TPM agency reports will be shared with the World Bank, and will include the actions taken to address the implementation issues identified by the TPM agency, if any.

IV. Appraisal Summary

Economic and Financial Analysis

Explanation:

The parent project was estimated to have the following direct economic benefits: i) accruing around US$88 million in lives saved from direct maternal and child health and nutrition services; and ii) USD$170 million in lives saved from secondary care, giving an internal rate of return of 75 percent and a benefit-cost ratio (BCR) of 1.5. Additional economic benefits are expected to materialize as a result of the additional resources provided by the AF. Those resources will be mainly used to support activities pertaining to: i) CMAM activities; ii) preventive supplements feeds; iii) early detection of malnourished cases with proper referral; and iv) promoting healthy nutrition practices, e.g. breastfeeding.

The World Health Assembly, representing 176 member states, endorsed the first-ever global nutrition targets in 2012, focusing on six areas: stunting, anemia, low birthweight, childhood overweight, breastfeeding, and wasting. These targets aim to enhance investments in cost-effective interventions, lead better implementation modalities, and hasten progress toward decreasing malnutrition. Alderman, et al (2016) have supported the conclusion that all targeted nutrition interventions have a BCR of well above 1. The study has estimated that for every dollar invested in interventions combating wasting, stunting, anemia in women and promoting breast feeding practices, the returns are US$4, 11, 12 and 35, respectively. This makes investment in nutrition interventions one of the best value-for-money actions in development. Furthermore, nutrition interventions help form a solid basis for successes in other sectors as well.

Hoddinott et al (2013) calculated the BCR of nutrition interventions designed to reduce

malnutrition and stunting in 17 low-income and lower middle-income countries. The study indicates a strong correlation between investment in nutrition and future effects on: i) wages (taller individuals may earn more, more so in low and middle-income countries where physical productivity matters in some manual occupations); ii) improved cognition and hence wages (individuals with higher cognitive scores earn more, and also via their increased schooling achievement, also earn more); and iii) a reverse correlation with potentially increased health costs associated with chronic disease in adulthood, for which undernutrition in childhood can be a risk factor. For Yemen, a Present Value Benefit of US$1,735 for every US$97.11 worth of interventions (both discounted at 5 percent) has been calculated. This has given a much more generous BCR of 17.9. Further, the aforementioned future benefits of the nutrition interventions have been assumed to stop at 36 years of age. Nevertheless, relaxing this assumption and assuming some longer term benefits for the interventions would raise the BCR to 38 at the age of 50. Using the above mentioned methodology would yield an economic return worth of US$1.43 billion over a 30-year period and US$3.04 billion over a 45-year period.

Technical Analysis

Explanation:

Design

Yemen is on the verge of famine and the vulnerable groups (children, mothers and IDPs) are currently the most hit by the negative consequences, including malnutrition. Food insecurity along with the acute shortages of essential preventive and therapeutic nutritional services are endangering the human development prospects of the country. This AF has been specifically designed to respond to this crisis and ensure that the Yemeni population continues to have access to a package of critical nutrition (prevention and treatment of malnutrition and provision of fortified food) and health services in line with the significant needs on the ground. Furthermore, the design reflects the important lessons learned from previous Bank experience in the country, notably the parent EHNP, Health and Population Project, ECRP, and from previous Bank engagement in emergency health and nutrition operations in countries with similar sociopolitical situations such as Horn of Africa Emergency Nutrition and Basic Health Project. This translates to: (a) using the existing, on the ground, technical capacity of the Ministry of Public Health and Population (MOPHP) staff located all over the country at the Governorate Health Offices (GHOs) and Directorate Health Offices (DHOs); (b) partnering with leading UN organizations either directly (WHO and UNICEF) or indirectly (WFP); and (c) allowing flexible needs-based targeting mechanisms for both the parent project and AF that would better respond to the changes of the conflict situation, particularly the food insecurity and related risk of famine along with malnutrition.

To guide the design of this AF, and as in the parent EHNP, two major approaches were used in formulating the project activities:

(a) Achieving a balance on two fronts: (i) providing a package of essential nutrition services based on the principle of continuum of care throughout the lifecycle (childhood, adolescence/adulthood, pregnancy, childbirth, postnatal period), and with different models of service delivery (including clinical care settings, outreach, and household and communities); and (ii) supporting primary health care (PHC) facilities

and first level referral centers for nutrition with the basic inputs for maintaining their operational capacity.

(b) Supporting the delivery of an integrated package of services building on the experience of the parent EHNP. 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) realistic distribution of services in the fixed facilities assures optimum resource utilization; (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 a functional fixed facility or overwhelmed by IDPs.

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. UNICEF and WHO will engage the decentralized organizational and technical structure of the MOPHP, other sister UN agencies, INGOs and CBOs to: (a) provide preventive and therapeutic nutrition packages to the most vulnerable groups (children, mothers and IDPs); (b) maintain, revive and retain the Yemeni nutrition operational capacities especially at the central, GHO and DHO levels; and (c) prevent the collapse of the facilities providing nutritional services and maintaining the basic foundations and institutions for the post-conflict recovery phase.

Targeting

The targeting approach of EHNP along with the AF will be modified to prioritize the areas with the highest food insecurity and malnutrition rates nationwide. This will follow a transparent, evidence-based and pre-agreed upon set of criteria for each type of activity. As in the parent project, governorate/district prioritization will be revisited periodically to appropriately respond to the changing security considerations.

In the context of worsening food security and nutrition situation in Yemen and the recent findings of the EFSNA and IPC, the Food Security and Nutrition Clusters in the country are working together to identify the highest priority and high priority districts on the basis of severity of food insecurity situation and high GAM rates. The Food Security and Nutrition Clusters have agreed to consider two critical indicators only – Food Consumption Score and GAM rates. The list of districts in various categories will be agreed on and will be focused on by multiple clusters for interventions to prevent possible famine and decrease rates of GAM. Selected highest and high priority districts will be prioritized by this AF (Annex-3).

Scale Up

The additional resources under the AF will be used to scale up the nutritional target results offered under the parent project. This AF will add a total of 1,000,000 expected beneficiaries to the target of 7,000,000 beneficiaries under the parent EHNP. In particular, the AF will target 450,000 children (under 5 years of age) beneficiaries in addition to the 600,000 targeted under the parent project, and around 460,000 mothers would benefit from an array of preventive and therapeutic

nutrition services versus 200,000 under the parent project. Together with health interventions, the project will benefit over 4 million children. Finally, the AF would reach out to 161,290 family members of the CMAM treated patients with fortified nutritious supplements/food that would help shield them from similar deterioration.

Social Analysis

Explanation:

Similar to the parent project, the Involuntary Resettlement OP/BP 4.12 is not triggered and the proposed AF is not expected to pose social safeguard risks. However, there are non-safeguard (social) risks that may negatively affect implementation of the project. 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.

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 groups.

Environmental Analysis

Explanation:

The proposed AF is classified as Environmental Category "B". Activities supported by this AF 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.

A Safeguards Action Plan (SAP) with the required safeguards instrument has been prepared and cleared for the parent project, and a Medical Waste Management Plan (MWMP) was prepared by the grant recipients, cleared by the Bank, and disclosed on the World Bank external website. The implementing agencies in collaboration with the appropriate Yemeni authorities are implementing the MWMP to ensure proper management and safe disposal of any medical wastes.

The implementing organizations have institutional arrangements and implementation mechanisms in place and long-standing experience in Yemen on managing medical wastes. 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 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.

Other Changes
Explanation:
Risk
Explanation: The nature and level of risks as identified in the parent project remain valid and relevant for the AF. The overall risk rating is High. This rating stems from the exceptional context of ongoing conflict and the impending famine in the Republic of Yemen. The key risks that may hinder the effective implementation of the project include political and governance risks, macroeconomic risks, technical design and institutional capacity risks, fiduciary, stakeholder, and other risks. The mitigation measures that were identified in the parent project remain valid.

V. World Bank Grievance Redress

26. 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/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

Annex 1. Results Framework

Project Name:	Yemen Emergency Health and Nutrition Project Additional Financing (P163741)			Project Stage: Additional Financing	Status: DRAFT
Team Leader(s):	Moustafa Mohamed ElSayed Mohamed Abdalla	Requesting Unit:	MNC03		
Product Line:	IBRD/IDA	Responsible Unit:	GHN05		
Country:	Yemen, Republic	Approval FY:	2017		
Region:	MIDDLE EAST AND NORTH AFRICA	Lending Instrument:	Investment Project Financing		
Parent Project ID:	P161809	Parent Project Name:	Emergency Health and Nutrition Project (P161809)		

Project Development Objectives

Original Project Development Objective - Parent:

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

Proposed Project Development Objective - Additional Financing (AF):

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

Results

Core sector indicators are considered: Yes

Results reporting level: Project Level

Project Development Objective Indicators

Status	Indicator Name	Core	Unit of Measure		Baseline	Actual(Current)[8]	End Target
Revised	People who have received essential health, nutrition and population services	☐	Number	Value	0.00	5000000.00	8000000.00
				Date	13-Jan-2017	30-Mar-2017	31-Jan-2020
				Comment			Target was increased from 7 million.

[8] Actual results are expected to become available in July 2017, six months after the parent project approval.

No Change	People who have received essential health, nutrition and population services (% female)	☐	Percentage Sub Type Supplemental	Value	0.00		60.00
No Change	People who have received essential health, nutrition and population services (% IDPs)	☐	Percentage Sub Type Supplemental	Value	0.00		10.00
No Change	People who have received essential health, nutrition and population services (% children under 5)	☐	Percentage Sub Type Supplemental	Value	0.00		50.00

Intermediate Results Indicators

Status	Indicator Name	Core	Unit of Measure		Baseline	Actual(Current)	End Target
No Change	Number of outreach rounds conducted	☐	Number	Value	0.00		3000.00
				Date	13-Jan-2017		31-Jan-2020
				Comment			
No Change	Number of mobile team rounds	☐	Number	Value	0.00		1500.00
				Date	13-Jan-2017		31-Jan-2020
				Comment			
No Change	Health facilities provided with equipment and medical/non-medical supplies (number)	☐	Number	Value	0.00		300.00
				Date	13-Jan-2017		31-Jan-2020
				Comment			
Revised	Women who have received basic nutrition services (number)	☐	Number	Value	0.00		660000.00
				Date	13-Jan-2017		31-Jan-2020
				Comment			Target was increased from 200,000.
Revised	Children under 5 who have received basic nutrition	☐	Number	Value	0.00		1050000.00
				Date	13-Jan-2017		31-Jan-2020

	services (number)			Comment			Target was increased from 600,000.
No Change	Children immunized (number)	☐	Number	Value	0.00		5500000.00
				Date	13-Jan-2017		31-Jan-2020
				Comment			
No Change	Pregnant women receiving antenatal care during a visit to a health provider (number)	☒	Number	Value	0.00		200000.00
				Date	13-Jan-2017		31-Jan-2020
				Comment			
No Change	Births (deliveries) attended by skilled health personnel (number)	☒	Number	Value	0.00		40000.00
				Date	13-Jan-2017		31-Jan-2020
				Comment			
No Change	New electronic disease early warning system (eDEWS) data collection sites (number)	☐	Number	Value	0.00		600.00
				Date	13-Jan-2017		31-Jan-2020
				Comment			
Revised	Health personnel receiving training (number)	☒	Number	Value	0.00		4500.00
				Date	13-Jan-2017		31-Jan-2020
				Comment			Target was increased from 4000.
No Change	Local NGOs involved in service provision (number)	☐	Number	Value	0.00		15.00
				Date	13-Jan-2017		31-Jan-2020
				Comment			
No Change	Beneficiaries satisfied with services provided	☐	Percentage	Value	0.00		30.00
				Date	13-Jan-2017		31-Jan-2020
				Comment			
New	Number of community nutrition sites covered by a new	☐	Number	Value	0.00		1100.00
				Date	1-Jun-2017		31-Jan-2020

	Integrated Nutrition Surveillance System			Comment			

Annex 2. Revised Costing Table

Revised component's Costs			
The AF will not change the component/subcomponent structure of the parent project. However, the additional resources will be used to revise the components' costs as per the following:			
Component Name	**Costs under Parent Project USD Million**	**Proposed additional costs under AF USD Million**	**Revised total Costs (Parent + AF) USD million**
Component 1: Improving Access to Health, Nutrition, and Public Health Services	**161.0**	**78.49**	**239.49**
Subcomponent 1.1: Strengthening the Integration of Primary Health Care Model (UNICEF)	88.54	59.09	147.63
Subcomponent 1.2. Supporting Health and Nutrition Services at the First Level Referral Centers (WHO)	52.46	13.90	66.36
Subcomponent 1.3. Sustaining the National Health System Preparedness and Public Health Programs (WHO)	20.00	5.50	25.50
Component 2: Project Support, Management, Evaluation and Administration	**9.00**	**4.51**	**13.51**
- UNICEF Indirect Cost	3.60	1.81	5.41
- WHO Indirect Cost	2.22	1.00	3.22
- TPM and Evaluation	1.50	0.35	1.85
- Direct Costs	1.68	1.35	3.03
Component 3: Contingent Emergency Response (UNICEF)[9]	**30.00**	**0.00**	**30.00**
Total Financing	**200.00**	**83.00**	**283.00**

[9] This component has been triggered in light of the unprecedented rates of malnutrition and imminent risk of famine.

Annex 3. Detailed Description of Additional Activities and Targeting Mechanism

Description of Additional Services:

1. The AF will scale up and broaden the spectrum of the nutritional activities under the parent project. Specifically: a) Community Management of Acute Malnutrition Model (CMAM); and b) Integrated Nutritional Surveillance System (INSS).

2. CMAM is an approach that focuses on prevention and management of acute malnutrition in children and women, improving the nutrition status and general well-being. Acute malnutrition comprises two types: SAM and MAM. A SAM child is eleven times more at risk of death than a non-malnourished child, while a MAM child has three times greater risk of death than a non-malnourished child. CMAM includes both preventive and curative elements that are implemented in community and health facility levels of interventions.

3. CMAM includes four main components: (i) treatment of SAM children without complications in Outpatient Therapeutic Feeding Programs (OTPs); (ii) treatment of MAM children and acutely malnourished PLW in TSFP; (iii) treatment of SAM children with medical complications in Therapeutic Feeding Centers/Stabilization Centers (TFC/SC); and (iv) community mobilization, including sensitization for community members and a community health volunteer (CHV) role in active case finding (screening and referral of malnourished children and women of reproductive age), awareness raising on key messages, such as IYCF practices, and counselling.

4. Screening will take place in the community using Mid-Upper Arm Circumference (MUAC), and looking for bilateral pitting edema and, at the OTP/TSFP, using Weight-for-Height (WFH) and MUAC measurements and assessment of bilateral pitting edema. The screening comprises active and passive case finding along with self-referrals.

a. **Active Case Finding (Screening):** Children with SAM or MAM in the community will be identified through repeated periodic **house to house** screening of children 6 to 59 months of age through CHVs. Children with SAM or MAM will be identified with MUAC and the presence of bilateral pitting edema. Furthermore, MUAC and WFH will be measured at the health facilities (OTP and TSFP) to ensure that the referred malnourished child meets the admission criteria. This form of active screening helps reach those families that may not be covered routinely by the health programs, and those children who are too unwell to come to the facility. Active case finding always includes identification and referral for acutely malnourished PLW; however, where BSFP is present, the malnourished PLW is referred to those activities for additional nutritional supplements.

b. **Passive Case Finding:** Children who appear malnourished or unwell will be brought to the OTP and TSFP by the CHVs. At the OTP and TSFP, the weight, height and MUAC will be recorded and presence of bilateral pitting edema will be assessed. Anthropometric examination will also be undertaken for all children attending the OPD services at these same health facilities. Children identified as SAM or MAM by any of the following criteria will be admitted into the appropriate program.

<u>Prevention and Management of MAM Cases</u>

5. **Targeted Supplementary Feeding Program.** The MAM services will support the treatment of an estimated 115,000 children with the provision of sufficient RUSF (Plumpy'Sup) which provides 535 kcal per day, for an average of three months until discharged from the TSFP as cured. Additionally, each family of a MAM or SAM child will receive monthly household nutritional supplements assistance comprised of fortified basic foods to meet daily caloric and micronutrient requirements.

6. There is very good coordination between SAM and MAM programs, and CHVs will ensure that MAM children do not miss the TSFP activities. CHVs are informed when a child is transferred from OTP to TSFP or when a child is absent/defaulted from TSFP, so that they can follow up with the child and the mother or caregiver at home to investigate the reasons, and encourage the return of the child to successfully complete their MAM treatment.

7. **Blanket Supplementary Feeding Program.** The primary objective of BSFP is to prevent deterioration in nutritional status and related morbidity and mortality in high risk groups such as children 6 to 23 months and PLW, when the prevalence of acute malnutrition is high and levels of food insecurity are severe. In such cases, all vulnerable individuals receive supplementary nutritious edibles regardless of malnutrition status. Thus, the preventive assistance of BSFP offered under this activity will support an estimated 160,000 children 6 to 23 months with a monthly 1.5 kg take-home ration of a LNS, Plumpy'Doz, which provides daily 281 kcal of energy and essential micronutrients, including iron. An estimated 225,000 PLW will receive a monthly 6 kg ration of fortified blended flour, Super Cereal, starting from the second trimester through six months of breast feeding to prevent malnutrition and micronutrient deficiencies.

8. **Fortified Blended Food (FBF).** Added to the BSFP and TSFP, General FBF program will be also introduced to the package. FBFs are blends of partially precooked and milled cereals, soya, beans, and pulses fortified with micronutrients (vitamins and minerals). Special formulations, which may contain vegetable oil or milk powder, will aim to cover the recommended mean daily per capita nutrient intake[10]. The FBF will be provided to households with malnourished children or PLWs to ensure a minimum calorie intake and prevent the onset of malnutrition.

Management of SAM Cases:

<u>Outpatient Therapeutic Feeding programs (OTP):</u>

9. The majority of children with SAM are treated in the OTP, which provides home-based treatment and rehabilitation for those who have appetite and are free of medical complications. In addition, children admitted to the TFCs will be transferred to the OTP after their medical condition is stabilized, edema resolved and have started gaining weight. Around 85-90 percent of children with SAM can be admitted directly into the OTP, treated with routine drugs and given therapeutic feeding in sachets to eat at home. In Yemen, there are two types of OTPs;

10. <u>Fixed OTP at Health Facilities</u>: Fixed OTPs established at fixed Health Units, Temporary Health Units, Health Centers, Rural Hospitals and referral hospitals, as per national guidelines CMAM services, will be available on the same schedule of the health facility, on a daily basis. The fixed OTPs will cover all the villages in Level 1 (within 5 km radius of health facility). In areas where OTP is

[10] Recommended by WHO, 1995

combined with TSFP, the two will function on separate days of the week or together on daily basis based on the resources at HFs level.

11. Mobile OTPs: The Mobile OTPs will be operated by Mobile Teams and as stated earlier, each mobile team will comprise of 4-5 workers and one CHV with a dedicated vehicle. These mobile teams will provide all health and nutrition services including OTP and TSFP. Unlike Fixed OTPs, the mobile OTPs will also function as mobile TSFPs. The mobile teams function for 25 days in a month and will move in their designated area based on a micro-plan. The Mobile OTPs will cater to the needs of Level 2 and Level 3 villages (more than 5 km from a health facility) and at each site the Mobile OTP will function on weekly basis or once every alternate week. For example, village A will have the Mobile OTP every first and third Monday of the month, village B on every first and third Tuesday and village X on every second and fourth Thursday. The days and the site of the Mobile OTP visits will be fixed and the community would be made aware of the days as well as the specific site. The CHVs will mobilize the community to benefit from the various services that the Mobile OTP will provide.

12. Children who fulfil the admission criteria to the OTP will be admitted and enrolled in the program. A child enrolled in the OTP will have all the details filled in the OTP card, and a unique SAM number will be assigned. Weight, height and MUAC of the child will be recorded and the health worker will assess the child for medical complications; this will include checking for edema, vomiting, and taking temperature, assessing the respiration rate, signs and symptoms of anemia, and dehydration. The health worker will also check the immunization status of the child. The child will be provided Ready-to-Use Therapeutic Foods (RUTF) for one or two weeks based on the service delivery schedule and antibiotics for one week as per the treatment schedule, the mother/caregiver will be instructed on how to administer the RUTF and antibiotics as well as the date of the next visit.

13. Once admitted in the OTP, the child will have to visit the OTP every one or two weeks. During the fortnightly follow-up visits, children with SAM already enrolled in the program will receive the ration of RUTF for the next week or two weeks. A health worker will enquire about the compliance of RUTF from the previous visit, test the appetite, look for medical complications, record weight and MUAC, and advise the mother on select health and nutrition issue. The counselling component of the package of services that will be provided at the OTP will be strengthened and monitored closely.

14. A child admitted in the OTP will be followed up and treated until the child reaches the discharge criteria or up to a maximum of 16 weeks. A child who does not recover after 16 weeks of treatment will be discharged as “Non-cured” and will be referred to the nearest TFC or a hospital for a detailed examination.

15. CHVs will ensure that SAM children do not miss the OTP activities. CHVs are informed when a child is absent/defaulted from OTP, so that they can follow up with the child and the mother or caregiver at home to investigate the reasons, and encourage the return of the child to successfully complete their SAM treatment.

Management at OTP

16. Management of children with SAM can be broadly divided into the following 10 steps: i) Anthropometric assessment; ii) Medical assessment; iii) Appetite assessment; iv) Decide if the child should enrolled/ continue in OTP or be transferred to TFC; v) Nutritional treatment; vi) Medicines; vii)

Health education and counselling; viii) Fortnightly follow-up while in CMAM program at the community level; ix) Discharge criteria for CMAM program; and x) Follow-up after discharge from CMAM program.

Inpatient care for SAM children with complication

17. SAM children with poor appetite and/or medical complication and bilateral pitting edema are referred to the inpatient care (TFC/SC) until their condition become stabilized and are referred back to OTP.

18. TFC/ SC will be established in main referral hospitals, rural hospitals or main HCs at the district level. Children with SAM with poor appetite and/or medical complications are directly enrolled or referred to inpatient care (TFC/SC) from OTP and treated according to protocols based on the national guidelines and WHO guidelines. These children are transferred to the OTP once they meet the transfer criteria, which include resolution of the medical complications, return of appetite and a minimum weight gain for 3-4 days etc. Every OTP in the district will be linked to TFC and the OTP staff will be aware of the linked TFC.

Service Delivery:

19. **Integrated health and nutrition outreach services.** Given the significant service gap, this activity 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. The package of PHC services under outreach rounds and mobile teams is similar (except that malnourished children are screened & referred at integrated outreach activities level, while they are treated by mobile teams) and will be flexible to accommodate additional services based on the identified needs of each area. Under the project, this activity will support active mass screening of children in communities for acute malnutrition.

20. **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 & community health workers (CHWs). 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.

21. **The mobile teams** will deliver a package of health and nutrition services to targeted vulnerable populations living in Level 2 and Level 3 villages, IDPs settlement areas, remote and hard-to-reach populations every two weeks. They are a short to medium term strategy to provide services in the absence of functional health facilities. This activity will support the deployment of mobile teams to provide an integrated package of health and nutrition services that includes vaccination, CMAM, and other health and nutrition activities.

Integrated Nutritional Surveillance System:

22. The objective of this system is to measure and monitor food security, nutritional status, nutrition-related health outcomes, as well as knowledge, attitudes and practices on Infant and Young

Child Feeding practices and WASH. A food and nutrition surveillance system is an essential instrument for the detection of nutrition and nutrition-related health problems and for monitoring policy implementation for both developmental and emergency programs.

23. The nutritional status of a target population is influenced by many factors, including social, economic and health, in addition to environmental and food security status. Therefore, the response to the surveillance information will concern many different areas of interventions and different sectors of interest. Optimally, INSS would be the only and unified source for food and nutrition information and reports. It integrates multi-sectorial sources of data to initiate a timely and multi-sectorial response linked to the surveillance indicators.

24. According to the bio-statistical calculations, Yemen urgently needs 3,574 CNS nationwide to generate an ongoing, systematic and representative national report. Currently, only 45 percent of health facilities are functional, thus the AF will support the establishment of the nutrition surveillance sentinel sites at these facilities.

25. This surveillance will consist of 2 modules:

a. Routine Surveillance System: this module depends on reporting from the CNS (facility based) and from the community volunteers (community based) on passive basis.

b. Active Surveillance System: this module depends on field assessment of the community nutritional status and will be conducted by the trained health workers at the CNS. It includes a back-up plan for nutrition surveillance when the reporting rate from the community volunteers drops below 80 percent due to uncontrolled emergency situation in the country.

Targeting Mechanism:

26. The AF will scale up the depth and breadth of the nutrition services under the parent project, and will aim to prioritize districts based on the EFSNA and IPC findings in the context of worsening food security and nutrition situation in Yemen. The Food Security and Nutrition Clusters in the country are working together to identify the Highest Priority and High Priority districts on the basis of criticality of food insecurity situation and high global acute malnutrition rates. The FS and NC have agreed to consider a composite of the IPC and EFSNA results to categorize the severity and urgency of the nutritional situation in different districts. The list of districts in various categories will be agreed upon and will focus on multiple interventions to prevent a possible nutritional catastrophe. Selected highest and high priority districts will be the focus of this project. It is also agreed, that upon the availability of any updated survey/study results, the priority districts list may be revisited.

27. The ‘Integrated Food Security Phased Classification - IPC’ is an international interagency working group that uses standardized protocols (tools and procedures) to respond to the need for a common approach for classifying various food insecurity situations, within and among countries, and across time. Acute food insecurity is classified according to 5 phases: 1) None/Minimal; 2) Stressed; 3) Crisis; 4) Emergency; and 5) Humanitarian Catastrophe/Famine. In Yemen, the IPC was carried in late February 2017 where 69 analysts representing different agencies from different organizations participated in the process and a subsequent review of the results by a parallel group was carried out. The results are representative down to the district level. IPC has revealed that the food insecurity levels are alarming; out of the 22 governorates, seven are in phase 4 (Emergency), ten governorates are in

phase 3 (Crisis), and a further three governorates would have slid into phase 4 if it was not for the ongoing assistance.

28. The 'Emergency Food Security and Nutrition Assessment- EFSNA' is a joint survey that was conducted by FAO, UNICEF and WFP in cooperation with the authorities in Yemen in November 2016. It is the first national, household-level assessment conducted in the country since the escalation of the conflict in mid-March 2015. According to the WHO classification, GAM rates are classified into: i) Critical (GAM > 15 percent of all children); ii) Serious (10.1-15 percent); iii) Poor (5-10 percent); and iv) Acceptable (< 5 percent). The results have shown that four governorates are in the critical category, seven in the serious category and eight are in the poor category.

Table 3: IPC and EFSNA Data by Governorate

Governorate	Population (projected 2016)	IPC Levels 3&4		EFSNA
		% of Population	Number of individuals affected	GAM Rates
Abyan	557,000	62%	345,340	16%
Aden	895,000	58%	519,100	14%
Al Bayda	744,000	64%	476,160	7%
Al Daleh	698,000	70%	488,600	11%
Al Hodiedah	3,097,000	42%	1,300,740	25%
Al Jawf	576,000	62%	357,120	11%
Al Maharah	144,000	19%	27,360	-
Al Mahweet	677,000	51%	345,270	13%
Amran	1,040,000	53%	551,200	6%
Dhamar	1,862,000	50%	931,000	9%
Hadramaut	1,384,819	19%	263,116	20%
Hajjah	2,702,000	60%	1,621,200	12%
Ibb	2,778,000	51%	1,416,780	8%
Laheg	961,000	73%	701,530	13%
Mareb	321,000	52%	166,920	8%
Raymah	551,000	59%	325,090	7%
Sa'adah	1,044,000	64%	668,160	9%
Sana'a	1,133,000	54%	611,820	5%
Sana'a City	3,094,000	35%	1,082,900	6%
Shabwah	619,000	63%	389,970	13%
Soqatra	63,181	18%	11,373	-
Taiz	3,117,000	60%	1,870,200	17%
Total Yemen	**28,058,000**	**52%**	**14,590,160**	

Table 4: Number of Priority Districts per Governorate

	Number of Districts						
Governorate	Highest priority (Nutrition + Food security)	High priority (Nutrition + Food security)	High priority (Food security only)	Medium priority (Food security only)	High priority (Nutrition only)	No priority identified	**Total**
Abyan	6		5				**11**
Aden					6	2	**8**
Al Baidha			4	3		13	**20**
Al Dale'e	2	1	1			5	**9**
Al Jawf			2		2	8	**12**
Al Mahra					9		**9**
Al Mahweet		2	2		2	3	**9**
Amran		3	3	3	1	10	**20**
Dhamar	1	4		1	2	4	**12**
Hadhramout	8	5			14	1	**28**
Hajjah	11	1	7	7	2	3	**31**
Hodeidah	6	6			12	2	**26**
Ibb		3		7	1	9	**20**
Lahj	4	3	2	3		3	**15**
Mareb			5	1		8	**14**
Raymah		1	1	1	1	2	**6**
Sa'ada	7	4	3		1		**15**
Sana'a	2		1	4	1	8	**16**
Sanaa City				4	1	5	**10**
Shabwa	3			12		2	**17**
Socotra					2		**2**
Taiz	9	3	6		5		**23**
Total	**59**	**36**	**42**	**46**	**62**	**88**	**333**