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Report no: PAD638

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED GRANT

IN THE AMOUNT OF SDR 6.6 MILLION
(US$10 MILLION EQUIVALENT)

TO THE

REPUBLIC OF YEMEN

FOR A

MATERNAL AND NEWBORN VOUCHER PROJECT

MARCH 5, 2014

Human Development Department
Middle East and North Africa Region

This document is being made publicly available prior to Board consideration. This does not imply a presumed outcome. This document may be updated following Board consideration and the updated document will be made publicly available in accordance with the Bank's policy on Access to Information.

Currency Equivalents

(Exchange Rate Effective January 31, 2014)

Currency Unit	=	Yemeni Rial (YER)
YER 100	=	US$0.465279
US$1	=	0.65SDR

Fiscal Year

January 1 – December 31

Abbreviations and Acronyms

ANC	Ante-Natal Care
BEmONC	Basic Emergency Maternal Obstetric and Newborn Care
CAS	Country Assistance Strategy
CBO	Community Based Organization
CEmONC	Comprehensive Emergency Maternal Obstetric and Newborn Care
CHM	Complaints Handling Mechanism
DA	Designated Account
FM	Financial management
FP	Family planning
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
HCW	Healthcare waste
HNP	Health, Nutrition and Population
HRITF	Health Results Innovation Trust Fund
HPP	Health and Population Project
IAD	Internal Audit Department
IFR	Interim Financial Report
IPF	Investment Project Financing
IUCD	Intrauterine Contraceptive Device
IVA	Independent Verification Agent
KfW	Kreditanstalt für Wiederaufbau
LBW	Low Birth Weight
M&E	Monitoring and Evaluation
MDGS	Millennium Development Goals
MENA	Middle East And North Africa
MIS	Management Information System
MNCH	Maternal, Neonatal and Child Health
MNVP	Maternal and Newborn Voucher Project
MOF	Ministry of Finance
MOPIC	Ministry of Planning and International Cooperation
MOPHP	Ministry of Public Health and Population
MOU	Memorandum of Understanding
MTR	Mid-term review
MWRA	Married Women in Reproductive Age
NGO	Non-Governmental Organization
OOP	Out of Pocket
PBC	Performance Based Contracting
PBF	Performance Based Financing
PDO	Project Development Objective

PFS	Project Financial Statements
PNC	Post-Natal Care
QIP	Quality Improvement Program
RBF	Results-based financing
RH	Reproductive Health
RHVP	Reproductive Health Voucher Project
SDR	Special Drawing Rights
SFD	Social Fund for Development
SHI	Social Health Insurance
SMH	Safe Motherhood
SMP	Safe Motherhood Project
SSN	Social Safety Net
SWF	Social Welfare Fund
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency For International Development
VMA	Voucher Management Agency
VMT	Voucher Management Team
VSP	Voucher Service Providers
WA	Withdrawal Application
WHO	World Health Organization

Regional Vice President:	Inger Andersen
Country Director:	Hartwig Schafer
Acting Sector Director:	Enis Barış
Sector Manager:	Enis Barış
Task Team Leader:	Alaa Mahmoud Hamed Abdel-Hamid

REPUBLIC OF YEMEN
Maternal and Newborn Voucher Project (P144522)

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PAD DATA SHEET

Yemen, Republic of

Maternal and Newborn Voucher Project (P144522)

PROJECT APPRAISAL DOCUMENT

MIDDLE EAST AND NORTH AFRICA

MNSHH

Report No.: PAD638

.

Basic Information			
Project ID P144522	EA Category C - Not Required		Team Leader Alaa Mahmoud Hamed Abdel-Hamid
Lending Instrument Investment Project Financing	Fragile and/or Capacity Constraints [ ]		
	Financial Intermediaries [ ]		
	Series of Projects [ ]		
Project Implementation Start Date 31-Mar-2014	Project Implementation End Date 30-Jun-2019		
Expected Effectiveness Date 07-Aug-2014	Expected Closing Date 31-Dec-2019		
Joint IFC No			
Sector Manager Enis Baris	Sector Director Enis Baris	Country Director Hartwig Schafer	Regional Vice President Inger Andersen

Borrower: Ministry of Planning and Development Cooperation	
Responsible Agency: The Social Fund for Development	
Contact:	Title:
Telephone No.: (967-1) 449-671	Email: aaldilami@sfd-yemen.org

Project Financing Data(in USD Million)					
[ ]	Loan	[X]	Grant	[ ]	Guarantee
[ ]	Credit	[ ]	IDA Grant	[X]	Other

Total Project Cost:	20.00	Total Bank Financing:	10.00

Financing Gap:	0.00

Financing Source	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	10.00
Health Results Innovation Trust Fund	10.00
Total	20.00

Expected Disbursements (in USD Million)

Fiscal Year	2015	2016	2017	2018	2019	2020	0000	0000	0000
Annual	2.00	3.00	5.00	5.00	5.00	0.00	0.00	0.00	0.00
Cumulative	2.00	5.00	10.00	15.00	20.00	20.00	0.00	0.00	0.00

Proposed Development Objective(s)

The Project Development Objective is to increase the utilization of maternal and newborn health services in the project target areas.

Components

Component Name	Cost (USD Millions)
Component 1: Improving Access to Maternal and Newborn Health Services	16.36
Component 2: Results-Based Monitoring, Voucher Management, Quality Assessment, Technical Audit, and Project Management	3.64

Institutional Data

Sector Board

Health, Nutrition and Population

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	100		
Total		100		

☑ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes		
Theme (Maximum 5 and total % must equal 100)		
Major theme	Theme	%
Human development	Population and reproductive health	70
Human development	Child health	15
Human development	Health system performance	15
Total		100

Compliance		
Policy		
Does the project depart from the CAS in content or in other significant respects?	Yes [ ]	No [X]
Does the project require any waivers of Bank policies?	Yes [ ]	No [X]
Have these been approved by Bank management?	Yes [ ]	No [X]
Is approval for any policy waiver sought from the Board?	Yes [ ]	No [X]
Does the project meet the Regional criteria for readiness for implementation?	Yes [X]	No [ ]

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

Legal Covenants			
Name	**Recurrent**	**Due Date**	**Frequency**
External Technical Auditor as set forth under Schedule 2.I.C.1 of the Financing Agreement		Not later than six (6) months after effectiveness	
Description of Covenant			
The Recipient shall, not later than six (6) months after Effective Date, recruit an External Technical Auditor, in accordance with the provisions of Section III.C of Schedule 2 to this Agreement, to independently verify, *inter alia*, that the internal control systems of the Voucher Program are operating			

in an effective and efficient manner.			
Name	**Recurrent**	**Due Date**	**Frequency**
Independent Verification of Output as set forth under Schedule 2.I.F.6(a) of the Financing Agreement		not later than six (6) months after the commencement of Voucher Program	
Description of Covenant			
The Recipient shall, through the Project Implementing Entity, not later than six (6) months after the commencement of Voucher Program (and thereafter with such frequency as shall be set out in the Operations Manual), cause the External Technical Auditor to carry out an independent verification of the Voucher Program and furnish to the Project Implementing Entity, the Recipient and the Association, a report which shall include an opinion on the reliability of the statements of claims registries and recommendations on how to further improve the Voucher Program and Project implementation.			
Name	**Recurrent**	**Due Date**	**Frequency**
Independent Verification of Output as set forth under Schedule 2.I.F.6(b) of the Financing Agreement		not later than six (6) months after the commencement of Voucher Program	
Description of Covenant			
The Recipient shall cause the external verification system referred to in sub-paragraph (a) immediately above to be reviewed during the mid-term review referred to in Section II.A.2 of this Schedule, and thereafter, make any changes to the external verification system as shall be agreed with the Association.			
Name	**Recurrent**	**Due Date**	**Frequency**
TORs for the Independent External Technical Auditor as set forth under Schedule 2.I.C.3. of the Financing Agreement		Not later than 3 months after effectiveness date	
Description of Covenant			
The Recipient shall cause the Project Implementing Entity to, not later than three (3) months after the Effective Date, prepare and submit to the Association, the terms of reference for the reviews referred to in paragraph I.C.2 of the Financing Agreement, in form and substance satisfactory to the Association.			

Conditions	
Name	**Type**
Additional Conditions of Effectiveness as set forth under Article V.5.01 (a) of the Financing Agreement	Effectiveness
Description of Condition	
The Co-Financing Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of this Agreement) have been fulfilled.	

Name	Type
Additional Conditions of Effectiveness as set forth under Article V.5.01 (b) of the Financing Agreement	Effectiveness

Description of Condition

The Subsidiary Agreement has been executed on behalf of the Recipient and the Project Implementing Entity.

Name	Type
Disbursement Conditions as set forth under Schedule 2.IV.B.1.(b) of the Financing Agreement	Disbursement

Description of Condition

No withdrawal shall be made:

under Category (1) unless a pertinent Service Agreement has been signed between the Recipient and Service Providers, as shall be evidenced by the first three (3) Service Agreements, which shall be submitted to the Association.

Name	Type
Disbursement Conditions as set forth under Schedule 2.IV.B.1.(c) of the Financing Agreement	Disbursement

Description of Condition

No withdrawal shall be made:

Under Category (1), unless the voucher management information system for processing claims submitted by respective Service Providers, and data validation has been established within the Project Implementing Entity, and said voucher management information system is operational, in a manner satisfactory to the Association.

Team Composition

Bank Staff

Name	Title	Specialization	Unit
Mira Hong	Senior Operations Officer	Operations Officer	MNSSP
Lars C. Lund	Consultant	Consultant	EASDE
Alaa Mahmoud Hamed Abdel-Hamid	Senior Health Specialist	Team Lead	MNSHH
Edith Ruguru Mwenda	Senior Counsel	Senior Counsel	LEGAM
Andrianirina Michel Eric Ranjeva	Finance Officer	Finance Officer	CTRLA
Ayala Peled Ben Ari	Consultant	Consultant	MNSHH
Aakanksha Pande	Economist (Health)	Young Professional	MNSHH
Maiada Mahmoud Abdel Fattah Kassem	Finance Officer	Finance Officer	CTRLA

Siele Shifferaw Ketema	Program Assistant	Program Assistant	ITSSP
Shivendra Kumar	Consultant	Consultant	SARPS
Aissatou Dicko	Senior Program Assistant	Senior Program Assistant	MNSHD
Moad M. Alrubaidi	Sr. Financial Management Specialist	Financial Management Specialist	MNAFM
Safa'a Abdullah Al-Sharif	Program Assistant	Program Assistant	MNCYE
Samira Al-Harithi	Procurement Analyst	Procurement Analyst	MNAPC
Ali Ahmed Al-Mudhwahi	Senior Health Specialist	Senior Health Specialist	MNSHH

Non Bank Staff

Name	Title	Office Phone	City
Corinne Grainger	Lead Health Results Specialist		
Anna Gorter	Voucher Specialist		
Nehad Kamel	consultant		
Souraya El Assiouty	Team Assistant		

Locations

Country	First Administrative Division	Location	Planned	Actual	
Yemen, Republic of	Muhafazat Ta`izz	Muhafazat Ta`izz	X		
Yemen, Republic of	Sanaa	Sanaa	X		
Yemen, Republic of	Hadramawt	Muhafazat Hadramawt	X		

I. Strategic Context

A. Country Context

1. Yemen is one of the poorest countries in the Middle East and North Africa (MENA) region, with nearly half of its estimated population of 25.5 million living on less than US$2 per day.[1] Yemen ranks 160th out of 186 countries on the 2012 Human Development Index. The country has one of the highest population growth rates in the world, placing pressure on educational and health services, drinking water, and employment opportunities. The mass protests, violent clashes and political unrest in 2011 have negatively affected the economic condition of Yemen. Poverty, which was already increasing prior to the crisis, is estimated to have risen further from 42 percent of the population in 2009 to 54.5 percent in 2012. Poverty is particularly high in rural areas, which are home to about 73 percent of the population and 84 percent of the poor. Women, who are already severely disadvantaged in Yemen, have suffered disproportionately as a result of the crisis. Preliminary figures from 2011 indicate decreased access to basic and social services and economic opportunities, as well as high levels of gender-based violence as a result of the unrest. These effects have compounded the severe gender imbalances that already existed.

2. The past several decades, however, have witnessed significant improvements in key development indicators, including average life expectancy, which increased from 42 years in 1970 to 65 years in 2011,[2] with the life expectancy of women mirroring the overall trends, and a significant increase in the enrolment rates in basic education, reaching 54 percent for both boys and girls.[3] Despite these achievements, there remain many areas of concern, among which are the very high maternal and child mortality rates and the rapid population growth rate.[4]

3. There are limited available financial resources (both public and private), limited infrastructure (less than half the population has access to basic health services), and few systems in place to support service delivery (e.g., for medical supplies and drugs). In addition, most of the population lives in isolated rural communities, making both the delivery of, and access to, services at the community level a complex challenge. Health services, although improving, do not cover more than 30 percent of the rural population or more than 45 percent of the total population. Given these challenges, it is unlikely that Yemen will achieve health-related Millennium Development Goals (MDG) 4 (child health) or 5 (maternal health) by 2015.

4. Although up-to-date statistics are not available, United Nations organizations believe that more than half the Yemeni population now needs some kind of humanitarian assistance, with more than ten million people lacking sufficient food, twelve million without access to clean water, and one million children malnourished. A shocking 60 percent of deaths in children aged five years and under in Yemen are related to malnutrition.[5] In addition, unemployment levels are extremely high, especially for Yemen's young people, about 70 percent of who are unemployed, with little or no provision of financial assistance. Poverty and malnutrition are conclusively linked to poor maternal and newborn outcomes[6] and are likely to be contributing to continued high rates of maternal mortality and morbidity in Yemen.

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[1] Population Reference Bureau World Population Data Sheet 2011

[2] https://www.cia.gov/library/publications/the-world-factbook/geos/ym.html

[3] Human Development Index, UNDP, 2010

[4] Maternal mortality was estimated in the UNDP HDI report to be 210 per 100,000 live births. Infant mortality is around 60 per 1,000 live births, which puts it closer to its African neighbors of Eritrea (42) and Djibouti (73), rather than its Arab neighbors Oman (8) or Saudi Arabia (15).

[5] M. Meleigy (2010), *Yemen conflict takes its toll on civilians*, The Lancet Global Health Network http://www.thelancetglobalhealthnetwork.com/archives/739, January 23rd 2010

[6] Robert E Black, Cesar G Victora, Susan P Walker, Zulfi qar A Bhutta, Parul Christian*, Mercedes de Onis, Majid Ezzati, Sally Grantham-McGregor, Joanne Katz, Reynaldo Martorell, Ricardo Uauy, and the Maternal and Child Nutrition Study Group, *Maternal and child under nutrition and overweight in low-income and middle-income countrie*s, Lancet series on Maternal and child Nutrition 1, Published Online June 6, 2013 http://dx.doi.org/10.1016/S0140-6736(13)60937-X

B. Sectoral and Institutional Context

5. Maternal, Newborn and Child Health, and Reproductive Health. Although Yemen has made great strides in reducing the maternal mortality ratio, it remains high at 210 deaths per 100,000 live births,[7] which translates to some 40 women dying every week due to pregnancy and birth-related complications. While some progress has been made in the last four years to provide women with antenatal healthcare services, most mothers still deliver at home with little or no support. Across the region, Yemen continues to have the lowest level of antenatal care coverage, although according to a recent report from the Ministry of Public Health and Population (MOPHP), the proportion of women benefiting from antenatal healthcare services increased from 40 percent to 55 percent during 2006–2010.[8] Although Yemen's maternal health policy refers to skilled attendants as doctors, nurses and midwives, nearly 21 percent of births are attended by traditional birth attendants[9] and only 36 percent of births are attended by skilled health staff.[10] As a result, many women suffer from hemorrhage, anemia, infections, and/or obstetric fistula, and in many cases, these conditions result in death.

6. Given the young age at which many girls marry, particularly in rural areas, the adolescent fertility rate is high at 80 births per 1,000 girls aged 15–19 years. Contraceptive prevalence is low at 28 percent[11] with 21 percent in rural and 42 percent in urban areas for any contraceptive method; and 13 percent in rural and 34 percent in urban areas for modern contraceptives.[12] Almost a quarter of married women (24 percent)[13] have an unmet need for family planning.

7. Yemen has very high rates of malnutrition with 43 percent of children under the age of five years being moderately to severely underweight and 58 percent suffering from moderate to severe stunting.

8. Yemen has one of the highest population growth rates (3.02 percent per year) in the world, with population set to double in the next 23 years.[14] The high population growth rate is aggravating the effects of natural phenomena, such as sandstorms and dust storms, which result in soil erosion and crop damage. Desertification (land degradation caused by aridity) and overgrazing are also problems.[15]

9. Yemen is facing a human resource crisis in public healthcare. A recent report commissioned by the MOPHP exposed serious shortages in staff skilled in Maternal, Neonatal and Child Health (MNCH) Nationwide, only 60 percent of the 261 obstetricians and only 5 percent of the 794 neonatal nurses needed to staff Government health facilities are working.[16] However, this does not reflect the reality of skilled medical personnel in the country. It has been argued that there is a surplus of trained clinicians in urban areas (particularly in Aden and Sana'a), most of whom operate in the private sector and, although efforts have been made by development partners such as United Nations Population Fund (UNFPA) to train additional personnel, many midwives are under-employed or unemployed.

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[7] *World Health Statistics 2012*, WHO
[8] IRIN (2010)
[9] Into Good Hands: progress reports from the field, UNFPA, 2004
[10] *World Health Statistics 2012*, WHO,
[11] Population Reference Bureau World Population Data Sheet 2011
[12] MOPHP of Yemen & UNICEF 2006, Multiple Indicator Cluster Survey 2006, MOPHP; PAPFAM; UNICEF, Sana'a
[13] Yemen National Reproductive Health Strategy 2011-2015
[14] NATIONAL SOCIAL PROTECTION MONITORING SURVEY IN YEMEN, Baseline Analytical Report, Min. of Planning and International Cooperation-Yemen, UNICEF-Yemen, International Policy Centre for Inclusive Growth-Brazil. June 2013.
[15] http://en.wikipedia.org/wiki/Geography_of_Yemen#cite_note-cp-1 accessed on 8 August 2013
[16] Needs Assessment Study for the One-year Diploma Training of General Practitioners on Obstetrics, Neonatology and Anaesthesiology, and of Nurses on Neonatology and Operating Theatre Nursing For EmONC Services in Yemen. Republic of Yemen Ministry of Public Health and Population Sector 2012.

10. In rural areas, it is common for midwives, as well as other health staff, to work in public health facilities in the morning and then to work in their own private practice in the afternoon and evening. Thus, "free" healthcare is only available for a limited time every day and even then, informal fees often apply.

11. National Health Policy. The reduction of the number of maternal and neonatal deaths as well as the number of deaths of children under five is one of the main expected results listed in the 2010-2025 National Health Policy. The health and population sector's objectives, according to the third five-year development plan, are as follows: (i) strengthening the national health system; (ii) combating epidemics, endemic infectious diseases and reducing morbidity and mortality rates; and (iii) improving the health care delivery system. The policy defines areas or priority that address maternal and newborn mortality including improving the quality and utilization of health services, and access to emergency obstetric care. A national Reproductive Health Policy was developed that states "In an effort to accelerate maternal and newborn survival toward the achievement of MDGs 4 and 5, the Reproductive Health (RH) department at Population Sector has focused on two main areas of RH: maternal and newborn health and family planning."[17] Both areas are addressed through the proposed voucher project.

12. Maternal and Child Health Acceleration Plan (2013-2015). Yemen has developed a plan that aims to accelerate the reduction of maternal and under-five mortality to progress towards MDGs 4 and 5. Its main objectives are: (i) to reduce maternal mortality by 24 percent from 200 to 153 per 100,000 live births; (ii) to reduce under-five mortality by 14 percent from 72 to 62 per 1000 live births; and (iii) to reduce neonatal mortality by 15.6 percent from 32 to 27 per 1000 live births. These are complemented by specific operational targets to be achieved by 2015. This project will contribute to the implantation of this plan.

13. Donor engagement: The World Bank has been working to strengthen health systems and the supply of health services through the Health and Population Project (HPP), the Social Fund for Development Project Phase IV (SFD IV), and the Safe Motherhood Project (SMP). They have been working to strengthen the delivery of maternal, neonatal and child health (MNCH) services in selected governorates.[18] These projects have components that included expanding and strengthening MNCH outreach services and services provided at the community level (such as midwifery services), as well as selected upgrading of first-level referral facilities which will be linked with the delivery at outreach sites and community-based services. The Maternal and Newborn Voucher Project (MNVP), along with other interventions, will work to strengthen demand for these services at the midwife, health unit, Basic Emergency Maternal Obstetric and Newborn Care (BEmONC) and Comprehensive Emergency Maternal Obstetric and Newborn Care (CEmONC) levels, to take advantage of the expanded capacity in the health system and to enable poor women to access the improved quality services.

14. In addition to the maternal and newborn health voucher program, the World Bank is financing the Yemen Emergency Targeted Nutrition Intervention, with funding from the Japan Social Fund, which targets early childhood nutrition interventions and also provides conditional cash assistance. In addition, a larger group of multilateral and bilateral agencies are providing emergency and ongoing assistance for nutrition in Yemen, mostly through United Nations agencies and non-governmental organizations (NGOs).

[17] The Republic of Yemen, Ministry of Public Health and Population (MOPHP), Population Sector/Reproductive Health, the Yemen National Reproductive Health Strategy 2011 – 2015, February 2011.

[18] HPP governorates are Sana'a, Hodeidah, Reimah, Al Dahla'a, Al Baydah, Aden (urban slums only), while SFDIV governorates extended in other governorates such as Taiz, Hadramout, etc., and SMP governorate is Sana'a city.

C. Higher Level Objectives To Which The Project Contributes

15. The project will support the Government of Yemen's efforts to achieve the fourth and fifth MDGs in reducing child mortality and improving maternal health, respectively. Specifically, to support a reduction in maternal mortality, the Project will increase access to a package of institutional delivery care: Ante-Natal Care (ANC), normal delivery, referral for complicated delivery and Post-Natal Care (PNC) services in rural and urban areas in selected governorates. Family planning (FP) is included in the package in order to contribute to a reduction in maternal mortality in Yemen.

16. Linkage to World Bank Group Goals. The World Bank Group has established two goals to anchor its overarching mission and to galvanize international and national efforts in this endeavor: (i) end extreme poverty at the global level within a generation and (ii) promote "shared prosperity" which is defined as a sustainable increase in the well-being of the poorer segments of society. This project contributes to the achievement of both goals as it aims for sustained social inclusion and achieving progress in non-monetary dimensions of welfare including health, as well as about enhancing voice and participation of all segments of society, with a particular emphasis on underserved and vulnerable groups.

17. Linkage to World Bank Group Framework for Engagement in MENA. In response to the Arab Spring, the Bank Group has articulated a Framework for Engagement in the MENA Region that proposes to do things differently and to provide support that could not be provided before. Among the Bank Group's priorities for the Region under this framework are two of particular relevance to this project: (i) better governance through enhanced transparency and accountability; and (ii) increased social and economic inclusion of disadvantaged groups through economic measures and enhanced voice and participation, particularly of women and minorities.

18. Linkage to MENA Health, Nutrition and Population Strategy. This project is congruent with the World Bank's future strategic direction in the health sector in MENA. The new World Bank Health, Nutrition, and Population (HNP) strategy for MENA (2013-2018) has the twin objectives of creating fair and accountable health systems in a sustainable manner. This project is a concrete way through which both these principles can be mainstreamed into country health systems.

19. Linkage to Yemen's Interim Strategy (ISN). The proposed project supports the first pillar of the Interim Strategy Note (FY 2013-2014), namely, achieving quick wins and protecting the poor by creating short-term jobs, restoring basic services, improving access to social safety nets, and revitalizing livelihoods, and the third pillar, namely, enhancing governance and local service delivery by supporting local governance, capacity building, service delivery, and improved citizen engagement, in that it will protect the poor from catastrophic health care costs, such as those associated with emergency obstetric care. Vouchers are specifically mentioned in the ISN paragraph 55 'New activities that would target the vulnerabilities of poor people and marginalized groups' as one of a number of approaches which are quick to reach the poor. The project is closely aligned with the priorities identified under the Mutual Accountability Framework agreed between the Government of Yemen and donors.

II. Project Development Objective(s)

A. Proposed Development Objective(s)

20. The PDO is to increase the utilization of maternal and newborn health services in the project target areas.

21. The MNVP will contribute to the reduction of maternal and newborn mortality. It will also contribute to meeting the unmet need for family planning, allowing families to plan and space births.

B. Project Beneficiaries

22. The target group of beneficiaries would be around 224,000 poor women of reproductive age (15–49 years old)[19] and their newborn children in rural and urban areas in the MNVP target districts.

23. The project will distribute three types of vouchers: (i) Maternal and Newborn Health Vouchers that will target the pregnant poor women of reproductive age and their newborn children; (ii) Family Planning Vouchers that will be distributed to poor women of reproductive age; and (iii) an obstetric fistula voucher that will be available to all women who present with symptoms of obstetric fistula.

C. PDO Level Results Indicators

24. The project's key results will be measured by the following indicators:[20]

- People with access to a basic package of health, nutrition, or reproductive health services; (core indicator)
- Direct Project Beneficiaries (number), of which female (percentage) (core indicator)
- Proportion of pregnant women receiving antenatal care during a visit to a health provider (percentage)

25. In addition, the respective intermediate outcome indicators will be included in the results framework at the PDO level:

- Providers contracted to the voucher management agency which meet at least the agreed minimum standards as specified in the quality improvement program (QIP) assessment process (number)
- Pregnant women who receive a Safe Motherhood (SMH) voucher;
- Pregnant women receiving antenatal care during a visit to a health provider (number) (core indicator)
- Births (deliveries) attended by skilled health personnel (number) (core indicator)
- Women who receive and use a voucher for pre-operative assessment and for repair of vesico-vaginal fistula (number);
- Women who receive a FP voucher (number);
- Women who receive and use a FP voucher (number);
- Deliveries by C-section taking place with vouchers in EmONC facilities participating in the MNVP, as a percentage of total deliveries assisted by a skilled birth attendant with vouchers (%).

III. Project Description

26. The proposed project, to be supported by an IDA Grant of US$10 million equivalent, plus US$10 million from the Health Results Innovation Trust Fund (HRITF), would be five years in duration. The project instrument would be an Investment Project Financing (IPF). The project would support the establishment of a community-based maternal and newborn health and family planning program using a demand-side financing intervention, and would use a voucher system to provide women and their newborns with access to safe motherhood services, neonatal care, and family planning services. The project would also provide a small cash benefit for pregnant women living in rural areas to be used for the cost of transport, and food and accommodation for one companion where a woman is hospitalized during

[19] In Yemen exceptions to the reproductive age group are acceptable given the socio-cultural context.
[20] FP is not included in the PDO indicators as it has only a small amount of project funds allocated to it

delivery of her baby or for pregnancy, delivery and post-delivery complications of the mother and the baby.

27. The supply-side, in terms of delivery of health services, would be supported by the HPP in the same target governorates and if necessary and relevant, other resources will be brought in (for example short training courses for service providers by FP experts available in the country on the provision of long acting FP methods). The HPP, with a Closing Date of September 30, 2017, will be operating in parallel with the proposed Project. The proposed project will also be aligned with the Social Fund for Development Project, as it established a considerable number of emergency obstetric care facilities that can provide a strong start to the project in other governorates not included in the HPP such as Taiz and Hadramout. These governorates will be considered to be included among the target project governorates of the HPP to ensure the delivery of an integrated package of services in the World Bank financed projects in Yemen. Further, the proposed project will be aligned with the Safe Motherhood Project, as it established a number of satellite safe motherhood clinics in Sana'a city.

A. Project Components

28. Component 1: Improving Access to Maternal and Newborn Health Services (USD 16.36 million equivalent total) using a demand-side results-based payments approach for the marketing, distribution and reimbursement of vouchers and small cash benefits for maternal and newborn health services and family planning services for target beneficiaries.

29. Component 2: Results-Based Monitoring, Voucher Management, External Technical Audit, and Project Management (USD 3.64 million equivalent total). This component would include support for: (i) capacity building activities for the SFD; (ii) External Technical Audit; (iii) communications strategies; (iv) monitoring and evaluation; (v) project management operating costs for SFD; and (vi) external financial audit.

B. Project Financing

30. The proposed project is to be financed through an IDA Grant in the amount of US$10 million equivalent. The project has received additional grant funds amounting to US$10 million from the HRTIF, thus the project total amount will be US$20 million. The IDA and HRITF funds will be fully fungible.

Project Cost And Financing

Project Components	Project cost (US$)	IDA Financing (US$)	% Financing	HRITF Financing (US$)	% Financing
1. Improving Access to Maternal and Newborn Health Services	16.40 million	8.2 million	50	8.2 million	50
2. Results-Based Monitoring, Voucher Management, External Technical Audit, and Project Management	3.60 million	1.8 million	50	1.8 million	50
Total Costs Total Project Costs	20 million	10 million		10 million	
Front-End Fees	0	0			
Total Financing Required	20 million	10 million		10 million	

C. Lessons Learned and Reflected in the Project Design

Lessons from World Bank Results-Based Financing interventions in Yemen

31. In the health sector in Yemen, the only results-based financing (RBF) intervention which has both been implemented over a number of years and monitored on a regular basis is that of the WB-financed Safe Motherhood Project (SMP), which used an approach with some similarities to a voucher scheme. The SMP used community based registration of potential clients to increase demand for services, as well as providing supply-side support to contracted providers for services and to set up satellite clinics near to target population groups to facilitate access. A number of lessons from the implementation of SMP have influenced the design of the MNVP. These include:

32. Linking results to payments is effective in improving outcomes. Reimbursement payments are paid retrospectively, and reflect the actual services delivered. Voucher schemes offer a simple model by establishing a direct link between payments and outputs. However, for the voucher scheme to run well it will need time and capacity development. The roll-out under the project will be phased to ensure that experience from the pilots on the ground can help inform the scale up of implementation later.

33. Sufficient contracted providers are needed on the supply side. This project will contract a mix of private and public providers in sufficient numbers and at appropriate levels (from the community, through BEmOC to referral hospitals) so that a complete package of services can be offered to women that are guaranteed to be free at the point of access. The IDA financed Health and Population Project will fund the upgrading of basic and comprehensive emergency obstetric care facilities to complement the funding of vouchers under this project.

34. Using reimbursement pricing to self-target poorer clients: the pricing policy can be used to keep the payments to providers at a low enough level to self-select those facilities which provide services to poorer clients (i.e. it is likely to exclude the expensive private facilities who consider the reimbursement levels to be too low for quality service provision).

Lessons from a wider review of RBF indicate the need for:

35. Intensive program preparation including training and capacity building, sensitization around demand-side financing and RBF and set-up of management and financial payment systems is important to ensure fast and efficient processing of claims and payments to providers, and to avoid fraud. The project is learning from the KfW Voucher Project which started a few months ahead of this project. Experience from the KfW project will inform the preparation of this project and will ensure the design of a sound claim processing mechanism and payments to providers.

36. Sensitization of, and advocacy with, a range of stakeholders (from high level political stakeholders and IDPs down to the community beneficiaries) to support the continued acceptance and sustainability of the approach and to leverage additional future funding, so the project has ensured adequate funding for the design and implementation of a communication strategy that will inform project beneficiaries about the services of the project and will encourage providers to participate in service delivery.

37. The continuous flow of funds to the voucher scheme; a gap in voucher distribution and service provision through the voucher scheme can damage the reputation of the scheme and necessitate intensive efforts and resources to get it up and running again. Intensive marketing efforts are needed to rebuild the lost trust in the scheme. This is why the project is adopting a pilot approach to learn early enough of the specific problems that may encounter the project and develop an appropriate strategy to address them before scaling up implementation.

38. Learning from other reproductive health and maternal health voucher programs elsewhere. Considerable experience has been built up across many countries in which successful voucher schemes for reproductive health (RH) and maternal health are operating. Attention will be paid to enabling sharing of this experience with stakeholders in Yemen and a number of activities for learning and knowledge sharing are planned in this regard.

Other lessons drawn from voucher programs around the world include

39. MIS systems and fraud control. Voucher programs necessitate strong Management Information Systems (MIS) both to analyze progress and help counteract fraud. Through the establishment of efficient claims processing systems and verification processes, voucher schemes lend themselves to transparent reporting, and measures such as trend analysis (utilization management) and unique serial numbers that link vouchers to specific distributors and providers also help to deter and detect fraud. The cost and other inputs for the design and operation of a robust MIS must be built into the design and include expertise in both information technology and in voucher program design;

40. Economy and efficiency. Setting prices and establishing efficient payment systems is important. If pricing is not in tune with the real costs incurred, then providers - particularly private sector providers - will pull out, and this has been seen in several vouchers programs. On the other hand, prices should be at the lowest acceptable level to ensure economy. Experience shows that providers do accept to contract at prices which are at, or even slightly below, the level of their costs, because participation in a voucher scheme provides good value in terms of marketing and increased client flow. Given that evidence for setting accurate reimbursement prices in voucher schemes is weak, varying the value of the voucher and the cash benefit over the program period could be an important strategy to help determine the efficiency of the program and the project will do so as evidence of how the voucher scheme is working is becoming available. Another important consideration is the ratio of management/administrative costs to service delivery costs (provider payments) which should decrease over time as efficiencies improve and more vouchers are distributed, and as illustrated in reviews of longer-running voucher schemes such as those in Kenya and Uganda. This ratio for the project is in line with what is observed elsewhere.

IV. Implementation

A. Institutional and Implementation Arrangements

Role of SFD in implementing the voucher scheme

41. Implementing Agency. The SFD will be the implementing agency for the project and will manage the health voucher program under the health unit through a Voucher Management Team (VMT). SFD will act as the proposed payer for the health services under the voucher scheme. This is consistent with the development of the SFD which is considering shifting its focus from one of investing in inputs which support building and rehabilitation of health facilities and training of health workers, to focus on output-based disbursements, thereby stimulating demand for and utilization of health services. Fiduciary management, including procurement and financial management, as well as monitoring and evaluation, will be carried out by the respective departments within the SFD.

42. Role and Key Tasks for SFD: The key role for SFD through the VMT will be the operational responsibility for the day-to-day implementation of the voucher scheme in Yemen. Key tasks will be to: (i) map and identify voucher service provider clusters; (ii) contract voucher service providers based on assessment of quality standards; (iii) develop and manage all sub-contracts (consultant services, NGOs, etc.); (iv) coordinate production and distribution of vouchers; (v) pay health facilities for services provided based on claims submitted and checked; (vi) monitoring and evaluation; and (vii) verification and fraud control.

43. The SFD, through a recipient-executed trust fund from HRITF, is receiving technical assistance focusing on building its capacity to meet the requirements of a Voucher Management Agency (VMA), including: (a) identification of roles and responsibilities; (b) hiring staff and identification of consultants; (c) development of MIS and utilization management approach; (d) development of templates and registers for operationalizing the scheme (distributor registers, provider registers, contract templates and so on); (e) developing detailed work plans and timelines and preparation of guidelines for program implementation; and (f) design and printing of the vouchers.

B. Results Monitoring and Evaluation

44. The Monitoring and Evaluation (M&E) framework comprises internal monitoring of implementation processes and activities, and external program monitoring and evaluation, as follows:

- Voucher Program Monitoring (internal M&E) comprises data collected through the program MIS, as well as data collected through fraud control and verification activities. Data are collected which enable management decisions to be made based on an assessment of whether the program is moving towards its objectives;
- External M&E includes: (i) External Technical Audit on a six-monthly basis, which will provide independent monitoring of results on behalf of both SFD and World Bank; and (ii) an Impact Assessment which will gather baseline, mid-line and end-line data to assess the impact of the vouchers on access to safe delivery and family planning services.

45. Internal Program Monitoring: the program monitoring system will provide data with which to identify the timely implementation of activities, the achievement of intended results, and positive and negative unintended effects. Regular and accurate data collection and analysis are critical for dynamic course correction. Key activities to establish the monitoring system will comprise: (i) capacity building of SFD in monitoring of voucher programs; (ii) design of a program database; (iii) development of registers and forms to gather data (voucher distributor registers, provider data collection forms); (iv) development of the claims processing system, which will feed data into the MIS; and (v) design of wider monitoring and verification activities (such as spot checks of providers, client satisfaction surveys, sampling of beneficiaries at the household level) which will provide data with which to counter-check the MIS data.

46. Sources of Data are: (i) the routine data collected through the claims processing system; (ii) data routinely collected at health facility level; (iii) additional data collected by SFD such as from distributor registers, spot checks and ad-hoc surveys; and (iv) information collected during the verification processes. GIZ will be separately contracted to undertake provider assessments for entry to the voucher scheme, as well as regular quality assurance, and data from these assessments will be made available to SFD.

47. Data Validation and Verification: Data validation and verification will be done both internally by SFD, and externally through regular External Technical Audits. Internal verification will be aligned with the system used by the RHVP and will take place at three principal levels: (i) at the district level, the Voucher Distribution Supervisor or contracted Consultant verifies a sample of 5 percent[21] of all claims made through a combination of telephone and/or home visits (the sample is generated monthly by the MIS and sent through the Branch Office to the person tasked with this activity; (ii) at Governorate level, 3-5 percent of the sample verified at the district level is then re-validated by the governorate team (done by telephone and if relevant through household visits); and (iii) at the central level, a random sample of claims are also verified quarterly through contracted consultants. Also at the central level, the VMT will

[21] Over time sample size can be reduced and move to a focus on high value, high risk services if the incidence of fraud is lower than expected (and correspondingly increased if it is higher).

conduct trend analysis of the claims being processed to identify outlying data (utilization management) which is an established anti-fraud tool used in voucher schemes. A matrix of the different levels at which verification will take place is provided in Annex 2.

48. At SFD, day-to-day monitoring activities will be carried out by the M&E and IT Officer at central level, and overseen by the Project Manager, with technical support from SFD's monitoring and evaluation department. At the branch office (governorate) level, there will be a team of three full-time people, one of whom will be responsible for data entry and processing. External technical assistance will be utilized for the set-up and smooth running of the M&E system and as far as possible, systems, processes and documents will be adapted from the KfW-financed RHVP monitoring systems.

49. Independent Verification of Results. An External Technical Audit will be contracted, using the World Bank procurement processes, by the management agency SFD to verify program outputs and processes and ensure the correct use of funds on a six monthly basis. The first audit will be six months after service provision has started. Based on the results it can then be decided whether to increase frequency of external verification to quarterly. The External Technical Auditor will audit the program processes; paying particular attention to, and verifying, reported service numbers. This audit with check health facilities and MNVP registers at the providers level, examine a sample of distributor register, as well as a sample of beneficiary households. The audit will also look at different levels of monitoring as undertaken by SFD to ensure that payments are being verified adequately against claims and services actually provided. Reports will include recommendations on how to further improve project implementation and prevent fraudulent behavior or abuse. The verification system will be reviewed at the mid-term and changes can be made to sample size and frequency of verification.

50. An Evaluation of Impact and Performance (the Impact Evaluation) will be separately contracted by the Bank, funded from a Bank-executed Trust Fund amounting to USD 1.5 million, and will look at the impact the vouchers have on service utilization, the cost of the services used, the efficiency of the voucher scheme, the supply-side response and the impact of combined demand- and supply-side interventions. It is expected that the evaluation will run using a 'before and after' design and step wedge design which will make use of different timings, activities and phasing to create natural controls (i.e. districts where the voucher scheme is yet to be introduced).

51. It is expected that the evaluation will collect baseline data, midline data from areas where the scheme is being implemented and from areas where implementation is yet to start, and end-line data. Baseline data will be supplemented through information collected by the GIZ-supported QIP assessment of health facilities to assess minimum standards of care.

52. Project Monitoring requirements include semi-annual progress reports, which will report on project activities and outputs compared with targets, a brief overview of financial status and project disbursements, a summary of challenges and constraints and recommended course of action. Annual progress reports will be more detailed and provide a budget and work-plan for the coming year and will revise indicators and targets as appropriate. A mid-term review (MTR) will look at both performance according to intermediate outcome indicators and internal processes. A round of data collection will be conducted at the mid-term as part of the separately contracted Impact Evaluation at the end of the third year of the project and will review overall performance in terms of achieving expected outputs and outcomes.

C. Sustainability

53. Financial sustainability. Although institutional delivery has been free of charge for Yemeni women since 1998, lack of awareness among the population and lack of financing mean that out-of-

pocket payments are still the norm, putting facility-based delivery out of reach for many women, particularly those in rural areas. Vouchers provide a means to overcome the financial access barrier to specific services by making those services free at the point of access for beneficiaries and can lead to a sustained health seeking behavior change in relation to institutional deliveries. As with all demand-side financing tools, the payments (in this case reimbursements to providers) need to be financed. Although experience from a small number of countries has shown that governments do make growing financial commitments to reproductive health voucher programs over time (i.e. Uganda, Kenya), the current economic situation in Yemen[22] means that external funding for voucher reimbursement payments will continue to be required in the medium term. This is also the case with the KfW-financed RHVP. Over time, the MNVP will strengthen its targeting of poorer women, utilizing existing poverty identification approaches (such as those developed by the Social Welfare Fund (SWF)) and aligned with Government systems for targeting the poor and other benefits from social assistance programs. This will contribute to the sustainability of the approach.

54. Institutional sustainability. The introduction of a voucher program introduces a degree of institutional sustainability through the set-up and operation of the VMA. The key tasks of the VMA are to identify and contract appropriately qualified health providers, and to manage the reimbursement payments to providers, based on verified utilization data. Thus voucher programs introduce and build skills and knowledge in principle for future Social Health Insurance (SHI) in terms of targeting, contracting, purchasing, quality assurance/control and claims processing. Through the set-up of a Voucher Management Team (VMT) within the SFD to act as VMA, and the development of a detailed capacity building plan for this VMT, the World Bank-financed MNVP will build institutional knowledge and skills that will enable the SFD to take on the role as 'payer' for the voucher scheme. Once the VMT is established and functioning well, the SFD should be able to manage additional funds in the future both to act as a strategic purchaser for maternal and newborn health services, and to gradually expand the basket of services available. This will lay the ground for medium-term and sustainable longer-term benefits. In addition, increased demand will lead to improved provider behaviors; i.e. improved quality of maternal services and increased capacity to attend to a larger number of pregnant women. It will also incentivize new providers to organize themselves and operate in new areas to meet the demand induced. An exit strategy will be built into the design as the end of the financing period approaches, developed with the Government and key partners.

55. Operational sustainability. The proposed alignment and complementarity between the WB-financed and the KfW-financed voucher schemes, together with wide consultation with key donors during the preparation of the WB voucher scheme (UNFPA, WHO, UNICEF) will enhance the acceptability and sustainability of vouchers as an important approach to increasing access to FP and MNH services for poor women living in rural and urban areas in Yemen. The proposed use of joint mechanisms for the KfW and World Bank schemes, such as for quality assurance, program governance and verification, and the shared learning between the teams should result in greater management efficiency. The size and geographical spread across a number of governorates for the combined voucher schemes means that the project can expect to have a significant and demonstrable impact on institutional delivery rates in Yemen which will lead to greater sustainability of the approach, and this will be measured through the impact evaluation.

[22] World Bank: http://www.worldbank.org/en/country/yemen/overview accessed on 020913

V. Key Risks and Mitigation Measures

A. Risk Ratings Summary Table

Risk	Rating
Stakeholder Risk	Moderate
Implementing Agency Risk	
- Capacity	Substantial
- Governance	Substantial
Project Risk	
- Design	Substantial
- Social and Environmental	Low
- Program and Donor	Moderate
- Delivery Monitoring and Sustainability	Substantial
Overall Implementation Risk	**Substantial**

B. Overall Risk Rating Explanation

56. A substantial risk rating was selected for implementation. This has been given because the voucher scheme mechanism is new in Yemen. A number of risk mitigation measures have been built into the design of the MNVP, including: (i) delivery and monitoring procedures are being adopted (as far as possible) from KfW, who started implementation of its RHVP in April 2013, and who is providing invaluable lessons learned, including on fraud prevention and mitigation, appropriate pricing of services, as well as tools and templates; (ii) the project design emphasizes fraud control as described above with fraud control at all levels of implementation.

57. Furthermore, although improvements have been seen since the 2011 popular uprising in Yemen, security still poses a challenge to program implementation; particularly the provision of international technical assistance. Foreign nationals are unable to leave the capital Sana'a and their movements within the city are severely curtailed. It is essential to build up the capacity of the proposed Yemeni implementing agencies, and in particular those that could be responsible for purchasing services for the voucher program, Social Fund for Development (SFD).

VI. Appraisal Summary

A. Economic and Financial Analysis

58. Appropriateness of Public Sector Provision or Financing. The target beneficiaries of this project would be women of reproductive age (15–49 years old) and their newborn children in rural and urban areas in selected governorates, with focus on the poorer segments. The geographic distribution of health services is biased towards the economically advantaged areas. In addition, the maternal mortality in Yemen is concentrated among poor women living in rural areas. Around 20 per cent of Yemeni households face catastrophic expenses due to MCH healthcare. As a result, this target group tends to have worse health outcomes than the higher income population.

59. Women in rural areas and urban slums suffer the most from poor quality of services related to MNCH. Facing financial and cultural barriers that prevent their access to service providers, they are unable to access high quality affordable healthcare and as a result skimp on care or skip care altogether.

The needs of this population can best be met through public sector financing due to existing market failures and to those financial and social barriers that prevent them from accessing these services. The project, through IDA financing, will provide public funding through the SFD to act as a Voucher Management Agency that will purchase maternal and newborn health services for poor beneficiaries. Public sector funding is concerned with reducing inequities for the most vulnerable as part of addressing market failures which could decrease access of the poor to these services.

60. Economic Analysis Summary. The MNVP is expected to yield significant economic and financial returns to Yemen by improving utilization of maternal and newborn health services in the impoverished areas. This would involve responding to a broad range of issues, including: (i) ensuring access to quality maternal health services for the target population; (ii) reducing both maternal morbidity and mortality; (iii) positively impacting on infant mortality and morbidity; and (iv) reductions in the levels of fraud. The outcome of these impacts would be enhanced efficiency and improved ability to control costs and health spending. As is common in similar project investments, the returns are gauged by means of a cost-benefit analysis based on a number of plausible assumptions with respect to the costs and associated benefits from the implementation of the project.

61. Through the employment of a societal perspective cost-benefit analysis, it is suggested that the MNVP investments would be able to generate an economic return of around 80 percent, largely attributable to the identified direct mortality and morbidity benefits. The benefit-cost ratio of the project stands at 5.78. This estimate is sensitive to the set of necessary assumptions about the services uptake rate, and the realization of the benefits depends on the effective implementation of the project.

62. Given the project nature, it is unlikely that it will create any negative fiscal or financial burden on the Government over the implementation period. The Government, through its 2012-2022 health strategy, is clearly committed to the MCH improvements and this has been clear through the strides achieved over the last 10 years.

63. World Bank's Value added. The World Bank has several comparative advantages, which result in creating value added—being able to leverage World Bank engagement in other sectors in Yemen to strengthen this project; being able to build on a long history of engagement in the health sector in Yemen; and being able to share global expertise on MCH and FP voucher schemes to the Yemeni government.

64. Yemen has also developed a country acceleration plan to achieve its MDGs 4 and 5 by 2015, which lack the necessary financial resources to be implemented. This project will make available US$20 million which will be an immediate response to cover the gap in financing this plan.

65. Further, through the HRITF, the World Bank is able to bring in an additional grant amounting to US$10 million, making the total amount of the project US$20 million. The World Bank, through a Bank-executed Trust Fund amounting to US$1.5 million, will make available funds for impact evaluation for the country voucher program including those grant financing provided by KfW. The World Bank also will depend on its technical expertise present among the HRITF team to provide technical assistance to this project.

B. Technical

66. The Bank team assessed the proposed project design and found it satisfactory and suitable for implementation in Yemen building on the experience gained from the ongoing Yemen Safe Motherhood Project (SMP) that piloted demand side financing approaches to deliver maternal health services.

67. The project is proposing to use vouchers[23] to enable women to choose either to deliver with a midwife at home or in a health facility, be it the midwife's home-based clinic or the health unit or center. As traditionally, women tend to deliver at home with the assistance of traditional birth attendants, vouchers will be expected to overcome the cultural and socioeconomic factors that hinder poor pregnant women living in rural areas from accessing maternal health services; thus improving their access to these services as well as improving their utilization behavior. The scheme is expected to incentivize pregnant women to receive quality maternal and newborn health services and to be assisted medically during delivery. Under the proposed project, facility-based deliveries would be promoted over home deliveries through setting price differentials. Timely referral would be facilitated for complicated care and caesarean sections, when necessary with an additional cash payment to be made to poor women in rural areas to contribute towards the cost of transport to/from the facility and food when delivering their baby in a health facility or for pregnancy complications. Family planning (FP) services was added to the package to assist couples in planning their families, spacing births and to improve the health of mother and child. Poor women have many access barriers to FP services, among them financial and informational barriers, which are reduced by the use of vouchers. Voucher services would be free at the point of delivery.

68. Voucher distribution strategies will be developed by SFD and rolled out at the governorate level with their relevant Branch Offices. The project may use one of several approaches, including organization of voucher distribution by the VMT using volunteers or consultants contracted directly by SFD or sub-contracting of community-based organizations to distribute the vouchers. Whichever method adopted, voucher distributors would be recruited and trained to distribute the vouchers in all areas of the MNVP target districts and inform women and their families about the voucher services.

69. Package of Services. The project would support a defined package of mother-baby essential quality services, based on the 'Mother-Baby Package' and Family Planning services defined by the World Health Organization (WHO). The safe-motherhood voucher would include four antenatal care visits, normal delivery, caesarean sections where needed, one postnatal care visit for mother and newborn up to two weeks post-delivery, a second postnatal care visit to include family planning, as well as management of pregnancy-related complications of the mother or the newborn during all pregnancy phases: antenatal, during delivery and postnatal. A separate voucher would be available for family planning counseling and provision of short term methods and long-acting and permanent family planning methods. The MNVP will also enable women to receive treatment for obstetric vesico-vaginal fistula by providing a first referral examination and payment for transport to the first referral facility (participating in CEmONC) and, where necessary, to the designated hospital in each Governorate where she will receive a pre-operative assessment by a trained physician. When necessary, the woman will be transferred for treatment at a specialist fistula center.

70. Voucher Service Providers. Voucher service providers will be a combination of contracted for-profit, non-profit, and public providers, designed to ensure effective referral (CEmONC clusters) and sufficient providers to ensure access and choice for potential beneficiaries. Services that require hospitalization are expected to be provided mainly by public service providers. In rural areas where a functional health facility is available with 24/7 services, this center would be the preferred point of entry for pregnant woman. In remote rural areas, the entry point to the voucher scheme is likely to be the private or community midwife, with or without a delivery room (but preferably with a delivery room). For family planning services the nearest health facility would be the entry point. Health units (approved midwives and health units) will play an important role in provision of ANC, PNC as well as FP services. These providers would also be the principal conduit for distributing the cash contribution for transport for the woman and her companion, as well as food and accommodation for the woman's companion, where

[23] a type of coupon which acts as an 'invitation' to obtain a specific set of services, often within a limited timeframe (i.e., pregnancy and up to four weeks post-delivery

the woman is hospitalized and her companion cannot be accommodated at the health facility. Approved providers would be reimbursed at a pre-agreed price for services provided according to the agreed package of voucher services. Reimbursements will be categorized according to provider type (private non-profit, private for profit, public), and may be categorized according to the level of health system (health center, hospital, etc.) and possibly location (urban, rural).

71. Quality Assessment and Approval of Providers: There are two principal activities where quality is routinely assessed in voucher schemes: the initial provider selection and approval (or accreditation) process; and on-going quality assurance. Arrangements will be the same as developed for the KfW-financed RHVP. All potential voucher service providers will be assessed using quality assessment tools developed through Quality Improvement Program (QIP) of the MOPHP and adapted for use by the RHVP, with financing from the German Government's Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ). The QIP tools assess a range of aspects of the quality of the VSP including management capacity, infrastructural and transport facilities, availability of staff, supplies, medicines and equipment as well as skills of available staff. Those providers meeting minimum standards of care will be invited to participate in the voucher program, and may also be invited to join the QIP which would support them to plan and improve quality of care. These minimum standards will allow for a sufficient number of providers to enter the scheme, while also protecting beneficiaries from poor quality service provision. Provider contracts will include a clause that the project expects them to invest at least 60 percent of voucher revenues to improve their capacity and quality to provide health services, be it voucher services or non-voucher services. Every facility in the project will be visited at least once per year to re-assess the quality of the services. GIZ will be separately contracted through the Bank's HPP and the initial provider assessments will be integrated with health service provider assessments for that project.

Project Stakeholder Assessment

72. The MOPHP - Population Sector is currently going through a change of leadership. A new Acting Deputy Minister for the Population has been appointed and the Director of the Reproductive Health Department is being replaced because the previous director resigned. The MOPHP- Primary Healthcare Department is implementing an outreach program that integrates the delivery of maternal health services. The MOPHP together with the health offices at the governorates level will be the counterpart for the SDF for this project.

73. A number of development partners, including, inter alia, UNFPA, WHO, UNICEF, the Dutch Development Cooperation, Marie Stopes International, KfW, and GIZ, have particular interest in reproductive health. A Reproductive Health Thematic Group has been established to support the MOPHP-Population Sector. These donors also finance a number of projects supporting reproductive health. One particular project of importance and relevance is the KfW-Funded RHVP (Euro 7.0 million) implemented in Yemen by Yamaan Foundation, a national NGO.

74. There is an ongoing Reproductive Health Voucher Project (RHVP) financed by KfW (2012 – 2015) which will operate in parallel to the MNVP with financing of EUR 7 million. Lessons from the KfW RHVP have informed the design of the MNVP. The use of similar design and implementation arrangements for the KfW and World Bank schemes, such as project steering, service package, voucher distribution strategies, provider selection, pricing of services and quality assurance should result in greater management efficiency and will facilitate possible future sharing of Governorates between the two programs. Aligning the two schemes will also enable shared learning between the voucher management agency teams, and enhance the acceptability and sustainability of vouchers as an important approach to increasing access to maternal and neonatal health and family planning services for poor women living in rural and urban areas in Yemen.

C. Financial Management

75. The assessment was conducted by Bank staff in accordance with the policies and guidelines for assessment of financial management (FM) arrangements in World Bank-Financed projects. It takes into account the capacity and experience of the implementing agency and the nature of the project related risks. The project's financial management arrangements, including the mitigating measures at the SFD are acceptable to the World Bank; the residual FM risk is Substantial. The project would make use of the country systems, as it will be implemented by the SFD with close coordination with MOPHP. The current systems of the SFD will be enhanced by the mitigating measures described below. The Bank team is comfortable that these measures are adequate to assure that project funds are used for the intended purposes.

76. The SFD will establish an acceptable Operations Manual specific for the MNVP describing the implementation and control procedures, including flow of funds for this project. The manual will include program objectives, program partners, contractual arrangements, program design (beneficiaries, voucher benefits package, other benefits, selection and contracting of providers, quality control, cost of service reimbursements, voucher distribution, and claims processing and data management, etc.), monitoring and evaluation and fraud control including the use of independent verification auditors and reporting requirements. Prior to payments to the service providers, the SFD will validate the services completed as per the submitted claims through a number of control procedures including field visits and comparison of claims submitted against contracts with the service providers.

77. Retroactive Financing will be granted for an aggregate amount not to exceed US$200,000 equivalent for eligible expenditures under Category (2) to cover consultancy services and operating costs incurred as of the Board approval date.

78. Disbursement Arrangements: Similar to the other operations implemented by the SFD, this project will follow the Report-based method for Reimbursement and Reporting eligible expenditures paid from the Designated Account and funds will be channeled through a pooled Designated Account maintained by the SFD at the Cooperative & Agricultural Credit Bank of Yemen.

D. Procurement

79. A procurement capacity assessment of SFD has been carried by the Bank procurement team. SFD has successfully managed implementation of procurement activities up to now through a robust MIS for procurement linked to financial management. Despite the large number of contracts that SFD handles, the MIS is flexible to accommodate changes as and when needed. The existing procurement capacity confirms its adequacy to meet the needs of the Project. Most of the procurement activities are in the form of consulting services and national competitive bidding. Annex 3 provides the details and results of the project procurement management assessment.

E. Social (Including Safeguards)

80. Social Impact. From the social perspective, this impact is likely to be highly positive. A focus on women and their newborn will improve the human development indicators of Yemen and contribute to a reduction in morbidity and mortality. Good maternal health and nutrition are important contributors to child survival; the lack of essential interventions to address these and other health conditions often contribute to neonatal morbidity and mortality (including stillbirths, neonatal deaths and other adverse clinical outcomes).[24] Family planning and medically assisted delivery are both essential interventions to

[24] The Partnership for Maternal Newborn and Child Health: *A global review of the key interventions related to reproductive, maternal, newborn and child health (RMNCH)*. Geneva, Switzerland: PMNCH; 2011.

improve maternal, newborn and child health. Universal access to reproductive health services, including family planning, is identified as one of MDGs and is essential to enable women to have greater control over their fertility. Moreover, other international agreements, including the Program of Action of the 1994 International Conference on Population and Development, promote individuals' freedom to decide the number and timing of their children as a basic human right and reproductive right.

81. The inclusion of a voucher to enable women to be assessed and treated for obstetric fistula will have an important social impact given the heavy stigma attached to the symptoms of fistula for women.

82. In addition, the provision of non-medical incentives to women utilizing voucher services, such as cost of transportation for women from their homes to the health facility and for onward transferal to higher facilities, as well as a contribution toward the cost of food and accommodation for one companion, will lessen the socio-cultural barriers that prevent women from accessing health services.

83. Poverty Targeting. The MNVP will select poorer women through two principal mechanisms: (a) the voucher distribution strategy; and (b) the health service pricing policy. Voucher distribution will be targeted geographically with different strategies appropriate for rural and peri-urban/urban areas. Voucher distribution in rural areas will be based on the assumption that all women and their families in rural Yemen are poor and consequently all women of reproductive age in rural areas of MNVP target districts will be offered vouchers. Voucher distribution in urban areas will use community-based targeting mechanisms to target the poor. SFD may sub-contract voucher distribution to local organizations, and in this case, the targeting mechanisms will be proposed during the tender process by sub-contracted local organizations (i.e., NGOs) who are closer to the communities they represent. Over time, MNVP will place greater emphasis on targeting the poor. Consequently, as part of the mid-term review, the MNVP will consider how to bring their poverty targeting strategies in line with those used by the Government of Yemen. The health service pricing policy will set differential reimbursement prices for different provider types (public versus private) and for providers at different levels (BEmONC & CEmONC versus basic maternity provider). These prices will be set at levels which are designed to exclude expensive health care providers which traditionally serve better off women and their families.

84. Gender Impact. The MNVP specifically targets poor women of reproductive age (15 – 49 years old) and their newborns, and women are clearly the main beneficiaries of the project. However, the voucher distribution strategy will work with both male and female distributors in order to have a wider reach in targeted communities, and will also work with religious and community leaders. Voucher distributors will also engage family members (including men where appropriate) in discussions regarding family planning and reproductive health, as well as the importance of medically assisted deliveries. By overcoming the financial barrier, vouchers can help to address gender imbalances at the household level by removing the costs associated with a women's access to care. Over time, as pregnancy- and delivery-related mortality and morbidity reduce in the project target areas, awareness in the community of the importance of skilled attendance at birth will increase, including among men.

85. Citizen Engagement Strategy: The vouchers will be distributed mostly through door-to-door visits using community distributors and, in addition to the registration of women who receive vouchers. The distributors will be trained to talk to women and their families about the importance of maternal, newborn and reproductive health. Using its extensive experience, SFD will develop a marketing strategy for the MNVP to ensure that targeted communities know about the program and women understand where and how to receive a voucher. The MNVP will also have a specific launch event in each of the selected Governorates. Consultations with beneficiaries, NGOs and CSOs will be carried out during project preparation and implementation through various approaches, such as individual interviews and focused group discussions. Examples of citizen engagement tools will include public display of information (billboards, information boards); information campaigns, community report cards on services received as

well as community monitoring of services delivered. In addition, the project will include a robust grievance redressal mechanism designed in a manner that is culturally appropriate to ensure the greatest reach and feedback of beneficiaries of services provided.

F. Environment and Social (Including Safeguards)

86. The project is classified as an environmental Category C (not requiring assessment) according to the World Bank's Operational Policy on Environmental Assessment (OP/BP 4.01) because its impact on the environment is expected to be minor and indirect, given that it will not finance inputs for service providers in the form of goods or works, but rather will pay for services already provided using vouchers. However, increased demand for services is likely to indirectly lead to increased soil and groundwater contamination from increased amounts of hazardous healthcare waste (HCW).

87. The project will only engage with healthcare providers who practice sound HCW management - a criterion which will be included in the project's minimum criteria for providers. All providers will be in compliance with the mitigation measures included in the SFD IV HCW Management Plan.[25] The providers will also be required to have valid quality certification from the GIZ-managed QIP, demonstrating their capacity for HCW management.

[25] Social Fund for Development Environmental Management Plan, updated on 27th January, 2009, Document No. E2364 V2, disclosed at the World Bank InfoShop on January 27, 2010

Annex 1: Results Framework and Monitoring

REPUBLIC OF YEMEN

Maternal and Newborn Voucher Project

PDO Level Results Indicators	Core	UOM	Baseline Original Project Start (2014)	Cumulative Target Values					Frequency	Data Source/ Methodology	Responsibility for Data Collection	Comments
				2015	2016	2017	2018	2019				
1. People with access to a basic package of health, nutrition, or reproductive health services	☒	Number	0	8.000	40,000	98,000	214,000	315,000	Semi-annual	MIS (SFD)	SFD	Number of people receiving a SMH or FP voucher
2. Direct Project beneficiaries	☒	Number	0	5,750	28,400	69,650	152,150	224,000	Semi-annual	MIS	SFD	Number of women who use SMH or FP voucher
Of which female (beneficiaries)	☒	%	0	100%	100%	100%	100%	100%	Semi-annual	MIS	SFD	Denominator is the total number of people using SMH and FP vouchers and numerator are the number of these clients who are female
3. Proportion of pregnant women receiving antenatal care during a visit to a health provider (percentage)	☐	%	0	40%	50%	60%	65%	70%	Semi-annual	MIS	SFD	The number of women using the voucher for at least one ANC divided by the total number of women receiving a SMH voucher.
Project Intermediate Level Results Indicators												
1. Providers contracted to the voucher management agency which meet at least the agreed minimum standards	☐	Number	0	60	130	245	470	610	Quarterly	MIS, QIP monitoring system	SFD	Total number of providers contracted by the VMA who meet at least the minimum standards of care as specified in the QIP assessment process.
2. Pregnant women who receive a SMH voucher	☐	Number	0	5,000	24,000	59,000	129,000	190,000	Semi-annual	MIS	SFD	Number of claims paid for ANC 1 by a contracted service provider
3. Pregnant women receiving antenatal care during a visit to a health provider (number) (core indicator)	☒	Number	0	2,000	11,500	32,500	78,000	120,700	Semi-annual	MIS	SFD	Number of people receiving SMH voucher (can be through male family member)
4. Births (deliveries)	☒	Number	0	2,500	12,000	29,500	64,500	95,000	Semi-	MIS	SFD	Number of claims paid for a

attended by skilled health personnel (Core indicator)									annual			medically assisted delivery at a contracted service provider
5. Women who receive and use a voucher for pre-operative assessment of vesico-vaginal repair	☐	Number	0	1	5	15	30	50	Semi-annual	MIS	SFD	The number of claims paid for pre-operative assessment and treatment of vesico-vaginal fistula repair by a contracted provider
6. Women who receive a FP voucher	☐	Number	0	3,000	16,000	39,000	85,000	125,000	Semi-annual	MIS	SFD	Number of people receiving FP voucher (can be through male family member)
7. Women who receive and use a FP voucher	☐	Number	0	1,400	7,600	18,500	40,400	59,400	Semi-annual	MIS	SFD	Number of claims paid for a FP method by a contracted provider
8. Proportion of deliveries by C-section taking place with vouchers in EmOC facilities participating in the MNVP, as a percentage of total deliveries assisted by a skilled birth attendant with vouchers	☐	%	0	10%	10%	10%	10%	10%	Semi-annual	Provider registers	SFD & External technical audit	Denominator is the total number of claims paid for assisted deliveries and numerator is the number of claims paid for C-sections, at contracted service providers

Explanatory Notes for the Results Framework (Modeling service numbers)

A costing and targets model was built specifically to estimate the potential service and distribution targets and the costs of reaching these targets, based on the model developed for the RHVP. However, since little data is available at this point in time (from the RHVP Tuban pilot), the model has used a series of temporary assumptions which, after one year, will be replaced by data on the actual uptake of services and the results framework will be updated. This may also change the average costs for the services.

The model (developed in Excel in linked worksheets) follows the following steps:

a) Decide what time period is being modeled e.g. two months;
b) Define a target population, in this case 100,000 inhabitants and define number of Married Women in Reproductive Age (MWRA) and expected deliveries;
c) Use this population data to calculate the number of women who will be pregnant and can be reached with a voucher in a period of two months (in a voucher project which is fully functional) and to estimate potential SMH voucher clients and potential FP voucher clients (those who are not pregnant). For example:

Table 1: Assumptions used in the model

Population	Number	% of pop
Population	100,000	
WRA	19,000	19%
MWRA	13,000	13%
Expected pregnancies	4,100	4.1%
Expected annual deliveries	3,900	3.9%
Non-pregnant MWRA	9,100	9.1%

d) Input costs per service;
e) Input assumptions on voucher and service uptake;
f) For each service at each price, use the assumptions to calculate how many services you might see in the time period and what the cost will be for the project;
g) Using assumptions on voucher uptake calculate how many vouchers would need to be distributed to achieve the target service numbers.

The model uses low, medium and high estimates for assumptions on voucher and service uptake, i.e., percentage of women accepting a SMH or a FP voucher and then on the percentages of those who received a voucher and actually used this for one or more services.

Assumptions

In order to estimate the number of SMH clients and FP clients the project can aim for within the given budget, it has been necessary to make a number of assumptions:

a) What proportion of a target population will accept vouchers
b) What proportion of those clients will redeem vouchers for the services provided
   - The project estimates that most clients who receive the SMH voucher will use it for ANC. However, not all will use it for delivery. Similarly not all of those receiving a FP voucher will use it.
   - Not all clients will redeem vouchers for services and those who redeem will not take all services on offer.
c) What proportion of deliveries will result in caesarean sections and complications

Assumptions made have been based on long experience of designing and implementing voucher projects in a range of developing countries. It is known from experience that initial uptake is low, but increases

significantly once clients see the voucher project working and trust that they will receive the package being offered to them. However, the Tuban pilot has shown that initial uptake can be very quick, specifically for SMH vouchers.

For the fistula voucher (which will be placed at the Voucher Service Providers (VSPs)) it is assumed that 100 women will make use of them over the life period of the project.

As the project is rolled out, patterns of uptake will be recorded and used to update projections for voucher delivery and to make changes to project implementation where needed.

Additional details can be found in the operational manual.

Annex 2: Detailed Project Description

REPUBLIC OF YEMEN

Maternal and Newborn Voucher Project

1. The PDO is to increase the utilization of maternal and newborn health services in the project target areas.

2. The MNVP will contribute to the reduction of maternal and child mortality and will contribute to meeting the unmet need for family planning, allowing families to plan and space births, thereby supporting the Government of the Republic of Yemen to work towards the achievement of MDGs 4 and 5. The MNVP will also contribute to a reduction in population growth and alleviate pressure on Yemen's scarce natural resources.

3. Component 1: Improving Access to Maternal and Newborn Health Services (US$16.36 million) using a demand-side results-based payments approach for the marketing, distribution and reimbursement of vouchers and small cash benefits for maternal and newborn health services and family planning services for target beneficiaries.

4. Component 2: Results-Based Monitoring, Voucher Management, External Technical Audit, and Project Management (US$3.64 million equivalent total). This component would include support for: (i) capacity building activities for the SFD; (ii) External Technical Audit; (iii) communications strategies; (iv) monitoring and evaluation; (v) project management operating costs for SFD; and (vi) external financial audit.

5. The proposed project, to be supported by an IDA Grant of US$10 million equivalent, plus US$10 million from the HRITF, would be five years in duration. The project would support the establishment of a community-based maternal and newborn health and family planning program using demand-side financing intervention, and would use a voucher system to provide women and their newborns with access to safe motherhood services, newborn care, and family planning services. It would also provide a small cash benefit for pregnant women living in rural areas to be used for the cost of transport, and food and accommodation for one companion where a woman is hospitalized during delivery of her baby or for pregnancy, delivery and post-delivery complications of the mother and the baby.

How do Vouchers Work?

6. A voucher is a type of coupon which acts as an 'invitation' to obtain a specific set of services, often within a limited timeframe (i.e., pregnancy and up to four weeks post-delivery). The vouchers enable women to choose either to deliver with a midwife at home or in a health facility, be it the midwife's home-based clinic or the health unit or center. Vouchers were selected to overcome the cultural and socioeconomic factors that hinder poor pregnant women living in rural areas from accessing maternal health services; thus improving their access to these services as well as improving their utilization behavior. Reviews of many voucher programs shows that vouchers can address a range of barriers to access, as illustrated in the table below. Traditionally, these women tend to deliver at home with the assistance of traditional birth attendants.

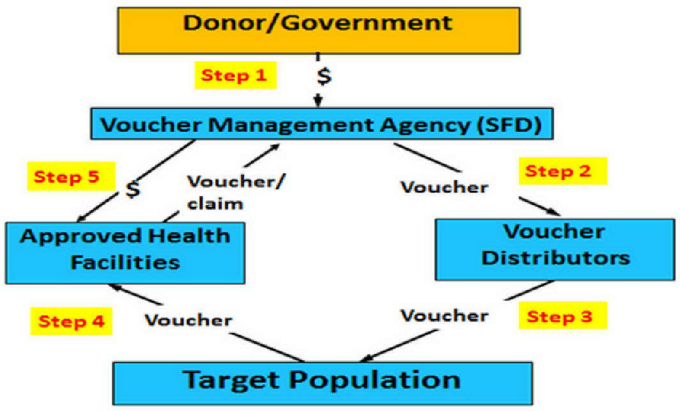
Table 2: Barriers addressed by voucher programs[26]

Barrier	Performance Based Contracting N=7	Performance Based Financing N=8	Voucher N=18	Results Based Budgeting N=4	Total N=37
Supply-side barriers addressed:					
Availability	7	8	18	4	37
Affordability	3	2	18	4	27
Acceptability	7	8	18	4	37
Demand-side barriers addressed:					
Availability	5	7	18	1	31
Affordability	1	1	9	1	12
Acceptability	5	7	18	1	31

7. The voucher scheme is expected to incentivize women to receive quality maternal health services and to be assisted medically during delivery. Under the proposed project, facility-based deliveries would be promoted over home deliveries. Timely referral would be facilitated for complicated care and caesarean sections, when necessary. In rural areas, an additional cash payment would be made to poor women to contribute towards the cost of transport to/from the facility and food when delivering their baby in a health facility or for pregnancy complications (costs will be closely monitored to ensure they are not disproportionate to overall costs of services). Family Planning services assist couples in planning their families, spacing births and improves the health of mother and child. Poor women have many access barriers to FP services, among them financial and informational barriers, which are reduced by the use of vouchers. Services would be free at the point of delivery.

8. The following diagram illustrates how vouchers move through the system:

Figure 1: Flow of vouchers through the system



[26] Taken from Gorter AC, Ir P and Meessen B, *Evidence Review, Results-Based Financing of Maternal and Newborn Health Care in Low- and Lower-middle-Income Countries*, February 2013, study commissioned and funded by the German Federal Ministry for Economic Cooperation and Development (BMZ) through the sector project PROFILE at GIZ – Deutsche Gesellschaft für Internationale Zusammenarbeit.

Voucher Service Packages

9. There will be two separate voucher booklets (each with multiple coupons for different individual services which make up the voucher service package). One will be a Safe Motherhood Voucher Service Package and the other will be a Family Planning Voucher Service Package. The service packages and other benefits (transport, accommodation) are the same as those of the KfW-financed RHVP, with two small exceptions: (i) the World Bank would pay for one period of short-term family planning methods. This service is not provided by the RHVP in order to prevent double funding by KfW of contraceptive methods; and (ii) the World Bank will provide access to the existing UNFPA-supported vesico-vaginal fistula repair program by reimbursing first referral, pre-operative assessments and repair when necessary at a qualified CEmONC provider.

10. The Safe Motherhood package (US$13.7 million) will be based on the WHO's defined mother-baby package and may be modified to align with the Yemeni national health guidelines and local needs as appropriate. Services will include the following:

    a. Antenatal care – at least four antenatal visits providing basic care and ANC 5+ in complicated cases. Consultations will consist of checkups (history, BP examination, fundal level, measurement of weight and physical exam), iron/folate supplementation, tetanus toxoid immunization TT2, health and nutrition education, management of conditions and referral if needed;
    b. Normal delivery care - clean and safe delivery, basic newborn care, post-partum services and care;
    c. Caesarian section, where indicated;
    d. Essential obstetric care - management of complications resulting from pregnancy, delivery or post-delivery for mother and newborn, such as eclampsia, sepsis, hemorrhage, abortion complications, premature delivery, fetal distress, and emergency conditions as deemed necessary;
    e. Post-natal care, including post-delivery family planning counseling and methods, information and education on a wide range of contraceptive options;

9. Eligible beneficiaries will be able to receive obstetric care for either normal delivery or emergency obstetric care. The delivery care must be provided by an approved provider (i.e., which has first been assessed against minimum standards of care) and could be provided at home of the eligible beneficiary assisted by an approved and contracted midwife, at a basic voucher service provider (fixed unit), or at the hospital.

10. Family Planning Service Package: (US$0.19 million) The family planning voucher package will comprise the following services:
    a. Family planning counseling on all methods;
    b. Pregnancy test if indicated;
    c. Provision of short-term methods (pills, condoms and injections) for a limited period of time (reimbursable only for non-public voucher service providers);
    d. Provision of Intrauterine Contraceptive Device (IUCD), implants and Bilateral Tubal Ligation. The latter will be offered when specifically asked for or on medical indication, but not routinely, as this is not culturally sensitive;
    e. Removal of IUCD and implants;
    f. Management of reproductive tract infections and sexually transmitted infections for those who want an IUCD (will be offered once providers have been assessed and/or trained in these areas).

11. Obstetric Fistula: (US$0.1 million) In addition, the MNVP will enable women to access pre-operative assessment and treatment for obstetric fistula repair. Women identified in the

community as potentially needing fistula treatment will be referred to the nearest CEmONC for a first assessment and then referred to the designated hospital in each Governorate where she will receive a pre-operative assessment and treatment if needed. The facilities will be reimbursed the cost of these assessments and repair, and the women may be eligible to receive reimbursement for the cost of transport to the facility at each level and food and accommodation for a companion during hospitalization (see 11 below). The project also links with the private midwives association of Yemen so that the woman can be accompanied to and from the fistula center by a midwife.

12. Non-medical benefits: The costs allocated to non-medical benefits (transport, food and accommodation) are included in the SMH package. Each voucher client will be entitled to additional non-medical benefits to facilitate the woman's arrival and stay at the participating facility in the case of a delivery or complications. These additional benefits are aimed at lessening the socio-cultural constraints to accessing health services, particularly in rural areas of Yemen which are dispersed and hard-to-reach which contributes to the high rate of home births in the country. They include:
    a. Payment of transport for the client and a companion from their community to an approved service provider for normal delivery or emergency management of a complication and back to their home. This will be based on actual costs and is likely to be set according to distance bands around the facility (i.e. those living close by will not be eligible, while a higher amount will be paid to those living furthest away);
    b. Payment of food and accommodation costs for one companion, whose costs are not covered by the hospital, to accompany them for any condition requiring hospitalization e.g. caesarean section or management of a complication (a fixed amount per night).

    The costs for transport and accommodation will be closely monitored. The project will use data to explore whether transport cost reimbursement is necessary for all women or a sub-group of women, as well as more effective reimbursement modalities (lump-sum, reimbursement of actual cost) is the most appropriate. This is explained in more detail in the project operations manual.

Voucher Service Providers

13. Voucher service providers will be a combination of contracted for-profit, non-profit, and public providers, designed to ensure effective referral (CEmONC clusters) and sufficient providers to ensure access and choice for potential beneficiaries. Services that require hospitalization are expected to be provided mainly by public service providers. In rural areas where a functional health facility is available with 24/7 services, this center would be the preferred point of entry for pregnant woman. In remote rural areas, the entry point to the voucher scheme is likely to be the private or community midwife, with or without a delivery room (but preferably with a delivery room). For family planning services the nearest health facility would be the entry point.

14. Services will be provided at three main levels, as follows:
    a. Comprehensive Emergency Obstetric and neonatal care (CEmONC): These facilities must be able to provide a full range of emergency obstetric and neonatal services. It is expected that these will be mostly larger public hospitals;
    b. Basic Emergency Obstetric and neonatal care (BEmOC): These facilities must be able to provide comprehensive ANC, PNC, normal deliveries and basic emergency obstetric and neonatal services. These are likely small district hospitals, public health centers and private clinics and small private hospitals;
    c. Regular Voucher Service Providers: These facilities must be able to provide basic or comprehensive ANC, PNC, family planning services and preferably normal delivery 24

hours a day at home and/or at the facility. They will be mostly public health units and private and community midwives.

15. Facilities and midwives providing institutional deliveries would be the principal conduit for distributing the cash contribution for transport, food and accommodation for the woman and her companion during hospitalization.

16. For referrals, the referring facility has to put in place transport arrangements for referral to higher level as part of the contract. They will also arrange and make clear referral agreements with the facilities to which they are referring, so women are not refused entry and the referral facility knows whom to expect (the referral system is assessed as part of the QIP quality assessment process for entry to the voucher scheme).

17. Mapping of providers: SFD will collect data on the location of providers and the services they provide from a variety of sources, including governorate health offices and private provider associations and networks (i.e. Association of Private Midwives, Rayaheen, and so on). Attempts will be made to proactively involve private providers at this stage and SFD may also advertise for providers who are interested to join the MNVP. Potential and interested providers will be asked to provide information on the services they provide. Using these data, clusters (i.e. one CEmONC, several BEmOCs and between 5 to 10 regular service providers) will be identified and potential health facilities will be selected based on service provision, staff capacity, proximity to communities and to good transport links and, in the case of facilities providing normal deliveries, being open 24 hours a day.

18. Quality Assessment and approval of providers to join the MNVP: The aim is to recruit at least one service provider per 10,000 people and possibly more in areas where travel is difficult. All providers will be assessed using quality assessment tools developed through the GIZ-supported Quality Improvement Program (QIP) and adapted for use by the KfW-financed RHVP. The Bank will contract with GIZ separately to provide quality assessment and assurance services to the MNVP and the QIP team will work closely with SFD to ensure that activities are aligned to ensure the smooth roll-out of the voucher program in the selected Governorates. The assessment will include the following broad areas:

    a. Observation of the staff practicing their skills;
    b. Monitoring of equipment, drugs and infrastructure;
    c. Willingness to improve and participate in the voucher program/QIP will be evaluated;
    d. The QIP will assess the presence or absence in the health facility of the minimal standards for the provision of each separate service (e.g., ANC) in the voucher benefit package.

19. Based on the QIP assessment, the health facility may be invited to participate in the voucher program. Taking into account the current limited capacity of the public and private facilities, SFD will permit facilities to enter the program as long as they adhere to the standard requirements related to voucher service provision. Voucher service providers may fall into one of three categories:

    a. The facility meets the national standards of care and is invited to join the MNVP;
    b. The facility meets minimum standards for joining the MNVP and agrees to embark on a program of quality improvement, which may be financed through the HPP (or possibly other funding agencies). Providers can be enrolled in the QIP program which assists facilities to improve their quality in the area of management, infection control and service provision;
    c. The facility does not meet minimum standards of care and is not invited to join the MNVP until quality has improved

20. Contracting of providers: All providers to the MNVP will be required to sign a Memorandum of Understanding (MOU) (public facilities) or a contract (private providers) with SFD acting as the VMA. These MOUs and contracts are an essential tool in managing service providers and any disputes that might arise during the implementation of the program. The contract explains what services the service provider should provide and an agreed price list for each of those services, which forms the basis for processing claims and payments by the VMA. It also outlines what the provider can expect in terms of oversight from the VMA and may give recommendations on how the facility should re-invest the income from the program in quality and staff incentives. The two key areas of oversight are around quality and fraud control. All service providers must accept visits, monitoring and information requests from SFD, and QIP as appropriate. Approved providers will receive orientation on the voucher scheme by SFD prior to negotiating on and signing their contract. Once contracted the providers will receive training on how the program works and what is expected from them, including in relation to administrative issues and fraud prevention. During the preparation phase, SFD will develop contract templates which will be based on those used in the KfW RHVP.

21. Approved providers would be reimbursed at an agreed price for services provided according to the agreed package of voucher services. These prices will be established during project preparation and agreed by the Bank and SFD. They will be aligned with levels being paid through the KfW RHVP and will be categorized according to provider type (private non-profit, private for profit, public). Prices may also differ according to the level of health system (health center, hospital, etc.) and possibly location (urban, rural) and will be assessed annually and changed as appropriate.

22. Quality Assessment of Services Provided. The GIZ-supported QIP will also provide quality assessment services to the MNVP (as part of the separate contract between the Bank and GIZ) on a regular basis. Every facility in the project will be visited at least once per year and facilities will be assessed for quality more regularly where: (a) a service provider wants to add one or more new voucher services to its contract; (b) serious complaints about quality have been received; (c) the annual assessment finds significant failings that have to be addressed in a short time; (d) a follow-up assessment is required to ascertain that improvements have been made; or (e) the facility is carrying out a high number of Caesarean Sections or dealing with a higher volume of complications than expected.

23. Facilities which only reach the minimum standards of care will be expected to adhere to a quality improvement program which QIP will establish together with the facility team. The Bank may finance these supply-side improvements through HPP and if necessary leverage additional funding through other donor-financed projects, working closely with MOPHP and the relevant Governorate Health Office where the facilities are public health facilities.

Project Beneficiaries

24. The target group of beneficiaries would be women of reproductive age (15–49 years) and their newborn children in MNVP target districts. The vouchers will be universally targeted in rural areas (i.e. Yemeni women in reproductive age in one of the MNVP target districts are eligible to receive a voucher, and to exchange that voucher for a designated service). This means that no woman will be excluded from having a medically assisted delivery through the MNVP based on her socio-economic status. However, the vouchers will be targeted at poorer women and their families using a number of mechanisms: (i) the voucher distribution strategy, which will target poorer women, particularly in urban and peri-urban areas; and (ii) the pricing strategy which will set reimbursement prices at a level which is designed to focus on providers that are mostly used by poor women.

Voucher Distribution and Targeting

25. Rural Targeting of Vouchers: In rural areas, the vouchers will be distributed to poor women of reproductive age based on the assumption that all women living in rural areas are poor: despite a general decline in poverty, poverty levels have remained very high in rural areas where the majority of women are poor.[27] Poverty data exist that have been drawn from the 2004 census and the 2005/06 Household Budget Survey and it is considered unlikely that poverty levels have significantly changed since this time, except to have worsened in areas which have witnessed, or continue to suffer from, conflict and security-related problems. It is recommended that SFD consider how to utilize these and any new data to target the vouchers to poorer women, in line with the Government of Yemen's targeting mechanisms for the social cash transfer program.

26. Urban Targeting of Vouchers: In urban areas, voucher distribution will be based on community-based targeting mechanisms whereby community-based organizations are contracted by SFD to distribute vouchers based on a poverty targeting mechanism. As part of the tendering process, organizations (community-based organizations (CBOs), NGOs) will be asked to propose effective targeting mechanisms for identification of the poor. Thus the approach may differ from one district to the next.

27. Voucher distributors will conduct house to house visits to distribute the vouchers (SMH vouchers to pregnant women, and FP vouchers to non-pregnant MWRA) and to meet directly with potential female clients, as well as to attend public meetings and events to target husbands and influential community leaders. During distribution they will also provide information on the fistula vouchers, ensuring wide dissemination of the voucher service. Distributors and community based organizations will be engaged through a performance based contract. This contract will pay a fixed fee for administrative costs and marketing activities, such as workshops for community leaders, plus a performance-based component for each voucher distributed and used.

27. Distributors will be responsible for marketing the voucher including disseminating information on sales points, voucher entitlements and services provided. The MNVP will link with other relevant projects working at the community level (such as HPP) to market the voucher scheme.

28. Over time, targeting mechanisms will be adjusted and become increasingly be aligned with approaches used by the government of Yemen with support from organizations such as the Social Welfare Fund to identify the poor.

29. Pricing Strategy: The pricing policy will be used to target the vouchers at poorer clients. Payment levels to providers of voucher services will be set at a level which is designed to exclude expensive private hospitals (unless they wish to provide services at a reduced price for corporate social responsibility reasons). Together with a distribution strategy which focuses on poor areas (and in urban areas uses poverty identification mechanisms), this form of self-targeting should exclude the majority of women who can easily afford to pay for the services.

Voucher Design and Printing

30. The VMA will oversee the design and printing of the voucher booklets containing coupons for each service offered. The voucher may be marked with the MNVP logo and slogan (they may take on the logo and slogan of the KfW vouchers so as to promote one national scheme). The vouchers should clearly state that the voucher are free of charge so that no informal charges can be made by providers for any part of the agreed voucher service package. It will also have a unique serial number and may contain barcodes which help to track clients through the system and prevent fraud. The voucher will also contain educational messages about the services offered

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and will be used to fill in information about the client and services provided (i.e. it will form the basis of the paper claim sent to SFD for processing).

31. It is important for SFD to establish early on a safe system for getting the vouchers from the printer to the distribution points using a system of signed and dated forms which can act as a paper trail.

Claims Processing

32. The voucher management agency (VMA) is responsible for the processing of voucher claims and payments to participating health providers. Claims will be sent to the Branch office of SFD located in each Governorate where the amounts claimed will be checked against the contract and entered into the system. At this stage, the amounts claimed for non-medical costs such as transport, food and accommodation will also be checked. All data will be processed by the M&E and IT Officer and will be entered onto the program MIS.

33. At central level, the SFD Voucher Management Team (VMT) will conduct further checking of the claims, both financially and medically (i.e. was the correct treatment given, detailed review of all claims for complications of pregnancy and delivery and so on), as well as check the data entered by the branch office for accuracy. A consultant may be hired to undertake the medical review of claims until the number of claims being processed calls for a permanent position in the VMT. SFD will also look at the trends in the data (number of vouchers distributed by area/distributor), number of voucher services provided by provider/area, number of C-sections and complicated deliveries and so on). In this way the VMT will become used to identifying outlying data which may indicate possible fraudulent activity, which can then be investigated in more detail.

34. The VMT will communicate to the relevant Branch Office all cases which require further investigation. They will also send monthly a sample of voucher beneficiaries who should be interviewed, either through home visits or by telephone (which is part of the verification process: see paragraph 38 below).

35. If claims are eligible, reimbursements will be sent by bank transfer or other suitable means directly to the service provider within 4–6 weeks of claims being received. At the same time, a communication explaining any adjustments or suspension of claims is sent to the service provider.

Data Validation and Verification

36. Data validation and verification is done both internally by SFD, and externally through regular External Technical Audits. Internal verification will be aligned with the system used the RHVP and will take place at three principal levels: (i) at the district level, the Voucher Distribution Supervisor or contracted Consultant verifies a sample of 5 percent[28] of all services delivered through a combination of telephone and/or home visits (the sample is generated monthly by the MIS and sent through the Branch Office to the person tasked with this activity; (ii) at Governorate level, 3-5 percent of the sample verified at the district level is then re-validated by the governorate team (done by telephone and if relevant through household visits); and (iii) at the central level, a random sample of claims are also verified quarterly through contracted consultants. Also at the central level, the VMT will conduct trend analysis of the claims being processed to identify outlying data (utilization management) which is an established anti-fraud tool used in voucher schemes.

[28] Over time sample size can be reduced and move to a focus on high value, high risk services if the incidence of fraud is lower than expected (and correspondingly increased if it is higher).

37. Independent Verification of Outputs will be done by an External Technical Auditor which will be contracted by SFD and report to both SFD and the Bank. The first audit will be 6 months after service provision has started. According to results it can then be decided whether to increase frequency of external verification to quarterly. The External Technical Auditor will audit the program processes; paying particular attention to, and verifying, reported service numbers. This process will involve a review of SFD processes for processing claims and contracting, facility-based verification of service utilization data, and may also include community-based verification. Reports will include recommendations on how to further improve project implementation and prevent fraudulent behavior or abuse. The verification system will be reviewed at the mid-term and changes can be made to sample size and frequency of verification.

The following matrix shows the different levels of verification:

Table3: Verification at a glance in the MNVP

Level	What is verified?	frequency	Who verifies?
Internal verification			
District	Randomly generated sample of 5% of claims traced back to the clients' homes	Monthly	Voucher distribution supervisor plus contracted consultants where appropriate. By home visit and/or telephone.
Governorate	3 – 5% of district sample is re-validated at governorate level. Spot checks	Monthly	Voucher management agency Governorate team. By telephone and/or home visit
Central	Trend analysis of data. Spot checks. Separate but small random sample of claims traced to households	quarterly	Central voucher management agency staff
External verification[29]			
Technical audit	Verification of data (services, claims & payments) at VMA, health facility and household levels	Six monthly	Third party contracted agency

Fraud control

38. The control of fraud is a key component of any voucher program. There are a number of ways in which fraud can be committed by distributors and service providers and tried and tested methods to detect them. The principal tool for deterring and addressing fraud is the provider contract which sets out clearly how the provider must act, and the consequences for fraudulent action, which include exclusion from the program and loss of outstanding income. The voucher management agency will use a variety of methods to monitor for fraud developed by the RHVP, including:

[29] In addition to the Technical Audit there is a financial audit which is contracted out to a suitable third party organization. This is an annual process and is not part of the voucher verification but a financial audit of the program.

a. Routine Measures include: careful and detailed checking of claims at each level (district, governorate and central levels - see paragraph 32 – 37 above), monitoring trends in service numbers and identification of outlying results (utilization management) which may arise from fraudulent activity, careful checking of claims for additional benefits such as transport, food and accommodation, and ensuring vouchers are very hard to duplicate;
b. Specific activities aimed at fraud detection include: internal data validation by SFD (see above) which is principally done by interviewing a random sample of voucher clients in their homes about the services received; and unannounced spot checks of providers and distributors alike; and the External Technical Audit;
c. Each suspected case of abuse or fraud will be investigated thoroughly by SFD staff using interviews with beneficiaries, distributors, and health staff and doing spot checks of facilities.

Roll-out of the Voucher Scheme

39. SFD will pilot the design of the voucher scheme in a single district in three Governorates: in Taiz with the aim of piloting the scheme in rural areas; and in Sana'a City for urban areas, and in Hadramout in coastal areas (which has a different profile of health care providers). This will enable SFD to refine the voucher distribution strategy and adapt it to the specific context on the ground, and to establish all of the systems and processes necessary to manage the voucher scheme (including management, claims processing, procurement, and so on).

40. Once the pilots are successfully underway, the program will be rolled out using a staggered approach in each target Governorate. It is proposed that the scheme is introduced to each new Governorate with a three month delay: 1st in Taiz; 2nd in Sana'a City; and 3rd in Hadramout. This will facilitate the Impact Evaluation which will use a step wedge and before and after design to create natural controls through the staggered roll-out of the voucher program.

41. Within each Governorate the voucher scheme will be rolled-out to three new districts every three months. Given that SFD will be undergoing a period of intense capacity building, it is advised that they start with the peri-urban areas near to the capital city of each Governorate and then expand into more rural areas. This will give SFD time to establish good systems and processes for managing the program.

Annex 3: Implementation Arrangements

REPUBLIC OF YEMEN

Maternal and Newborn Voucher Project

I. PROJECT INSTITUTIONAL AND IMPLEMENTATION ARRANGEMENT

A. Project Administration Mechanisms

1. Implementing Agency. The SFD will be the implementing agency for the project and will manage the health voucher program under the health unit through a Voucher Management Team (VMT). SFD is the proposed payer for the voucher scheme. This is consistent with the natural development of the SFD which is shifting its focus from one of investing in inputs to support building and rehabilitation of health facilities and training of health workers, to focus on output-based disbursements, thereby stimulating demand for and utilization of health services. Fiduciary management, including procurement and financial management, as well as monitoring and evaluation will be carried by the respective departments within the SFD.

B. Voucher Management Agency

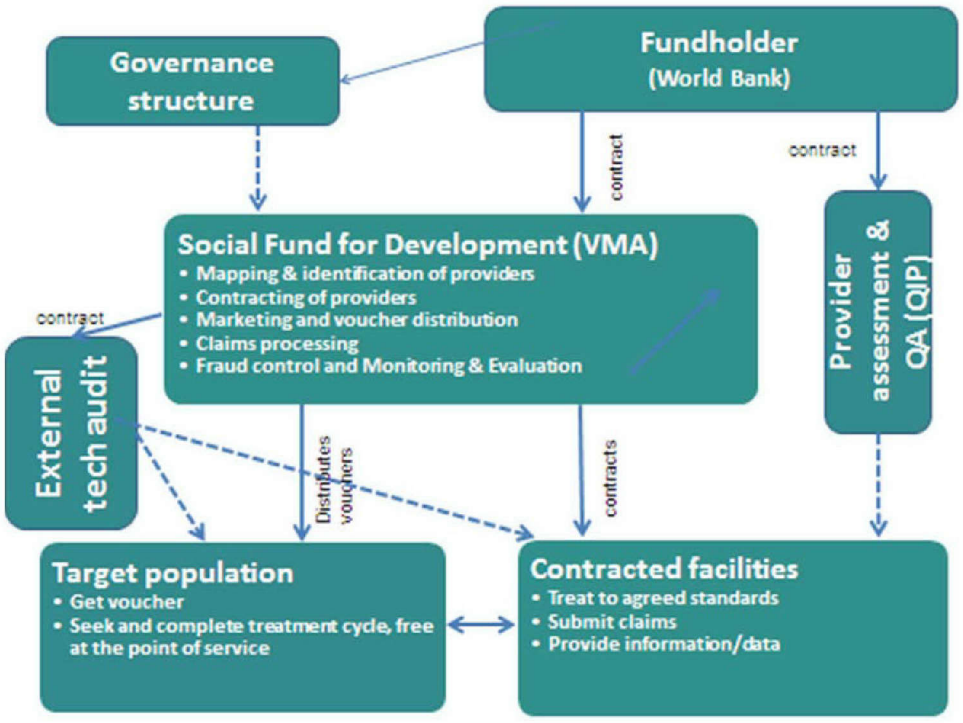
2. The roles of the different institutions involved in the design and implementation of the MNVP are set out in the table and description of specific activities below and the relationship between them is illustrated in the diagram.

Table 4: Institutions involved in the design and implementation of the MNVP

ORGANIZATION	ROLES AND RESPONSIBILITIES
World Bank	• Financing agency • Programme oversight and governance • Signs off on all key reports and approves disbursement requests
MOPHP	• Strategic guidance • Guidance on use of voucher income in public health facilities and decision making on additional supply-side investments in MNVP participating facilities
Social Fund for Development (Voucher Management Team)	• Operational responsibility for implementation of the MNVP • Coordinates production and distribution of vouchers (including data collection on beneficiaries) • Mapping, identification and selection of service providers • Contracts local organizations and individuals (i.e. for voucher distribution, data validation and verification, etc.) • Contracts participating health facilities • Paying health facilities for services provided • M&E • Internal data verification and fraud control
QIP (financed through sub-contract with HPP)	• Assessing service providers for inclusion into the programme against agreed minimum standards (signal functions, national protocols) • Regular assessments to ensure quality standards are maintained (quality assurance) • Working with facilities to develop trainings and quality

	improvement plans which may be financed through HPP for supply-side investments (i.e. equipment, training) as well as possible additional investments (UNFPA, Dutch etc.) as well as through income from voucher revenues.
External Technical Audit	• Conducts six month independent checks on all aspects of programme implementation - including marketing, distribution, service provision and claims processing – to be discussed

Figure 2: Diagram showing institutional relationships for MNVP



3. The SFD will set up and staff the Voucher Management Team (VMT) which will include the following positions:

   a. Headquarters: Project Manager; Provider Coordinator; Monitoring & Evaluation and IT Officer; Accounting Officer, Administrative Assistant;

   b. Branch or Governorate Office: Governorate Coordinator; Provider Coordinator; Accounting & Data Processing Officer.

4. Job descriptions for each of these positions will be adapted from the KfW RHVP by the SFD team with external technical assistance, as part of program preparation. Training and induction of the core team members will benefit from external technical assistance as necessary.

5. Additional consultants will be hired on an as-needed basis for tasks such as voucher distribution, medical review of claims, verification, revalidation of verification, and so on. SFD is experienced in World Bank procurement processes and used to employing consultants in the implementation of its projects and will draw on this experience in the MNVP.

6. An External Technical Audit Agency will be contracted by SFD which will report to both SFD and the Bank on all aspects of performance during the preceding six month period. This activity is described above in Annex 2: Detailed Project Description, and will include review of: contracting (of local organizations, individuals and health facilities); claims processing and payments (to health facilities for services provided and to other sub-contractors); M&E and data verification at all levels and fraud control.

C. Capacity Building of SFD

7. SFD will need to build their internal capacity to manage the voucher program. This may be done through a combination of:

    a. Building knowledge about voucher programming and practical capacity building in Yemen based on the implementation of the KfW scheme including field visits to participating providers, governorate and district health offices; provision of resource materials; study visits to voucher schemes operating in other countries (such as Kenya and Uganda).
    b. Hiring, induction and training of new staff (see above); and
    c. External technical assistance by experts in voucher design and programming.

8. Specific Program preparation tasks linked to the set-up of the VMT include:

    d. Determine infrastructure needs and equip office space;
    e. Establish detailed roles and responsibilities and develop job descriptions for Voucher Management Team (VMT)
    f. Induction and training of staff
    g. Identification of roles which will be filled through consultants and/or external organizations, and development of TOR and RFPs (IT company or experts, External Technical Auditor, NGOs for voucher distribution in urban areas, NGOs and individuals for distributing vouchers and verification services at household level; other consultancy tasks as appropriate);
    h. Establish strong working relationship with the KfW VMA (Yamaan Foundation) both at HQ and field office level.

9. Specific tasks related to preparation for roll-out of the MNVP include:

    a. Develop the MIS: contracting IT expertise for developing the MIS in close coordination with the SFD IT department and the VMT to ensure the MIS fulfills all needs and is closely aligned to the current management and information systems used by SFD, including by the finance department;
    b. Design and printing of the voucher;
    c. Design and development of registers, complication forms and other forms;
    d. Develop detailed strategies for: mapping, selection and contracting of providers; quality assurance and improvement (in coordiuation with QIP as appropriate); delivery of vouchers at each level; data validation; verification and fraud control (framework for addressing fraud); claims processing and payments; utilisation management (trend analysis); reporting guidelines at every level (frequency, content);
    e. Preparation of guidelines (based on KfW RHVP guidelines and World Bank Operational Manual);
    f. Schedule scale-up;
    g. Visit Governorates (Governorate Health Office, District Health Office, Gov council) and set-up regular liaison;
    h. Mapping of providers in Taiz, Hadramout and Sana'a, assessment of the quality of providers, contracting of the providers
    i. Voucher program launch in each governorate and start distribution of vouchers and provision of services.

10. To inform these processes, SFD will move quickly to set-up of two pilots in Taiz (rural) and Sana'a City (urban) and ensure leesons are learned and fed back into refining the voucher program implementation and guidelines. This will entail the development of detailed work plans for national level and governorate SFD teams for developing the two pilots and rolling out of the program. Furthermore, the Mid-Term Review (see below) will review the project's overall performance, and evaluate efficiency and effectiveness of project activities, management arrangements, targeting mechanisms and technical assistance. The results of the review will provide a basis for a mid-course correction, indicating modifications to the design if necessary, and a revised project implementation plan, targets, and disbursement projections based on the estimated number of services during the remaining years of the project.

II. FINANCIAL MANAGEMENT, DISBURSEMENT AND PROCUREMENT

A. Financial Management

Financial Management Arrangement

11. **Executive Summary:** This Annex documents the results of the FM Assessment for the Maternal and Newborn Voucher Project (MNVP). The assessment was conducted by Bank staff in accordance with the policies and guidelines for assessment of FM arrangements in World Bank-Financed projects. It takes into account the capacity and experience of the implementing agency and the nature of the project related risks. The project's financial management arrangements, including the mitigating measures at the SFD are acceptable to the World Bank; the residual FM risk is Substantial. The project would make use of the country systems, as it will be implemented by the SFD with close coordination with the Ministry of Public Health and Population. The current systems of the SFD will be enhanced by the mitigating measures described below. The Bank team is comfortable that these measures are adequate to assure that project funds are used for the intended purposes.

12. The Project will be implemented by the SFD and the Project's proceeds will be channeled through the SFD and deposited into a pooled USD Designated Account (DA) to be managed by the SFD. Report based disbursement through Designated Account will be the main disbursement method, along with Reimbursement, Direct Payment and Special Commitments. Requests for payments from the Grant funds will be initiated through the use of Withdrawal Applications (WAs) supported by unaudited Interim Financial Reports and Form of Payments against contracts subject to the World Bank's Prior Review, for two quarters as provided in the IFRs. In addition, the SFD will contract with an External Technical Audit Agency to independently verify and certify that the internal control systems of the voucher program are operating effectively and have been conducted at an acceptable level. Specific terms of reference would be agreed upon in order to establish that the technical and financial audit would include an opinion on the reliability of the Statements of Claims Registries submitted in support of withdrawal applications. It would also consider that, as a minimum, the auditor would perform sample-based reviews of the claims database management system, verification of individual files, and field interviews with beneficiaries. The specific terms of reference for these reviews would be agreed upon with the Bank prior to the first disbursement under Component 1.

13. An FM assessment was conducted with the objective to determine whether: (i) the SFD has adequate FM arrangements to ensure Project funds will be used for the purposes intended in an efficient and economical way; (ii) the controls and processes at the SFD can be relied upon; and (iii) the FM system in place is able to generate reliable and accurate project reports on a timely basis.

14. The SFD has extensive experience in implementing World Bank-financed projects, including SFD I, II, III and IV, thus, they have in place strong FM systems. However, this project is new to the SFD and in Yemen, thus, a number of additional risks are identified and relevant mitigating measures are agreed upon as described below.

15. **The FM assessment confirmed that SFD has adequate FM capacity to implement the Project subject to the establishment of the operational and control systems related to the voucher program.** The SFD departments, units and staff including the financial staff will be utilized to implement this project. The SFD FM Department based in Sana'a is adequately staffed with a qualified financial manager assisted by a deputy financial manager and six accountants. Besides the SFD's office in Sana'a, there are nine branch offices country-wide. The branch offices are adequately staffed with operational staff and accountants. The SFD's internal controls are deemed adequate, the internal audit department is adequately staffed, but due to the nature of the voucher program, the SFD will assign a team responsible for the implementation of this project as well as required systems to enable the SFD to implement the program. The flow-of-funds procedures including the controls over cash balances and transfers to the field offices are acceptable and will be used under the project noting that branch offices will be equipped with the claims processing system to allow them to carry out the review and verification of claims submitted by the service providers. The SFD has developed an Operational Manual setting out the structure of the several programs, including fiduciary arrangements and the relation with the branch offices which are deemed to be adequate and updated to reflect the specifications of the voucher program. The SFD will be issuing, on a quarterly basis, IFRs reviewed by an external auditor acceptable to the Bank, and on an annual basis, Project Financial Statements (PFS) and overall Entity's Financial Statements, audited by an external auditor acceptable to the Bank.

16. The current FM arrangements, which are working satisfactorily, are appropriate for the proposed Project and will be kept, with the caveat that the SFD will maintain separate accounting records and banking arrangements for the proposed project and will assign a team and establish systems to implement the voucher program. Accounting books and records are properly maintained using an Oracle based accounting and reporting system, required quarterly unaudited IFRs and annual audited financial statements are produced on time and are reviewed/audited by an independent external auditor, and management acts promptly on any internal control issues raised in the auditor's management letter. Unqualified annual audit reports have been received in a timely manner. The audit report for the year ending 2012 has been received with no major issues raised. The audit report submission requirement remains the same, with the audit report being due within six months from the end of the fiscal year of December 31.

Organization and Staffing

17. SFD was established in 1997 as an autonomous State organization under the Council of Ministers. The Prime Minister is the Chairman of its Board of Directors. Since its establishment, SFD has become one of Yemen's main development actors, with support from the government and the donor community. The main executive agency is the SFD Head Office in Sana'a and it has nine Branch Offices. The SFD Head Office is headed by its Managing Director who is also a member and secretary of the SFD's Board. The Head Office has 14 units dealing with all SFD's affairs on the national level.

18. The Finance Department is in the Head Office and is managed by a Financial Manager who reports directly to the Managing Director. The Financial Manager is supported by a deputy and six accountants with no material staff turnover in the department. This department is responsible for managing all the FM and Disbursement activities of the SFD with significant support from accountants at the SFD's nine branch offices.

19. Additionally, the SFD has an Internal Audit Department (IAD) headed by a qualified Manager who is supported by 4 staff with adequate experience and qualifications that are relevant for the proposed project. The IAD is responsible for conducting regular audits on the SFD's Programs as required by the Program Management but at least on a quarterly basis, including performing audits for the SFD's Branch Offices, preparing all required documents for annual external audits, and reviewing and investigating in case of any irregularities found. If there are findings that require action, the internal auditor gets responses from the related branches, departments or units. The

internal auditor follows-up on any actions agreed upon with the concerned branches, departments or units. The IAD submits its audit reports to the SFD's Managing Director.

Accounting System & Internal Controls

20. The SFD has an internally developed automated accounting system which has been in operation for years and is deemed adequate for this project. The accounting system is capable of recording project financial transactions, including allocation of expenditures in accordance with respective components, activities, disbursement categories and sources of funds. The system has controls over the preparation and approval of transactions ensuring all transactions are correctly made and adequately explained. The system is sufficiently flexible to design separate chart of accounts adequate to properly account for and report on project activities and disbursement categories. The system is capable of proper record keeping and has a backup system in the SFD's server.

21. The SFD has an Operational Manual setting out the structure of the several programs implemented by the SFD, including procedures for proper segregation of duties in terms of authorizing and recording transactions, and custody of assets, descriptions of the roles of the SFD's staff including the internal audit department, the project's accounting policies and procedures and internal controls. The Manual has been updated to reflect the specifications of the voucher program.

22. The SFD prepares monthly bank reconciliations, prepared by the accountants and reviewed and approved by the Financial Manager or his deputy. The SFD prepares quarterly IFRs showing the source and use of funds by component, expenditure category, activities and the reconciliation of the DA. Additionally, the SFD prepares semi-annual progress reports detailing the physical progress made for each project.

23. The SFD maintains a fixed assets register for the assets financed by the Bank, Government and other donors. The internal auditors conduct a yearly physical count of the equipment (computers, printer, vehicle, etc.) financed from the Project.

24. **Complaints Handling Mechanism (CHM) in SFD:** The SFD has developed a CHM through which SFD manages, responds and monitors complaints within its activities as part of an ongoing process to improve its accountability. The complaints are received by branch managers/ unit's heads, units' heads, project officers, and consultants, directly, or by fax and mail, or through some complaint boxes in some SFD programs. The SFD gives the priority to investigate complaints of financial nature and classify them as sensitive complaints. Complaints which are not resolved in the branch offices or become a dispute are usually dealt with at the Headquarter level with the full support of the Technical Unit and the SFD's attorney. Types of complaints received by SFD offices (according to their sources):

    - Complaints of beneficiaries/possible beneficiaries (related to projects implementation activities)
    - Complaints of contractors/suppliers/ consultants (implementation)
    - Complaints on behalf of groups/communities
    - Behavior of a SFD staff member
    - Behavior of a partner staff member

25. Investigation: Depending on the subject of complaint investigation takes place at the office level and field verification as needed. Response is made accordingly and complainants get informed. Complaints related to procurement and contractual issues are dealt with as per the standard bid documents. SFD staff exchange experience related to complaints and disputes handling through their meetings and workshops, and through direct contact with the technical unit which is in charge of dealing with complaints and disputes.

26. **Implementation of Voucher program**: The SFD has established an acceptable Operations Manual describing the implementation and control procedures, including flow of funds for this project. The manual includes program objectives, program partners, contractual arrangements, program design

(beneficiaries, voucher benefits package, other benefits, selection and contracting of providers, quality control, cost of service reimbursements, voucher distribution, and claims processing and data management, etc.), monitoring and evaluation and fraud control including the use of independent verification auditors and reporting requirements. Prior to payments to the service providers, the SFD will validate the services completed as per the submitted claims through a number of control procedures including field visits and comparison of claims submitted against contracts with the service providers.

27. **Eligibility of service providers and cost of service:** All facilities will be assessed and accepted according to pre-set criteria as per the operations manual. The SFD will contract with accepted facilities based on negotiated prices for the agreed upon services. Under the KfW voucher project recently launched in Yemen, a review was done of current prices paid by customers in the public and private sector in various Governorates in Yemen, and a first list of potential prices was developed and discussed with the MoPHP and the private sector. Cost of public service is determined to be lower than private sector which is reasonable as public service providers receive budget from the Government. The price list will be used by the SFD and assessed during project implementation. Cost of the beneficiaries' transportation cost, and food and accommodation for one companion during hospitalization of the pregnant woman, will be advanced by the service providers and then added to the service provider's claim submitted to the Social Fund.

28. **Service providers' FM arrangements:** The Bank discussed with the MoPHP the FM arrangements of the public service providers to ensure that funds received from the vouchers project is properly used to improve the quality of service. As a result, the MoPHP agreed to provide public service providers with instruction on the use of funds received from the voucher project. Additionally, quality of service provided to the beneficiaries will be assessed and monitored.

29. **Claims processing:** The Social Fund will develop an MIS for the program. This database will collect data on all different components of the program. It will first and foremost enable the SFD to efficiently process claims for services provided. Second, and of equal importance, is the information that the database will produce for monitoring of the voucher program. This data will be used by the SFD to monitor fraud, distributor performance, provider performance, program spending on services and patterns of service uptake through a range of management indicators.

30. The SFD will receive all claims from service providers directly. Claims will be checked against the service provider contracts, vetted by medical professionals to ensure correct procedures are followed and accepted claims will be paid directly to the service providers' bank account or through money transfer.

31. **Fraud Control:** The control of fraud is a key component of this voucher program. It will be clearly stated in all contracts between the SFD and its contractors that fraud will not be tolerated and, if discovered, will result in immediate exclusion from the program and loss of outstanding income.

The SFD will use a variety of methods to monitor for fraud:

- Routine methods – will include careful checking of claims, monitoring trends in service numbers and charges for extras such as transport, and ensuring vouchers are very hard to duplicate. The MIS will enable the SFD to measure patterns and detect irregularities in the claims processing system, e.g. sudden increases in complicated deliveries or in claims from a specific provider, and to trigger alerts which the VMA can then follow up on. The SFD will review all claims for complications to ensure that services provided are medically justifiable. The SFD will prepare a regular reconciliation of vouchers printed – vouchers distributed – vouchers reimbursed by areas, which will play an important part in identifying mismatches.
- Each voucher has an individual number; it is printed on special high-quality paper that is easy to differentiate from normal paper, with a logo using a special printing process only available at three printers in the country to reduce the risk of counterfeit vouchers being produced. A phone number is printed on each voucher that links to an information line run by the SFD. This is a confidential service

and can be used to report fraud as well as ask for medical information. As the program expands this hotline will be a useful resource in the collection of client data and can be used for surveys of client satisfaction.

- Specific activities aimed at fraud detection – including verification questionnaires aimed at clients, mystery client visits to service providers and unannounced spot checks of providers and distributors alike. A sample of reimbursement claims will be checked monthly. However, if the SFD is alerted to the possibility of fraud they will investigate immediately. The SFD will aim to follow up on five percent of voucher clients who use their voucher for the first time or deliver using a voucher service provider:
  - A sample of patients will be interviewed in the community to enquire about their experience at the health facilities.
  - SFD will also use their staff and/or contracted individuals to conduct these questionnaires and to accompany a proportion of the field visits to ensure the quality of the work.
- Unannounced visits and spot checks will be made to service providers.
- The SFD will contract the distribution NGO or individuals to assist in questioning clients on the services they have received and the SFD will also contract an independent verification agent (IVA) to conduct periodic checks on claims processing, service providers and distribution.

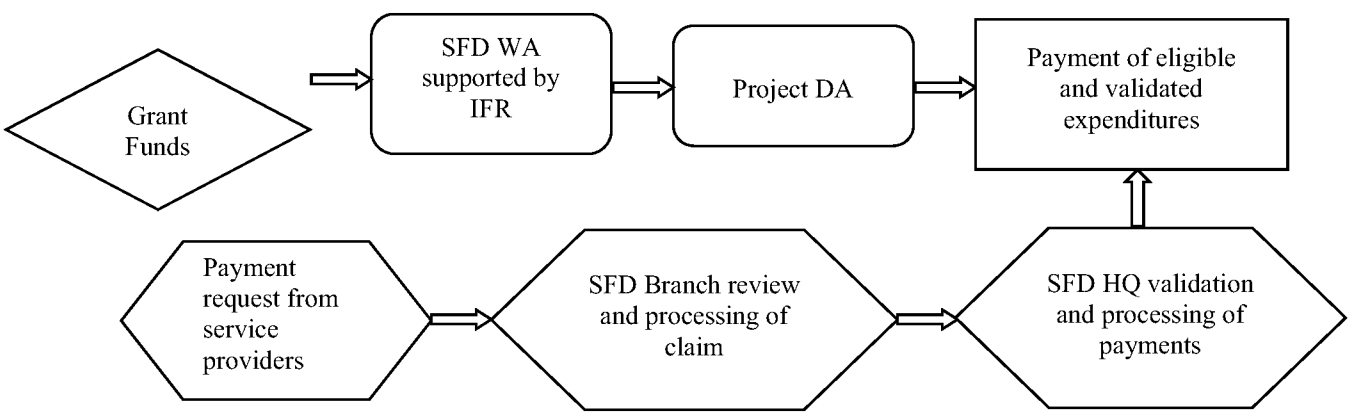
The detailed procedures will be documented in the project's operations manual.

B. Flow of Funds and Disbursement Arrangements

32. The Project funds will be channeled through the SFD and deposited into a separate pooled USD Designated Account (DA) in a commercial bank acceptable to the World Bank, to be opened and maintained by the SFD and under conditions acceptable to the World Bank. Report-based disbursement will be the main disbursement method, along with Reimbursement, direct payment and special commitments. Requests for payments from the Grant funds will be initiated through the use of the World Bank's withdrawal applications supported by IFRs and Form of Payments against contracts subject to the World Bank's Prior Review, for two quarters as provided in the IFRs. Disbursement to the beneficiaries from the SFD's pooled DA will follow the SFD's Operational Manual and World Bank Guidelines.

33. The chart below describes the flow of funds and process for requests for payments

Figure 3: SFD Flow of funds Chart



Eligible Expenditures, Project Financial Reporting & Budgeting

34. The following table specifies the categories of Eligible Expenditures that may be financed out of the proceeds of the Financing ("Category"), the allocations of the amounts of the Financing to each

Category, and the percentage of expenditures to be financed for Eligible Expenditures in each Category:

Table 5: Eligible Expenditures

Category	Amount of the Financing Allocated (expressed in SDR)	Percentage of Expenditures to be Financed (inclusive of Taxes)
(1) Results based-payments for Voucher Program under Part A of the Project	5,400,000	50%
(2) Goods, non-consulting services, consultants' services, Operating Costs, and Training under Part B of the Project	1,200,000	50%
TOTAL AMOUNT	6,600,000	

35. The SFD provides regular quarterly budget reports, which are included in the IFRs provided to the World Bank. The SFD Finance Department has a planning system with an accountant in charge of receiving the related information (contracts, Procurement Plan, etc.) from the SFD Procurement Specialist. Based on these, the related budget reports are prepared on a quarterly basis and included in the quarterly reports sent to the Bank. The SFD submits the IFRs generated from their accounting system on a quarterly basis. These reports are submitted to the World Bank timely with the external auditor's review report.

36. **Interim Financial Reports (IFRs) arrangement:** IFRs will be prepared by the SFD and submitted to the World Bank *quarterly*. IFRs will be submitted to the Bank no later than 45 days after the end of the quarter. The IFRs will be reviewed by an independent external auditor acceptable to the World Bank and the reports will consist of: (a) source and uses of funds by Component and Expenditure Category; (b) a reconciliation of the DA and advances to the sub-accounts; and (c) Cash forecast for two quarters. The IFR form will be agreed upon by Project Negotiation.

External Audit

37. Entity: Annual Audited Financial Statements of SFD are required to be sent to the World Bank as the SFD is a Continuing Entity. Such reports should be submitted to the World Bank within six months of the end of the Recipient's fiscal year (December 31).

38. Project: Annual Audited Financial Statements of the project are required to be sent to the World Bank within six months from the end of the Recipient's fiscal year (December 31).

- The annual financial statements will be audited by an independent external auditor acceptable to the World Bank and based on TORs acceptable to the Bank. Each report will cover the period of each fiscal year-end and is due to the Bank within six months from the end of each fiscal year.
- The external auditor report (in English and Arabic) shall encompass all Project's components and activities and shall be in accordance with internationally accepted auditing standards e.g.,

International Standards on Auditing. The audit report and opinion will cover the Project's financial statements, reconciliation and use of the Designated Account (DA) and sub-accounts, use of direct payments, and withdrawals based on Interim Financial Reports.

- The auditor is required to prepare a "management letter" identifying any observations, comments and deficiencies, in the system and controls, that the auditor considers pertinent, and shall provide recommendations for their improvement.
- The cost for the external auditors will be funded from the proceeds of the Project.

39. External Technical Audit: In addition to the above audit reports, the SFD will contract with an Independent Technical Auditor to independently verify and certify that the internal control systems of the voucher program are operating effectively and have been conducted at an acceptable level and constitute a reliable base for the disbursements of Grant funds. Specific terms of reference would be agreed upon as described above.

Corruption

40. Fraud and corruption may affect the project resources. The above fiduciary arrangements, including the capacity of the SFD, reporting and audit arrangements will reasonably reduce the risk of corruption from a technical perspective through the fiduciary arrangements but may not be effective in case of collusion. Also, prevention measures will be taken by the SFD at several levels; e.g. the vouchers will be printed on special kind of papers similar to those used for check books, and will have logos to authenticate individual vouchers. Also, the SFD will systematically verify service delivery through announced and unannounced facility visits and following up at home with sampled beneficiaries to confirm they received services. These measures can deter fraud since the awareness of enforcement systems is often enough to prevent people from committing fraudulent acts.

Supervision Plan

41. The project's FM arrangements will be supervised by the World Bank's Financial Management Specialist in conjunction with the World Bank's overall supervision of the project, which will be performed at least on a semi-annual basis. The supervision will be carried out to ensure adequate FM arrangements continue to be in place and the capacity of the FM unit is adequate.

42. **FM Action Plan:** The following FM action plan has been developed and agreed upon with the Recipient.

Table 6: FM Action Plan

No.	Action	Due date	Responsibility
1	Developing project's operations manual acceptable to the Bank.	Completed	SFD
2	Establishing the MIS for the SFD to assume the role of the Voucher Management Agency.	By Project Disbursement for Component 1	SFD
3	Developing TOR for the Independent External Technical Auditor acceptable to the Bank.	Within 3 months after effectiveness	SFD
4	Agree upon Project IFR form	Completed	SFD

C. Procurement

General

43. Procurement activities under the project would be carried out in accordance with "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants," dated October 15, 2006 ("Anti-Corruption Guidelines"). Procurement of

goods, and non-consultant services would be carried out in accordance with the IDA's "Guidelines: Procurement of Goods, Works, and Non-Consulting Services under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" dated January 2011, and Consultant firms and individuals will be selected in accordance with the IDA's "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" dated January 2011, and the provisions stipulated in the Legal Agreement. For each contract being financed by the Grant, the different procurement or consultant selection methods, estimated costs, and prior review requirements, would be agreed between the Recipient and IDA and included in the Procurement Plan.

44. Procurement of Goods and *non-consulting services* procured under this project would include but will not be limited to supply and install IT equipment, office furniture, and office equipment. Goods contracts valued above US$500,000 or equivalent would be awarded through ICB procedures.

45. Other method: (a) Goods estimated to cost less than US$500,000 may be awarded following NCB procedures *using the current NCB (National Competitive Bidding) for goods which has been approved by the Bank under SFDP IV subject to the following additional provisions below.*

(1) A Recipient-owned enterprise in the Republic of Yemen shall be eligible to bid only if it can establish that it is legally and financially autonomous, operates under commercial law, and is not a dependent agency of the Recipient;
(2) bidding (or pre-qualification, if required) shall not be restricted to any particular class of contractors or suppliers, and non-registered contractors and suppliers shall also be eligible to participate;
(3) the modified national standard bidding documents approved by the Association shall be used;
(4) registration shall not be used to assess bidders' qualifications; qualification criteria (in case pre-qualification was not carried out) and the method of evaluating the qualification of each bidder shall be stated in the bidding documents, and before contract award the bidder having submitted the lowest evaluated responsive bid shall be subject to post-qualification;
(5) a foreign bidder shall not be required to register or to appoint an agent as a condition for submitting its bid and, if determined to be the lowest evaluated responsive bidder, shall be given reasonable opportunity to register, without let or hindrance; the registration process shall not be applicable to sub-contractors;
(6) all bids shall be submitted in sealed envelopes and may be submitted, at the bidder's option, in person or by courier service;
(7) all bids shall be opened at the same time in a public bid opening which bidders shall be allowed to attend and which shall follow immediately after the deadline for submission of bids;
(8) evaluation of bids shall be carried out in strict adherence to the criteria declared in the bidding documents and contracts shall be awarded to the lowest evaluated responsive bidder, without resorting to the rejection of bids above or below a certain percentage of the pre-bid estimate (bid price bracketing);
(9) no bidder shall be requested or permitted to modify its bid after the bid closing date shall have elapsed and bids submitted after the deadline for submission of bids shall be returned to the bidder unopened;
(10) post-bidding negotiations with the lowest or any other bidder shall not be permitted;
(11) under exceptional circumstances, the procuring entity may, before the expiration of bid validity, request all bidders in writing to extend the validity of their bids, in which case bidders shall not be requested nor permitted to amend the price or any other condition of their bids; a bidder shall have the right to refuse to grant such an extension without forfeiting its bid security, but any bidder granting such extension shall be required to provide a corresponding extension of its bid security;

(12) rejection of all bids is justified when there is lack of effective competition, or bids are not substantially responsive, however, lack of competition shall not be determined solely on the basis of the number of bidders; and

(13) each contract financed from the proceeds of the Financing shall provide that the contractor or supplier shall permit the Association, at its request, to inspect their accounts and records relating to the performance of the contract and to have such accounts and records audited by auditors appointed by the Association.

(b) Shopping; Goods contracts valued below or equivalent of US$75,000 as agreed in the previous SFDP IV may be procured through shopping procedures by soliciting at least three responsive quotations.

(c) Direct Contracting; direct contracting would be used under the project as per the procurement guidelines clause 3.6 through 3.7. The prior review threshold of direct contracting applies to contracts above US$10,000 as agreed in the previous SFDP IV

46. Selection of Consultants: Consultancy Services procured under this Project would be provided by firms and individuals, and could include, but will not be limited to the following: (i) technical firms to do the verification of enrollment, (ii) capacity building activities for the Social Fund for Development (SFD), the implementing agency for the project, in the area of results-based financing; (iii) quality assurance of service provision; (iv) monitoring of compliance with medical waste management; (v) independent monitoring of project targets and verification of project outputs – the External Technical Audit Agency – see above; (vi) project impact evaluation; and (vii) project management.

47. Consultant firms and individuals will be selected in accordance with IDA Guidelines for Selection and Employment of Consultants (dated January 2011). For firms, all contracts above US$300,000 will be procured using Quality and Cost Based Selection method (QCBS). Least Cost-Based Selection (LCS), Single source selection (SSS), and selection based on Consultant Qualification procedures (CQS) would be used for small contracts of standard or routine nature estimated to cost less than US$300,000 or equivalent. Shortlist of consulting firms for services estimated to cost less than US$300,000 equivalent per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines. All consulting services contracts above US$300,000 will be subject to IDA's prior review.. All individual consulting assignments will be selected in accordance with Section V of the Guidelines for Selection of Consultants paragraphs 5.2, 5.3 and 5.4 of the Consultant Guidelines for the Selection of Individual Consultants; and (g) Single-source procedures for the Selection of Individual consultant.

Training activities

48. Training activities would include but will not be limited to: conducting workshops, professional training.

49. Prior Review Threshold: Thresholds for applicable procurement methods (not limited to the list below):

Table 7: Thresholds for applicable procurement methods

	Procurement Method	Contract Value Threshold	Prior Review USD
1.	ICB (Goods)	>= US$500,000	>= US$500,000
2.	NCB (Goods)	< US$500,000	
3.	Shopping (Goods)	< US$75,000	
4.	Direct contract (Goods)	> US$10,000	

Selection of consultants

50. Prior Review Threshold: Selection decisions subject to Prior Review by IDA as stated in Appendix 1 to the Guidelines: Selection and Employment of Consultants:

Table 8: Thresholds for Selection and Employment of Consultants

	Selection Method	Prior Review Threshold	Comment :
1.	Consulting Firms (Competitive)	> US$200,000	
2.	Consulting Firms (Sole Source)	All contacts	
3.	Individual Consultants (Competitive)	< US$100,000	
4.	Individual Consultants (Sole Source)	All contacts	

Procurement Plan

51. The Recipient will develop a procurement plan for project implementation which provides the basis for the procurement methods. The Procurement Plan will be updated in agreement with the Project Team annually or as required to reflect the actual project implementation needs, including improvements in institutional capacity.

Table 9: Summary of the planned procurement packages for the first 18 months after project effectiveness

Proposed Package	Category	Estimated Cost in USD	Prior/ Post	Method of Selection	Start date	End date
Supply and install IT equipment (laptops, printers)	Goods	2,000	Post	NS	June - 15	Dec.- 15
Supply of office equipment and other purchases	Goods	2,000	Post	NS	June - 15	Dec.- 15
Supply of office furniture	Goods	2,000	Post	NS	June - 15	Dec.- 15
External technical audit	Consulting Services	650,000	prior	QCBS	Dec-14	Dec-19
Project communication strategy	Consulting Services	90,000	Post/ first contract will be subject to prior review	CQS/IC	Jun-14	Dec-15
Quality Verification and certification	Consulting Services	60,000	Post/ first contract will be subject to prior review	CQS/IC	Sep-14	Dec-15
IT systems / bar-code technology	Consulting Services	50,000	Post	CQS/IC	Jun-15	Dec-15
External Financial audit	Consulting Services	10,000	post	LCS	Jun-15	Sep-15

52. Short list comprising entirely of national consultants: Short list of consultants for services, estimated to cost less than US$300,000 equivalent per contract, may comprise entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

Assessment of the agency's capacity to implement procurement

53. A procurement capacity assessment of SFD has been carried by the Bank procurement team. SFDP has successfully managed implementation of procurement activities up to now through a robust MIS for procurement linked to financial management. Despite the large number of contracts that SFDP handles, the MIS is flexible to accommodate changes as and when needed. The existing procurement capacity confirms its adequacy to meet the needs of the Project.

54. Procurement activities under the proposed project will be the responsibility of the SFD. The Project Implementation Unit (PIU), established to implement the original project, remains the same and its role and structure will not change. It is the same PIU that implemented the previous World Bank financed Maternal and Newborn Voucher Project. The assessment noted the sufficient capacity of SFD to undertake procurement for the Project and identified steps to further strengthen the capacity of staff in procurement through: (i) further formal training in World Bank procurement procedures for Training of voucher distributers, Capacity building activities for (SFD) including results-based financing, Quality Verification and certification; (ii) development of a 'Procurement Manual' to guide the team in its daily procurement activities; and (iii) ensuring that complete records are maintained for each procurement package.

55. **Procurement Risk:** is considered **Moderate** with the above mitigation measures.

Frequency of Procurement Supervision

56. In addition to the prior review of contracts, supervision to be carried out from World Bank offices. The capacity assessment of the Implementing Agency has recommended two annual supervision missions to visit the field to carry out post review of procurement actions.

D. Environmental and Social (including safeguards)

57. The project's impact on the environment is expected to be minor and indirect, given that it will not finance any on the ground inputs or works, but rather increase access to services already provided using vouchers. Therefore, the project is classified as an environmental Category C according to the World Bank's Operation Policy on Environmental Assessment (OP/BP 4.01), not requiring environmental assessment. However, increased demand for services might indirectly contribute to soil and groundwater contamination from the additional amounts of hazardous HCW.

58. The project will work with health care providers in the project governorates. The project will only engage with providers who practice sound HCW management - a criterion which will be included in the project's minimum criteria for providers. Providers will be considered as practicing sound HCW management if they follow the SFD IV HCW Management Plan[30], and have valid quality certification from the GIZ-managed Quality Improvement Program (QIP), demonstrating their capacity for HCW management.

59. As part of the project's ongoing quality assurance procedures, potential providers will be checked for their HCW management practices and certification prior to their engagement in project activities. Annual reevaluations will be carried out by the project in collaboration with the QIP and by SFD as part of its annual environmental audits.

[30] The Health Care Waste Management Plan was required under the Social Fund for Development Environmental Management Plan, updated on 27th January, 2009, Document No. E2364 V2, disclosed at the World Bank InfoShop on January 27, 2010

Safeguard Policies Triggered

60. No safeguard policies are triggered by the project.

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

E. Monitoring and Evaluation

Arrangements for Results Monitoring

61. The overall M&E framework comprises internal monitoring of implementation processes and activities, and external program monitoring and evaluation, as follows:

- Voucher Program Monitoring (internal M&E) comprises data collected through the program MIS, as well as data collected through fraud control and verification activities. Data are collected which enable management decisions to be made based on an assessment of whether the program is moving towards its objectives;
- External M&E includes: (i) External Technical Audit, initially on a six monthly basis (but possibly more regularly if required), which will provide independent monitoring of results on behalf of both SFD and World Bank; and (ii) the Impact Evaluation which will gather baseline, mid-line and end-line data to assess the impact of the vouchers on access to safe delivery and family planning services, as well as answer a number of additional important questions around for instance, coverage of the voucher services.

62. Internal Program Monitoring: the program monitoring system will provide data with which to identify the timely implementation of activities, the achievement of intended results, and positive and negative unintended effects. Key activities to establish the monitoring system will comprise: (i) capacity building of SFD in monitoring of voucher programs; (ii) design of a program database; (iii) development of registers and forms to gather data (voucher distributor registers, provider data collection forms); (iv) development of the claims processing system, which will feed data into the MIS; (v) design of wider monitoring and verification activities (such as spot checks of providers, client satisfaction surveys, sampling of beneficiaries at the household level) which will provide data with which to counter-check the MIS data.

63. Set up of MIS: The MNVP MIS will be integrated as far as possible with SFD's existing monitoring arrangements and systems and oversight for its operation will be provided by SFD monitoring and evaluation department. However, the design of the MIS will follow the MIS setup of the RHVP (type of registers, variables, how they are interlinked etc.). Core management data which will be collected to monitor program effectiveness and efficiency include:

- voucher sales
- rates of redemption of vouchers for each service
- voucher distributor performance
- voucher service numbers

- financial disbursements

64. The MIS will be made up of a number of different data 'registers', each containing information important to the running of the program and to measuring its outputs, and which together form the program database. These registers will be developed by SFD, with external support as appropriate, as part of its preparation and capacity building plan. The database is likely to contain at least the following information.

Table 10: Roles and Responsibilities for the MNVP

Register	Content
Provider	Name, address, type (public/private), level (CEmONC, BEmONC etc.), services provided, claims (submitted/suspended/amended/paid), amount paid, score of initial and annual quality assessments, type and date of HPP and other supply side investments in facility
Distributor	Name, address (governorate, district), eventually NGO/organizational affiliation, contact details, vouchers distributed, vouchers redeemed[31]
Voucher distribution	Vouchers printed (date/type), vouchers distributed to different distributors (date/type), client name, address, ID, contact details, type of voucher received, date, name of husband
Claims entry	Key data input section where claims data is entered as it is submitted by service providers
Verification and fraud register	Key data related to verification activities at district, governorate and national level such as number and type of voucher services verified, results of verification, sanctions taken in case of fraud etc.
Financial	Data related to payments to providers and distributors: Name provider/distributor, Date transfer, Invoice number, Amount transferred and corresponding exchange rate

65. Registers are interlinked, meaning data entered in one area will automatically appear in other relevant areas of the database. From the management information system the VMA will be able to draw reports that can be used for M&E purposes such as:

- Service provider reports detailing number of services provided per provider per month
- Distributor reports detailing type and number of vouchers distributed and vouchers utilized
- Key ratios such as number of vouchers redeemed as a proportion of those distributed and the numbers distributed per area or per distributor.

66. A wide range of data will be collected periodically. The VMA will use a mixed methods approach to M&E comprising quantitative data to be collected via the claims processing system and through regular reports from service providers and distributors, and qualitative data which will be drawn from client satisfaction surveys and routine monitoring visits by program staff. Sources of Data

[31] These last two pieces of data are used both to measure distributor performance and to calculate the performance based payment.

are: (i) the routine data collected through the claims processing system; (ii) data routinely collected at health facility level; (iii) additional data collected by SFD such as from distributor registers, spot checks and ad-hoc surveys; (iv) information collected during the verification processes. GIZ will be separately contracted to undertake provider assessments for approved entry to the voucher scheme, as well as regular quality assurance, and data from these assessments will be made available to SFD.

67. Data Validation and Verification: In addition to the routine processing of claims (see Annex 4), data validation and verification is done both internally by SFD at different levels, and externally through the six monthly technical audit (if necessary, i.e. serious problems are identified, on a quarterly basis). Internal verification occurs at three principal levels: (i) at the district level, the Voucher Distribution Supervisor or contracted Consultant verifies a sample of 5 percent of all services delivered through a combination of telephone and/or home visits (the sample is generated monthly by the MIS and sent through the Branch Office to the person tasked with this activity; (ii) at Governorate level, 3-5 percent of the sample verified at the district level are then re-validated by governorate team member (done by telephone and if relevant through household visits); and (iii) at the central level a random sample of claims are also verified quarterly through contracted consultants. Also at the central level, the VMT will conduct trend analysis of the claims being processed to identify outlying data (utilization management) which is an established anti-fraud tool used in voucher schemes.

68. At SFD, day-to-day monitoring activities will be carried out by the M&E and IT Officer at central level, and overseen by the Project Manager, with technical support from SFD's monitoring and evaluation department. At Branch Office (Governorate) level, there will be team of 3 full-time people, one of which will be responsible for data entry and processing. External technical assistance will be utilized for the set-up and smooth running of the M&E system and as far as possible, systems, processes and documents will be adapted from the KfW-financed RHVP monitoring systems.

69. The External Technical Audit will be done through sub-contract by SFD to an appropriately qualified organization using World Bank procurement processes. This audit will check health facility and MNVP registers at the provider level, examine a sample of distributor registers, as well as a sample of beneficiary households. The audit will also look at the different levels of monitoring as undertaken by SFD to ensure that payments are being verified adequately against claims and services actually provided.

70. An Evaluation of Impact and Performance (the Impact Evaluation) will be separately contracted by the Bank and will look at the impact the vouchers have on service utilization, the cost of the services used, the efficiency of the voucher scheme, the supply-side response and the impact of combined demand- and supply-side interventions. It is expected that the evaluation will run using a 'before and after' step wedge design, making use of different timings, activities and phasing to create natural controls (i.e. districts where the voucher scheme is yet to be introduced).

71. It is expected that the evaluation will collect baseline data, midline data from areas where the scheme is being implemented and from areas where implementation is yet to start, and end-line data. Baseline data will be supplemented through information collected by the GIZ assessment of health facilities to assess minimum standards of care.

72. The overall objective of the Evaluation is to assess the impact of the scheme in five areas:

- What is the impact of the MNVP on the pre-defined 'Key Results' as set out in the Results Framework?
- What is the cost effectiveness of this scheme (i.e. actual reimbursement cost per activity/per client, total cost per voucher issued)?

- How efficient is the scheme (i.e. the ratio of VMA/overhead costs to reimbursement costs, proportion of vouchers fully/partially/not utilized, comparison of 'clinical costs' with 'non-clinical costs (e.g. transport)?
- To what extent was there a 'supply-side response? Did approved providers invest their reimbursements in: infrastructure; equipment; staff; staff training; improving client-friendliness; and so on?
- How does utilization differ among areas with only a demand side voucher intervention as compared to areas with a demand side voucher intervention as well as a supply side health facility strengthening intervention?

73. Project Monitoring requirements include:

- Semi-annual progress reports: These will report on the status of the project activities and cover project implementation over a period of six months. The report should describe the implementation status of key activities, project outputs derived during the previous six months compared to benchmarks, a brief overview of financial status and project disbursement, a summary of project challenges and constraints, and recommended actions. The report will include data that will originate from a synthesis of MIS and other monitoring data. Each report will provide important information needed to monitor the project and will include internally validated figures for performance and monitoring indicators. It should be provided no later than a month after the end of six-month period;
- Annual progress reports: Annual progress reports will cover project implementation over the previous year and provide a proposed budget and work plan for the subsequent year. It will also provide revised projections for project targets with respect to changes in the implementation plans. In addition to the semiannual reporting requirements (which would be combined with the annual report for the same period), these reports will include a summary of project performance, including reporting on the core management indicators set out above (vouchers distributed, vouchers transacted and so on). It will also contain a brief description of supply-side investments in MNVP participating facilities. Data will originate from a synthesis of MIS data, semi-annual reports, internal verification reports, external technical audit and qualitative monitoring tools (client exit interviews, small scale survey studies). These reports should be provided annually, within forty five days after the end of each calendar year;
- Project mid-term review report: The MTR report will be prepared at the end of the third year of the project. The function of the MTR will be to review at the mid-term point the project's overall performance in terms of achieving its expected outcomes. In addition, the MTR will assist in the evaluation of the efficiency and effectiveness of project activities; project management arrangements; the supervision mechanisms and the MIS; the effectiveness of institutional strengthening technical assistance activities; and the effectiveness of the project's targeting mechanisms. The results of the review will provide a basis for any modifications to the design, including changes in the reimbursement levels to providers. The MTR will include information about project expenditures and implementation progress compared to planned activities. It will also include a revised project implementation plan, targets, and disbursement projections based on the estimated number of services during the remaining years of the project;
- Project completion implementation and results report (ICR): The ICR will include an assessment of the achievement of the project development objectives, details on the status of implemented activities and the services provided to the target communities and the overall use of funds. This report will also include a summary of the Project's performance and monitoring indicators throughout the project's lifecycle. This report is to be submitted to IDA no later than six months after the Grant Closing Date.

F. Role of Partners

74. The MNVP will be aligned as much as possible with the KfW-funded RH Voucher Program. Possible joint or shared design components could include: using the same coordination body or other governance structure; a shared voucher design and anti-fraud mechanisms; selection and quality assurance of providers; coordination and cooperation on setting different voucher reimbursement or subsidy levels for providers (public versus private; level of the health system; rural versus urban); contracting templates; and possible provision of joint technical assistance. Aligned systems for monitoring of participating providers would also be beneficial and this should also be aligned as much as possible with the existing data collection systems in place in the public sector.

75. The proposed project is also aligned with the Yemen Health and Population Project, as it aims to improve access to a basic package of MNCH services in rural and urban slum districts with poor MNCH indicators. The HPP will be responsible for the following: (i) training of midwives, the main providers of services in rural areas; and (ii) upgrading Emergency Obstetric Care Centers (basic and comprehensive) in project target areas by training providers and equipping health centers with emergency obstetric care medical equipment and drugs. As well, the HPP will provide outreach services in remote rural areas that will integrate the delivery of maternal and reproductive health services in project target governorates.

76. The proposed project is also aligned with the Social Fund for Development Project, as it established a considerable number of emergency obstetric care facilities that can provide a strong start to the project in other governorates not included in the HPP such as Taiz and Hadramout. These governorates will be considered to be included among the target project governorates of the HPP to ensure the delivery of an integrated package of services in the World Bank financed projects in Yemen.

Annex 4: Operational Risk Assessment Framework (ORAF)

REPUBLIC OF YEMEN

Maternal and Newborn Voucher Project

<table>
<tr><td colspan="7">Project Stakeholder Risks</td></tr>
<tr><td>Stakeholder Risk</td><td>Rating</td><td colspan="5">Moderate</td></tr>
<tr><td rowspan="2">Risk Description:
SFD is unable to reach the target direct beneficiaries (poor pregnant women and poor women of reproductive age living in the project target areas) and indirect beneficiaries (voucher health service providers</td><td colspan="6">Risk Management:
There is robust evidence base that voucher increase utilization of services and moderate but growing evidence that vouchers can lead to improved quality of care. SFD have experience in contracting and it is expected that the health care providers will readily join the MNVP due to the voucher reimbursements provided through the project. The SFD will also depend on the use of trained midwives in rural areas to compensate for the lack of health facilities, as well as the use of NGOs and other community based organizations (CBOs) that can better reach the target population. The SFD has a comparative advantage in implementing community based activities through promoting the voucher scheme through their huge team of community health workers and its ability to work with NGOs/CBOs.</td></tr>
<tr><td>Resp:
Client</td><td>Status:
In Progress</td><td>Stage:
Implementation</td><td>Recurrent:
☐</td><td>Due Date:
29-Mar-2019</td><td>Frequency:</td></tr>
<tr><td colspan="7">Implementing Agency (IA) Risks (including Fiduciary Risks)</td></tr>
<tr><td>Capacity</td><td>Rating</td><td colspan="5">Substantial</td></tr>
<tr><td>Risk Description:
Description:

i. The implementing agency may not have adequate capacity to manage the project as they do not have any experience with use of voucher schemes.

ii. There is a concern that SFD is spreading itself too thin in engaging in various sectors/activities in which they may not have a comparative advantage and duplicating the role of the line ministries.</td><td colspan="6">Risk Management:
i. SFD has been implementing projects since 1997 and has sufficient staff to implement project activities, including procurement and FM management. It has an excellent M&E system supported by a strong MIS. There are nine branch offices covering all 23 governorates, and through these offices, SFD is able to reach out to most communities delivering basic services to places which the Government cannot reach. Most of its operations have now been decentralized, and sufficient capacity has been built at the branch office level to implement complex operations. In addition, SFD has a long list of trained national consultants who can be mobilized to complement SFD staff in meeting human resource needs. It also has internship programs to hire recent university graduates, especially from rural areas, and to train them to participate in the development field. SFD is now capable of carrying out a complex impact evaluation.</td></tr>
</table>

iii. SFD's capacity to carry out the financial, verification, and procurement management functions.	ii. The SFD has a long history of intervention in the health sector. This project is consistent with the natural development of SFD which is shifting its focus from investing in inputs supporting building and rehabilitating health facilities and training of health workers towards output-based disbursement stimulating demand for health services and increasing utilization of these services. iii. The SFD has an effective FM system and qualified FM staff and internal control system capable of implementing the FM arrangements under the project. The SFD has past experience in monitoring projects and will benefit from technical assistance from this project. Procurement of consulting services is anticipated, with no procurement of goods or works planned. A formal procurement capacity assessment would be carried out during preparation to identify capacity gaps, if any, and to suggest measures to improve capacity to the extent required to mitigate related risks.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Client	Not Yet Due	Implementation	☐	29-Mar-2019	
Governance	**Rating**	**Substantial**				
Risk Description: Description: i. Weak social accountability and governance environment in Yemen may lead to elite capture and could affect service quality. ii. Inaccuracy of the invoices submitted by the service providers for reimbursement noting the amount to be reimbursed depends on variables such as provider type, level of health system and location iii. The low capacity of community midwives and checks and balances to be implemented for the management of the cash benefits due for selected beneficiaries	**Risk Management:** Risk Management: i. The participatory techniques and the governance mechanisms incorporated in the SFD's Operational Manual will ensure transparency of processes and reduce opportunities for elite capture. Complaint handling mechanism and communication strategy are in place and transparent participatory and social accountability arrangements will be utilized. In addition, SFD has been partnering with local communities and local authorities to empower them through its nine branch offices. The program empowers the local authorities to prepare self-initiated development plans with community participation in line with the available local resources and based on the priorities of local communities. As of September 2012, 1,294 village councils had been formed with equal numbers of male and female members being trained. In this current phase, 38 NGOs and 933 CBOs have been supported to strengthen their capacity. ii. Both the SFD and community-based organizations, through verification and claim processing, will verify the accuracy of all documentation submitted to the SFD for reimbursement.					

iii. The SFD will train the community midwives on the required checks and balances which will be documented in the project's operations manual.

Resp:	Status:	Stage:	Recurrent:	Due Date:	Frequency:
Client	Not Yet Due	Implementation	☐	29-Mar-2019	

Risk Management:

i. Targeting will be based on established criteria that is reflected in the project's operations manual and tested on a sample basis to ensure compliance.

ii. The project design incorporates a strong fraud prevention strategy. A range of tried and tested activities include: sampling five percent of all voucher claims and following back to the client; unannounced/ad-hoc visits to providers by VMA representatives; a robust claims processing system such as those used by private health insurers, including trend analysis to identify statistical anomalies in claims. These are detailed in the project operations manual.

Resp:	Status:	Stage:	Recurrent:	Due Date:	Frequency:
Client	Completed	Preparation	☐		

Project Risks

Design	**Rating**	**Substantial**

Risk Description:

i. Insufficient number of providers for comprehensive and basic emergency obstetric and neonatal cares (CEmONC and BEmONC) with the capacity to offer services of adequate quality to women through the voucher program and poor referral system.

ii. Quality standards in all health units (particularly in lower level health facilities, are too low for the introduction of a voucher scheme, which will lead to increased demand, thereby putting additional pressure on service providers. For entry level midwives, start-up costs may be too high for those midwives deemed to be performing below the minimum standard of care.

iii. Difficulties in reaching women in rural and hard-to-reach areas and cultural barriers will prevent women

Risk Management:

i. The MNVP will be introduced in Governorates where the HPP is working and will therefore benefit from supply-side investments in participating health facilities (infrastructure, training). Additionally, the entry point for the project in rural areas will be private midwives operating at the community level who will be encouraged to refer women for an institutional delivery and, where necessary, to provide assistance at delivery in the community. There is a large and growing network of private, community-based midwives in Yemen (well over 3,000) and the Yemeni Reproductive Health Strategy explicitly aims to expand the network of community midwives to cover 70 percent of rural areas by 2015. The MNVP will explicitly address weaknesses in the referral system by strengthening linkages between the different levels of the health system (MW, through Basic Emergency Obstetric and Neonatal Care to Comprehensive Emergency Obstetric Neonatal Care) in participating geographical areas and aligning with other projects working to improve referral system in the project area (such as interventions providing ambulance services for referral). Referral from the household to the provider (the 'first delay' in accessing care) will be partly addressed through providing financial contribution towards the cost of transport in rural and hard-to-reach

<table>
<tr><td rowspan="2">from seeking institutional delivery services. In addition, capacity of the community volunteers to identify and register beneficiaries might not be adequate.</td><td colspan="6">areas

ii. MNVP may also follow the model of the KfW RHVP which will work with the GIZ-financed Quality Improvement Program (QIP) to measure and improve quality of care in participating facilities. Other mechanisms can be explored such as making advance payments to midwives, repayable against voucher reimbursements.

iii. Lessons and experience gained through Safe Motherhood Project (SMP) in reaching and registering women will feed into the design of MNVP. Likewise lessons from other voucher programs, which have successfully adopted a voucher distribution strategy of door to door visits (i.e., Pakistan), will be taken in consideration. Additionally, the SFD has many years of experience working at the community level and an in-depth understanding of potential barriers to accessing health services and will be using local community organizations for reaching rural and hard to reach areas. The KfW Voucher Project has a similar objective to increase access to and utilization on quality MNCH and FP and will be in operation for at least one year before MNVP starts, thus providing lessons from the field. Experience shows that a combination of addressing financial and transport barriers to accessing services, together with targeted information about services will overcome cultural barriers. This has been demonstrated in the SMP in Yemen as well as in voucher schemes elsewhere. In addition, the pilot in Lahj for the KfW-financed VP will inform the design of targeting strategies for both voucher programs in Yemen. Further, a training program will be carried out by the SFD to train the community volunteers in the identification and registration process.</td></tr>
<tr><td>Resp:
Client</td><td>Status:
Not Yet Due</td><td>Stage:
Implementation</td><td>Recurrent:
☐</td><td>Due Date:
29-Mar-2019</td><td>Frequency:</td></tr>
<tr><td>Social and Environmental</td><td>Rating</td><td colspan="5">Low</td></tr>
<tr><td rowspan="2">Risk Description:

i. Indirect minor environmental impact as a result of improper handling of increased volumes of medical waste generated by service providers (public facilities and profit and non-profit NGOs)

ii. No social safeguard risks are identified with this project.</td><td colspan="6">Risk Management:

i. Public facilities are expected to already apply the HPP EMP medical waste management guidelines and auditing system. Profit and non-profit NGOs will receive similar training and will be audited as part of the quality assurance activities of the MNVP. Funds will also be set aside for continued auditing of both public and NGO service providers after the closing of the HPP.</td></tr>
<tr><td>Resp:
Client</td><td>Status:
In Progress</td><td>Stage:
Implementation</td><td>Recurrent:
☐</td><td>Due Date:
29-Mar-2019</td><td>Frequency:</td></tr>
<tr><td>Program and Donor</td><td>Rating</td><td colspan="5">Moderate</td></tr>
</table>

<table>
<tr><td>Risk Description:

i. Risks inherent in adopting a voucher approach in Yemen, as opposed to other approaches (input-based, performance-based contracting and so on)

ii. The voucher scheme encourages a vertical approach to programming instead of reinforcing system-wide strengthening

iii. Lack of alignment between MNVP and the KfW RH Voucher Program leads to confusion about the voucher approach</td><td colspan="6">Risk Management:

i. The design of MNVP will be based on a similar voucher program being financed by KfW that started its operational phase in May 2013. The KfW scheme has a small pilot in Lahj during the Design Phase (Nov'12 – April'13) followed by its introduction in three Governorates. MNVP will learn both from the KfW Yemeni voucher scheme as well as other voucher programs elsewhere (Kenya, Uganda, and Cambodia etc.). Specifically, synergies can be gained in the design of the voucher, marketing & distribution strategy, claims processing methodologies, fraud prevention measures, monitoring and evaluation framework. There is strong evidence that the voucher approach leads to increased utilization (Meyers et al., 2011; Bellows et al., 2011)

ii. A focus on maternal and newborn care and family planning is firmly in line with government policy and will support the MOPHP in addressing two of the weakest areas of MDG progress. In spite of the initial focus on two service packages (safe delivery, and Family Planning), the voucher scheme can be designed in such a way as to impact on other levels (e.g., "spill-over effects" to other services through improved infection control and other quality improvement measures, staff retention and training and so on). Once successful implementation is achieved, expansion to other services can be considered as well expansion geographically to other areas.

iii. A Coordination or Oversight body with representation from donors and other key stakeholders in government and IDPs is proposed to ensure learning across voucher projects as well as other SFD initiatives such as the social cash transfer program.

<table>
<tr><th>Resp:</th><th>Status:</th><th>Stage:</th><th>Recurrent:</th><th>Due Date:</th><th>Frequency:</th></tr>
<tr><td>Client</td><td>In Progress</td><td>Implementation</td><td>☐</td><td>29-Mar-2019</td><td></td></tr>
</table>
</td></tr>
<tr><td>Delivery Monitoring and Sustainability</td><td>Rating</td><td colspan="5">Substantial</td></tr>
<tr><td>Risk Description:

i. Sustainability of the voucher program</td><td colspan="6">Risk Management:

i. Voucher programs which target the poor and underserved in remote rural areas will require long-term funding. Some institutional sustainability will come through capacity building of Yemeni institutions such as SFD (in voucher management) and other government partners involved in coordination (governance). Voucher programs introduce skills into the health sector which facilitate the later introduction of social health insurance, including provider selection, accreditation, contracting and payment; monitoring and evaluation and fraud prevention. Where a nominal charge is made for the voucher, this can also introduce the concept of pre-payment. Additionally, the</td></tr>
</table>

	Coordination or Steering body will act as the main agency for leveraging additional funding from other institutions.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Client	Not Yet Due	Implementation	☐	29-Mar-2019	
Other (Optional)	**Rating**					
Risk Description:	**Risk Management:**					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
				☐		
Overall Implementation Risk:	**Rating**	**Substantial**				
Risk Description: The substantial risk for implementation has been given because of the novelty of the voucher scheme mechanism in Yemen.						

Annex 5: Implementation Support Plan

REPUBLIC OF YEMEN

Maternal and Newborn Voucher Project

Implementation Support Plan

1. Given the substantial risk rating of the project, the World Bank team will need to provide continuous implementation support to the project by organizing at least three missions per year throughout the project duration.
2. In addition, the team will strengthen its presence in the field by the presence of a Senior Health Specialist to provide support on the ground on a daily basis.
3. Given the technical requirements for the design and implementation of the voucher scheme, the Bank team will be supported by the services of an international consultant firm specialized in voucher schemes.

Table 11: Implementation Support Plan

Time	Focus	Skills Needed	Resource Estimate	Partner Role
First twelve months	1- Building the capacity of the SFD to be a qualified VMA 2- Launch the pilot in two project target governorates 3- Unification of the guidelines with KfW 4- Conduct the baseline survey for impact evaluation	-Senior Health Specialist -Voucher Management Specialist -Financial Management Specialist -Health Planner -Health Specialist -Research Assistant -Program Assistant -Team Assistant	USD 200,000	KfW is implementing a voucher program in other governorates in Yemen ahead of the IDA financed project. There will be exchange of experience between the two projects through learning and knowledge events
12-48 months	Full fledge implementation of the voucher scheme in project governorates	- Senior Health Specialist - Voucher Management Specialist - Financial Management Specialist	USD 200,000	Unifying technical and operational guidelines for the Voucher Program with KfW.

		- Health Planner - Health Specialist - Research Assistant - Program Assistant Team Assistant		
Other				

Table 12: Skills Mix Required

Skills needed	Number of staff weeks	Number of Trips	Comments
- Senior Health Specialist - Voucher Management Specialist - Financial Management Specialist - Health Planner - Health Specialist - Research Assistant - Program Assistant - Team Assistant	6 2 2 4 8 4 4 4	At least 15 for the duration of the project	

Partners

Name	Institution/Country	Role
KfW	HQ and Country office	KfW is implementing a voucher program in other governorates in Yemen ahead of the IDA financed project. There will be exchange of experience between the two projects through learning and knowledge events and unifying technical and operational guidelines for the Voucher Program.

Annex 6: Economic and Financial Analysis

REPUBLIC OF YEMEN

Maternal and Newborn Voucher Project

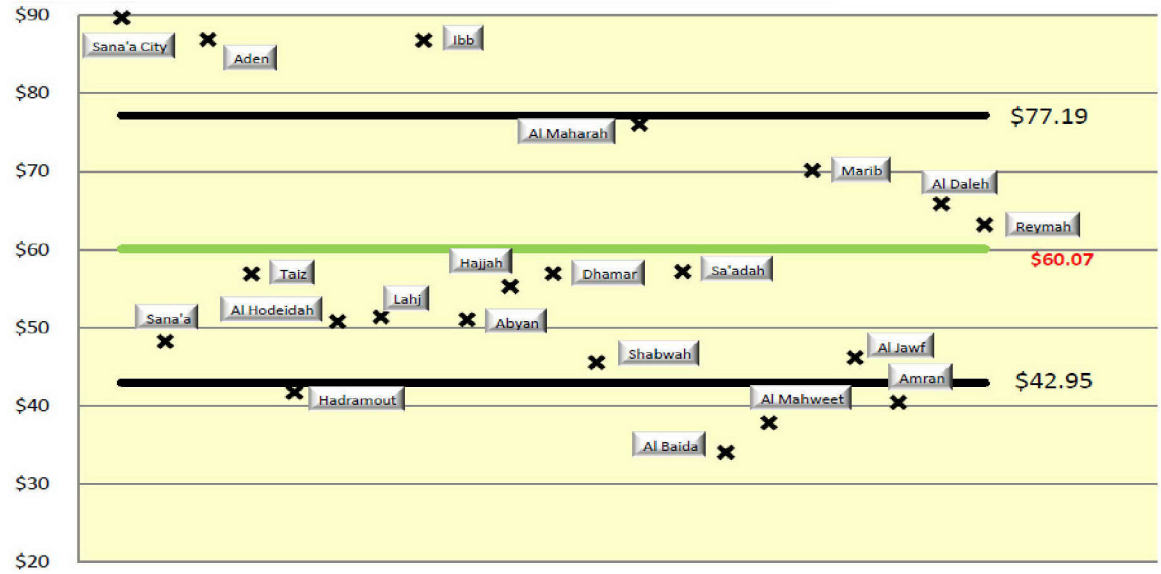
I. Background

1. Yemen has the highest maternal mortality in the MENA region with 1 in 90 lifetime risk of maternal mortality. In every 100,000 live births, around 210 women die from obstetric complications according to the UNICEF (UNICEF, 2013). This high maternal mortality is mainly due to the shortage of skilled personnel (doctors, nurses, midwives) for antenatal, delivery and postnatal care.

2. Pregnancy and child birth are life-threatening events in Yemen. Maternal mortality is the leading cause of all deaths among women aged between 15-49 years (Chase, 2003), and most of them occur during the third trimester and the first week after pregnancy (Carine Ronsmans, 2006). According to the DFID, most of the maternal mortality in the developing countries, like Yemen, is entirely avoidable (DFID, 2010). Additionally, the high maternal mortality in the country is only the tip of the iceberg. For each woman who dies, around 30 others suffer critical illnesses and chronic disabilities (DFID, 2010).

3. Spending on health in Yemen is characterised by a low Government contribution (5.23 percent of total GDP, of which 29 percent is the Government share; Yemen-NHA 2007) and high out of pocket payment (67 percent of total health expenditures). Patterns of geographical and socioeconomic inequity persist. Although the average per capita health expenditure stands at USD60, the picture becomes different once stratified by Governorates (Figure-1; NHA 2007). The geographic distribution of health services is biased towards the economically advantaged areas. The majority of maternal mortality in Yemen is concentrated among poor women living in rural areas (DS., 2000).

Figure 4: Average per capita health expenditures by Governorate in Yemen, NHA 2007



4. Poverty is one of the main risk factors for maternal mortality in Yemen. The poorest mothers, compared to the wealthiest, are 75-86 percent less likely to receive prenatal and delivery care. Currently, around 40 percent of the population, particularly poor women, has no access to health services (Sanaa, 2009). An estimated 84 percent of women nationwide deliver at home, and only 22 percent of women have skilled assistance during delivery (RHR, 2008) (UNDP, 2010).

5. In an effort to increase equity in the health system, the objective of the project is increase access to and utilization of maternal and newborn health services in selected poor rural and urban areas in Yemen. This is to be realized through the adoption of a voucher scheme for the provision of the maternal and child health services to the beneficiaries (demand side financing) and the capacity building of the SFD and the providers through the linkage with the on-going HPP (supply side).

II. Cost Benefit Analysis

6. This economic analysis seeks through a number of plausible assumptions, to weigh the benefits and costs of such an intervention, and to specifically address the following questions;

    a. What would be the cost of implementing such a project (in comparison with the current situation i.e. status quo)?
    b. What would be the benefits of implementing such a project? (in comparison with the current situation i.e. status quo)?

7. The analysis employs a societal perspective and is based on an analytic horizon of ten years (five years of project intervention and five years post intervention). Given uncertainty in costs after this period and high rate of discounting, additional costs and benefits after a ten year period may have limited value.

8. Given the total health expenditures in Yemen (US$1.3 billion, 2011) and the annual government contribution (US$0.38 billion, 2011), the project accounts for 0.7 per cent of the total health expenditures and targets around 1 per cent of the total population of 24.0 million people. For all calculations an exchange rate of 1 YER=US$0.004 is used (as of September 6, 2013).

A. Direct Benefits

Benefits due to decreased mortality, morbidity, and out of pocket expenditures

9. Different types of inequity are evident in the health system particularly with respect to access and utilization of maternal health services. Around 40 percent of the population have no access to health services due to their disadvantaged locations in the rural and poor areas. Approximately 84 percent of Yemeni women deliver at home due to a variety of reasons among which are the transportation fees and the lack of services. The utilization of maternal health services is severely in favour of the wealthiest quintile when compared to the poorest women (Tanja AJ Houweling a, 2011). In terms of efficiency, the productivity of the Government maternal health delivery system is low. One measure of the low productivity is the very low attended skilled deliveries, which indicates that a substantial portion of fixed capital is not well utilized.

10. Shifting from out-of-pocket (OOP) payments for maternal healthcare services at the time of use to prepayment through the voucher scheme (demand-side financing) is a step towards averting financial hardships associated with paying for health services. The percentage of women encountering catastrophic maternal health expenditures in Yemen is not available. International evidence from comparable socioeconomic populations suggests that maternal health expenditure induced poverty increased by 20 percent in both urban and rural areas (Saradiya Mukherjee, 2013). For this reason, demand side maternal healthcare financing programs need to consider the costs incurred during prenatal, prenatal and postnatal periods.

11. With the effective coverage of the target population, the project is expected to directly address the aforementioned issues in the target area through the generous package of prenatal, delivery, postnatal, and family planning health services as well as food and transportation subsidies. Utilization rates are expected to match those among higher income groups. Additionally, the target population and their families should be protected against health expenditure shocks.

12. **Target population**: Based on the cost estimates of the currently running KFW safe motherhood program in Yemen. The average cost of the safe motherhood project stands around US$70 (provision of health services) + US$2.50 (for family planning services) + US$5.30 (for distribution of vouchers). Additionally and adopting the redemption rate of the same project (75 percent), it is expected that the US$16.2 million allocated for the first component of the project will cover around 330,000 eligible women, of which around 250,000 will redeem the vouchers.

13. **Mortality benefits:** The impact of maternal health voucher programs on the utilization of health services is evident. It ranges from as low as 50 percent increase to reach 200 percent in some cases. The positive association between utilization and improvement of health status is established. All maternal mortality in the developing world is entirely avoidable and preventable according to DFID (DFID, 2010). Assuming that the project in Yemen will directly prevent **maternal mortality** of the target population over the ten year period, the project would be expected to save around 240 lives in total. This number is based on conservative estimates given that the average MMR in Yemen (210 per 100,000) is far better than the one among the poorest. If we assume that these lives are saved over a period of 4 years starting at the end of the first year of implementation, the total number of life years saved because of the project would be **1800 life years** ((60*9)+ (60*8)+ (60*7)+ (60*6)).

14. 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 USD 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 U.S and US$50,000 per year of quality life use internationally. Adopting a very conservative assumption (US$10,000 for each of life-year saved) for the Yemen context will yield a total annual economic benefit of **US$18 million** for the target population.

15. The average Infant mortality rate, on the other hand, stands at 44 per 1000 births in Yemen. Yemen DHS survey revealed an apparent variation of neonatal, infant and child mortality between urban and rural areas (DHS, 2001). Another study in Yemen has shown that the majority of infant mortality direct causes (prematurity 47 percent and birth asphyxia 23.7 percent) are preventable (Sallam, 2005). So, if we adopt the average infant mortality rate on our target population, around 5060 infant mortalities could be estimated. This is a conservative assumption given the low socioeconomic indicators of the target population. Assuming a mere 25% project effectiveness with respect to the **preventable infant mortality** (70 percent of the total infant mortalities), around **6630** life years would be saved by the project (70 percent of 5060*25 percent=885 lives) over four years of implementation starting from the end of first year ((221*9) +(221*8)+(221*7)+(221*6)). Adopting the same estimates of the statistical value of lives, the project would save around **US$66.3 million.** These cost saving estimates are conservative given that surviving motherless children are 3-10 times more likely to die within two years of birth compared to those with surviving mothers according to the WHO. Also, the infant mortality rates adopted from the DHS are lower than the UNICEF and WHO estimates.

16. **Morbidity benefits:** Covering around 115,000 beneficiaries mainly from the poor, would also result in savings in terms of morbidity. In fact, maternal mortality is only the tip of the iceberg. For each woman dies, around 30 others suffer critical illnesses and permanent disabilities according to DFID (DFID, 2010). Adopting this, around 7200 women of the target population are expected to face critical maternal morbidities.

17. The project shall positively impact both labour supply and workplace productivity. International evidence suggests 20 percent higher productivity of women if their health problems were addressed during pregnancy (Islam, 2006). Other evidence estimates an average loss of 22.6 work days of productivity in one single episode of illness during and after delivery (IMMPACT, 2010). This is manifested by both absenteeism (not present at work as a result of injury or illness) and presenteeism (low at-work productivity due to impairment from a medical condition).

18. Adopting the ICRC figures of the average annual salary in Yemen US$1200 and using wage as a proxy for productivity (Resource-center, 2009), each sick woman due to only one single episode of illness will be losing around US$112.5 (22.5 work days*1200/235 total work days). The implementation of the project shall save around **US$0.8 million** (7200 expected morbidities*112.5 USD)

19. Unfortunately, the cost of maternal mortality and morbidity is not limited to mothers. In Yemen, around 32 percent of children are born with low birth weight (LBW), which constitutes 60-80 percent of neonatal deaths (UNICEF, Key Facts and Figures on Nutrition, 2013). Under international plausible assumptions, around USD 580 are needed to move LBW children into non-LBW category (Islam, 2006). The effective implementation of the project could partially address this issue through the antenatal, postnatal and family planning healthcare services. Assuming a conservative 10 percent effectiveness of the project in this regard on the target population and excluding the expected infant mortality (5060), the project is expected to save around **US$1.84 million** (32 percent of target population-(5060 expected mortality)*580 USD*10 percent effectiveness). This is an extremely conservative estimation due to the exclusion of the cost of stunting (1 in 2 children in Yemen) and its consequences on future earnings (22 percent loss of yearly income in adulthood). Yemen loses around 3 percent of its entire annual GDP due to stunting.

20. **Health expenditure benefits:** The project through its voucher scheme shall save direct out of pocket health expenditures paid by the target population. The target population don't usually spend much money on prenatal or delivery services due to the fact that they deliver at home. The main financial burden is primarily attributed to the treatment of post-delivery and life-threatening obstetric complications. International evidence from comparable low income countries in Africa suggests an average cost per case of USD 48-256 (Ye F, 2012).

21. Adopting the lowest cost (US$48), the project is expected to save the target population around **US$0.35 million** (7200 morbidities*48). This figure is conservative when we consider the other OOP expenditures on the infant morbidity treatment.

B. Indirect Benefits

Improvements in quality of MCH services and declines in fraud

22. Demand side financing of healthcare services could potentially positively enhance the quality of services through different provider payment mechanisms and incentive schemes. The proposed payer functions of the project along with the grievance mechanism are expected to partially address the poor quality of services provided in the target governorates. This impact shall be maximized by the on-going HPP in Yemen (supply side financing).

23. Moreover, the effective adoption of payer functions through the voucher schemes is expected to depend on information management system. This, per se, is expected to ameliorate poor medical practices, reduce fraud waste and abuse, and improve the quality of services. It is reasonable to assume that the combination of the information system that will be introduced through this project along with the institutional development that will be undertaken by the SFD, is expected to reduce the financial impact of poor quality practice and fraud, waste and abuse by only 10 per cent in the target area. This poor practice represents 10 per cent of public health expenditure. Accordingly, a 10

per cent reduction in the financial impact of the poor practice of services provided to the 1 per cent population (230,000 mothers and infants) benefiting from the project in Yemen would yield approximately **USD 0.4 million** per year (0.10 *USD 0.4 bn*0.01). These estimates are excluding the economic and social benefits of better quality services and customer satisfaction.

Benefits due to family planning

24. A recent economic analysis undertaken on the impact of family planning in Yemen has shown a cumulative cost saving of USD 60 million in the education sector alone if family planning needs were met in the country over a period of 5 years (USAID, 2009). The same analysis concluded that the cost savings outweigh the family planning costs with a factor of 8 to 1 (Figure-2&3) due to its impact on other MDGs.

Figure 5: Cumulative primary education cost-savings, 2010-2015 (in USD millions)

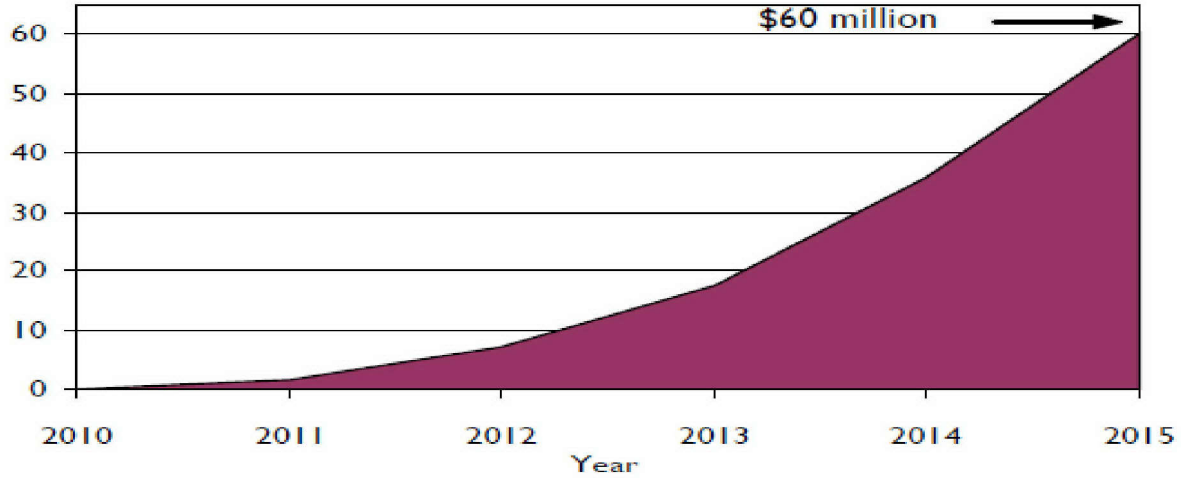
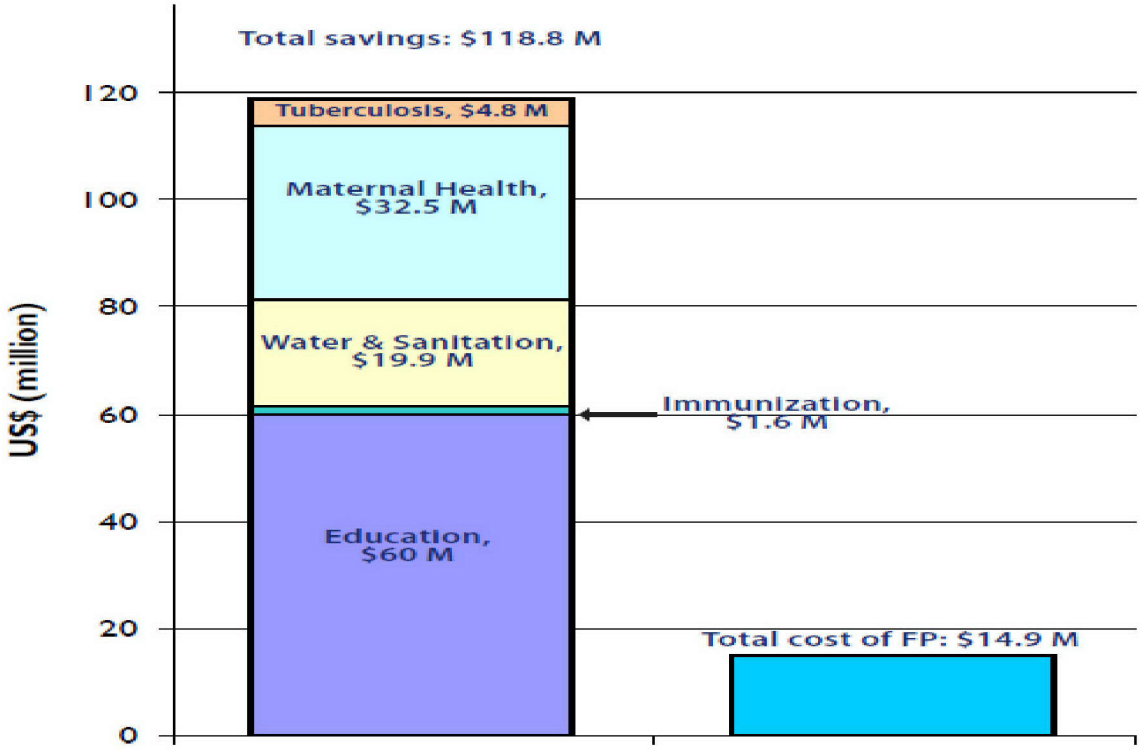


Figure 6: Social sector cost savings and family planning costs in Yemen



25. Accordingly and excluding the health benefits from the above estimates, a factor of 5.8 to 1 of cost savings shall be yielded. This means that for every USD 5 spent on family planning services, around USD 29 shall be saved. Therefore, the project is expected to save around **USD 3.3 million** (USD 29*115,000). The direct cost savings from family planning avoided mortality and morbidity are excluded, though the USAID concluded that meeting family planning needs alone in Yemen could avert around 316,000 infant and child deaths along with 3,700 maternal deaths. This explains how conservative the aforementioned estimates are with regard to the generous service package provided to the target population.

26. Another excluded benefit is the one attributed to the labour intensive methods applied by the project. A number of community volunteers will be recruited in the process of distributing and raising the awareness of the target population. The actual number of community volunteers is yet to be decided but international evidence suggests a positive impact on both the community solidarity and the awareness of the program. Another element of the indirect benefits is the avoided child labour due to maternal mortality or morbidity.

C. Summary

27. Combined together and maximised by the on-going HPP, the project is expected to address some critical issues of equity, efficiency, and accountability of the financing and delivery of maternal health services in the target areas. This could materialise through encouraging the aggregate demand for maternal health services by the poor and building the institutional capacity of the payer (SFD).

Table 13: Expected savings

Savings	USD, millions
Mortality benefits (Direct)	84.3
Morbidity benefits (Direct)	2.64
OOP savings (Direct)	0.35
Efficiency improvements and reductions in fraud (Indirect)	0.4
FP social sector benefits (Indirect)	3.3
Total	**91**

28. Based on the set of assumptions outlined above and on bringing in the financial costs of the project investments, the returns to the project are summarized below. It is assumed that all costs are split equally over the first two year period and benefits accrue equally over the remaining eight year period.

Table 14: Returns of the project

Benefits/Costs	Present Value of Flows (US$)
Benefits	Cash flow net of recurrent costs: US$ 91 million to 2023 (discount rate 10 per cent)= present value of **USD 55.17 million**
Costs	Investment: US$10 million to 2023 (discount rate 10 per cent)= present value **of USD 9.55 million**
Net Present Value	**USD 45.62 million**
Benefit-Cost Ratio	**5.78**
Internal Rate of Return	**80 per cent**

D. Sensitivity Analysis

29. In order to understand the robustness of the project to different paces of realising the benefits and different discounting rates, the tables below summarises the potential returns and NPV of the project. The third table, however, draws different scenarios of voucher redemption. All estimates show a positive net present value and BCR greater than 1.

Table 15: Sensitivity analyses with different discount rates

Year	Net financial flow	Present Value		
		Base 10%	Low 15%	High 5%
0	-5	-5.00	-5.00	-5.00
1	-5	-4.55	-4.35	-4.76
2	11.38	9.40	8.60	10.32
3	11.38	8.55	7.48	9.83
4	11.38	7.77	6.50	9.36
5	11.38	7.06	5.66	8.91
6	11.38	6.42	4.92	8.49
7	11.38	5.84	4.28	8.08
8	11.38	5.31	3.72	7.70
9	11.38	4.82	3.23	7.33
NPV (USD, million)		**45.62**	**35.04**	**60.26**
BCR		**5.78**	**4.75**	**7.17**
IRR (%)		**80**	**80**	**80**

Table 16: Sensitivity analyses with different disbursement and benefit realization patterns

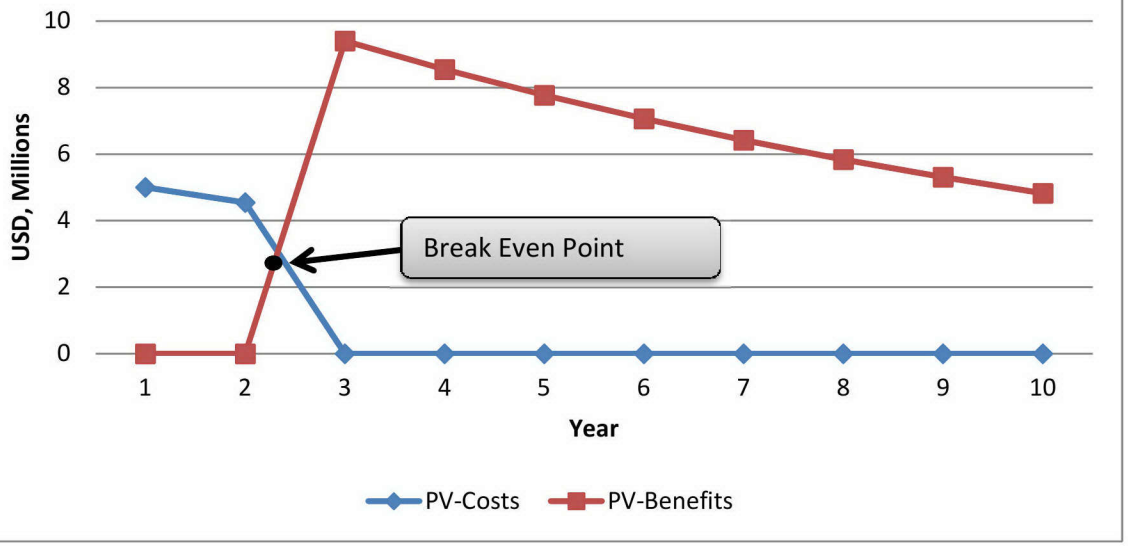
Year	Present Value (10% discounting)		
	Base (Benefits after 2 years)	Low (Benefits after 5 years)	High (Benefits after 1 year)
0	-5.00	-5.00	-5.00
1	-4.55	-4.55	-4.65
2	9.40	0.00	8.36
3	8.55	0.00	7.60
4	7.77	0.00	6.91
5	7.06	11.30	6.28
6	6.42	10.27	5.71
7	5.84	9.34	5.19
8	5.31	8.49	4.72

9	4.82	7.72	4.29
NPV	**45.62**	**37.58**	**48.68**
BCR	**5.78**	**4.93**	**6.1**
IRR (%)	**80**	**43**	**143**

Table 17: Sensitivity analyses with different service uptake rates

Year	**Present Value (10% discounting)**		
	Base (75%)	**Low (50%) (75000/150000)**	**High (90%) (120000/130000)**
0	-5.00	-5.00	-5.00
1	-4.55	-4.55	-4.55
2	9.40	6.12	9.83
3	8.55	5.56	8.94
4	7.77	5.05	8.13
5	7.06	4.59	7.39
6	6.42	4.18	6.72
7	5.84	3.80	6.11
8	5.31	3.45	5.55
9	4.82	3.14	5.05
NPV	**45.62**	**26.34**	**48.17**
BCR	**5.78**	**3.76**	**6.05**
IRR (%)	**80**	**56**	**83**

Figure 7: Net present value costs and benefits



30. The breakeven point will be realized during the second year or by covering only 60 percent of the estimated utilizing population (115,000)

III. Financial Sustainability and Fiscal Impact

31. Although the project is based on a grant financing tool, the very high returns from investment are expected to allow the government to replicate and/or scale up the project. The Government of Yemen, through its 2012-2022 health strategy, is clearly committed to the MCH improvements and this has been clear through the strides achieved over the last 10 years. Close independent monitoring, verification and validation of the project activities are expected to enhance the economic benefits and thus, the financial sustainability of similar replicas of the project.

32. Considering the new dedicated pro-poor MCH governmental agenda, the following measures are of critical importance, namely; (i) high level of commitment by the Government to invest in similar demand side financing MCH projects, particularly in the rural and farfetched areas the premiums after close of project; (ii) consider some co-sharing mechanisms in the future based on the success story of this project, like in Kenya and Uganda voucher programs; (iii) adequate technical and administrative capacity of the new SFD agency with regard to the effective cost containment and quality assurance. The project shall provide technical expertise with respect to the payer functions and optimal use of resources in the target areas; and iv) Integrating both family planning and MCH services together and working across sectors to maximize the synergy and cost-effectiveness.

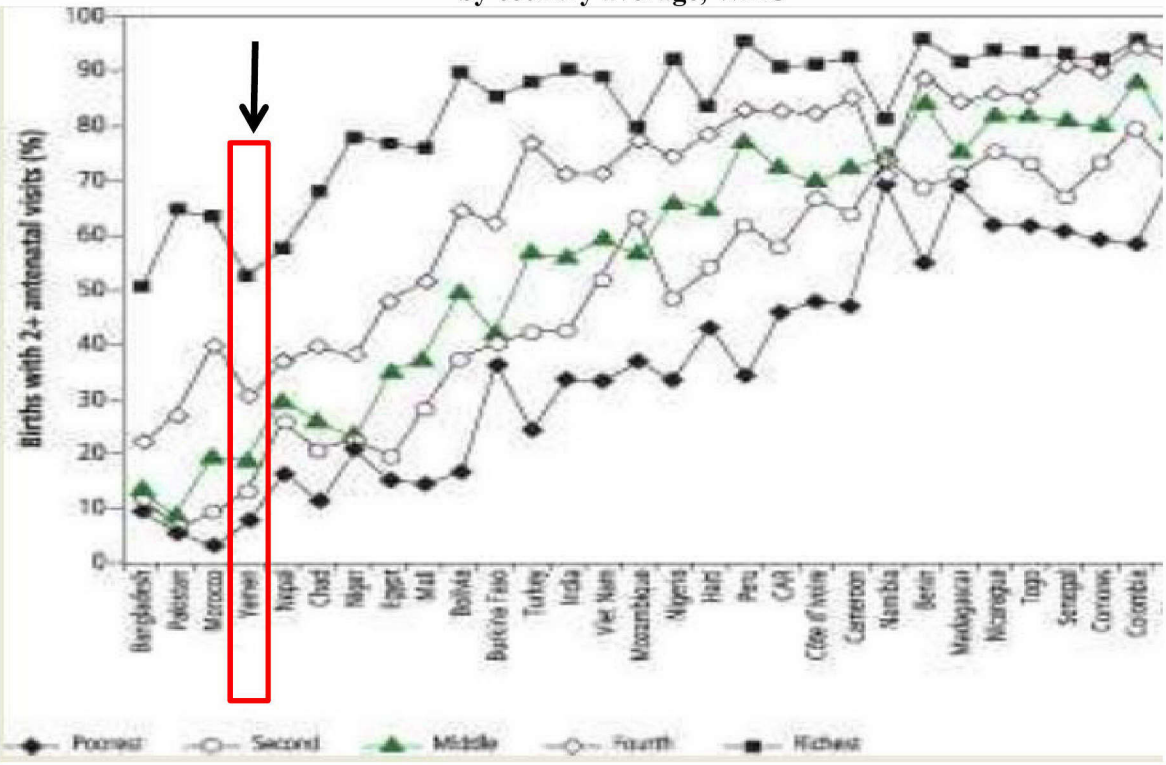
33. Given the project nature, it is unlikely that it will create any negative fiscal or financial burden on the Government over the implementation period (5 years).

IV. Appropriateness of Public Sector Provision or Financing

34. The target beneficiaries of this project are approximately 115,000 poor mothers in three of the below average per capita health expenditure governorates. The needs of this population can best be met through the public sector due to existing market failures which have excluded this population by leveraging existing public sector targeting methods that can be used to reach this population.

35. Due to endemic market failures, the poor women are excluded from the MCH and FP health services in Yemen. They are unable to access high quality affordable healthcare and as a result skimp on care or skip care altogether. The poorest mothers, compared to the wealthiest, are 75-86 percent less likely to receive prenatal and delivery care. Currently, around 40 percent of the population, particularly poor women, has no access to health services. An estimated 84 percent of women nationwide deliver at home, and only 22 percent of women have skilled assistance during delivery. The geographic distribution of health services is biased towards the economically advantaged areas. The majority of maternal mortality in Yemen is concentrated among poor women living in rural areas. Yemen is the fourth lowest country in the world with respect to professional delivery attendance, particularly the poor (Figure-5). Around 20 percent of Yemeni households face catastrophic expenses due to MCH healthcare. As a result, this target group tends to have worse health outcomes than the higher income population. The public sector, with its mandate of reducing inequities for the most vulnerable, is best positioned cater to the needs of this population.

Figure 8: Percentage of births with a professional delivery attendant for five wealth groups, ranked by country average, WHO



36. Reaching the poor is also difficult, and the public sector has targeting mechanisms such as geographic and community based targeting methodologies in place which can be used towards this end. By targeting and identifying the poor through labor-intensive community volunteers, the program provides an efficient use of public systems through the tie between social protection and health programs.

V. World Bank's Value Added

37. The World Bank has several comparative advantages, which result in creating value added—being able to leverage World Bank engagement in other sectors in Yemen to strengthen this project; being able to build on a long history of engagement in the health sector in Yemen; and being able to share global expertise on MCH and FP voucher schemes to the Yemeni government.

Benefits of using existing cash transfer schemes and synergies with Bank financed social protection project

38. This project directly leverages the World Bank's engagement in other sectors. The World Bank supports labor intensive public works, targeted nutrition interventions, and emergency crisis recovery projects for the poorest and most vulnerable in Yemen. Some of the intended beneficiaries of this project are expected to be the target population of the aforementioned cross sectoral projects. This allows the Bank to better understand the needs of the poor and provide them with improved access to social protection and healthcare services.

39. Additionally, the fourth social fund for development project, the payer of the vouchers project, is intended to build both the operational and technical capacity of the SFD to better respond to the needs of the most vulnerable population in Yemen. Therefore, the World Bank adds value with the

synergy of both projects and the availability of data on both the implementing agency and beneficiaries.

Building on past financial and technical assistance and congruence with future Bank strategic focus in the Yemeni health sector

40. Evident by its engagement in the health sector in Yemen, the World Bank has a long history of both financial and technical assistance and is largely viewed as a leader in this field with considerable convening power. In terms of financing, three recent health sector projects include Schistosomiasis Project (2009, Credit no. H542-RY, US$25 million); Health and Population Project (2011 - Credit no. H640- RY- US$35 million); Health Reform Support Project (2002 -Credit no. 3625-YEM - US$27.5 million), Child Development Project (2000- Credit no. 3326-YEM - US$28.9 million), Family Health Project (1993 - Cr no. 2525-YEM- US$26.6 million), and Health Sector Development Project (1990, Cr no. 2151-YAR - US$15 million)

41. In terms of technical assistance, the World Bank produced the Health Sector Review of Yemen in 2001. Besides, the Bank has engaged with the Yemeni authorities on health financing, service delivery, and health outcomes and as such this project is a natural extension of this work.

42. In addition, this project is congruent with the World Bank's future strategic direction in the health sector in MENA. The new World Bank HNP strategy for MENA (2013-2018) has the twin objectives of creating fair and accountable health systems in a sustainable manner. This project is a concrete way through which both these principles can be mainstreamed into country health systems.

Bank technical assistance drawing from international experience in health financing

43. The World Bank has been a pivotal player globally, in helping countries expand health coverage to the poorest. It has a Global Expert Team in health financing and has published several influential publications on health financing in developing countries. In addition, through its lending instruments it has provided support to countries expanding their MCH healthcare services to the poor. In Uganda, the Bank financed the Reproductive Health Vouchers in Western Uganda, which provides Reproductive health services to more than 200,000 Women, who tend to be among the poorest. The World Bank Institute (WBI) is one of the leading knowledge hubs on health financing including a one-week training course for health policy makers, "The Challenge of Universal Health Coverage– Health System Strengthening and Sustainable Financing." This course is offered in collaboration with Harvard University experts and is targeted to mid-level and high-level health and finance policy makers around the world.

44. As a result, the World Bank brings several advantages to bear which make it a suitable candidate to implement this project.

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Annex 7: Project Costs

REPUBLIC OF YEMEN

Maternal and Newborn Voucher Project

		ACTIVITY	IDA US$ M
Implementation			
Component 1		Improving Access to Maternal and Newborn Health Services (US$16.36 million)	**315 targeted**
		$16.36	**(190+125)**
1		Results-based payments for the reimbursement of vouchers for maternal and newborn health services	13.71
2		Results-based payments for the reimbursement of vouchers for family planning services	0.19
3		Results-based payments for the reimbursement of vouchers for Fistula	0.10
4		Distribution of vouchers	1.64
5		Marketing of vouchers	0.47
6		Training of voucher distributers	0.16
7		Design and printing of vouchers	0.09
Component 2		Results-Based Monitoring, Impact Evaluation, Quality Assurance, Verification, and Project Management (US$3.64 million)	
		$3.64	
1		Capacity building activities for (SFD) including results-based financing;	0.10
2		Project launching workshops	0.04
3		Independent external technical audit	0.65
4		Project communication strategy	0.20
5		Project management operating cost for SFD (includes claims processing and field supervision voucher distribution)	2.60
6		External financial audit	0.05
SUB TOTAL			
Physical Contingencies			
Price Contingencies			
TOTAL			**20.00**

Additional notes on setting the cost of service reimbursements

The KfW-funded RHVP established the initial value of reimbursements to providers through investigating the market prices paid by customers in the public and private sectors in different Governorates in Yemen, as follows:

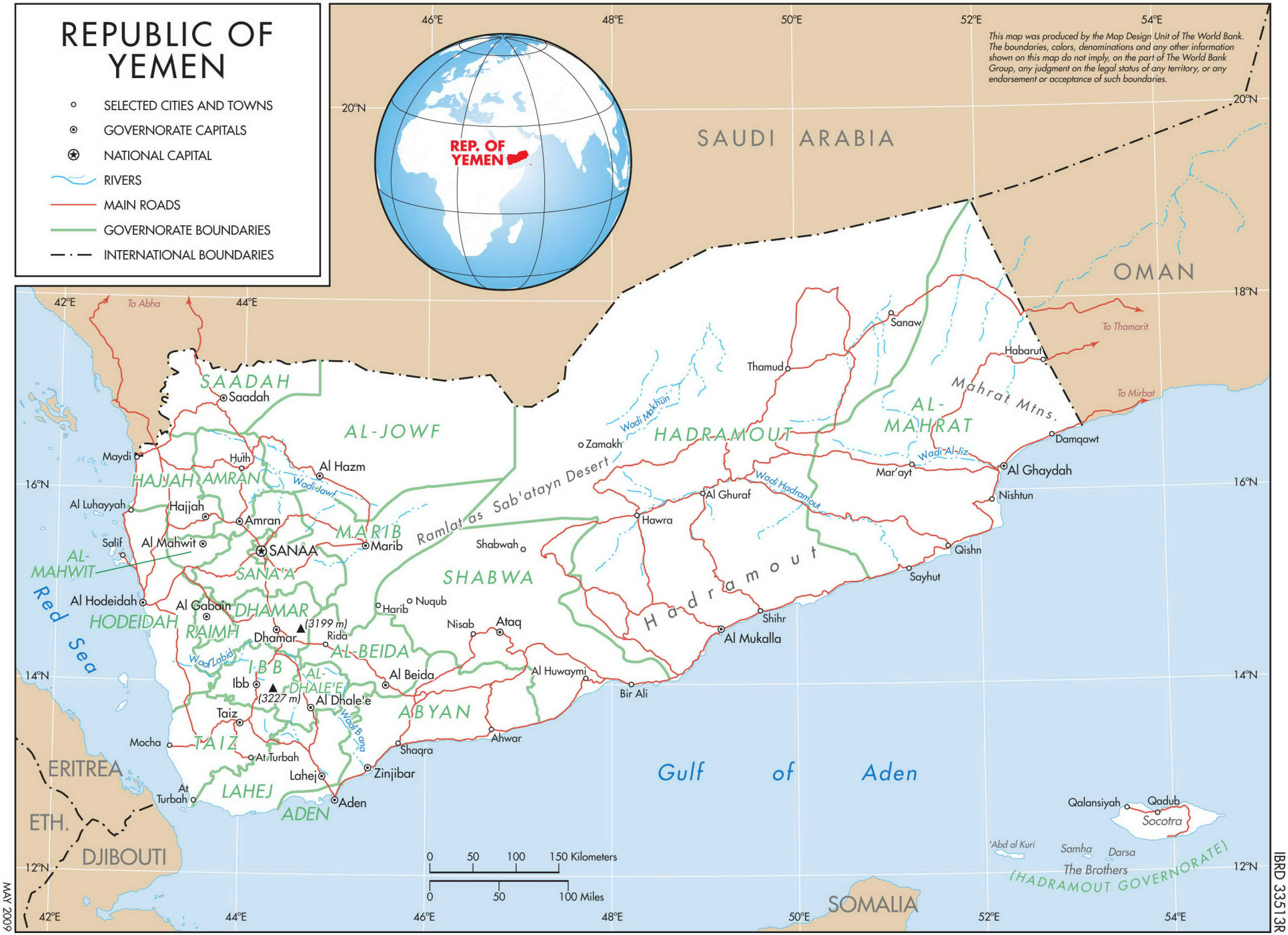
- Rapid Assessment of health facilities in Hajjah, Ibb and Lahj Governorates implemented in February 2012;
- Rapid assessment of health facilities in Lahj by the RHVP project in February 2013;
- Costing study of Health Services at district hospital level and health centers level commissioned by European Commission in 2008;
- Price lists from Rayaheen (Social Franchising network of the NGO Yamaan Foundation) and the World Bank Safe Motherhood Project;
- Interviews with stakeholders.

Using these data, a first list of prices was developed by the RHVP and discussed with key-informants. It was decided to establish the price for the public Voucher Service Providers at 80 percent of the price proposed for the private VSPs. Direct negotiations were then held with the public and private VSPs in Tuban district to be contracted by the RHVP. Several adjustments were made, prices for private sector slightly increased, while those initially developed for the public sector remained the same.

During the World Bank design workshop in Jordan (with representatives from World Bank, SFD, Options and MOPHP) the prices established for the RHVP were taken as a basis. One small adjustment was made to the price of normal delivery at home (for more details, see the Operational Manual). RHVP pays the actual price for costs of the management of complications; however the World Bank MNVP is considering using three cost bands: minor complications; medium-level complications; and major complications. These would need to be defined.

Although the project will pay transport, accommodation and food based on actual costs, it was necessary to estimate overall average costs per voucher service reimbursed, in order to budget for the MNVP. Using key-informants, average prices were established and, clearly these will vary according to the Governorate and district as well as over time. Experience gained during the urban and rural pilots will assist in refining the average costs for transport and food.

It is expected that, based on average rates of expected uptake of services, the average cost for service provision and payment of transport, food and accommodation to the project of one safe motherhood voucher distributed will be around US$72 and the average costs of one FP voucher distributed will be around US$1.50 (using medium estimates). This is based on a costing model which was built specifically to estimate the potential service and distribution targets and the costs to reach these targets. However, since very little data is available (some data is available from the RHVP Tuban pilot) at this point in time, the model has used a series of temporary assumptions which, after one year, will be replaced by data on the actual uptake of services. This may also change the average costs for the services. The overall costs for fistula services are estimated to be around US$100,000.


REPUBLIC OF YEMEN
SELECTED CITIES AND TOWNS
GOVERNORATE CAPITALS
NATIONAL CAPITAL
RIVERS
MAIN ROADS
GOVERNORATE BOUNDARIES
INTERNATIONAL BOUNDARIES
REP. OF YEMEN
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ETH.
DJIBOUTI
SOMALIA
Red Sea
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SAADAH
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HAJJAH
AMRAN
MA'RIB
SANA'A
AL-MAHWIT
HODEIDAH
RAIMH
DHAMAR
AL-BEIDA
I.B.B
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TAIZ
LAHEJ
ADEN
SHABWA
ABYAN
HADRAMOUT
AL-MAHRAT
Saadah
Maydi
Huth
Al Hazm
Al Luhayyah
Hajjah
Amran
Salif
Al Mahwit
SANAA
Marib
Al Hodeidah
Al Gabain
Dhamar
Rida
Harib
Nuqub
Nisab
Ataq
Ibb
Al Beida
Al Dhale'e
Taiz
Mocha
At Turbah
Lahej
Zinjibar
Aden
Shaqra
Ahwar
Al Huwaymi
Bir Ali
Shabwah
Zamakh
Thamud
Hawra
Al Ghuraf
Mar'ayt
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Al Mukalla
Sayhut
Qishn
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Al Ghaydah
Damqawt
Habarut
Sanaw
Qalansiyah
Qadub
Socotra
'Abd al Kuri
Samha
Darsa
The Brothers
(HADRAMOUT GOVERNORATE)
Ramlat as Sab'atayn Desert
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Wadi Bana
Wadi Mukhtin
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