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AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

PROJECT PAPER

YEMAN

OPTIONS FOR FAMILY CARE

279-0090

UNCLASSIFIED

Project Paper

OPTIONS FOR FAMILY CARE

USAID/Yemen

Project Number 279-0090

August 1991

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: X (A = Add, C = Change, D = Delete) — Amendment Number: _____

DOCUMENT CODE: 3

2. COUNTRY/ENTITY: YEMEN

3. PROJECT NUMBER: 279-0090

4. BUREAU/OFFICE: BUREAU FOR EUROPE AND NEAR EAST — ENE

5. PROJECT TITLE (maximum 40 characters): OPTIONS FOR FAMILY CARE

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 09 DD 30 YY 99

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)

A. Initial FY 91 B. Quarter 4 C. Final FY 98

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY 91 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	500		500	18000		18000
(Grant)	(500)	( )	(500)	(18000)	( )	(18000)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country	---		--		5894	5894
Other Donor(s)						
TOTALS	500		500	18000	5894	23894

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1)	DPA			0		10,600		18000	
(2)									
(3)									
(4)									
TOTALS									

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code

B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

IMPROVE AWARENESS OF BROAD POPULATION ISSUES AND INCREASE ACCESS TO A WIDE RANGE OF FAMILY CARE IN ORDER TO EXPAND OPPORTUNITIES AND OPTIONS AVAILABLE TO FAMILIES.

14. SCHEDULED EVALUATIONS

Interim MM YY MM YY 03 96 Final MM YY 03 99

15. SOURCE/ORIGIN OF GOODS AND SERVICES: [X] 000 [X] 941 [X] Local [ ] Other (Specify) _____

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)

17. APPROVED BY

Signature: Curann O'Hacy

Title: Acting Director, USAID/Sanaa

Date Signed: MM 09 DD 10 YY 91

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

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GLOSSARY

ACCS	Accelerated Cooperation for Child Survival Project
AID/W	Agency for International Development/Washington
AVSC	Association for Voluntary Surgical Contraception
BUCEN	U.S. Bureau of the Census
CA	Cooperating Agency, associated with S&T/POP
CHCW	Community Health Care Worker
CPR	Contraceptive Prevalence Rate
CSO	Central Statistics Organization
DHS	Demographic and Health Survey
DPS	Directorate of Planning and Statistics (MOPH)
EDSP	Education Development Support Project
EPI	Expanded Program of Immunization
FGR	Focus Group Research
FP	Family Planning
FPHCW	Female Primary Health Care Worker
GHO	Governorate Health Office
GDP	Gross Domestic Product
HMI	Health Manpower Institute
HPN	USAID Division of Health, Population and Nutrition
IEC	Information, Education and Communication
IPC	Interpersonal Communication and Counseling
IPPF	International Planned Parenthood Federation
IUD	Intra-Uterine Device
JHPIEGO	Johns Hopkins Program for International Education Gynecology and Obstetrics
JHU/PCS	Johns Hopkins University Population Communications Service
KAP	Knowledge, Attitudes and Practice
LCCD	Local Council for Community Development
MIS	Management Information System
MOPH	Ministry of Public Health
MOI	Ministry of Information
MPD	Ministry of Planning and Development
MWRA	Married Women of Reproductive Age
NGO	Non-Governmental Organization
OC	Oral Contraceptive
OPJM	USAID Office of Project Management
PHC	Primary Health Care
PHCW	Primary Health Care Worker
PSRC	Population Studies and Research Center
ROY	Republic of Yemen
ROYG	Republic of Yemen Government
S&T/POP	Office of Population, AID/W Bureau for Science and Technology
SEATS	Family Planning Service Expansion and Technical Support Project
SOMARC	Social Marketing for Change Project
SWAY	Support for Women's Associations in Yemen Project
TA	Technical Assistance
TFR	Total Fertility Rate
TOT	Training of Trainers

UNFPA	United Nations Population Fund
UNICEF	United Nations Childrens Fund
USAID/Y	Agency for International Development Mission to Yemen
VSC	Voluntary Surgical Contraception
WHO	World Health Organization
WID	Women In Development
YEDCO	Yemen Drug Company for Industry and Commerce
YFCA	Yemen Family Care Association
YPPU	Yemeni Physicians and Pharmacists Union
YWU	Yemeni Women's Union

PROJECT AUTHORIZATION

Country: Republic of Yemen

Project Name: Options for Family Care

Project Number: 279-0090

1. Pursuant to Section 104 (b) of the Foreign Assistance Act of 1961, as amended, I hereby authorize Part I of the Options for Family Care project for the Republic of Yemen ("Grantee"), involving planned obligations not to exceed Ten Million Six Hundred Thousand Dollars ($10,600,000) in grant funds over five years from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process. The funds will help finance the foreign exchange and local currency costs of goods and services required for the project. The total life of the project, consisting of Parts I and II, is planned for eight years and a total obligation of $18,000,000. Part I consists of three phases over the five years. It is expected that Part II, covering the final three years and a planned obligation of $7,400,000, will be authorized during the third phase of Part I to assure continuity of funding for planned activities. The planned Project Activity Completion Date (PACD) for the Project is September 30, 1999 and the initial FY 1991 obligation is $500,000.

2. The project will consist of the provision of technical assistance, training, commodities, and other support in furtherance of the Grantee's national population program, which is intended to incorporate demographic and population concerns into planning decisions at all levels. Project outputs will emphasize: (a) data collection and policy analysis; (b) awareness-raising and communications; (c) skills development and service delivery; (d) commercial marketing of contraceptives; and (e) multisectoral linkages.

3. The Project Agreement, which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority, shall be subject to the following essential terms and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate:

a. Source and Origin of Commodities, Nationality

(1) Except as provided in subsection (2) or (3) below, or as A.I.D. may otherwise agree in writing, the following requirements will apply to all A.I.D. financing under the Project:

(A) Commodities other than motor vehicles shall have

their source and origin in the United States or other country included in A.I.D. Geographic Code 941, or in Yemen;

(B) Motor vehicles shall have their origin in the United States;

(C) Suppliers of commodities or services (other than ocean transportation) shall have their place of nationality in the United States or other country included in A.I.D. Geographic Code 941, or in Yemen; and

(D) Ocean transportation shall be on flag vessels of the United States or other country included in A.I.D. Geographic Code 941, or in Yemen.

(2) Local cost financing is authorized pursuant to the rules contained in A.I.D. Handbook 1B, Chapter 18.

(3) Pursuant to the authority redelegated to the Mission Director in Yemen under Delegation of Authority 652, I hereby approve a source and origin waiver from A.I.D. Code 000 to Code 935 to permit the procurement of up to three motor vehicles whose value (exclusive of transportation costs) will not exceed $50,000.

(A) This waiver is authorized by Handbook 1B, sec. 5B4a(2) because U.S.-manufactured vehicles cannot, at the present time, be adequately serviced or maintained in Yemen due to a lack of spare parts, replacements, and service facilities for such vehicles.

(B) I hereby certify that exclusion of procurement of the vehicles from Free World countries other than the cooperating country and countries included in Code 941 would seriously impede attainment of U.S. foreign policy objectives and the objectives of the foreign assistance program.

(C) I also hereby determine that special circumstances (as described in subsection (3)(A) above) exist, within the meaning of section 636(i) of the Foreign Assistance Act of 1961, as amended, justifying procurement of vehicles not manufactured in the United States.

b. Conditions Precedent

Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D. the following:

(1) An opinion of counsel acceptable to A.I.D. that this Agreement has been duly authorized and/or ratified by and executed on behalf of the Grantee, and that it constitutes a valid and legally binding obligation of the Grantee in accordance with all of its terms;

(2) The name and office designation of the Grantee Project Representative in the Ministry of Planning and Development;

(3) Specimen signatures of the agent or agents authorized to sign project agreements, project amendments, or project implementation documents on behalf of the Grantee; and

(4) The names and titles of the employees of the Government designated to fulfill the required Project counterpart positions.

Prior to any disbursement, or the issuance by A.I.D. of documentation pursuant to which disbursement will be made for local costs, the responsible A.I.D. officer shall make the programming determinations required by A.I.D. Handbook 1B, section 18A1, as to reasonableness of costs and nonfinancing of identifiable customs duties.

c. Special Covenants

(1) Facilitating Implementation. The Grantee covenants that it will permit and facilitate participation of a variety of public and private sector organizations in the implementation of the Project, and that A.I.D.may negotiate agreements with such private sector organizations without obtaining further approval from the Grantee.

(2) Counterpart Funds. The Grantee covenants that it will, pursuant to assurances submitted to A.I.D. on or before the date of execution of the Grant, make all budgetary and other arrangements necessary to ensure that the agreed counterpart contributions for the Project are provided in a timely manner during each Grantee fiscal year.

4. After a detailed review of the types of training necessary for the fulfillment of the purposes of this Project, I hereby authorize training of participants in third countries pursuant to A.I.D. Handbook 10, Chapter 8, and a waiver of host government funding of international travel pursuant to A.I.D. Handbook 10, Chapter 16, section 16C.

5. This project directly supports the development objectives of both the ROY and A.I.D. and has been determined to be technically feasible.

Viviann Gary
Acting Director, USAID/Yemen

Date: Sept 10, 1991

I. EXECUTIVE SUMMARY

A. Project Title: Options for Family Care

B. Project Number: 279-0090

C. Grantee: The Government of the Republic of Yemen (ROYG)

D. Counterpart Agencies: Ministry of Planning & Development, Central Statistics Organization, Ministry of Information, Ministry of Public Health, Yemen Drug Company, Health Manpower Institute, Sana'a University Faculty of Medicine, Yemen Family Care Association. Associations may be made with other ministries, non-governmental and private organizations as appropriate.

E. Total Planned: $18.0 million
USAID Contribution Part I - $10.6 million
Part II - $ 7.4 million, subject to future AID authorization

F. Terms: Grant to the Republic of Yemen

G. Life of Project: 8 years (1991-1999)

H. Goal and Purpose:

The goal of this project is to improve family health and welfare in the Republic of Yemen.

The purpose of the project is to improve awareness of broad population issues and increase access to a wide range of family care in order to expand opportunities and options available to families.

I. Strategy and Description

Yemen is at an early stage of its demographic transition; death rates are declining but birth rates remain high, resulting in rapid population growth. The level of development of family planning programs in Yemen may be described as emergent, implying limited awareness and use of modern, effective birth-spacing methods and limited service delivery. The challenge, therefore, is to build support and credibility for family planning among policy makers, service providers in the public and private sectors, and the population at large.

To address this challenge, the project will support activities in five areas, with the following expected outputs at the end of the project:

1) Data collection and policy analysis: Demographic and related data are collected, analyzed, understood, and applied;

2) Awareness and communications: Awareness of the advantages of birth spacing and safe motherhood is widespread;

3) Skills development/service delivery: Accessibility to quality family care services is improved through institutionalizing effective training capability (pre- and in-service);

4) Commercial marketing: A wide range of sources and types of family care supplies and services is available in the private sector from which families can choose; and

5) Multi-sectoral linkages: Opportunities for women are expanded and the health, education, and private sectors are strengthened.

J. Project Implementation

The project will be implemented according to a "rolling plan" (or series of workplans) that emphasizes setting performance targets for discrete periods of time ("phases" of 18-24 months), designing activities to meet those targets, and evaluating the progress and impact of those activities regularly. Successful activities will be extended and/or replicated. Workplans covering 18-month periods will guide the progression of project activities. Each workplan will have specific objectives, a timetable for review, and evaluation criteria for determining whether the activity should be "rolled over" into the next planning period. Every 18 months, the project will sponsor two workshops: 1) with counterpart institutions, to review what has happened, what has worked or not worked and why, and to develop plans for the coming Phase; and 2) with donors and the Ministry of Planning and Development (MPD) to discuss lessons learned and to coordinate activities for the following 18 months. Based on the impact evaluation and the workshops, a new workplan will be developed and "rolled over" into another 18-month plan.

Because of the lack of information on demographic variables and population trends, data collection and analysis will be a priority in the early years of the project. The data collected will inform policy analysis and feed into awareness-raising and communications programs. The data will also provide important baseline information for evaluating progress toward project goals. The skills development/service delivery component of the project will improve the capacity of the health sector (public and private) to meet the increased demand for quality services through technical, counseling and managerial training for health care workers. The commercial marketing component will develop the technical and marketing skills of Yemen's private sector in

order to increase the range and supply of contraceptive commodities. Multi-sectoral linkages will be promoted over the life of the project and will support such activities as: women's literacy, grants to organizations supporting women and health activities, and training and support for community outreach workers.

The Project Paper provides a workplan (Annex G) for the first Phase of the project and an illustrative plan for the entire life-of-project. The crucial element to understand is that there is flexibility to experiment with a number of approaches and to draw on the skills of a range of institutions, both international and domestic, in order to achieve the project purpose. This is especially true at this time, September 1991, when the ROYG as well as a number of donors, such as UNFPA and UNICEF, are in the process of developing new five year plans. This project is meant to be able to respond to the priorities and directions set by the ROYG. Thus, while the first phase of the project will commence prior to the completion of the ROYG's planning exercise, the priorities set by the ROYG, the lessons learned from Phase I and the activities taken up by the ROYG and other donors will shape the workplan for Phase II. During Phase III (end of Part I) there will be a mid-term evaluation which will be used to determine if Part II (Phases IV and V) will be authorized.

The project initially will rely on "buy-ins" or "add-ons" to centrally-funded S&T/POP projects for training and technical assistance. Staff of these projects, in turn, will establish collaborative working relationships with appropriate local organizations in the public and private sectors for the implementation of project activities. Yemenis will be hired to coordinate and provide technical guidance for various components of the project such as training and social marketing. Overall coordination and monitoring for A.I.D. will be managed by the USAID/Sana'a Office of Project Management (OPJM), Division of Health, Population and Nutrition (HPN). The Ministry of Planning and Development will provide oversight for the ROYG and be the central point of contact for USAID. In addition there is a lead technical agency/institution for each of the first four components.

II. Background

In the space of 20 years, the **governorates of northern Yemen** (previously the Yemen Arab Republic) stepped out of the middle ages, leaving behind a millennium of feudal rule, and into the twentieth century. From 1918 to 1962, the country was essentially cut off from outside influences. Eight years of civil war followed. In the twenty years since, great progress has been made in developing systems of education, health, transportation, and communications.

Economic growth has been impressive. Annual GDP growth rates averaged 5.6% between 1980-87, exceeding those of other countries in the region such as Tunisia, Morocco, and Jordan. Per capita income is over $640 per year. Agriculture as a share of gross domestic product (GDP) has declined from 44% to 34% of GDP. Remittances from migrant workers in the Gulf states have been a major source of foreign exchange. Since the Gulf War, however, the majority of migrants have returned and the Government must now cope with increased demands for jobs and services.

The numbers of schools, health facilities, and health personnel in the northern governorates have increased extremely rapidly. Five thousand new primary schools have been built in the last 20 years. Between 1979 and 1988, the number of hospitals increased from 25 to 39, health centers increased from 93 to 297, and health care units increased from 97 to 361. The number of doctors and dentists increased six-fold between 1975 and 1985.

Despite economic growth and improvements in infrastructure, social indicators have been slow to change. Female literacy and school enrollment of girls remain low (3% and 6% respectively) (OPTIONS database, 1990). Infant mortality has declined from 160 deaths per 1000 live births 15-20 years ago (World Bank, 1990b) to 136/1000. Maternal mortality is 10/1000. The total fertility rate (TFR), around 8.9 children per woman, is among the highest in the world.

The southern governorates (previously the Peoples' Democratic Republic of Yemen - PDRY) have had a different history and present a somewhat different picture. What was the PDRY is comprised of the former British Crown Colony of Aden and Eastern and Western Aden protectorates. After becoming independent in 1967, the country followed a Marxist path marked by political instability and limited economic growth.

In general, the southern governorates have experienced less economic development than their northern neighbors. GNP per capita in 1988 was less than $450. Less than one percent of the land is arable and industrial activity is still rudimentary. However, the 1970s brought relative prosperity as remittances

from abroad increased with the rise in the price of oil. The government made development of human resources a priority (World Bank, 1990a). Numerous schools were built and literacy and enrollment rates for girls are higher than in the northern governorates (25% and 32%, respectively). Although the economic situation deteriorated significantly in the 1980s, the demographic picture remains slightly more optimistic than in the north. The 1988 census suggests an infant mortality rate between 105-120/1000 and a TFR of 6.7. Attitudes towards women are also somewhat more liberal in the southern governorates.

The northern and southern governorates were united into the Republic of Yemen (ROY) in May 1990. The process of unification will continue over the next several years as health and education systems are standardized and the two economies are integrated. An immediate economic challenge to the new nation is to absorb the large number of returnees from the Gulf.

The united Yemen is in the early stages of its demographic transition; mortality rates are declining but birth rates remain high, resulting in rapid population growth. Official government statistics show a total population size of 11.3 million and a TFR of 8.3. At the current population growth rate of 3.1% per year, the population will double in size in just 20 years. Contraceptive prevalence is estimated at 3.5% of married women of reproductive age. It is estimated that urban populations will double in the next eight years. Thus, it is not surprising that the Government has become concerned about the implications of rapid population growth, despite the fact that this has gone unaddressed in the past. In addition, there is growing recognition of the implications of closely spaced births and high risk pregnancies for the health of mothers and children.

A. Government of Yemen National Population Strategy

The ROYG has begun the process of developing a national population strategy and plans to hold a National Population Policy conference in October 1991. The strategy is multi-sectoral in nature, recognizing the relationship between population growth and improvements in other development sectors (Farah, 1991).

The draft strategy has the following guiding principles:

1) To incorporate demographic and population-related concerns into planning decisions at all levels;

2) To reorient development plans and investments to mitigate and better address population problems;

3) To promote more rapid extension and adoption of maternal and child health and family planning services;

4) To energize sectoral programs to increase their emphasis on other development-oriented issues, such as women's development, education, literacy, etc.;

5) To strengthen the institutional capacities of Yemen to undertake population studies, research, analysis and strategic planning, and to heighten management and coordination capabilities; and

6) To increase the role of the private sector, NGOs, community participation, and external donor assistance in the implementation of population policies and programs.

The long-term goals are to: reduce infant and maternal mortality by 50% by the year 2010, reduce the TFR to between 4-5 by the same year, and reduce the population growth rate to around 2% per year by 2023. The government proposes to accomplish these goals by: 1) increasing contraceptive use to 30% by 2015, 2) reducing very early marriage and increasing birth intervals, 3) promoting breastfeeding and childhood disease prevention programs, and 4) expanding and enhancing women's participation in economic and social activities. It is important to note that abortion is illegal in Yemen and it will have no role in the proposed expansion of family care services.

The ROYG strategy parallels A.I.D.'s rationale and strategy for population assistance. The A.I.D. rationale for population assistance is based on the recognition that rapid population growth places a tremendous burden on the development process and that couples have the right to choose freely the number and spacing of their children. Provision of family planning services can help reduce fertility and improve the health of mothers and children. A.I.D. also believes that the private sector has an important role to play in the provision of family planning and health services.

B. USAID/Sana'a Portfolio

Increasing the participation of women in development is a unifying theme of the USAID/Sana'a portfolio. In addition to specific Women in Development (WID) activities, the portfolio includes a primary education project directed at increasing efficiency, effectiveness, and access to basic education and a child survival project aimed at strengthening basic health services for women and children. The Options for Family Care project adds population to this portfolio and also has women as both important participants and primary beneficiaries.

1. WID Activities

The Mission's WID program has two major goals: 1) to increase the participation of rural and urban Yemeni women in development

activities and 2) to increase the benefits, both social and especially economic, that women receive from this development. The project, begun in 1991, is implemented by World Education (a PVO) and the Yemeni Women's Associations (YWA) in Taiz and Ibb. Activities focus on strengthening the capacity of the YWAs and their branches to be self-sustaining by improving the quality and services provided to its members. It is expected that the YWAs and their central organization will participate in the Options for Family Care project, particularly in the execution of outreach activities and other training activities for women, starting in Phase II.

2. Education

The Mission's Education Development Support Project (EDSP) focuses on improving basic education in Yemen through a combination of technical assistance and training. The project intends to improve the access, efficiency and effectiveness of primary education through the development of an outcome-based primary education system.

The project, which runs from 1987-1997, started slowly due to problems with contractor personnel, the Gulf situation, and unification. A new chief of party has been chosen and the project now relies more heavily on Yemeni consultants. Learning from EDSP's experience, the Options for Family Care project will also look to Yemenis to provide on-the-ground technical guidance.

3. Health

The purpose of the Mission's bilateral health project, Accelerated Cooperation for Child Survival (ACCS) is to institutionalize Yemeni capacity to ensure child survival by strengthening basic health services for women and children.

The project, which runs from 1986 to 1994, has four components: expanded and upgraded primary health care (PHC) for child survival; accelerated immunization services; health education; and special activities, including health care financing.

The major lesson to be learned from earlier health projects is that construction and equipment are not sufficient to develop a functional system, although often highly desired. The shortage of trained health workers, weak management skills and commitment, and inadequate recurrent cost support impede the operation of many facilities. Thus, the ACCS project includes an emphasis on skills development for males and females in decentralized training centers - currently in four governorates. The Options for Family Care project will complement ACCS activities through such undertakings as decentralized refresher training for Primary Health Care Workers (PHCWs), strengthening training in counseling

and communications and support for increased practical training opportunities.

4. Population Strategy

The USAID population strategy, prepared in 1990, is consistent with both the ROYG and AID/W strategies. Its objectives are to increase awareness of population issues and to increase access to a wider range of family care in order to expand opportunities and options available to families. The strategy proposes that these objectives be accomplished through: formulation of a favorable policy climate; support for information, education, and training activities to increase public awareness; improvement of delivery of maternal and child health services; development of institutional capabilities; and encouragement of multi-sectoral linkages. The strategy promotes private sector participation in delivery of health services and broader participation by women in the development process.

Guided by the strategy team's assessment, the Mission prepared a Project Identification Document (PID) for an eight-year economic development/demographic transition project. The PID was approved in Washington in August 1990, with project authorization and approval authority for the Project Paper delegated to USAID/Yemen.

A number of activities that contribute to the project outputs are already underway. These activities were designed as a "bridge" in the period between project design and project implementation. (See Annex F for a summary of "bridging" activities.) In addition to providing continuity in this interim period, the "bridging" activities are an opportunity to explore various approaches to population assistance in the Yemeni setting. Some of these activities will be continued under the bilateral project.

C. Activities of Other Donors in the Population Sector

Although there is considerable international donor activity in Yemen, the work of the various countries and agencies is somewhat scattered and uncoordinated. Many small support activities exist, but no underlying strategy links them. Since unification, interest in coordinating activities has increased and the ROYG holds donor meetings periodically. In addition, the Options for Family Care project will include meetings every 18 months with the ROYG and other donors in an effort to ensure coordination and to avoid duplication of activities.

.1.. UNFPA

UNFPA activities have focussed on development of institutional capacities at the central level. A UNFPA Country Strategy Team visited Yemen during the late stages of PP design phase to develop a country plan for the next five years. Although not the final word, it is expected that UNFPA activities will broaden its mandate and work in an array of areas with a focus on the health of mothers.

UNFPA is the primary donor of contraceptive commodities to the public sector in Yemen. UNFPA and USAID have reached an agreement that UNFPA will continue to provide contraceptives to the public sector and USAID will work to assure adequate contraceptives for the private sector.

2. UNICEF

To date, UNICEF activities in the health field have been directed at immunization in particular and improving child health in general. However, they have recently proposed expanding their program to include maternal health interventions such as birth spacing.

UNICEF is having a detailed child and women situational analysis prepared (draft expected in October 1991). This report will then be used as basis for developing their new five year plan which will commence in 1993.

3. The Netherlands

Dutch assistance provides support for health activities in Dhamar, Rada, and Hodeidah. The Dhamar project consists of support for five health centers including separate training centers for male and female primary health care workers. In Rada, the Dutch are supporting an integrated rural development project including health education and a PHC clinic. In Hodeidah city, the Dutch provide support for a health care an prevention program for the urban poor centered around two urban health clinics and involving training of urban PHC workers.

In addition, the Dutch are supporting development of institutional capacity within the new, unified Yemeni Women's Union and have assisted the women's associations in Dhamar, Taiz, and Hodeidah with construction of facilities, training, and institutional development.

4. International Planned Parenthood Federation (IPPF)

The IPPF has provided financial and technical support to YFCA since its founding in 1976. Currently, the annual IPPF grant represents over 90% of the budget of YFCA. YFCA operates family

planning clinics in Sana'a and Taiz, provides contraceptives to about 40 MOPH and other clinics and to some private doctors in Sana'a, organizes training courses, assists other organizations, including the MOPH, in establishing family planning clinics, and undertakes programs to publicize family planning and provide information to the general public.

5. Others

A number of other donors (WHO, World Bank, OXFAM, the Swedish, Japanese, German, and British) provide assistance in the health area in general, including technical and financial assistance for the construction and operation of hospitals, support for Primary Health Care (PHC) programs, establishment of training centers, and support for EPI and/or specific disease related activities.

III. Project Rationale

For the first time in its history, Yemen finds that the weight of population growth threatens continuing social and economic progress and the goal of improving family well-being. Yet, progress in the population sector is hampered by a number of societal and institutional constraints. The Options for Family Care project will address these constraints where possible and will seek creative means of working within them where necessary. Unification itself presents a challenge to the new project. The relative economic underdevelopment of the southern governorates will place additional demands on the budget. However, social attitudes and higher educational attainment of women in the southern governorates are more favorable to the proposed type of initiative.

The level of development of family planning programs in Yemen may be described as "emergent", implying limited awareness and use of modern contraceptive methods and limited service delivery (See Destler, 1990). The challenge for a program at the emergent stage is to build support and credibility for family planning within all sectors of society--among policy makers, service providers in the public and private sectors, and the population at large. To meet this challenge, the Options for Family Care project encompasses activities that address needs in all areas of the program: data collection and analysis, policy development and implementation, information and communication, training, service delivery, and marketing. The comprehensive nature of the project will lay the foundation for building a sustainable Yemeni family planning program that responds to client needs through the provision of quality services and an appropriate method mix, and involves collaboration between the public and private sectors to meet projected demand.

The major factors affecting family health and welfare and the contribution of women to economic production are the traditional separation of male and female worlds and the seclusion of women. Thus in spite of tremendous advances in education, primary gross enrollment rates are only about 22% for females, compared with 67% for males (CSO, 1991). While 27% of enrollments in grades 1 through 6 are female, this percentage drops to around 14% for preparatory and secondary school enrollments (WB 1991). About 17% of females are literate while some 55% of Yemeni males can read and write (WB 1991). Thus, not surprisingly, women's basic knowledge of health and family care issues is limited. Lack of female mobility affects access to health services for both women and their children. Most providers of contraceptive services require the written consent of the husband. When women are allowed to attend health centers, they can only be examined by female health care workers. This further limits their access to care, since lack of education and mobility have prevented large

numbers of women from entering the health professions in the past. Thus, lack of female mobility is a major factor contributing to the high maternal and infant mortality rates (10/1000 and 130/1000 respectively) and low life expectancy (less than 50 years for both sexes). Attitudes towards women are changing, as evidenced by the fact that approximately 50% of all medical school students in Yemen are women and the first graduating class was predominantly women. Nonetheless, it is obvious that any program in Yemen aimed at women and children must also reach men.

Various studies have highlighted the potential contribution of women to economic development in Yemen (see for example RAPID, 1982; World Bank, 1990c). These note that key factors limiting women's participation are illiteracy and lack of education. The project will address these through incorporation of literacy training into its skills development activities, thereby opening the doors to other opportunities. The training activities in general also will provide women with marketable skills in the health/population field.

Religion is also an important factor influencing attitudes. The Quran can be interpreted as limiting the role of women to the home and condemning any restriction on family size. However, there are other interpretations of the Quran that recognize the value of women in society and the importance of maintaining a balance between family size and resources. Some religious leaders are beginning to make declarations in this direction and have been active participants in family life education activities in schools and in mobilizing support among the religious community, for example, for the Expanded Program for Immunizations (EPI). In Taiz, the women's religious schools offer family care education and a female staff doctor provides family care services so that married students can complete their education. Given the high value that Islam places on the family, there is considerable potential in Yemen for increasing the acceptance of family care by promoting the health benefits of birth spacing and safe motherhood.

Because of the perceived sensitivity of family care, information on the subject is not at all widespread. According to data on the northern governorates from the 1979 Yemen Fertility Survey (YFS, 1983), only 22% of women had ever heard of any contraceptive method and only 3% had ever used any method. Approximately 19% of currently married, fecund women wanted no more children. This percentage ranged from 9% of those under 25 years of age to 51% of those over 45, indicating considerable unmet demand among women. Contraceptive prevalence may now be around 10% in some cities, but it seems likely that women's demand has increased more rapidly than has their access. Information on the current demographic situation is sorely needed

and collection and dissemination of improved demographic data will be a priority for the project.

Geographic isolation is another major barrier to development (including the delivery of basic services) in Yemen. Yemen has over 20,000 villages dispersed throughout the coastal desert plains of the Tihama and literally perched atop its rugged mountain ranges. However, two major networks provide opportunities for overcoming geographic and cultural isolation: the commercial networks of stores and shops, including pharmacies and drugstores, particularly in the north, and the mass media, especially television.

Yemen has an ancient tradition of commerce and trade. The Kingdom of Saba controlled the Gold and Incense Road, the critical link with the Orient and East Africa. Since the early 1960s, commerce has been fueled by remittances from migrant workers in the Gulf States, and now by oil. The array of consumer goods available in northern cities is extensive and many such goods can now be found in the most remote village shops. However, economic conditions have deteriorated since the Gulf crisis and commodities are not as prevalent as before. On the positive side, over a dozen oil companies are now searching for oil in areas which, due to unification, are open for exploration.

An astonishing 85% of households have access to television. The successful use of television spots to promote the recent immunization campaign has shown how effective this medium can be for increasing awareness and utilization.

Both commerce and television affect the demographic transition in many ways. They provide new opportunities and create demand for all that the modern world has to offer. It appears that some families are beginning to desire fewer children so that they can invest more in each child's future and participate more fully in the benefits of a growing economy. Commercial networks and television also offer direct potential for expanding access to and awareness of family care products to meet this growing demand.

Another major constraint in terms of family care is that child spacing has not been a part of the curricula or job descriptions of health professionals in the past. Therefore, relatively few providers and facilities are able to offer family care services, nor do they see it as one of their responsibilities. Out of several hundred Ministry of Public Health (MOPH) facilities, only small number provide family care services. At many of these delivery points, the acceptor rates are low due to a perceived lack of quality services (this is especially true for the IUD). In-service training and short courses for existing personnel would greatly expand access to family care. In addition, every

attempt will be made to ensure that family care is integrated into all existing health curricula and job descriptions.

The public health system faces serious constraints in terms of financial resources (less than 4% of the national budget is devoted to health), staffing (especially female personnel), management, and coverage. As mentioned above, there is potential for strengthening the existing MOPH system, particularly with regard to maternal/child health and family care, through technical and management training, and by increasing the number of female health personnel. Some centers and districts have been very innovative in their efforts to improve family care services by offering day care services, literacy training, and dormitory facilities to female trainees and employees. These centers have growing numbers of family care acceptors.

Opportunities outside the public sector are limited in the southern governorates, which, prior to unification, followed the socialist, non-market-oriented model for provision of goods and services. Nonetheless, the project will look for opportunities to expand and strengthen the private sector in these governorates. In the northern governorates, however, major opportunities do exist outside the MOPH system, in the very active and growing private health sector. The project will take advantage of this dynamic private sector. More than 217 pharmacies and 799 drugstores are potential or actual points of sale for birth spacing methods. Most of the approximately 1,000 Yemeni physicians have private practices. (In fact, Yemen officially recognizes the right of MOPH employees to have private practices and most work for the MOPH in the morning and conduct their private practice in the afternoon.) In addition to the profit-making enterprises of the private sector is the not-for-profit sector, particularly the Yemen Family Care Association (YFCA). This organization has implemented many pioneering efforts in the field of birth spacing and safe motherhood. The centers sponsored by the Local Councils for Cooperative Development (LCCD) are another resource. These are elected bodies whose clinics are allowed to charge fees and in some areas they are perceived as providing higher quality services than government clinics.

This project is Yemen's first bilateral population project. While this is a constraint in terms of data, experience, and institutional capability, it also affords a unique opportunity to be innovative.

IV. Project Description

A. Project Goal and Purpose

The project **goal** is to improve family health and welfare. Evidence of progress towards the goal will be measured by increases in birth interval length, decreases in high-risk pregnancies, and declines in infant and maternal mortality as measured by national censuses and surveys.

The **purpose** of the project is to improve awareness of broad population issues and increase access to a wide range of family care in order to expand opportunities and options available to families. Achievement of the purpose will be measured by: 1) an increase in contraceptive prevalence from less than 10% to over 20% in urban areas by the end of the project and 2) increased awareness of methods, sources, and advantages of family planning among policy makers, service providers, and users. The government population policy statement, Ministry of Health records, and data from knowledge, attitude, and practice (KAP) studies (such as the Demographic and Health Survey (DHS) or focus groups) will provide verification of the indicators.

B. Beneficiaries

The project will benefit a broad cross-section of Yemeni society. Participating agencies (Union of Physicians and Pharmacists, YFCA, LCCDs, women's associations, etc.) will benefit by improved capability to provide services. Yemeni health professionals and paraprofessionals will benefit through improved skills. Private physicians, pharmacists, and drugstore operators will benefit both professionally and financially through training and increased client demand for quality birth spacing services and/or products. Yemeni families will benefit from improved health status as a result of increased awareness of family care issues, wider choices, and the positive impact of birth spacing on family health. Women, in particular, will benefit through greater access to a wider range of quality, sustainable services provided by suitably-trained providers and by improved access to other opportunities such as education and literacy. Yemenis in the aggregate will benefit from the direct and indirect impact of the project on national economic development.

C. Project Components

The Options for Family Care project, summarized in the attached Logical Framework (Annex B), is designed to meet needs across the population sector in Yemen. The five components and expected outputs of the project are the following:

1) Data collection and policy analysis: Demographic and related data are collected, analyzed, understood, and applied;

2) Awareness and communications: Awareness of the advantages of birth spacing and safe motherhood is widespread;

3) Skills development/service delivery: Accessibility to quality family care services is improved through institutionalizing effective training capability (pre- and in-service);

4) Commercial marketing: A wide range of sources and types of family care supplies and services is available in the private sector from which families can choose; and

5) Multi-sectoral linkages: Opportunities for women are expanded and the health, education, and private sectors are strengthened.

These components are described in more detail in the following pages.

IV.C.1 DATA COLLECTION AND POLICY ANALYSIS

1.1. Overview

The most recent in-depth fertility data for Yemen are over ten years old and only apply to the northern governorates. The lack of current data and data collection and analysis skills limit the ability of the government to incorporate population issues into development planning. Data on population trends are essential for strategic planning at every level of both the public and the private sectors. Analyses of population trends and their impact on the sustainability of social services and basic infrastructure and on the well-being of families is important in several respects. First, these analyses can help increase support from policy makers for family care services and for broader policies that affect population growth. Second, the analyses can help policy makers evaluate the sustainability of different policy alternatives, particularly with respect to the provision and financing of basic services.

The **Central Statistics Organization**, which is linked to the MPD, will be the lead counterpart agency for this component of the project. It is the focal organization for demographic data collection, analysis and dissemination and, as such, has been tasked to take the lead in population policy development.

1.2. Data Collection and Analysis

Planning for Yemen's first Demographic, Maternal and Child Health Survey (DHS) is already underway. Fieldwork is planned for early 1992; preliminary results should be available in the late spring and the final report should be completed by the fall. These results will provide baseline data against which to measure project progress. The data can also be used by policy makers and program managers for planning purposes.

Phase I of the project will support three secondary analyses of the 1992 DHS results by Yemeni researchers and institutions, thereby building institutional capacity for data analysis. The DHS provides a rich source of data for examining issues such as the relationship between education and age at marriage; regional differences in the status of women as measured by educational attainment or labor force participation; and attitudes towards use of contraception and unmet need. Technical assistance for these analyses might include, for example, training in the use of microcomputer statistical packages such as SPSS.

The project plans to support a second DHS and secondary analysis in 1997/98, the final years of the project. The two surveys, then, will permit an analysis of how the demographic situation in Yemen has changed over the life of the project.

The first unified, national census is planned for 1994. The project will offer technical assistance and training, from the U.S. Bureau of the Census (BUCEN), prior to, during and after the census taking. During Phase I the project will support two persons to attend the 11 month Sampling and Statistical Methods course and one person to the 9 month Population and Health Manpower Information Systems course offered by BUCEN. Support for a total of two CSO and/or MOPH staff to attend these courses annually throughout the project is envisioned. Likewise additional project support is budgeted to prepare for and conduct the census as well as analyze and disseminate the data as requested. The information from the census should be available by 1996. The analysis of these data will be used to evaluate progress and to design the last phase of project activities.

In addition, via this component and the Awareness and Communications component of the project, at least five KAP-type surveys will be conducted over the life of the project - one during each phase. These will focus on various communities or audiences that have been targeted by the project (e.g. opinion leaders, pharmacists, drug store and health facility clients, men, rural women, etc.) and will provide information for assessing the impact and sustainability of project activities, particularly with respect to changes in attitudes and behavior, as well as support design of activities in the Awareness and Communications and Commercial Marketing components of the project.

1.3. Policy Development and Implementation

The policy environment for population activities in Yemen is currently quite favorable. The Population Studies and Research Center (PSRC), which is within the CSO, has been very active in sensitizing policy makers to population and development issues in the country. The PSRC has made a number of presentations demonstrating the economic costs of rapid population growth (including RAPID presentations supported as part of the "bridging" activities) and has been assigned the responsibility for Yemen's population policy formulation. Over the past year, PSRC has produced a draft population policy, held a series of meetings in various ministries to review the document, and will be conducting a comprehensive program of activities leading up to a National Population Conference in October 1991, where the final policy will be declared.

The project will build on the momentum of the conference, beginning the process of dissemination and implementation of the policy. The project will provide technical assistance in areas such as: improving PSRC's capacity to engage in effective policy formulation and to serve as a resource to sectoral ministries for design and implementation of plans; tracking the effectiveness of policy implementation; expanding and strengthening support for

population policy at the regional level; investigating the feasibility of charging for public sector services, and facilitating private sector participation (e.g., analysis of laws and regulations affecting contraceptive imports and supply). The specifics of Phase I activities will be designed in conjunction with the CSO and PSRC after the completion of the October 1991 Population Conference.

The design of effective implementation plans will require a significant amount of information collection and analysis beyond that conducted for the Population Conference. In particular, target setting requires analysis of demographic and health statistics; refinement of sectoral plans requires a comprehensive review of resource and budgetary factors. Thus it is likely that Phase I activities will include technical assistance to strengthen the capacity of the relevant ministries to incorporate population data and policy objectives into development planning. DHS data will be particularly useful in this regard. DHS data provide a baseline for projecting the demand for social services (health, education, family planning) and employment to compare against the availability of financial and human resources. Raising awareness of these supply-and-demand relationships using different fertility assumptions is an effective way of encouraging realistic policy planning and building support for family planning services.

Additionally three workshops for policy makers are planned for Phase I. These may include a post-conference workshop in 1992 to consider next steps in implementation of the population policy; a workshop for lawyers and parliamentarians (with participation from the women's groups) to raise awareness of issues related to family care; and a workshop in 1993 for the various ministries concerned with international trade and importation of commodities to raise awareness of the impact of legislation on private sector participation in the provision of health and family care services.

IV.C.2. AWARENESS AND COMMUNICATIONS

2.1. Overview

The Awareness and Communication component will work primarily through the **Ministry of Information (MOI)**. It includes a comprehensive information, education and communication (IEC) campaign aimed at increasing awareness of, support for and acceptance of the benefits of family care and family planning across Yemeni society, and at making the public aware of the various options available for birth spacing. It strategically overlaps with all other components of the Project to supply information to the various segments of the public as needed.

The audience for the campaign can be divided into three groups: 1) opinion leaders; 2) providers; and 3) potential users. As little data exists, the Project will conduct knowledge, attitude and practice (KAP) and focus group research (FGR) into the opinions, knowledge, attitudes and practices of the above groups. This will include all areas effecting family planning including KAP information about physicians, clinics, and pharmacists. This information will be used to develop baseline information to identify KAP and interests of each group, to provide input into the Commercial Marketing component and to provide feedback to the Policy Analysis portion of the Project. Culturally appropriate and effective messages and training interventions can then be designed to reflect and address the needs of each group.

A highly specialized focus of the component of the Project will be the development of Centers of Excellence through the **Yemen Family Care Association (YFCA)**. Once fully established, these Centers will provide complete family care and planning services and information, with a strong concentration on interpersonal communication and counseling (IPC). It is anticipated that these will then act as models for the development of future clinics into Centers of Excellence.

The various aspects of this component of the Project generally progress as follows:

1. Research
2. Analysis
3. Project design(s)/implementation
4. Materials design
5. Materials development/testing
6. Training/workshops
7. Materials distribution
8. Development of Centers of Excellence, including outreach, refresher, up-graded, and advanced training
9. Continued training in other areas of the project
10. Formative and final evaluation, on-going planning

2.2. Activities to improve Awareness, Knowledge, Attitudes and Support AMONG OPINION LEADERS

During Phase I, research with all target groups, including opinion leaders, begun during the "bridging" period will be analyzed and further research will be undertaken to determine knowledge, attitudes and opinions of opinion leaders and others. Interventions and materials will be designed and delivered to address the need for information and to enhance the ability to give support for increasing family health interventions thereby providing the base for future program support. Individual consultants will work in conjunction with the Ministry of Information (MOI) to develop workshops and materials for leaders, providers and clients.

Interventions aimed at the wide range of opinion leaders will include:

i. Workshops

* A Project Orientation Workshop in January, 1992, for central level officials, including media officials, representatives from the different service provision sectors and key opinion leaders. The discussions will focus on the purpose, objectives, proposed outline of Project activities.
* Two workshops for all governorates will be held in the fall of 1992. These workshops will be for governorate level officials and leaders to discuss up-coming and on-going IEC activities in their governorates. The workshops will be preceded by KAP and media habits surveys and the results of the surveys will be utilized in the workshops.
* An evaluation-of-activities workshop, with representation from all of the governorates, will be held in the fall of 1993, roughly one year after the initial two governorate workshops. The need for on-going evaluation workshops specifically for IEC activities will be examined at that time.

ii. Mass Media

Mass media events will be overseen by the MOI with technical assistance and possible collaboration with other Ministries. These will include:

* TV and news coverage of population issues, including discussions between religious leaders and government leaders on the place of birth spacing and family planning in Islam and in Yemen respectively.
* Training and provision of population and family planning materials for media staff. This activity will include training of a network of print and media reporters, with possible collaboration of other donors, who are assigned to specifically cover these issues.

Note: A video presentation with accompanying print materials will be delivered during the Population Conference in October, 1991, as part of the "bridging" activities.

2.3. Activities to Improve Awareness, Knowledge, Attitudes and Capabilities AMONG PROVIDERS

Before a country-wide campaign gets under way that will bring an increase of potential users into the clinics, pharmacies and drug stores, providers in Yemen will need increased education in the area of family health and planning, both in the technical and IEC/IPC arenas. Thus training for and materials developed for use by providers are of utmost importance. Providers need information on IEC/IPC and experience in how to use this information. Workshops and institutionalization of training activities will be supported and materials will be designed as part of the Skills Development and Service Delivery component of this project.

Materials developed to increase provider awareness and for use with clients should be developed and tested during "bridging" and Phase I of the Project. They will be handed out during the workshops and other training activities in subsequent phases.

2.4. Activities to Improve Awareness, Knowledge, Attitudes and Practice AMONG POTENTIAL USERS

As support for family planning grows and as the ability to provide good services increases, the Project will work to improve the health of women and families by increasing knowledge of the options available and people's ability to make choices about their reproductive lives. After results are obtained from the research being done (KAP, DHS and FGR), various types of materials will be developed to help women and men understand the importance of family health and planning. Mass media, video, and print materials will all be used to address this issue. Centers of Excellence will be developed that use available training and educational materials and additional and/or expanded training and service components to improve their services.

i. Research

Building on bridging activities, further research will be conducted. A media habits survey and a KAP survey of MWRA and men will be conducted during the first six months of 1992 with the results available for the workshops described above. Additional KAP surveys will be conducted at least every two years to evaluate Project progress and success. In support of the social marketing component, this research will include carefully worded questions about specific methods of contraception and who uses them to find out more about the acceptance and constraints attached to promotion of these methods.

ii. Mass Media Activities

* Generic TV messages of commercial-length (spots or micro-programs; 30 seconds to 5 minutes) will be developed for the general public on women's health needs, ways to improve women's health, and the positive economic effect of improved health and smaller families. Preparatory research for this and other aspects of the Project will take place during Phase I of the Project. Production will begin during Phase II.

* A TV drama may start to be developed during Phase I. It will be preceded by market research to determine who watches television at what times of day and the reactions of potential target audiences to a drama or series of dramas. Assuming a satisfactory response, technical assistance will be provided to/through the MOI to carry out research and begin development on scripts for the TV drama(s). The drama(s) will focus on MWRA and men but will also underline the role and benefits of family planning for the larger community. Continued technical assistance in filming and production will be given and equipment needs will be assessed in Phase II. It is expected that the TV drama(s) will be released in Phase III.

* A song will be developed that is associated with the spots/microprograms, the TV drama(s), and, of course, with family planning services in general to reinforce the idea of family planning and activities. A high profile campaign is not intended to center around the song, rather, as the EPI campaign showed, subtly introduced music can be a potent medium in Yemen. The song will receive radio as well as TV time, through performances and spots. The thrust of the message might center on the importance of birth spacing as a health intervention and how the changes in women's health and lives bring a better life to the family, however, research will be needed to be done on this. The song will be tested for release in Phase I.

iii. Print materials

* General and method-specific materials for use with clients will be developed under the Centers of Excellence (see below) and other components of the Project after an assessment of what is needed is completed as part of the "bridging" activities. Point-of-sale materials will be developed under the Commercial Marketing component. Some print materials for providers to use with clients have been or are being developed during the "bridging activities". These and appropriate materials from other countries will be tested during Phase I. Current materials available or in process in Yemen include: posters available from YFCA; two family planning posters and an all methods flyer are in process with AVSC and UNICEF funding; and a flip chart for educating clients is in process with support from SEATS and others.

iv. Logo development

A logo will be developed for release during Phase I. The logo will be developed and introduced through packaged contraceptives and with the Centers of Excellence; and will be used to signify family planning services nationally. The logo will be designed to be easily identifiable.

v. Experiments in Excellence: Centers of Excellence

As the Project begins, two YFCA-supplied clinics will be chosen to initiate the process of the creation of Centers of Excellence as models for other health clinics. Some Centers of Excellence will include laboratory and delivery services. These Centers will develop the following minimum qualifications for provision of high quality services:

- Referral and counseling services;
- Educational materials available for provider, outreach workers and client use;
- Clinical services including examinations;
- Record keeping;
- Follow-up of clients;
- On-going training for clinical and outreach staff in: management and supervision, record keeping, clinical updates, IEC/IPC, outreach, and evaluation; and
- On-going evaluation.

The initial two Centers should be functioning on a high level by early Phase III. Upon each Center's "graduation" into Excellence, a ceremony involving high officials should take place and be given television air time. The family planning logo will be underlined for association with family planning centers during this "graduation" so that the logo gets national recognition and is recognized as the sign for family planning services. The Centers should expand through training developed and implemented by original project staff, with outside TA. The initial Center(s) should begin to expand to other Centers by Phase II or III.

If the evaluation indicates that the Centers of Excellence approach is successful, then starting in Phase II or III of the Project, two clinics in another region will be developed into Centers of Excellence. At the same time as the start-up of the second two Centers, those individuals who were trained from the first two Centers will begin, with assistance as needed, to train the staff from five surrounding clinics in order to create a multiplier effect. Again depending upon the evaluation, in Phase III or IV the process could be replicated in a new region with two new clinics. In this manner a total of thirty Centers could be created by the end of the Project (six with direct and extensive project support and 24 through ancillary support to trainers from the original six).

After an assessment is done of educational materials needed, materials development will take place through the YFCA and other agencies. Various types of materials will be tested and developed for providers to use, such as flip charts, posters, brochures, wall charts amd videos for use first in Centers of Excellence clinic waiting rooms.

For instance, print materials are needed for outreach workers to use during home visits, and primarily a flip chart that has very simple language/instructions on the back of each picture to make it easy for community health care workers (CHCWs) to use. The flip chart should focus on family planning as a part of larger health issues to underline overall good health practice and to be sensitive to cultural issues. Training for these outreach workers will be the domain of the Multisectoral linkages component and the Centers of Excellence.

Due to cultural barriers (i.e. the taboo of women seeing male doctors), the geographic isolation of the villages in Yemen, and the intense need to provide services to the villages, an outreach component to the Project is essential. Initially, the focus of this additional outreach activity will be the Centers of Excellence. YFCA, and others, already use outreach volunteers successfully and few problems have been encountered outside of a small attrition rate due to marriages. Refresher training will be held for those already performing outreach functions. Recruitment and training will be conducted on an on-going basis to add to this force of workers, tapping into the Women's Association which has an excellent relationship with YFCA. Expanded outreach will take place at a later date when feasible.

IV.C.3 SKILLS DEVELOPMENT/SERVICE DELIVERY

3.1. Overview

The lead organization for this component is the **Ministry of Public Health (MOPH)**. Activities will support governorate health offices and pre-service health training institutions to improve accessibility to quality family care services through institutionalizing effective training capabilities and increasing the number of female health professionals and paraprofessionals. It is anticipated that, as a result of the project, birth spacing/maternal health modules will be integrated in the training curricula of professionals and paraprofessionals providing MCH services. Approximately 70 pre-service faculty will receive skills upgrading, and some of these will become master trainers, while approximately 36 governorate-level personnel will be trained as trainers in a decentralized training system. It is anticipated that some 2,350 health workers will receive refresher training during the 8-year project life. Furthermore, the bridging activity to improve clinic management skills and method-specific knowledge (through an approach called the "cafeteria approach") will have been replicated in 75 clinics. And finally, over 700 physicians will attend workshops which will address counseling and method specific issues.

The project will improve women's access to quality maternal health and family care services by developing the system's capacity to provide such services. It will achieve this aim by addressing major gaps which exist in the present service delivery system. This includes: the poor quality of services at all levels due in part to the lack of female health workers; poor supervisory skills; and the lack of trained health care workers in birth spacing and maternal health service delivery although newly trained workers do have some kind of training in birth spacing methods.

The shortage of trained female health workers will take many years to resolve. However, current trends are encouraging. Over half of all medical students are women; increasing numbers of women students are enrolling in the HMI midwifery programs; and candidates for training as female primary health care workers (FPHCWs) increasingly have at least primary and often preparatory school education in some of the more developed governorates such as Hodeidah and Sana'a.

However, although some birth spacing teaching is included in the curricula for physicians, midwives and PHCWs, training is heavily theoretical rather than skills based. Training in client education and counseling and interpersonal communication is practically non-existent. Trainees need hands-on practice in educating clients in the health advantages of birth spacing for mothers and children; counseling clients on choice of birth spacing methods; managing

birth spacing acceptors; and identifying and managing high risk pregnancies. This applies to both pre-service and in-service trainees. To date, field workers have usually received no birth spacing training and prospects for them receiving adequate refresher training are limited. In addition, given prevalent male attitudes toward birth spacing, the limited mobility of women, and the scarcity of female health workers in most governorates, male workers need training in birth spacing and safe motherhood in order to inform and educate their male clients as well as give them the appropriate advice on methods.

The Project will respond to these needs by developing the system's capacity to provide all health workers with adequate and appropriate training in birth spacing and maternal health through support for the development or enhancement of birth spacing and safe motherhood modules in pre-service training and by establishing an institutionalized in-service training system which is sensitive to the differences in health structure development in the country. Both of the main areas of focus will ensure the system is able to provide skills-based training. The in-service training component will also develop the capacities of governorate health authorities to manage, implement and sustain these programs. Project activities will build on the experience in training gained through the ACCS project and in the activities implemented during the "bridging" period. The ACCS project will continue to assume responsibility for increasing the number of female primary health care workers (FHPCWs) until 1994.

Project activities to enhance pre-service training capacities will include an analysis of curricula to determine what modules actually exist and identify further needs. Based upon these findings, the Project will support activities in curriculum development or enhancement. Other donors will be encouraged to support the remaining gaps. Additional pre-service training activities will include upgrading teaching skills; monitoring and evaluation of teachers' and students' skills; and ensuring that there are practical and properly equipped training sites.

Project activities will help establish a two-track in-service training system sensitive to the structure and capacities of health services in the different governorates. Project activities for lesser-developed governorates will consist of specific training activities for particular categories of health workers. Project activities in more-developed governorates will be based on a governate-level team approach and will include support for training of trainers (TOT); training needs assessments; collection of qualitative and quantitative baseline data; training workshops; third country training to develop specific technical skills; monitoring of trainers' and trainees' performance; training evaluation; and development of institutional capabilities to manage training programs. Additional in-service training will include short-term technical courses during Phase I to cater to immediate

needs. Management skills of clinic directors and staff will be improved, based on the model developed under the SEATS "clinic" improvement project during the bridging period. Third country training may be provided for overall training program management.

Both pre-service and in-service activities will include development of training and client materials and training evaluation skills. All training will include monitoring the on-the-job performance of participants and evaluation of the impact of training on the family care/maternal health program, i.e., improved quality of service delivery, use of services, acceptor rates and maternal mortality rates. This is crucial to ensure that training is appropriate and effective.

The Project will develop the training competence of both public and private institutions. Pre-service activities will be limited to public sector institutions since there are no private institutions providing this type of training. Staff skills of HMI, governorate health offices, YPPU and YFCA will be developed to institutionalize in-service training.

The Project will provide limited equipment (e.g., IUD kits) to some trainees to ensure quality service delivery following the training. Equipment (in addition to training materials) will be provided to the governorate and other training programs. This will include flip charts, video equipment, overhead projectors, etc. Flip charts, method specific print materials, etc. for use by the trainees upon completion of training will be developed and distributed.

USAID will hire a full-time training specialist to supervise and monitor the training component.

3.2 Pre-Service Training

The following institutions currently provide pre-service training of health professionals and paraprofessionals:

- the University of Sana'a Faculty of Health Sciences trains physicians, pharmacists, nurses and health technicians;

- the University of Aden trains physicians and the Health Institute in Aden trains nurses and midwives. USAID has little information at present on the teaching programs at these institutions. An early project activity will be to collect this information.

- the Health Manpower Institute (HMI), based in Sana'a with regional centers in Hodeidah, Taiz, Dhamar, Hajjeh and Sa'adah, trains paramedical workers including midwives, nurses, medical assistants, pharmacy assistants and trainer/supervisors;

- the Ministry of Public Health (MOPH), in collaboration with HMI, trains both male and female primary health care workers (PHCWs)

At present, birth spacing is included in the physicians' curriculum at the Faculty of Medicine, but is not taught in the School of Pharmacy or the Nursing Institute at the University of Sana'a. At the HMI, birth spacing is taught in the nursing and midwifery programs, but is not included in the curricula for assistant pharmacists or medical assistants. The family planning modules in the HMI curricula were developed with USAID assistance, as was the midwifery curriculum developed with HMI Hodeidah and now applied in all HMI centers where midwifery is taught. Male PHCWs receive no training in birth spacing, whereas female PHCWs do have some.

Even where birth spacing modules do exist, there are a number of important gaps. For example, client education and counseling and training in interpersonal skills are not included in any curriculum. Faculty at both the University and HMI require some refresher training in birth spacing clinical skills and will require training in IEC, counseling and interpersonal communication if these are to be included in the curricula.

The project will respond to the above gaps in pre-service training through the following three interventions:

Analysis of all pre-service curricula. During Phase I, the Project will obtain all existing curricula (Universities of Sana'a and Aden; HMI/Sana'a and Aden Health Institute) pertaining to birth spacing and maternal health to identify what exists, what needs to be added, and where there is no training whatsoever. It will be necessary to study the implications of plans to merge the training institutions of the northern and southern governorates. The findings and recommendations will be presented at an evaluation meeting with other donors near the end of Phase I (April 1993) to enable donors to identify their respective areas of intervention.

Upgrading of teaching skills. Faculty of the universities and health training institutes will be trained to upgrade their teaching skills, both in terms of technical content and training methodology. University faculty will be trained in contraceptive technology, client education and counseling, and training methodology at Aïn Shams University in Cairo. Ten fellowships are already available under the bridging activities. Upon completion of this training in 1992, JHPIEGO will provide technical assistance for on-the-job performance monitoring of the faculty who attended the program and for further upgrading of the skills of certain faculty to monitor and provide on-the-job guidance in teaching methodology to other faculty members. The Project will provide funds to train an additional twenty university faculty at Ain Shams University, probably starting in 1993, after the first ten faculty have completed their training and an in-country evaluation of the

training and CA technical assistance has been completed. Bridging activities with AVSC have included specialized third-country training in surgical contraception. Such training and related research will continue under the Project and in later Phases will include the addition of new techniques. Third-country and in-country training will be provided whenever such training is more relevant or more advantageous in meeting the Project purpose.

The Project will fund in-country workshops to upgrade the clinical and teaching skills of HMI and other health institute faculty. During Phase I, a three-week training of trainers workshop will be implemented and will include training in adult education techniques, curriculum design, monitoring and evaluation, and IEC and counseling. This workshop will be designed to take into account present training skills and the training provided by AVSC under the bridging activities. This workshop will take place in Phase I and will include 30 participants who are trainers in the nursing and midwifery programs. These participants will be used as a resource under the in-service training program. Health institute faculty will receive further refresher training in an 5-day workshops during the project. Midwifery teachers who have received no formal training in IUD insertion will receive third-country training under the in-service training activities described below).

Refinement/Development of maternal health/birth spacing modules. Based on the pre-service analysis, the Project will provide support for revision of existing Faculty of Medicine and HMI curriculum modules on birth spacing/maternal health to become more skills-based and to include training in interpersonal communication, counseling and use of educational materials. The extent to which the Project or other donors will support this development/refinement of curricula will be discussed and decided at the end of Phase I. The Project will not be able to support across-the-board curriculum revisions/development.

Once the level of Project support has been determined, birth spacing/maternal health modules will be revised by the appropriate faculty members in conjunction with international consultants. This approach will enable the faculty members to apply the curriculum development techniques learned in the training courses. The final products will be manuals for teachers and students, teaching aids, service delivery protocols and checklists. These materials will be used as models for producing similar modules for pharmacists and nurses at the University of Sana'a and for pharmacy assistants and medical assistants (HMI). All modules will be skills-based and will cover practical training. The university modules will address practical training during internships. Appropriate practical training protocols and monitoring instruments will be developed for use during internships. Post-partum counseling will be included in the practical training modules where appropriate.

The HMI trainer/supervisor curriculum will be revised to enhance the levels of competence in these areas. The trainer/supervisors are responsible for the training and supervision of PHCWs. The revised curriculum will include adult education techniques, use of educational materials, training of trainers in IEC, counseling, interpersonal communication, evaluation of trainees' performance. Particular focus will be placed on supervisory techniques and tools and the organization of on-the-job training activities. Supervisory protocols and monitoring instruments for use by supervisors will be developed.

Depending upon the level of Project support, as defined at the end of Phase I, activities would include: creation of curriculum development task forces; task force meetings to develop specific modules; workshop to introduce modules to all faculty members; testing of modules; refinement of modules; printing; distribution; implementation; possible study tours to see how birth spacing and safe motherhood are taught in other Arab countries.

3.3 In-Service Training.

3.3.1 In-service Training for Health Workers

At present there is no institutionalized in-service training system for health workers in Yemen in either the public or private sectors. This type of training is limited to a small number of ad hoc activities organized mainly with the assistance of donor agencies. Most health workers have received no training in birth spacing service delivery. They are not well informed on birth spacing and are not able to offer accurate information to clients or ensure quality service delivery. The biggest group of health workers providing family care services are the PHCWs, followed by midwives and women physicians. In addition, field observation has identified considerable gaps in supervisory skills, which are a vital element in quality service delivery. Furthermore, informal surveys and enquiries conducted during the preparation of the USAID Population Strategy and this Project Paper indicated that the demand for birth spacing methods is significant in health centers and other facilities where quality services are provided.

The project will increase access to quality service delivery by assisting the MOPH to introduce an in-service training system at the governorate level and by developing HMI's capacities and input in providing refresher training for PHCWs in governorates where the health system is not well-developed and therefore not ready to support a governorate-level training team. This approach allows flexibility in a situation where sensitivity to regional differences in terms of health infrastructure and human resources is essential if any measure of success is to be achieved.

i. Immediate short-term training. Because the demand for birth spacing methods, the IUD in particular, appears to be directly

related to the quality of service given by female providers, the Project will provide immediate training to female health professionals in order to provide greater access to quality services in the short term.

Third country training in IUD insertion for female practitioners. During Phase I, two groups of fifteen female practitioners will be sent to Tunisia for training in IUD insertion. This will include theoretical training, counseling and hands-on practice. Tunisia has been selected as the site for training because of the Arabic language and because of its high number of IUD insertions which will participants with ample practical training, something not feasible in Yemen at this time.

Birth spacing skills development for midwives. One Pathfinder bridging activity provides refresher training in birth spacing to midwives through a 4-day workshop. The Project will provide funds for two more workshops in various parts of the country during Phase I for 20 midwives. If successful, an additional 60 midwives will be trained during Phase II.

ii. In-service training for health workers in the lesser developed governorates

Upgrading of Supervisory and PHCW Skills. As part of the bridging activities, Pathfinder has worked with HMI to develop a project to upgrade the skills of supervisors and both male and female PHCWs in Marib governorate. The purpose is to increase PHCW involvement in providing birth spacing information and services and to ensure that the services which are provided are of an acceptable standard. The results of this project will be evaluated and if the project is demonstrated to have a positive impact on women's access to health services, it will be replicated in other governorates where the health structure is not well developed. This will develop HMI's role as a key actor in in-service training, in addition to its current role as a pre-service training institute, and will prepare HMI for other activities within the Project. Two training activities based on the design of the bridging activity and a qualitative research study focusing on the contribution of the male PHCWs trained under the bridging activity will be implemented during Phase I. If successful, this activity will ultimately be replicated in all lesser-developed governorates by the end of the Project.

iii. Governorate-level In-service Training Teams

Governorate health offices, headed by governorate health directors, are responsible for the quality of health service delivery through MOPH health structures in their respective governorates. Supervisory capabilities in most governorates are limited and there is no organized system for in-service training, which is practically non-existent. The resources of some governorate health

offices are more developed than others. For example, in the Hodeidah health office there is a training officer and some health planning is performed. At the same time, other resources exist in these more developed governorates which can be used for in-service training, such as HMI centers (Sana'a, Hodeidah and Taiz), YFCA centers (Sana'a and Taiz), the health training institute in Aden, the Swedish clinic in Taiz and individual practitioners with specific qualifications in both the public and private sectors.

The Project will assist these more developed governorates to establish governorate-level multi-sectoral training teams or systems to institutionalize the planning, implementation, monitoring and evaluation of training activities. This is a concept currently being discussed within the MOPH.

Governorate-level in-service training will be coordinated by the governorate health offices in conjunction with local training resources (HMI, YFCA, etc.). Training teams will consist of trainers, planners and administrators. Training team activities will be integrated into the routine duties of the team members. Each team will plan, manage and implement annual training plans for the governorate.

At the end of Phase I, governorate health officials, HMI representatives from the governorate center, a YFCA representative and a Project consultant will meet in a three day workshop (10-12 participants per workshop) in each of three target governorates (Hodeidah, Taiz and Aden). The workshops will introduce participants to the concepts of governorate level training teams, training needs assessment and training program management. The participants will identify candidates for their governorate training teams (who will later participate in TOT workshops) and identify the first target group for training by each governorate team. A priority group of trainees might be the trainers or supervisors in order to upgrade supervisory techniques.

Subsequent Project phases would include the following activities:

<u>Training of Trainers (TOT) workshops</u> for governorate trainers. These workshops will be designed and facilitated by Health Institute trainers who received training under the pre-service activities during Phase I, with assistance from two international consultants. There will be two TOT workshops per year during the third and fourth years of the project, and one TOT per year in project years 5 through 8. TOT workshops will cover adult education techniques; curriculum development; workshop planning; clinical skills in birth spacing and safe motherhood; IEC skills in service delivery; counseling; performance monitoring; evaluation of training; training needs identification; management of training.

<u>Health worker training workshops</u> for the target groups identified at annual planning meetings. Each governorate team will plan and

implement at least two workshops after each of the TOTs in project years 3 and 4 and 4-6 workshops per year thereafter. Curricula for the training workshops in years 3 and 4 will be developed during the TOT workshops. The objective would be for each MCH health worker to participate in one or more workshops during the Project.

Annual three-day meetings will be held between governorate health officials and training teams to assess the year's activities, identify the training needs and develop a training plan for the following year.

The governorate-level in-service training system will be evaluated after two years (end of project year 4) to assess its impact on the quality of service delivery, on providing women with access to services and on birth spacing prevalence. It will also be evaluated in terms of the number of trainees and the quality of the training provided by the teams. The management of the system will also be evaluated. Depending upon the results of this evaluation, the system will either be refined and developed further or abandoned/adapted in favor of another system (e.g. working directly through HMI).

3.3.2 Health center management training

Improving the management skills of clinic managers and staff is essential to improvement in the quality and quantity of services offered. This activity will build on the SEATS experience with the "cafeteria approach" during the bridging period. Clinic managers will analyze their own needs and constraints and select the types of training or materials they consider most useful from a "menu" of choices in order to improve the quality of services provided by their clinics, thereby increasing the demand for these services. Participants will be able to test their choices and analyze the resulting changes in performance. Eight clinics participated in the pilot program during the bridging period. An additional ten clinics will participate during Phase I. If successful the program would aim at covering a total of 75 clinics throughout the country by the end of the project.

3.3.3 Private sector physicians and pharmacists

Private-sector pharmacists will be trained under the commercial marketing component while in this component private sector physicians will be trained in counseling and up-dated method specific information. During the bridging period, a TOT workshop will be held for physicians and pharmacists. The Project will sponsor an average of ten 1-2 day workshops per Phase in different areas of the country through the Union of Physicians and Pharmacists. Since physicians and pharmacists see clients in different stages of the process, each group will require an appropriate focus in the training.

IV.C.4 COMMERCIAL MARKETING

4.1. Overview

There is an active private sector in the health field in Yemen which could help expand significantly the availability of family planning information and contraceptives. Currently there are about 1,100 pharmacies and drug stores and over 1,000 general physicians who both work for the government and operate their own private clinics. The private sector already accounts for a substantial proportion of known contraceptives distribution within Yemen. Based on 1989 official registered importation of 138,000 cycles of oral contraceptives (OCs) and 5,432 IUDs, the private sector was responsible for the known distribution of 45% of OCs and 18% of IUDs in Yemen. There appears to be a large, but unsubstantiated, unregistered importation of contraceptives as well. At least six pharmaceutical distributors are currently importing contraceptives or have done so in the recent past. These include the **Yemen Drug Company for Industry and Commerce (YEDCO)**, the largest drug importer and manufacturer in Yemen, and its southern counterpart, the National Drug Company in Aden. Consumers have strong brand preferences for OCs and condoms. The price of OCs has been about 25 Rials per monthly cycle, a price within reach of many lower and middle class consumers. However, the price is rising as foreign exchange becomes more scarce. Observers in mid-1991 have noted one monthly cycle of OCs selling for as much as 80 Rials. The people of Yemen rely heavily on the private sector for provision of health services and on pharmacies to provide medications. Private sector implies somewhat better quality. It thus offers the potential as the major source for non-clinical contraceptive supplies to meet the increased demand likely during the next eight years.

In early 1990 a survey of pharmacies in Sana'a concluded that pharmacies were well stocked with contraceptives and it appeared that the private sector could continue to provide adequate supplies of contraceptives for a growing market. At the time of PID preparation in 1990, it was determined that there would be no need for A.I.D. supplies of contraceptives. The proposed social marketing program would concentrate on improving distribution, gathering better information on contraceptive usage for marketing purposes and analyzing pricing policies to increase sales while broadening the potential market.

However, conditions have changed over the past year. The current economic situation has created problems of foreign exchange availability. The result is that distributors are no longer importing contraceptives, a low margin pharmaceutical. A brief survey of contraceptive availability in pharmacies in major cities and some small towns of Yemen conducted by SOMARC staff in mid-1991 found major shortages of consumer preferred brands of contraceptives. While pharmacists indicated a willingness to buy

contraceptives to meet the growing demand, they were unable to do so because distributors were no longer importing adequate stocks on a regular basis.

UNFPA currently supplies contraceptives for the public sector. IPPF and Pathfinder Fund supply YFCA, a non-governmental organization. Discussions with these groups resulted in agreement on the respective roles of each organization with regard to future contraceptive supplies. USAID's comparative advantage is with the private sector, since in the long run the private sector will be the only sustainable supplier.

4.2 Proposed Activities

Although contraceptives are currently available in Yemen through private sector pharmacies, the concept of contraceptive social marketing (CSM) is new for Yemen. CSM is an approach which works to ensure the availability of contraceptive methods at reasonable prices for all. The CSM activities proposed under this Project will begin slowly and expand as acceptance of the concept and the market grow. The following targets appear reasonable and achievable by the end of the Project:

a. A consistent and affordable supply of modern contraceptives will be readily available in appropriate retail outlets in most urban areas and some rural areas. The initial products will be an IUD and a low-dose oral contraceptive, the two most popular contraceptives now available in the private sector. As the CSM program expands, other contraceptives would be included.

b. Staff from about 75% of the 1,100 pharmacies and chemist shops will be trained in modern contraceptive methods and their correct use, counselling of customers and referral to appropriate medical staff for problems. Sales promotion of CSM products will be supported by a national program of detailing to physicians and pharmacists.

c. Increased demand will be generated by IEC activities in addition to the promotion by physicians and pharmacists. Point of purchase materials will be created and distributed to retail sales outlets and instructional inserts will be included with the contraceptives to help consumers use the products correctly. Mass media campaigns would be conducted if deemed appropriate and acceptable by Yemeni officials. To the extent possible the media efforts will be coordinated with the planned IEC activities.

d. Regular research activities will be conducted to establish a baseline for measuring program outputs periodically and to ensure that informational materials and advertising are appropriate and effective.

The Phase I objective is to test acceptance of the conceptual CSM, fill the pipeline and insure adequate stocks of at least two types of contraceptives, which include instructional materials, to meet current demand and provide training for at least 100 pharmacists.

During Phase I, the Project will initiate a CSM program and will work with YEDCO as the local importer and distributor of contraceptives. YEDCO is the largest pharmaceutical importer and distributor in Yemen, with an extensive nationwide distribution network, good government contacts and an economically sound financial position. Although there are currently foreign exchange difficulties, YEDCO officials have indicated a willingness to import and distribute contraceptives, provided they are given assistance in dealing with the foreign exchange problem. CSM projects in other countries have negotiated successfully for lower prices with the multinational pharmaceutical companies providing contraceptives and preliminary indications are that advantageous prices will be offered to YEDCO.

During Phase I of the Project, USAID will utilize the services of a Cooperating Agency through the buy-in mechanism to initiate the CSM program. CA staff will be responsible for the following:

a. Conclude agreement with YEDCO in the important areas of importation and distribution, advertising and related IEC activities and marketing research.

b. Provide necessary technical assistance for overall program design, marketing, advertising, training, market research, management information systems and other needed areas to implement the CSM program. In coordination with USAID, evaluate the need for a full-time local project manager and identify suitable candidates.

c. Serve as a liaison between YEDCO, MOPH, USAID and other CSM program organizations to ensure that opportunities and constraints are identified and dealt with in a timely manner and important program developments are reviewed regularly by all parties to facilitate program expansion.

d. Develop and conduct, with YPPU, training workshops for pharmacists throughout the country.

e. Organize regular store audits and evaluations of program activities.

USAID is including some funds in the Project for purchase of contraceptives although the expectation is that the Yemeni private sector will be able to import most contraceptives. These contraceptives will go to YEDCO as part of the incentive for importing other contraceptives. Since IUDs are are one of the two most preferred methods in Yemen and supply is often scarce, USAID will procure and donate an initial supply of 25,000 CuT380A IUDs to

the CSM program. Since use of IUDs appears to be directly related to the availability of qualified female health practitioners, the Project's training component will, within the first year, train 30 women in IUD insertion and counseling. This will set the stage for increased service delivery capability for this contraceptive method.

Before the end of Phase I, USAID will determine whether to continue CSM and if future support for the CSM should be through buy-ins or competitive bidding on a contract for the remainder of the project. Much will depend upon the degree of success of the CSM program during Phase I. At the end of Phase I a determination will be made as to the amount and types of contraceptives that should be purchased directly by USAID in Phase II. During future phases, USAID will continue support for technical assistance, training, advertising, market research and commodity support as deemed necessary from surveys and the results of store audits.

IV.C.5 MULTISECTORAL LINKAGES

Several factors which are not specifically addressed in the other components of the Project have a substantial impact on women's health and fertility behavior, either directly or indirectly. For example, age at first marriage is one of the prime determinants of fertility. Women's education has a direct impact since the further a girl advances in school, the longer she is likely to postpone marriage. Studies around the world show that literacy and some primary education have a considerable impact on women's attitudes and decisions about health and birth spacing. The participation of women in the labor market also has an important effect on fertility and decision making about their own lives.

In line with the emphasis of the ROYG on expanding opportunities for women more generally, the multisectoral component of the Project will make it possible to provide linkages with other sectors which are likely to have a positive impact on women's development in the areas mentioned above.

Women can be reached through a number of channels: various branches of the Womens' Associations which are active in the field and which organize literacy classes, vocational training and, in some cases, training for income generating opportunities; agricultural extension projects; NGOs such as Girl Guides; Womens's Associations and YFCA outreach workers. Women's interests can also be furthered by actions to promote girls' access to education and to professional careers, as well as by sponsoring workshops and other activities to study issues relating to women's legal status and rights.

Opportunities to develop multi-sectoral linkages will be sought over the project life. This will involve working in conjunction with other USAID/Sana'a projects (e.g. EDSP, SWAY and ACCS) and by working directly with some of the organizations or channels mentioned above. Contributions could also be made to other donor projects in order to further the objectives of this component.

Possible areas for multi-sectoral activities include:

- Reviewing and refining safe motherhood/birth spacing/nutrition modules in literacy programs. (For each of the 4 years of study.)

- In addition to the above modules, providing other materials and aids (wall charts, brochures, videos, demonstration equipment) to enhance the teaching and understanding thereof.

- Providing grants to help new women's associations to establish themselves or to help existing associations to open branches and

thereby make literacy training available to a greater number of young girls and women.

- Outreach programs in conjunction with Women's Associations and YFCA volunteers and staff to counsel women in safe motherhood, birth spacing and other common women's problems using materials specially designed under the awareness and communication component.

- Paying educational stipends for women PHCW and midwife trainees.

- Identifying obstacles to girls' school enrollment and attendance in different regions and working with other agencies to find appropriate solutions.

- Using Girl Guides as health education facilitators in their families and immediate environment.

Needs and opportunities will be identified through meetings with USAID project staff, representatives of government and donor agencies, and NGOs and through the analysis of reports.

Phase I Activities

Due to budget constraints, no specific activities are planned during Phase I. During this period both the SWAY and ACCS projects will remain active in such areas as stipends to female PHCWs and grants to womens associations. Additionally USAID will apply for matching funds from central projects for assessing the capability of Women's Associations to increase literacy and promote primary education and outreach programs.

V. Project Implementation

A. Implementation Plan

Due to the comprehensive nature of the Options for Family Care project, it is unreasonable to expect that a single contractor would have the required expertise to undertake all the project activities. Similarly, it is unlikely that a single Yemeni institution would be strong enough or extensive enough to implement the project alone. Also, implementation will be decentralized to governorates and local institutions as much as possible in order to respond to different constraints and opportunities in different parts of the country and to conform to the decentralization trend instituted by the ROYG. Finally, flexibility to experiment with a number of approaches to achieving project outputs argues for drawing on the skills of a range of institutions, both international and domestic. For these reasons, the project initially will rely on buy-ins to centrally-funded S&T/POP projects for technical assistance and training. Staff of S&T projects, in turn, will establish collaborative working relationships with appropriate local organizations for the implementation of project activities, if they have not already done so in the bridging period. (See Annex E.5 for a list of local counterpart organizations.)

This approach does not preclude the option of, in the later years of the project, awarding an institutional contract for implementation of the bulk of project activities if appropriate. However, the project would like to rely on Yemenis to the greatest extent possible for long term on-the-ground activities.

The project will be implemented according to a "rolling plan" that emphasizes setting performance targets for discrete periods of time (18-24 months), designing activities to meet those targets, and regular evaluation of progress, of the impact of activities, and of the appropriateness of the targets. Successful activities will be extended and/or replicated. Workplans covering 18-month periods will guide the progression of project activities. Each workplan will have specific objectives, a timetable for review, and evaluation criteria for determining whether the activity should be "rolled over" into the next planning period. Every year and a half, the project will sponsor two workshops: 1) with counterpart institutions, to review what has happened, what has worked or not worked and why, and to develop plans for the coming year; and 2) with donors and the Ministry of Planning and Development (MPD) to discuss lessons learned and to coordinate activities for the coming 18 months. Based on the impact evaluation and the workshops, a new workplan will be developed and "rolled over" into another 18-month plan. A detailed implementation plan for the first Phase of the project is attached as Annex G.

Due to the time it takes to effectuate new buy-ins, Phase I of the project will actually have a duration of two years. During the first three to six months, "bridging" activities will continue, the paper work for buy-ins will be processed, and USAID and the counterpart institutions will solidify the understanding of their roles especially in relation to the Population Policy which is expected to be issued in October 1991. The first evaluation will be held 18 months after the start of the project, i.e. March 1993. This then will allow sufficient time for the evaluation workshops, preparation of the Phase II workplan and processing of the necessary contracting actions by October 1993, the start of Phase II. This sequencing, conducting the evaluation activities every 18 months and allowing six months to the start of the next phase will continue throughout the project so as to avoid down time due to contract processing. (Please refer to the Project Implementation Framework chart on page 42a.)

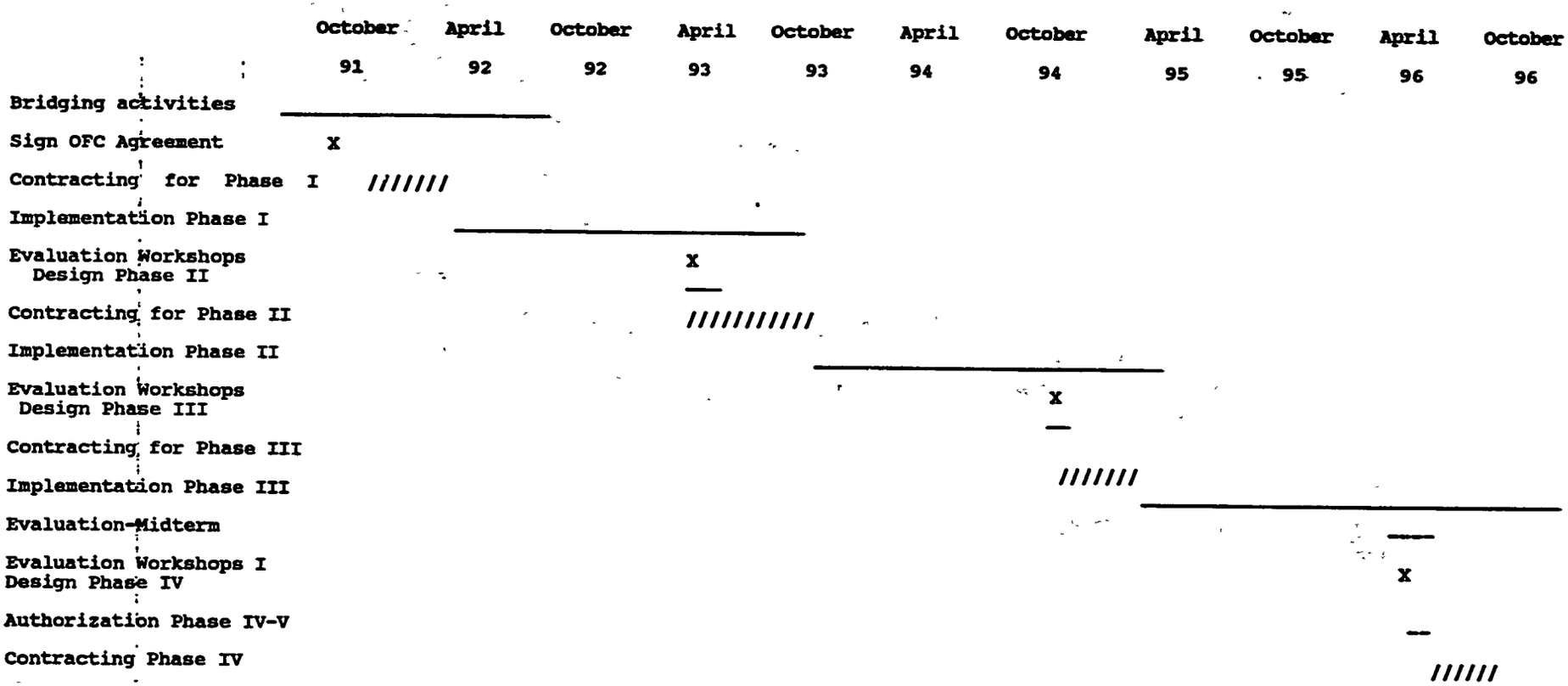
Because of the lack of information on demographic variables and population trends, data collection and analysis will be a priority in the early years of the project. The data collected will inform policy analysis and feed into awareness-raising and communications programs. The data will also provide important baseline information for evaluating progress toward project goals. The skills development/service delivery component of the project will improve the capacity of the health sector (public and private) to meet the increased demand for quality services through technical, counseling and managerial training for health care workers. The commercial marketing component will develop the technical and marketing skills of Yemen's private sector in order to increase the supply of contraceptive commodities. Multi-sectoral linkages will be promoted over the life of the project.

Limited third country training is proposed, namely for training midwives in IUD techniques in Tunisia and physicians in specialized reproductive health in Egypt. These sites were chosen because of the lack of training facilities in Yemen, the similarity of language, religion and customs which is especially important for the female midwives, the comparatively low cost of such training, and the availability of excellent and well managed training facilities in the two countries which have been developed with S&T/POP and USAID support. USAID will pay transportation costs for third country training. If any long-term training develops in later phases of the project, the ROYG will be responsible for transportation costs to the furthest point covered by Yemen Airlines.

B. Project-funded Staff

Project funds will be used to hire a full-time local training specialist beginning in mid-1992. Preference will be given to a Yemeni woman, with experience in design and implementation of training programs in the health and population sector. The

PROJECT FRAMEWORK FOR IMPLEMENTATION



training specialist will provide technical guidance on the development and implementation of all of the project's training activities. The majority of these fall under the Skills Training/Service Delivery component; however, each of the other components also includes important training elements (e.g., in policy analysis, logistics management, etc.).

In addition local hires will be sought for advisor/coordinator positions for commercial marketing, centers of excellence development, and institutionalization of governorate in service training. The duration of these positions will vary and may either be hired directly by USAID or by the buy-in cooperating agency which ever is appropriate. Additional personnel, such as a graphic artist (print material development) or computer specialist may also be employed as appropriate. In all cases Yemenis will be sought, however the project will not hire or secund government employees. Finally, the project plans to support International Population Fellows through the Michigan Fellows program. An Arabic speaker will be sought and if found will be placed with YFCA to assist with logistics management and the centers of excellence. If Arabic language capability is not available, the Fellow will be placed at the Mission and will provide technical guidance on the implementation of the commercial marketing component of the project.

C. Commodity Plan

Commodities procured through this project will generally conform to Geographic Codes 000 and 941, including U.S. or Yemen source and origin, except for the firm request for two vehicles which will be procured under Geographic code 935 and for which a waiver in included in the Project Authorization.

Where feasible, the project will procure equipment and supplies (computers, software, clinic supplies and equipment, textbooks, training materials etc.) through direct A.I.D. procurement rather than through agreements or contracts with various cooperating agencies. This will reduce overhead costs. Only two vehicles are required for Phase I activities. Up to six additional vehicles may be needed in future Phases, depending on the "rolling plan" evaluations. However, due to the strong A.I.D. policy to finance U.S. vehicles and potential changes in the supply of U.S. vehicles in Yemen, USAID will not procure additional foreign vehicles unless (a) project activities would be substantially impaired without them and (b) other alternatives, such as ROYG or other donor financing, are fully explored. The procurement of contraceptives will initially be through a fully funded PIO/C utilizing existing S&T/POP contracts. The need for specialized equipment, both medical and mass media production, will be assessed during Phase II. It is believed that some of these items may be procured through UNICEF which has developed with MOPH a standarized list of equipment and supplies which it can obtain at advantageous prices.

Additionally some specialized equipment and supplies (e.g. for AVSC activites) may be procured through the CA's.

See the following page for the list of Project Commodities planned.

D. Technical Assistance and Training Services

Due to the diversity of services needed and the importance of being able to respond to changes in the types of assistance needed, the traditional approach of obtaining technical assistance and training services--via a separate competitive master contract--was determined inappropriate for the initial phase of the project. The master contract approach would be more costly because of the additional layers of costs that are applied by prime contractors for subcontracts. Instead, the Mission will "buy-in" or "add-on" to agreements and contracts with the U.S. firms already established by AID/W/S&T/POP. This approach will reduce the time required to procure services and will enable the project to go operational at an earlier date. Another consideration is that the percent of contract services provided by Gray Amendment firms might be higher under thhis scenario, in that a larger number of these firms can be utilized through established agreements/contracts with S&T.

As the project progresses, however, determinations will be made to continue the buy-in/add-on network or to procure further technical assistance and training services by new competitive agreements/contracts.

E. Gray Amendment

This Project Paper was developed with full consideration of maximally involving Gray Amendment organizations in the provision of required goods and services. As noted above the initial phases of the Project are not appropriate for direct contracting with minority or Gray Amendment organizations since procurement will be primarily buy-ins or add-ons to S&T/POP projects. If an institutional contractor is selected for later project phases, full consideration will be provided for Gray Amendment firms.

PROJECT COMMODITIES

The following commodities with the estimated dollar costs have been identified for potential procurement under the Project:

	($000)
Data Collection and Policy Analysis	
Computers	150
Software and related training	150
Training equipment	25
Awareness Raising and Communications	
A. Media Production	
TV mini-bus (1)	40
Video and other audio-visual production equipment	160
B. Centers of Excellence	
Vehicle (1) for YFCA	25
Clinical equipment	200
Educational equipment, VCRs	50
Education materials for Centers, flip charts, posters, brochures, wall charts, videos	50
Skills Development and Services Delivery	
Vehicle (1) for training specialist	25
Vehicles (3) for training teams	75
IUD kits (600)	100
Training supplies and equipment, VCRs and overhead projectors	105
Commercial Marketing	
IUDs	125
Other contraceptives	375
Vehicle (1)	25
Multi-sectoral Linkages	250
Vehicle (1)	25
Training and demonstration equipment	100
Books, wall charts, brochures and videos	125
TOTAL ESTIMATED PROJECT COMMODITIES:	1,930

VI. COST ESTIMATE AND FINANCIAL PLAN

The eight-year USAID project budget is $18 million. An obligation of $500,000 is planned for Year 1 (FY 1991). The project is divided into two parts which will be authorized separately. Part I covers five years and three phases for a total USAID contribution of $10,600,000. Part II covers the final three years and includes two phases for a total USAID contribution of $7,400,000. Part II will be authorized in project year five if the mid term evaluation indicates that continued support for the sector is warranted and if the ROYG is fully supportive of the project activities.

The ROYG will provide the equivalent of $5.9 million in kind through staff (salaries and in-country per diem), office space, media production and air time, computer time, contraceptives and various training costs over the life of the project. The ROYG contribution represents 25 percent of the USAID contribution over the planned period of active USAID involvement. A written assurance of the ROYG's contribution will be received prior to or as part of the project agreement. USAID and ROYG contributions by project component over the life of the project are estimated as follows:

Data collection/policy analysis:

USAID will provide $2,255,000 for technical assistance, training and computer equipment for continuing work on the 1991 and 1997 Demographic and Health Surveys and the 1994 national census and population policy implementation, workshops and information dissemination activities. USAID plans initial buy-ins to the Bureau of the Census, Demographic and Health Surveys, and Options for Population Policy projects to provide assistance in this component.

The ROYG, through the MPD/CSO, will provide the equivalent of $760,000 to cover the salary costs for trainees at BUCEN; salary and in-country per diem for the counterparts for all DHS, census and policy implementation activities; provide office space and transportation for visiting consultants; and, computer time for data analysis.

Awareness raising/communications:

USAID will provide $3,282,000 to support a series of workshops on family care for government officials and influential individuals; develop a family care logo, song, television spots and TV drama(s); undertake market research studies; and support the development of centers of excellence to extend family care services. During Phase I, at least, USAID will finance buy-ins to the Population Communications Services project managed by Johns Hopkins University

for media development and the Pathfinder Fund to support the centers of excellence.

The ROYG's primary contribution to this component, through the MOI, will be the cost of television and radio air time, as well as salaries and in-country per diem of trainees and counterparts. Additionally, the operating costs of the facilities and contraceptives at the centers of excellence are included as part of the host country contribution. These costs are estimated to be the equivalent of $523,000.

Skills development/service delivery:

USAID will provide $6,282,000 to strengthen the capability of Yemeni training institutions to greatly expand both pre-service and in-service training in family care for health practitioners, trainers and administrators and provide third country training for specialized family care services. Especially during Phase I, the Project will rely on buy-ins to JHPIEGO, AVSC, Pathfinder Fund, SEATS and PAC IIb to provide the required technical assistance, training expertise and sub-project support to implement the proposed activities.

The ROYG will provide training sites, salaries and in-country per diem for counterparts, salaries for trainees and per diem for local training. Some of the contraceptive commodities provided by the public sector will also be considered as the government's contribution, even though they are provided primarily by UNFPA. The ROYG contribution is estimated to be the equivalent of $985,000.

Commercial marketing:

USAID will provide $2,590,000 to contract for technical assistance to help YEDCO expand private sector contraceptive sales and support market research, training of pharmacists, IEC activities, packaging, distribution and limited contraceptive supplies (mainly IUDs). USAID will also support a local-hire project manager for commercial marketing. During Phase I, USAID will arrange a buy-in to the SOMARC project to provide technical assistance, training, and research.

YEDCO and the Yemeni private sector will supply contraceptives as the major contribution of the private sector to the project, along with the cost of maintaining the logistics management system and supporting the national distribution system. These costs are estimated to be equivalent of $2,250,000.

Multisectoral linkages:

USAID will provide $2,350,000 for grants to the Women's Associations or other NGOs; stipends for female primary health care

workers; development of training courses; support of a Population Fellow through the University of Michigan; outreach training development of training materials; support for female literacy programs; and training equipment and materials.

The ROYG's primary contribution will be the costs of training some 200 FPHCW's and midwifes. Additionally grants to associations will require at least 25% counterpart contribution and the time of outreach workers will be considered as in kind project contributions. None of these costs will be incurred in the first phase of this project. The total value of these contributions is estimated to be the equivalent of $1,380,000.

USAID has also included funds for evaluation and related workshops ($200,000), project audits ($100,000) and contingency ($941,000).

The project budget in summary form can be found in Table 1 on the next page. Detailed budgets by Phase for USAID and ROYG contributions follow in Tables 2 and 3 respectively.

TABLE 1 Summary Budget
($000)

	PHASE I 10/91-9/93	PHASE II 10/93-3/95	PHASE III 4/95-9/96	PHASE IV 10/96-3/98	PHASE V 4/98-9/99	TOTAL
Data collection/ policy analysis	390	560	385	310	610	2,255
Awareness/ Communications	482	840	940	620	400	3,282
Skills development/ service delivery	962	1,555	1,250	1,305	1,210	6,282
Commercial marketing	430	490	565	590	515	2,590
Multi Sectoral	0	625	575	575	575	2,350
Evaluation (incl:workshops)	25	25	50	25	75	200
Audit			50		50	100
Contingency		250	151	275	265	941
TOTAL	**2,289**	**4,345**	**3,966**	**3,700**	**3,700**	**18,000**
Cumulative		6,634	10,600	14,300	18,000	

Notes: Budget includes total of:
Commodities: $1.93 million
Grants (clinics, NGO's): $1.1 million

TABLE 2

USAID BUDGET BY PROJECT PHASE
($000)

	Phase I	Phase II	Phase III	Phase IV	Phase V.	Total
DATA & POLICY						
DHS	Bridging			50	300	350
DHS analysis	100				100	200
Statis Training	90	60	60	60	60	330
Census		200	100			300
Dissemination/Census		50	50	50		150
						0
Policy Implementation	150	150	100	100	100	600
Design, Tracking &						0
monitoring						0
						0
Commodities (hardware						0
software, training)						0
Central level	50	50	25			125
Governorates		50	50	50	50	200
Sub Total	390	560	385	310	610	2255
AWARNESS						0
Communication						0
Media (Research, KAP Surveys	187	250	250	200	100	987
workshops training,						0
production)						
Commodities		100	100			200
Centers of Excellence	270	440	440	370	250	1770
Commodities	25	50	150	50	50	325
Sub Total	482	840	940	620	400	3282
SKILLS DEV/SERVICE DEL.						0
Preservice						0
TOT	150	75	75	75	75	450
Curricula Development	20	100	100	100		320
						0
In Service						0
IUD insert	125					125
Faculty	90	90	90	90	90	450
PHCW's/Midwifes	67	185	110	110	110	582
Gov.Training System	50	480	370	225	225	1350
Physicians	55	45	45	45	45	235
Materials	100	100	100	100	100	500
Management	250	250	250	500	500	1750
Training Specialist	30	45	45	45	50	215
Commodities/Supplies	25	185	65	15	15	305
Sub Total	962	1555	1250	1305	1210	6282.00

USAID BUDGET BY PROJECT PHASE
($000)

	Phase I	Phase II	Phase III	Phase IV	Phase V	
COMMERCIAL MARKETING						0
Research, CSM(train,packaging,						0
distribution)	325	375	375	400	400	1875
Local Hire	30	40	40	40	40	190
Commodities	75	75	150	150	75	525
Sub Total	430	490	565	590	515	2590
MULTI SECTORAL						0
Fellow		150	150	150	150	600
Literacy for Women		75	75	75	75	300
Grants to NGO's		100	100	100	100	400
Outreach training/dev.		150	150	150	150	600
Stipends female trainees		50	50	50	50	200
Commodities		100	50	50	50	250
Sub Total	0	625	575	575	575	2350
Evaluations/workshops	25	25	50	25	75	200
Audit			50		50	100
Contingency Inflation		250	151	275	265	941
Sub Total	25	275	251	300	390	1241
GRAND TOTAL	2289	4345	3966	3700	3700	18000

TABLE 3

HOST COUNTRY CONTRIBUTIONS BY PROJECT PHASE
($000)

	Phase I	Phase II	Phase III	Phase IV	Phase V	Total
DATA & POLICY						
DHS	Bridging			50	100	150
DHS analysis	20				20	40
Stats Training	40	25	25	25	25	140
Census		100	100			200
Dissemination/Census		20	20	20		60
						0
Policy Implementation	25	25	40	40	40	170
Design, Tracking &						0
monitoring						0
						0
Commodities (hardware						0
software, training)						0
Central level						0
Governorates						0
Sub Total	85	170	185	135	185	760
AWARENESS						0
Communication						0
Media (Research, KAP Surveys	75	75	34	34	34	252
workshops training,						0
production)						
Commodities						0
Centers of Excellence	31	50	50	50	50	231
Commodities		10	10	10	10	40
Sub Total	106	135	94	94	94	523
SKILLS DEV/SERVICE DEL.						0
Preservice						0
TOT	45	50	50	50	50	245
Curricula Development						0
						0
In Service						0
ID insert	5					5
Faculty	30	30	30	30	30	150
PHCW's/Midwifes	20	30	20	20	20	110
Gov.Training System	10	80	60	30	30	210
Physicians	20	20	20	20	20	100
Materials						0
Management	20	20	20	20	20	100
Training Specialist					45	45
Commodities/Supplies		5	5	5	5	20
Sub Total	150	235	205	175	220	985

HOST COUNTRY CONTRIBUTIONS BY PROJECT PHASE
($000)

	Phase I	Phase II	Phase III	Phase IV	Phase V	
COMMERCIAL MARKETING						0
Research, CSM(train,packaging,						0
Distribution)						0
Local Hire	300	450	500	500	500	2250
Commodities						0
Sub Total	300	450	500	500	500	2250
MULTI SECTORAL						0
Fellow		15	15	15	15	60
Literacy for women		20	20	20	20	80
Grants to NGO's		50	50	50	50	200
Outreach training/dev.		10	10	10	10	40
Stipends female trainees		250	250	250	250	1000
Commodities						0
Sub Total	0	345	345	345	345	1380
GRAND TOTAL	641	1335	1329	1249	1344	5898

VII. PROJECT MONITORING AND EVALUATION

A. Monitoring and Coordination

Overall monitoring of the project will be the responsibility of the Mission's Project Management Office and the Population Sector Specialist who will supervise all local hires and orchestrate the project activities. Much of the management burden for U.S. based technical assistance and training expertise is shifted to the S&T/Office of Population because of the project's reliance on buy-ins to centrally-funded Cooperating Agencies (CAs). S&T/POP Cognizant Technical Officers (CTOs) will provide technical guidance, review scopes of work, and process PIO/Ts.

On the host-country side, the Ministry of Planning and Development will be the overall coordinator responsible for signing project agreements. In addition, a lead institution for each project component has been identified. These lead institutions will facilitate coordination of the counterpart organizations involved in implementation of each specific component as appropriate. The lead organizations will also be responsible for collecting the information required to determine whether the targets for a given evaluation period have been met.

Contractors will brief Mission staff on the status of project activities at the conclusion of each country visit. These briefings will provide an opportunity to re-orient project activities if necessary. The Population Sector Specialist will maintain regular contact with the local counterpart organizations in order to monitor progress of project implementation between contractor visits. In addition, the Mission has begun a practice of bi-weekly meetings of international donors, local organizations, and visiting contractors in the population field. These meetings are a useful forum for sharing information and ideas and for coordinating activities.

The comprehensive nature of the project and the participation of numerous CAs and local counterpart institutions raise a number of management issues, not the least of which is maintaining the cohesiveness of the project. The "rolling plan" of implementation is designed to ensure that the project progresses in a logical fashion, that certain benchmarks are reached before new activities are initiated, and that activities have a logical relationship to one another and to the overall project purpose. The 18-month workplan will be the primary tool for monitoring progress. The evaluation workshops every 18 months will be the primary forum for sharing information, and guaranteeing that project activities remain in line with ROY need and complement those of other donors.

B. Evaluation

Routine monitoring of project implementation will be supplemented by more formal evaluation activities. These include an evaluation of each component every 18 months, regular evaluation workshops, a midterm evaluation in Phase III, and a final external project evaluation in Year 8. The project design includes collection of baseline data, target-setting, and development of evaluation benchmarks and criteria.

1. Data for Evaluation

Data collection activities to provide baseline data and assess progress over the life of the project have been built into the project design. The DHS will provide baseline data against which to measure project progress. (Preliminary results will be available in the spring of 1992.) A national census is planned for 1994 and will provide input to the design of activities in the later years of the project. In addition, the project will support smaller KAP-type surveys to gather information on project impact and guide project design. A second DHS in 1997/98 will provide quantitative information for the final project evaluation.

2. Evaluation Plan

Evaluation indicators for each output are summarized in the logical framework (Annex B). Interim benchmarks will be established at evaluation workshops to be held every 18 months. Ten evaluation workshops are anticipated, five for counterpart organizations and five for MPD and donors. At each workshop, the accomplishments of the project to date will be reviewed and evaluated against the targets, lessons learned and plans of the ROY and other donors will be discussed, and targets and activities for the next evaluation period will be set.

The evaluation workshops should address questions such as:

- Are contraceptive supplies adequate to meet demand? If not, what should the project do to facilitate increasing supply. Is there a demand for new types of methods?

- What evidence is there that the progress made will be sustainable?

- To what extent are Yemenis receiving on-the-job training and being trained to take over responsibilities currently undertaken by non-Yemenis? If this is not happening, what changes in the project should be made to increase the effectiveness of on-the-job training?

- What contributed to the success/failure of a particular activity?

- To what extent can an activity be replicated elsewhere in Yemen?

- Have the printed materials which have been developed, been tested? How are these materials being distributed? Is the distribution system effective?

- Is the project still contributing to Yemen's needs in the population sector?

The midterm evaluation and the final evaluation will address more general issues related to project design and impact. The logical framework summarizes the expected end-of-project status (EOPS). The project purpose will have been met if: 1) TFR declines to 6.5 over the life of the project, 2) CPR is increased to over 20% in urban areas, and 3) awareness of family care methods, sources, and advantages doubles. Comparison of the 1991/92 and 1997/98 DHS data will provide verification of the end-of project purpose-level indicators. Annex H includes suggested questions to be addressed in the mid-term evaluation which will be used to determine whether to authorize Part II of the Project. Other questions that both of the evaluations might address include:

- Was the assumption of government willingness to address population issues in a comprehensive manner correct?

- Was the project's reliance on the private sector to supply and distribute contraceptive commodities realistic in the Yemeni setting?

- Does the Yemeni family planning program have a solid foundation for expanding to meet future demand?

- What were the strengths/weaknesses of relying on the rolling implementation plan?

- What lessons can be learned from the project that may be applicable in other countries, particularly Muslim countries?

- To what extent is the capacity for data analysis, awareness-raising, and in service training institutionalized?

- What should be the next steps in strengthening Yemen's family planning program?

- What was the contribution of the project to raising the status of women?

- How much of the decline in TFR over the life of the project can be attributed to project activities?

VIII. SUMMARIES OF ANALYSES

Where appropriate more detailed project analyses are contained in Annex E and include thorough discussions of significant technical issues considered during project design. The summaries below highlight the main findings of these analyses.

A. Technical Analysis

Yemen is at a turning point in its history. Just a year ago, the northern and southern governorates were united. Shortly after unification, the Gulf Crisis escalated and the majority of Yemeni citizens working in the Gulf region have returned home in search of employment in the local economy. Absorbing the large number of returnees and coping with the associated decline in remittances are two of the immediate challenges to the new nation. In addition, the high population growth rate threatens future economic development.

Uncertainty of what the future holds with regard to the structure and capacity of the public sector, the health of the economy, and the opportunities for women, requires that the population project described in this PP remain flexible in its expected achievements and innovative in its implementation. The project design ensures this adaptability through a rolling plan of implementation that emphasizes 18-month cycles of activities, target-setting, and evaluation.

Perhaps the most significant technical issue affecting the likelihood of accomplishing the project purpose is the intention not to include a significant amount of A.I.D.-provided contraceptive commodities. This decision is based on the understanding with UNFPA that they will supply the public sector while USAID works with the private sector. USAID will provide incentives (partially in the form of direct supply) and training to the private sector for importation and distribution of contraceptives. The adequacy of this working relationship will be regularly tested over the life of the project, particularly in the early years.

The Options for Family Care project has the potential to make a significant contribution to building a foundation for a sustainable family planning program in Yemen. The project is designed to meet needs across the range of program components and the implementation plan ensures the flexibility to modify project activities as the situation warrants.

B. Financial Analysis

Studies in other developing countries over the past decade demonstrates that family planning projects yield a high internal

rate of return, generally 15-50%. A preliminary analysis for Yemen indicates an annual internal rate of return of 20 percent. However, there is limited data available in Yemen to carry out such an analysis and the preferred method of analysis is cost effectiveness, that is, finding the best trade-off between costs and effectiveness.

This project will utilize the buy-in mechanism to S&T/POP Cooperating Agencies, at least in Phase I which will continue many activities initiated with S&T/POP funds prior to and during the "bridging" period. Buy-ins seem to offer the most cost effective way of starting the new project. It would be difficult to identify one contractor to carry out the multitude of discreet activities contemplated during Phase I and a time-consuming process to seek competitive bids. It is USAID's intention to make this a Yemeni project as much as possible and avoid the presence of long-term foreign technical advisors. The project benefits financially from the buy-in mechanism because S&T/POP bears some of the overhead costs of the agreements and the CAs have generally been chosen on the basis of competitive bidding. In addition, the CAs are providing some of their central funds, especially during the "bridging" period, thereby increasing the net flow of resources to Yemen.

Costs during project life have been estimated using known costs of each CA contract or cooperative agreement. Costs of commodities, vehicles and local hire personnel are well established. A 5% contingency fund allows for unanticipated project activities and future cost increases.

The ROYG will contribute the equivalent of nearly $6.0 million over the life of the project, mostly in-kind contributions of staff salaries, media production and air time and commodities.

C. Economic Analysis

There are numerous economic benefits associated with averting unwanted births and postponing mis-timed births. Some benefits, such as recurrent education costs, are more easily measured; others, such as reduced medical costs attributed to high-risk births (e.g., high parity and closely spaced births) are more difficult to quantify. Some benefits, such as school fees, are measured at the family level, while others, such as recurrent health care costs, are measured at the national level.

The cost-benefit analysis undertaken for this project paper compares the costs of expanding Yemen's family care program with the savings associated with reduced government expenditures in the education and health sectors, owing to reduced numbers of school-age children and reduced numbers of maternal and child clients, respectively. The analysis begins in 1990. The marginal program costs of a moderate decline in fertility (from 8.3 to 6.0 by the

year 2015) are $6.9 million in 1995, $16.3 million by 2000 and $65.9 million in 2015. Saving do not accrue in the health and education sectors until 1998 when they are $3.8 million. These savings increase to $17.3 million by 2000 and $364.6 million by 2015. Thus, the "break-even" point, where annual savings equal annual costs occurs in 1998 and the "pay-back" point, where cumulative savings begin to exceed cumulative costs, occurs in 2001. The annual internal rate of return on the investment in family planning considered here is 20 percent. In other words, one would have to discount future benefits by 20 percent annually for the investment in family planning not to be cost-beneficial. Hence, the benefit-to-cost ratio for family planning in Yemen is quite favorable.

D. Social Soundness/WID Analysis

The social soundness analysis, which is incorporated into Section III (Project Rationale), suggests that this is an opportune time to undertake a project of this nature. The ROYG has drafted its first population policy and interest in integrating population issues into development planning is high. Growing receptivity to family planning was enhanced by religious leaders' endorsements of birth spacing at the 1989 Conference on Islam and Population and by the Safe Motherhood Conference in Jordan. Unification of the northern and southern governorates also provides the opportunity to take advantage of the relative progressiveness of attitudes towards women and of higher female educational levels in the south.

The demographic situation in Yemen is typical for a country at the beginning of its demographic transition. A recent study of the feasibility of farm irrigation (Hossain, 1991) nicely captures the demographic characteristics of rural areas in Yemen:

> "The farm family has 16 members comprising 3 adult males, 3 adult females and 10 children. Females are completely uneducated. Males, in general, can read and write. Only male children [go] to school, female children are not sent to school. Males are engaged only in agriculture, females are engaged both in agriculture and in household activities."

The situation in urban areas is slightly better but, on average, social indicators are among the lowest in the Arab world: fewer than 15% of women are literate, school enrollment of girls is low, the TFR is 8.3, infant mortality is 130/1000, and life expectancy for both sexes is less than 50 years (CSO, 1991).

The need for interventions in health and family planning and for activities to raise the status of women is clear. However, progress in the population sector is hampered by a number of societal and institutional constraints--low status of women, religious teachings, geographic isolation, lack of current data,

and institutional constraints--which are discussed in full in Annex E.4.

E. Administrative Analysis

A number of local institutions, from both the public and private sectors, will be involved in the implementation of the Options for Family Care project. These institutions, particularly the lead institution(s) for each project component, play an important role in ensuring that the project runs smoothly. The mandates, strengths, and weaknesses of the counterpart organizations are detailed in Annex E.5. The project will provide assistance to these organizations with the development of management information systems, as needed.

F. Environmental Analysis

The PID approval by AID/W included a categorical exclusion from a more detailed environmental assessment. The categorical exclusion was based on 22 Code of Federal Regulations Part 216.2 (c)(2)(viii) which covers "Programs involving nutrition, health care or population and family planning activities". Therefore, there is no annex with an environmental analysis.

IX. CONDITIONS AND COVENANTS

IX.A Conditions Precedent to Disbursement

1. First Disbursement

Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee will, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D. the following:

a) An opinion of counsel acceptable to A.I.D. that this Agreement has been duly authorized and/or ratified by and executed on behalf of the Grantee, and that it constitutes a valid and legally binding obligation of the Grantee in accordance with all of its terms;

b) The name and office designation of the Grantee Project Representative in the Ministry of Planning and Development;

c) Specimen signatures of the agent or agents authorized to sign project agreements, project amendments, or project implementation documents on behalf of the Grantee; and

d) The names and titles of the employees of the Grantee designated to fulfill the required project counterpart positions.

2. Disbursements for Local Costs

Prior to any disbursement, or the issuance by A.I.D. of documentation pursuant to which disbursement will be made for local costs, the responsible A.I.D officer shall make the programming determinations required by A.I.D. Handbook 1B, section 18A1, as to reasonableness of costs and nonfinancing of identifiable customs duties.

3. Notification

When A.I.D. has determined that the conditions precedent have been met, it will promptly notify the Grantee.

4. Terminal Dates for Conditions Precedent

If the conditions precedent have not been met within ninety (90) days of the date of this agreement, or such later dates as A.I.D.

may agree in writing, A.I.D., at its option, may terminate all or any portion of this agreement by written notice to the Grantee.

IX.B Special Covenants

1. Facilitating Implementation.

The Grantee covenants that it will permit and facilitate participation of a variety of public and private sector organizations in the implementation of the project, and that A.I.D. may negotiate agreements with such private sector organizations without obtaining further approval from the Grantee.

2. Counterpart Funds.

The Grantee covenants that it will, pursuant to assurances submitted to A.I.D. on or before the date of execution of the Grant, make all budgetary and other arrangements necessary to ensure that the agreed counterpart contributions for the Project are provided in a timely manner during each Grantee fiscal year.

3. Project Evaluation

The parties agree to establish an evaluation program as part of the Project and at one or more points therefore undertake an:

a. evaluation of progress toward attainment of the objectives of the Project;

b. identification and evaluation of problem areas or constraints which may inhibit such attainment;

c. assessment of how such information may be used to help over come such problems;

d. assessment of the continued validity of Project components and the need for continued Grant funding for each component; and

e. assessment of the continued validity of the Project at the end of Part I thereof, in connection with a decision or authorization of Part II.

4. Government Employees.

The Parties agree that the Grant will not be used to pay salaries or salary supplements of Grantee employees, and that in-country per diem, overtime, and similar costs are the sole responsibility of the Grantee outside of Grant funds.

5. Commodities

The Grantee agrees that:

a. It will clear all project commodities in a timely manner and will be solely responsible for any storage, demurrage or similar cha
rges, fees or levies, none of which shall be paid with Project funds; and

b. All commodities financed with Grant funds will, unless otherwise approved by A.I.D., revert to the public or private organization directly using the commodities at the end of the Project.

6. Miscellaneous.

The Grantee agrees:

a. To facilitate the travel of Project contractors and consultants to the Republic of Yemen through issuance of the necessary visas and within the Republic of Yemen through the issuance of appropriate in-country travel documents;

b. to provide technical assistance, evaluation and audit contractors or personnel with unrestricted access to all project activities and sites, as well as free use of data needed to accomplish their respective tasks;

c. to provide appropriate office space and counterpart staff for each of the activities funded under this Project in a timely manner; and

d. to fund, with other than Grant funds, travel on the national carrier to the farthest point that is also the closest point to the final destination (whether domestic or international) of the Government candidates participating in long-term training programs financed or supported by the Project, or to pay such costs as agreed in writing by the Parties.

7. Work Plans. The Grantee covenants that it will cooperate fully and in a timely manner in the development of work plans for each phase of the Project, and agrees that such work plans, when signed and approved by both parties to this Agreement, shall constitute the Grantee's authorization to make arrangements for the disbursement of Grant funds for the activities covered thereby.

IX.C Negotiating Status

has been undertaken in consultation with the Government of the Republic of Yemen, especially with the Ministry of Planning and Development. Staff of the MPD and other Ministries and organizations cooperated with the Project Paper design team and offered comments on sections of this paper.

Given this collaborative design process, we anticipate no difficulties in concluding an agreement as soon as this Project is authorized and translation of necessary documentation is complete.

X. ISSUES

A. Project Management Issues

1. Reliance on S&T/POP CAs

During development of the PP, it was decided that, at least in the early years, the project would rely primarily on buy-ins to central S&T/POP CAs for technical assistance and expertise. This decision was taken for a number of reasons:

- Due to the Gulf Crisis, bridging activities were delayed. These activities would have provided the needed information base for potential alternative project design.

- It allows the project to call on the expertise of a wide variety of contractor staff.

- It permits the flexibility to change CAs or the direction of project activities relatively easily, if necessary.

- It promotes management efficiency by shifting much of the management burden to S&T/POP, where project CTOs have technical and managerial expertise across the range of family planning program components. This is particularly important given that USAID/Sana'a does not currently have an HPN Officer.

Relying on central projects also raises some potential problems, however. One issue is that the Project Activity Completion Dates (PACDs) of central projects do not coincide with the Phases or PACD of the Options for Family Care project. The Mission is aware of this constraint and PACDs will be taken into account in choosing CAs and in designing the timeframe for specific project activities.

A second issue is that the timing and choice of buy-ins to accept is controlled by S&T/POP. In the past, there was a trade-off between central funding and buy-in funding because of project funding ceilings. The new core/companion contracting mechanism eliminates the buy-in ceiling, in theory permitting projects to accept unlimited buy-ins without jeopardizing core-funded activities. However this flexibility is at the expense of time since there is an increasing lag time between Mission submittal of scopes of work and AID/W signing of the buy-in. To address this problem the project has a six month lag time built into it. With respect to S&T/POP's choice of which buy-ins to accept, Yemen is a high priority country for the Office and, therefore, USAID/Sana'a buy-ins also receive high priority.

2. Participation of Numerous Counterpart Institutions

Project activities will be implemented in collaboration with a number of Yemeni institutions in both the public and private sectors. Coordinating the participation of these institutions presents a major challenge to the Mission. During project design, a lead counterpart organization was chosen for each project component. This organization will be the primary point of contact for the Mission regarding activities within a given component. It will also be necessary for the Mission to design an MIS system (non project funded) for tracking participating institutions, much the way the counterpart institutions will require MIS for managing project activities.

B. PID Review Issues

The PID Review Committee (PRC) commended the Mission on the PID. (The PID review cable is attached as Annex A.) The issues raised by the PRC have been addressed in the development of the PP and are summarized below.

Issue: The PRC emphasized the need, recognized in the PID, for the project design to "provide for assessing progress and performance, and making changes as part of implementation planning and decision-making."

Response: The project will be implemented according to a "rolling plan" based on 18-month workplans. Each workplan will have specific objectives, a timetable for review, and evaluation criteria for determining whether the activity should be "rolled over" into the next planning period. Details of the rolling plan are provided in Section V and a workplan for the first 18-month period is attached as Annex G.

Issue: The PRC noted that "demand analyses and studies to be done under the project should include particular attention to identifying the most appropriate and appealing [contraceptive] technologies for the Yemeni context."

Response: The project design includes a number of different kinds of studies over the life of the project to identify the most appropriate and acceptable contraceptive methods for Yemeni couples. The JHU/PCS bridging activity (see Annex F) will obtain information on current attitudes and preferences, particularly among men. Under the commercial marketing component, the CA and YEDCO will initiate market studies to determine the most effective and efficient ways of reaching the target clientele through the private sector. In addition, the data collection component of the project is designed specifically to improve the quality and availability of information on the attitudes and preferences of families with regard to contraceptive use. The DHS includes questions about the specific contraceptive methods women have used,

currently use, and would use in the future. Five secondary analyses of DHS data, focus groups with men and women, and monitoring of outreach programs are integral parts of the project design. All of these, plus KAP surveys, provide opportunities to assess changes in the structure of demand for contraceptive methods over the life of the project.

Issue: Noting the recent unification of the northern and southern governorates of Yemen and the resulting uncertainty that is inherently part of the transition period, the PRC stressed the need to "identify appropriate institutional arrangements that will enable the project to work with diverse groups, and particularly professional and trade associations and local councils, and to experiment with different approaches."

Response: The comprehensive nature of the project requires that a variety of public and private sector organizations participate actively in its implementation. Section IV.C. identifies the various local organizations with which the Mission proposes to work, by project component. A lead organization for each component has been identified. The Ministry of Planning and Development will provide oversight on behalf of the government and will be the central point of contact for USAID. The relative strengths and weaknesses of the various counterpart organizations are presented in Annex E.5.

Issue: The PRC recommended that "the Mission consider making the commercial marketing component a separate module of the project with discrete financing and distanced insofar as possible from government involvement."

Response: Commercial marketing is one of the five components of the project. This component will be initiated immediately. It will work through the Yemen Drug Company (YEDCO) which operates like a private company although it is over 50% government owned. YEDCO will be importing increased amounts of contraceptives while the project pays for a supply of IUD's, packaging, and training in counseling and method specific information for private retailers. Thus not only will the range and supply of contraceptives be increased but also the amount and appropriateness of information being provided to clients. (Details of the commercial marketing activities are contained in Section IV.C.4.)

Issue: The PID review cable noted that local production of commodities requires clearance from the ANE Bureau Environmental Coordinator.

Response: The Mission does not currently plan to support development of the capacity for local production of contraceptive commodities. If, however, such a capacity is developed and Mission support is considered, the Mission will seek all appropriate

clearances prior to inclusion of local production in any of the rolling workplans.

Issue: The PRC highlighted the need for the Mission to assess the impact on its mortgage of funding the project at the $18 million level if PDRP funds are not forthcoming.

Response: The $18 million project funding level does not depend on the availability of PDRP support since de-ob/re-ob options have opened by the termination of the agricultural sector activities as a result of the Gulf Crisis. However, in order to decrease the mortgage in the short term, the initial project authorization will be for $10.6 million covering the first five years (three Phases) of the project. The de-ob/re-ob funds could be used to draw down the mortgage. Of course, allocation of PDRP and/or fall out population funds to the project would ease the Mission's mortgage burden and permit an acceleration of project activities.

OPTIONS

FOR

FAMILY CARE

ANNEXES

A. PID Approval Message

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C. Statutory Checklist

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3. Economics
4. Social Soundness/WID
5. Administrative

F. Summary of Bridging Activities

G. Work Plan for Phase I Activities

H. Suggested Areas of Investigation for Mid-Term Evaluation

I. Bibliography

ANNEX A - PID Approval Message

UNCLASSIFIED STATE 267049/01

FM USAID-2 INFO AMB DCM

VZCZCSNC432EHV206
RR RUEHSN
DE RUEHC #7049/01 2230737
ZNR UUUUU ZZH
P 110738Z AUG 90
FM SECSTATE WASHDC
TO AMEMBASSY SANAA 7150
BT
UNCLAS SECTION 01 OF 02 STATE 267049

DATE/DUE	ACTION	INFO
8/19		
DIR/DD		
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ACTION TAKEN NOTED
DATE Aug. 14
BY

IOC: DISK 13 272
11 AUG 90 1209
CN: 04682
CHRG: AID
DIST: AID

AIDAC

E.O. 12356: N/A
TAGS:
SUBJECT: YEMEN DEMOGRAPHIC TRANSITION PROJECT (279-0090)
PID REVIEW

1. USAID DIRECTOR SHERPER PRESENTED PID TO PROJECT REVIEW COMMITTEE 24 JULY 1990. MISSION WAS COMMENDED FOR ATTAINING THIS SIGNIFICANT BREAKTHROUGH AS A RESULT OF PATIENT AND PERSISTENT POLICY DIALOGUE. THE DOCUMENT ITSELF WAS APPRECIATED FOR ITS INFORMATIVE AND WELL ORGANIZED PRESENTATION. AA/ANE HEREBY APPROVES PID, SUBJECT TO GUIDANCE BELOW, AND REDELEGATES PROJECT AUTHORIZATION AND PP APPROVAL AUTHORITY TO USAID DIRECTOR.

2. BACKGROUND: THIS WILL BE THE FIRST AID PROJECT DESIGNED TO SERVE A UNIFIED YEMEN AS WELL AS THE MISSION'S FIRST BILATERAL POPULATION PROJECT. DIRECTOR SHERPER NOTED THAT THE PID RESPONDS TO A RECENT REPUBLIC OF YEMEN (ROY) REQUEST, REFLECTING INCREASING LOCAL RECOGNITION OF THE MULTIPLE IMPACTS OF YEMEN'S CHANGING DEMOGRAPHIC SITUATION ON HEALTH, ECONOMY, AND SOCIETY, AS WELL AS THE IMPLICATIONS FOR SUSTAINABILITY IN ALL SECTORS. THE PROJECT IS CONSISTENT WITH THE ROY'S DRAFT

POPULATION STRATEGY OF MAY, 1990; THIS STRATEGY DRAWS UPON THE ANALYSIS IN THE USAID STRATEGY, WHICH WAS PREPARED WITH THE COOPERATION OF THE ROY, AND WHICH REFLECTS THE INTERACTIVE POLICY DIALOGUE AND A COLLABORATIVE WORKING RELATIONSHIP BETWEEN THE MISSION AND THE ROY.

THE PROJECT IS NOT A 'COMMODITY DROP' BUT RATHER ONE WHICH FOCUSES ON DEMAND CREATION AND RELIES ON THE PRIVATE SECTOR AS THE PRINCIPAL MEDIUM FOR MEETING DEMAND. THE APPROACH TO COMMERCIAL CONTRACEPTIVE MARKETING WILL NOT RELY ON DISTRIBUTION OF AID-SUPPLIED COMMODITIES; INSTEAD, IT WILL SEEK TO DEVELOP EXISTING SUPPLIERS' SKILLS THROUGH BETTER MARKETING TECHNIQUES, INVENTORY MANAGEMENT, INFORMATIVE MATERIALS, ETC. TO INCREASE SALES. THE PROJECT WILL FOCUS ON GENDER ATTITUDES AND MOTIVATING FACTORS, WHICH IS ESSENTIAL IN A SOCIETY WHERE MEN'S DECISIONS DETERMINE FEMALE ACCESS TO EDUCATION, FAMILY CARE, AND EMPLOYMENT. IT WILL ALSO

~~LINKED~~ WITH POLICIES AND ACTIVITIES SUCH AS HEALTH INSURANCE AND WOMEN'S ASSOCIATIONS, WHICH INFLUENCE BOTH DEMAND FOR AND PROVISION OF FAMILY CARE SERVICES.

3. TIMING: THE MISSION FELLS THAT THE COLLABORATIVE PROCESS OF PROJECT DEVELOPMENT PRESENTS AN EXTRAORDINARY OPPORTUNITY TO ASSIST THE NEW GOVERNMENT IN DEFINING AN APPROPRIATE ROLE IN A NEW ENDEAVOR. EVEN IN RURAL AREAS THERE IS A GROWING RECEPTIVITY TO FAMILY CARE. THIS TREND HAS BEEN ENHANCED BY RELIGIOUS LEADERS' ENDORSEMENTS OF BIRTH SPACING AT THE 1989 CONFERENCE ON ISLAM AND POPULATION AND BY THE SAFE MOTHERHOOD CONFERENCE IN JORDAN. IN ADDITION, THERE IS RELATIVE PROGRESSIVENESS IN SOUTH YEMEN WITH RESPECT TO THE ROLE OF WOMEN, AND THE REUNIFICATION MAY BRING BOTH OPPORTUNITIES TO TAKE ADVANTAGE OF THIS ATTITUDE AND OF A GREATER NUMBER OF EDUCATED/TRAINED WOMEN AVAILABLE TO PARTICIPATE IN THE PROGRAM.

4. FLEXIBILITY IN IMPLEMENTATION:

THE PROJECT HAS AN EXPERIMENTAL ASPECT AS IT INVOLVES DEVELOPING NEW PROGRAMS AND NEW WAYS OF WORKING IN YEMEN. IT MAY BE NECESSARY AND APPROPRIATE OVER THE COURSE OF THE PROJECT TO TRY DIFFERENT APPROACHES TO ACCOMPLISHING AN OBJECTIVE, FOR EXAMPLE, CHANGING AN IMPLEMENTING GROUP OR SHIFTING EMPHASIS FROM ONE TYPE OR TARGET OF TRAINING TO ANOTHER. THE PRC RECOGNIZED THIS NEED FOR FLEXIBILITY AND RECOMMENDED THAT THE PROJECT

DESIGN AS REFLECTED IN THE PP AND THE AGREEMENT, PROVIDE FOR ASSESSING PROGRESS AND PERFORMANCE, AND MAKING CHANGES AS PART OF IMPLEMENTATION PLANNING AND DECISION-MAKING.

5. AFFORDABILITY: LOCAL COST OF CONTRACEPTIVES AVAILABLE THROUGH PRIVATE CHANNELS IS CONSIDERED AFFORDABLE TO MOST POTENTIAL ACCEPTORS. THE PRIVATE COMMERCIAL SECTOR SMALL, LOCAL PHARMACIES IN PARTICULAR IS ALREADY EXPANDING TO REMOTE AREAS MORE RAPIDLY THAN THE PUBLIC SERVICE DELIVERY SYSTEM. IT IS EXPECTED THAT THE MOST RAPID INCREASE IN DEMAND IS LIKELY TO COME FROM MODEST TO MIDDLE INCOME GROUPS, AND IT IS TO THESE GROUPS THAT THIS MARKET-ORIENTED PROJECT IS SPECIFICALLY FOCUSSED. HOWEVER, THE INFORMATIONAL OUTREACH OF THE PROJECT, PARTICULARLY THROUGH TELEVISION - 85 PERCENT OF ALL YEMENI HOUSEHOLDS HAVE ACCESS TO TELEVISION - WILL REACH ALL ECONOMIC GROUPS, AND IS EXPECTED ALSO TO IMPACT ON THE ATTITUDES AND DEMANDS OF THE LOWEST INCOME GROUPS. TO THE EXTEND THAT THEY CANNOT AFFORD COMMERCIALLY OFFERED SUPPLIES, UNFPA AND OTHER DONORS IT

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EXPECTED TO CONTINUE TO PROVIDE FREE CONTRACEPTIVES FOR DISTRIBUTION TO THE POOREST. IT IS FELT THAT AID CAN BE MORE EFFECTIVE IN EXPANDING COVERAGE TO THE POOR BY HELPING THE ROY TO ADDRESS LONGER-TERM HEALTH CARE FINANCING ISSUES THAN BY BECOMING A SUPPLIER OF CONTRACEPTIVES.

6. FAMILY PLANNING TECHNOLOGY: ALTHOUGH THE PROJECT WILL NOT BE PROVIDING CONTRACEPTIVE SUPPLIES, ITS TRAINING, MARKETING, AND COMMUNICATION COMPONENTS WILL DEAL WITH THESE. THE PRC AGREED THAT THE DEMAND ANALYSES AND STUDIES TO BE DONE UNDER THE PROJECT SHOULD INCLUDE PARTICULAR ATTENTION TO IDENTIFYING THE MOST APPROPRIATE AND APPEALING TECHNOLOGIES FOR THE YEMENI CONTEXT, INCLUDING KEEPING ABREAST OF NEW TECHNOLOGIES. FOR EXAMPLE, GIVEN ON ONE HAND SUCH FACTORS AS THE UNRELIABILITY OF CONTRACEPTIVE SUPPLIES AT TIMES AND THE SANITARY DISADVANTAGES OF SOME METHODS IN THE YEMENI ENVIRONMENT, AND ON THE OTHER, THE FACT THAT MORE THAT 32 PERCENT OF WOMEN IN THE 35-44 AGE BRACKET, AND IN EXCESS OF 50 PERCENT OF WOMEN OVER 45 YEARS WANT NO MORE CHILDREN, THERE MAY BE AN EXCELLENT MARKET AMONG MATURE WOMEN FOR LONG-TERM CONTRACEPTIVE IMPLANTS AS THESE BECOME AVAILABLE.

7. RECURRENT COSTS: THE PROJECT WILL NOT CREATE RECURRENT COSTS, RELYING INSTEAD ON EXISTING CHANNELS AND GROWING PARTICIPATION OF PRIVATE SECTOR IN PROMOTING DEMAND AND MEETING SUPPLY NEEDS. THE PROJECT WILL NOT ENTAIL PROCUREMENT OF CONTRACEPTIVE COMMODITIES WITH THE EXCEPTION OF LIMITED QUANTITIES FOR TRAINING AND PILOT ACTIVITIES. EMPHASIS IS PLACED ON NORMAL MARKET FORCES FOR ENHANCING PRIVATE SECTOR INVOLVEMENT IN GENERATING DEMAND AND SUPPLY.

8. INSTITUTIONAL ARRANGEMENTS: WITH UNIFICATION UNDER WAY, IT IS UNDERSTOOD THAT THE INSTITUTIONAL FRAMEWORK CANNOT BE ANTICIPATED FULLY AT PRESENT, BUT IT WILL INVOLVE LESS GOVERNMENT AND MORE PRIVATE SECTOR. BY HELPING THE ROY TO DEFINE ITS PROPER ROLE VIS-A-VIS THE PRIVATE SECTOR, THE PROJECT IS ADDRESSING ONE OF THE CENTRAL THEMES OF OPEN MARKETS AND OPEN SOCIETIES. THE PROJECT'S PRIMARY PUBLIC COUNTERPART AGENCY WILL BE AN ENTITY CHARGED WITH POLICY, REGULATION, ANALYSIS, AND COORDINATION, RATHER THAN A GOVERNMENT MINISTRY SUCH AS HEALTH WHICH IS HEAVILY INVESTED IN DIRECT SERVICE PROVISION. THE COORDINATION FUNCTION IS PARTICULARLY IMPORTANT. IT WILL BE CRITICAL THAT THE PROJECT DESIGN TEAM CAREFULLY IDENTIFY APPROPRIATE INSTITUTIONAL ARRANGEMENTS THAT WILL ENABLE THE PROJECT TO WORK WITH DIVERSE GROUPS, PARTICULARLY PROFESSIONAL AND TRADE ASSOCIATIONS AND LOCAL COUNCILS, AND TO EXPERIMENT WITH DIFFERENT APPROACHES. THE REVIEW COMMITTEE RECOMMENDED THAT, DURING THE PP DESIGN PHASE, THE MISSION CONSIDER MAKING THE COMMERCIAL MARKETING COMPONENT A SEPARATE MODULE OF THE PROJECT WITH DISCRETE FINANCING AND DISTANCED INSOFAR AS POSSIBLE FROM GOVERNMENT

ACHIEVEMENT.

9. ENVIRONMENT: WHILE THE PROJECT MAY EXPLORE THE FEASIBILITY OF LOCAL PRODUCTION TO MEET SUPPLY NEEDS, THE REVIEW COMMITTEE NOTED THAT SPECIFIC CLEARANCE WILL HAVE TO BE OBTAINED FROM THE BUREAU ENVIRONMENTAL COORDINATOR (CURRENTLY ANE/PD/ENV) BEFORE THE PROJECT COULD SUPPORT FACTORY DESIGN, ETC.

12. WOMEN IN DEVELOPMENT: THE MISSION WAS COMMENDED BY THE REVIEW COMMITTEE FOR THE THOUGHTFUL AND INCISIVE TREATMENT OF GENDER ISSUES IN THE PID. AS PID STATES, THIS PROJECT ADDRESSES SOME OF THE MOST IMPORTANT BARRIERS TO WOMEN'S PARTICIPATION AND ECONOMIC PRODUCTIVITY. THE COLLECTION AND ANALYSIS OF GENDER DISAGGREGATED DATA FOR POLICY ANALYSIS IS A KEY COMPONENT OF THIS PROJECT AND SHOULD HAVE IMPORTANT IMPLICATIONS FOR OVERALL DEVELOPMENT.

11. PROJECT FUNDING: FOLLOWING THE PID REVIEW, MISSION DIRECTOR MET WITH ANE/DP AT DPRP SIDE MEETING TO DISCUSS DPRP FUNDING AVAILABILITY FOR THIS PROPOSED POPULATION INITIATIVE, CITING THE POLICY DIALOGUE AND PRIVATE SECTOR IMPLICATIONS OF THE PROGRAM. IT WAS DECIDED THAT, IF PROPOSAL WON DPRP SUPPORT BUT AT LESS THAN FULL FUNDING, MISSION WOULD NEED TO PROVIDE SUPPLEMENTAL FUNDS FROM ITS OYB, SINCE MISSION DID NOT WANT TO SCALE BACK PROPOSAL. UNDER SUCH CIRCUMSTANCE, MISSION WOULD NEED TO PREPARE ANALYSIS FOR AID/W REGARDING THE IMPACT ON ITS MORTGAGE. THE PPC/PE REPRESENTATIVE INDICATED THAT, GIVEN THE FACT THAT THE HEALTH INFORMATION ASPECTS OF THE PROJECT WILL INCLUDE TOPICS WHICH WILL PROMOTE REDUCTION OF INFANT MORTALITY AND MORBIDITY, SOME CHILD SURVIVAL FUNDS MIGHT BE USED IN ADDITION TO POP OR DPRP, TO PARTIALLY FUND THE PROJECT. ANE/DP WILL KEEP MISSION ADVISED AS TO THE AVAILABILITY OF DPRP FUNDS. BAKER
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ANNEX B

Logical Framework

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Goal: To improve family health and welfare in the Republic of Yemen.	*Average birth interval increased by 6 months. *Proportion of high-risk pregnancies decreased by one fourth. *25% decline in infant and maternal mortality.	*1994 Census results *Comparison of 1991/92 and 1997/98 DHS results	*Families will utilize expanded and higher quality services *Economic situation does not deteriorate drastically.
Purpose: To improve awareness of broad population issues and increase access to a wide range of family care in order to expand opportunities and options available to families.	EOPS: *CPR increased to over 20% in urban areas. *Awareness of methods, sources, and advantages of family care doubled. *TFR declined to 6.5.	*MOPH records *KAP studies *DHS results	*Other donors continue to be supportive. *Present trend of support among ROYG officials continues.

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Outputs: 1) Demographic and related data are collected, analyzed, understood, and applied to policy development.	*2 DHS surveys completed *5 secondary DHS analyses completed and disseminated. *Population policy, implementation plans and tracking system are in place. *3 policy workshops held *1 census completed and data disseminated.	*Published DHS reports *Published population policy *Trip reports *ROYG documents *Published census data	*Trend in openness to survey research continues. *Local officials are willing to cooperate. *ROYG willing to make significant policy changes to encourage private sector participation.
2) Awareness of the advantages of birth spacing and safe motherhood is widespread.	*Majority of people can identify FC with logo, song, TV drama and/or spots. *Awareness of and support for FC doubled. *30 functioning centers of excellence with significantly increasing client loads.	*Trip reports *Published survey results *MOI records *DHS results *KAP surveys *Site visits	*Messages designed with appropriate sensitivity can be broadcast. *Focus group participants are cooperative.
3) Accessibility to quality family care services is improved through institutionalizing effective in-service and pre-service training capability.	*Quality family care incorporated into pre-service curricula. *100 trainers trained. *Over 2000 health workers benefit from in-service training. *"Cafeteria" approach replicated in 75 clinics.	*Training curricula *Training records *Site visits *Trip reports	*Trainees willing to participate without additional salary support. *Positive trends in female education continue.

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
4) A wide range of sources and types of family care supplies and services is available in the private sector.	*75% of pharmacists trained in counseling and method specific information. *Pharmacies have consistent and reasonably priced supply of contraceptives.	*Trip reports *Site visits *Training records *Store audits *KAP surveys *Project records *Site visits *Training curricula	*Import restriction reduced. *Contraceptive supply through private sector is adequate to meet demand. *Foreign exchange available. *Other donors remain supportive.
5) Opportunities for women in other sectors are expanded and health, education and private sectors are strengthened.	*Female literacy rates increasing. *Outreach workers better trained. *Increased number of female workers.	*Project records *Training curricula	* Positive trends in female education continue.
Inputs: (US$000) Data/Analysis 2,255 Aware/Commun 3,282 Train/Service 6,282 Marketing 2,590 Multi-sector 2,350 Eval/Audit 300 Contingency 941 NOTE: above includes commodities of $1,930	*18-month workplans *Annual Project Agreements ~~*PIO/Ts for buy-ins~~ *PIO/Cs for commodities	*USAID staffing pattern *Audit reports ~~*Evaluation reports~~	*Qualified TA available. *Buy-in ceilings permit USAID buy-ins. *Adequate staff available to manage project implementation.

ANNEX C

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria plicable to the eligibility of countries to ceive the following categories of assistance:) both Development Assistance and Economic pport Funds; (B) Development Assistance nds only; or (C) Economic Support Funds ly.

COUNTRY ELIGIBILITY CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUND ASSISTANCE

1. Narcotics

a. **Negative certification** (FY 1991 Appropriations Act Sec. 559(b)): Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully? NO

b. **Positive certification** (FAA Sec. 481(h)). (This provision applies to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics control, disaster and refugee relief, narcotics education and awareness, or the provision of food or medicine.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct NA

affecting the United States, through which such drugs are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government):

(1) does the country have in place a bilateral narcotics agreement with the United States, or a multilateral narcotics agreement?

(2) has the President in the March 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without Congressional enactment, within 45 days of continuous session, of a resolution disapproving such a certification), or has the President determined and certified to the Congress on any other date (with enactment by Congress of a resolution approving such certification), that (a) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to satisfy the goals agreed to in a bilateral narcotics agreement with the United States or in a multilateral agreement, to prevent illicit drugs produced or processed in or transported through such country from being transported into the United States, to prevent and punish drug profit laundering in the country, and to prevent and punish bribery and other forms of public corruption which facilitate production or shipment of illicit drugs or discourage prosecution of such acts, or that (b) the vital national interests of the United States require the provision of such assistance?

c. Government Policy (1986 Anti-Drug Abuse Act of 1986 Sec. 2013(b)). (This section applies to the same categories of assistance subject to the restrictions in FAA Sec. 481(h), above.) If recipient country is a "major illicit drug producing country" or "major drug-transit country" (as defined for the purpose of FAA Sec 481(h)), has the President submitted a report to Congress listing such country as one: (a) which, as a matter of government policy, NA

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or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilitates the production or distribution of illegal drugs; (c) in which any member of a U.S. Government agency has suffered or been threatened with violence inflicted by or with the complicity of any government officer; or (d) which fails to provide reasonable cooperation to lawful activities of U.S. drug enforcement agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country?

2. **Indebtedness to U.S. citizens** (FAA Sec. 620(c): If assistance is to a government, is the government indebted to any U.S. citizen for goods or services furnished or ordered where: (a) such citizen has exhausted available legal remedies, (b) the debt is not denied or contested by such government, or (c) the indebtedness arises under an unconditional guaranty of payment given by such government or controlled entity? NO

3. **Seizure of U.S. Property** (FAA Sec. 620(e)(1)): If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? NO

4. **Communist countries** (FAA Secs. 620(a), 620(f), 620D; FY 1991 Appropriations Act Secs. 512, 545): Is recipient country a Communist country? If so, has the President: (a) determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism, or NO

restrictions on assistance to communist countries upon a determination and report to Congress that such action is important to the national interest of the United States? Will assistance be provided either directly or indirectly to Angola, Cambodia, Cuba, Iraq, Libya, Vietnam, Iran or Syria? Will assistance be provided to Afghanistan without a certification, or will assistance be provided inside Afghanistan through the Soviet-controlled government of Afghanistan?

5. **Mob Action** (FAA Sec. 620(j)): Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property? NO

6. **OPIC Investment Guaranty** (FAA Sec. 620(l)): Has the country failed to enter into an investment guaranty agreement with OPIC? NO

7. **Seizure of U.S. Fishing Vessels** (FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5): (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made? NO

8. **Loan Default** (FAA Sec. 620(q); FY 1991 Appropriations Act Sec. 518 (Brooke Amendment)): (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? NO

(b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1990 Appropriations Act appropriates funds? NO

9. **Military Equipment** (FAA Sec. 620(s)): If contemplated assistance is development loan or to come from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? NA

(Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

10. **Diplomatic Relations with U.S.** (FAA Sec. 620(t)): Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption? — NO

11. **U.N. Obligations** (FAA Sec. 620(u)): What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the "Taking into Consideration" memo.) — Yemen is not in arrears regarding its UN obligations

12. **International Terrorism**

a. **Sanctuary and support** (FY 1991 Appropriations Act Sec. 556; FAA Sec. 620A): Has the country been determined by the President to: (a) grant sanctuary from prosecution to any individual or group which has committed an act of international terrorism, or (b) otherwise support international terrorism, unless the President has waived this restriction on grounds of national security or for humanitarian reasons? — NO — NO

b. **Airport Security** (ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures? — NO

13. **Discrimination** (FAA Sec. 666(b)): Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?	NO
14. **Nuclear Technology** (FAA Secs. 669, 670): Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President?	NO
Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device?	NO
If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)	NO
15. **Algiers Meeting** (ISDCA of 1981, Sec. 720): Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the "Taking into Consideration" memo.)	Taken into consideration by A/AID in setting OYB for FY 1991 (12/24/90)
16. **Military Coup** (FY 1991 Appropriations Act Sec. 513): Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance?	NO

17. **Refugee Cooperation** (FY 1991 Appropriations Act Sec. 539): Does the recipient country fully cooperate with the international refugee assistance organizations, the United States, and other governments in facilitating lasting solutions to refugee situations, including resettlement without respect to race, sex, religion, or national origin?	YES
18. **Exploitation of Children** (FY 1991 Appropriations Act Sec. 599D, amending FAA Sec. 116): Does the recipient government fail to take appropriate and adequate measures, within its means, to protect children from exploitation, abuse or forced conscription into military or paramilitary services?	NO

COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO DEVELOPMENT ASSISTANCE ("DA")

1. **Human Rights Violations** (FAA Sec. 116): Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy?	NO
2. **Abortions** (FY 1991 Appropriations Act Sec. 535): Has the President certified that use of DA funds by this country would violate any of the prohibitions against use of funds to pay for the performance of abortions as a method of family planning, to motivate or coerce any person to practice abortions, to pay for the performance of involuntary sterilization as a method of family planning, to coerce or provide any financial incentive to any person to undergo sterilizations, to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?	NO

COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO ECONOMIC SUPPORT FUNDS ("ESF")

Human Rights Violations (FAA Sec. 502B): Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest?	NO

5C(2) - ASSISTANCE CHECKLIST

Listed below are statutory criteria ·licable to the assistance resources ·mselves, rather than to the eligibility of a ·ntry to receive assistance. This section is ·ided into three parts. Part A includes ·teria applicable to both Development ·istance and Economic Support Fund resources. ·t B includes criteria applicable only to ·elopment Assistance resources. Part C ·ludes criteria applicable only to Economic ·port Funds.

·SS REFERENCE: IS COUNTRY CHECKLIST UP TO ·E?

CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS

1. **Host Country Development Efforts** (FAA Sec. 601(a)): Information and conclusions on whether assistance will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture, and commerce; and (f) strengthen free labor unions.	(a) (b) (c) (d) (e) (f)	NA YES NA YES YES NA
2. **U.S. Private Trade and Investment** (FAA Sec. 601(b)): Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).		NA

3. **Congressional Notification**

a. **General requirement** (FY 1991 Appropriations Act Secs. 523 and 591; FAA Sec. 634A): If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the notification requirement has been waived because of substantial risk to human health or welfare)? — YES

b. **Notice of new account obligation** (FY 1991 Appropriations Act Sec. 514): If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures? — NA

c. **Cash transfers and nonproject sector assistance** (FY 1991 Appropriations Act Sec. 575(b)(3)): If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted? — NA

4. **Engineering and Financial Plans** (FAA Sec. 611(a)): Prior to an obligation in excess of $500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? — (a) YES (b) YES

5. **Legislative Action** (FAA Sec. 611(a)(2)): If legislative action is required within recipient country with respect to an obligation in excess of $500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance? — NA

6. **Water Resources (FAA Sec. 611(b); FY 1991 Appropriations Act Sec. 501):** If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, *et seq.*)? (See A.I.D. Handbook 3 for guidelines.) — NA

7. **Cash Transfer and Sector Assistance (FY 1991 Appropriations Act Sec. 575(b)):** Will cash transfer or nonproject sector assistance be maintained in a separate account and not commingled with other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)? — NA

8. **Capital Assistance (FAA Sec. 611(e)):** If project is capital assistance (*e.g.*, construction), and total U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively? — NA

9. **Multiple Country Objectives (FAA Sec. 601(a)):** Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

(a)	NA
(b)	YES
(c)	NA
(d)	YES
(e)	YES
(f)	NA

10. **U.S. Private Trade (FAA Sec. 601(b)):** Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). — NA

11. Local Currencies

a. Recipient Contributions (FAA Secs. 612(b), 636(h)): Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars. NA

b. U.S.-Owned Currency (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? NA

c. Separate Account (FY 1991 Appropriations Act Sec. 575). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies: NA

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?

12. **Trade Restrictions**

a. **Surplus Commodities** (FY 1991 Appropriations Act Sec. 521(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? NA

b. **Textiles (Lautenberg Amendment)** (FY 1991 Appropriations Act Sec. 521(c)): Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel? NO

13. **Tropical Forests** (FY 1991 Appropriations Act Sec. 533(c)(3)): Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas?

(a) NO
(b) NO

14. **Sahel Accounting** (FAA Sec. 121(d)): If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)?	NA
15. **PVO Assistance**	
a. **Auditing and registration** (FY 1991 Appropriations Act Sec. 537): If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?	Assistance instruments will not be awarded to PVOs which are not registered with A.I.D. or which have not complied with A.I.D. auditing and recordkeeping requirements
b. **Funding sources** (FY 1991 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?	No assistance instrument will be awarded to a U.S. PVOs which does not comply with the non-governmental funding requirements.
16. **Project Agreement Documentation** (State Authorization Sec. 139 (as interpreted by conference report)): Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).	The Grant Agreement will be below the minimum necessary for the application of this provision.
17. **Metric System** (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities?	YES

extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

18. **Women in Development** (FY 1991 Appropriations Act, Title II, under heading "Women in Development"): Will assistance be designed so that the percentage of women participants will be demonstrably increased? YES

19. **Regional and Multilateral Assistance** (FAA Sec. 209): Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs. NO

20. **Abortions** (FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 525):

a. Will assistance be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? NO

b. Will any funds be used to lobby for abortion? NO

21. **Cooperatives** (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life? NO

22. U.S.-Owned Foreign Currencies

a. Use of currencies (FAA Secs. 612(b), 636(h); FY 1991 Appropriations Act Secs. 507, 509): Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services.

No excess Yemen currency is owned by the U.S.

b. Release of currencies (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

NO

23. Procurement

a. Small business (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?

Limited, since most procurement will be through buy-ins to centrally funded contracts and cooperative agreements

b. U.S. procurement (FAA Sec. 604(a)): Will all procurement be from the U.S. except as otherwise determined by the President or determined under delegation from him?

YES

c. Marine insurance (FAA Sec. 604(d)): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?

NA

d. Non-U.S. agricultural procurement (FAA Sec. 604(e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)

NA

e. Construction or engineering services (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are ...

NA

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under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)

f. **Cargo preference shipping** (FAA Sec. 603)): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? NO

g. **Technical assistance** (FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? YES

h. **U.S. air carriers** (International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? YES

i. **Termination for convenience of U.S. Government** (FY 1991 Appropriations Act Sec. 504): If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? YES

j. **Consulting services** (FY 1991 Appropriations Act Sec. 524): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)? — YES

k. **Metric conversion** (Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? — YES

Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? — YES

Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage? — YES

l. **Competitive Selection Procedures** (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? — YES

24. **Construction**

a. **Capital project** (FAA Sec. 601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used? — NA

b. **Construction contract** (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? — NA

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c. **Large projects, Congressional approval (FAA Sec. 620(k)):** If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress? N/A

25. **U.S. Audit Rights (FAA Sec. 301(d)):** If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? N/A

26. **Communist Assistance (FAA Sec. 620(h).** Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? YES

27. **Narcotics**

a. **Cash reimbursements (FAA Sec. 483):** Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? N/A

b. **Assistance to narcotics traffickers (FAA Sec. 487):** Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance? YES

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28. **Expropriation and Land Reform** (FAA Sec. 620(g)): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? YES

29. **Police and Prisons** (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? YES

30. **CIA Activities** (FAA Sec. 662): Will assistance preclude use of financing for CIA activities? YES

31. **Motor Vehicles** (FAA Sec. 636(i)): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? YES

32. **Military Personnel** (FY 1991 Appropriations Act Sec. 503): Will assistance preclude use of financing to pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? YES

33. **Payment of U.N. Assessments** (FY 1991 Appropriations Act Sec. 505): Will assistance preclude use of financing to pay U.N. assessments, arrearages or dues? YES

34. **Multilateral Organization Lending** (FY 1991 Appropriations Act Sec. 506): Will assistance preclude use of financing to carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? YES

35. **Export of Nuclear Resources** (FY 1991 Appropriations Act Sec. 510): Will assistance preclude use of financing to finance the export of nuclear equipment, fuel, or technology? YES

36. **Repression of Population** (FY 1991 Appropriations Act Sec. 511): Will assistance preclude use of financing for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? YES

37. **Publicity or Propoganda** (FY 1991 Appropriations Act Sec. 516): Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? NO

38. **Marine Insurance** (FY 1991 Appropriations Act Sec. 563): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate? YES

39. **Exchange for Prohibited Act** (FY 1991 Appropriations Act Sec. 569): Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law? NO

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CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY

1. **Agricultural Exports (Bumpers Amendment)** (FY 1991 Appropriations Act Sec. 521(b), as interpreted by conference report for original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?	NA
2. **Tied Aid Credits** (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits?	NO
3. **Appropriate Technology** (FAA Sec. 107): Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	NA
4. **Indigenous Needs and Resources** (FAA Sec. 281(b)): Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.	The project addresses the reproductive health needs of the adult population, will utilize local technical expertise; and supports development of decentralized planning.

5. **Economic Development (FAA Sec. 101(a)):** Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?	The project will support expansion of contracepti sales through private sector outlets on a self-sustaining basis.
6. **Special Development Emphases (FAA Secs. 102(b), 113, 281(a)):** Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.	a) The project will make contraceptive services more widely available at affordable prices; b) NA c) encourage greater privat sector involvements; d) develop reproductive health skills of female health workers and bring reproductive health services to women and; e) utilize training facilities in other developing countries
7. **Recipient Country Contribution (FAA Secs. 110, 124(d)):** Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?	YES
8. **Benefit to Poor Majority (FAA Sec. 128(b)):** If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?	YES

9. **Abortions (FAA Sec. 104(f); FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 535):**

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? NO

b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations? NO

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? NO

d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? YES

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? NO

f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? NO

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization? NO

10. **Contract Awards (FAA Sec. 601(e)):** Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	YES
11. **Disadvantaged Enterprises (FY 1991 Appropriations Act Sec. 567):** What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?	Much of the early activi in this project will be by buy-ins/add-ons to existing assistance instruments which have already factored Gray Amendment considerations into the basic awards. Any future contracting, especially any long-term TA possibilities, will carefully consider Gray Amendment contracting an subcontracting possibili ies.
12. **Biological Diversity (FAA Sec. 119(g):** Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?	NA
13. **Tropical Forests (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c)-(e) & (g)):**	
a. **A.I.D. Regulation 16:** Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?	NA
b. **Conservation:** Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the	NA

feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

c. **Forest degradation:** Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development? NA

d. **Sustainable forestry:** If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry? NA

e. **Environmental impact statements:** Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment? YES

14. **Energy** (FY 1991 Appropriations Act Sec. 533(c)): If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases? NA

15. **Sub-Saharan Africa Assistance** (FY 1991 Appropriations Act Sec. 562, adding a new FAA chapter 10 (FAA Sec. 496)): If assistance will come from the Sub-Saharan Africa DA account, is it: (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) to be used to promote sustained economic growth, encourage private sector development, promote individual initiatives, and help to reduce the role of central governments in areas more appropriate for the private sector; (c) being provided in accordance with the policies contained in FAA section 102; (d) being provided in close consultation with African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (e) being used to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the need to protect vulnerable groups; (f) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic NA

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to maintain and restore the renewable natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

16. **Debt-for-Nature Exchange** (FAA Sec. 463): If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management. NA

17. **Deobligation/Reobligation** (FY 1991 Appropriations Act Sec. 515): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified? NA

18. **Loans**

a. **Repayment capacity** (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest. NA

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b. **Long-range plans (FAA Sec. 122(b)):** Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?	NA
c. **Interest rate (FAA Sec. 122(b)):** If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?	NA
d. **Exports to United States (FAA Sec. 620(d)):** If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?	NA
19. **Development Objectives (FAA Secs. 102(a), 111, 113, 281(a)):** Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?	1) The project will make contraceptive services more widely available at affordable prices; 2) NA 3) encourage greater private sector involvement; 4) develop reproductive health skills of female health workers and bring reproductive health services to women; and 5) utilize training facilities in other developing countries.

20. Agriculture, Rural Development and Nutrition, and Agricultural Research (FAA Secs. 103 and 103A):

a. Rural poor and small farmers: If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made. NA

b. Nutrition: Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people. NA

c. Food security: Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution. NA

21. Population and Health (FAA Secs. 104(b) and (c)): If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people

This project will focus on promoting reproductive health services through the private sector while other donors will assist governmental integrated programs. The project will train female health workers thereby giving more women access to health services.

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mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

22. **Education and Human Resources Development (FAA Sec. 105):** If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities. NA

23. **Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106):** If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is: NA

a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

c. research into, and evaluation of, economic development processes and techniques;

d. reconstruction after natural or manmade disaster and programs of disaster preparedness;

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

24. Sahel Development (FAA Secs. 120-21). If assistance is being made available for the Sahelian region, describe: (a) extent to which there is international coordination in planning and implementation; participation and support by African countries and organizations in determining development priorities; and a long-term, multidonor development plan which calls for equitable burden-sharing with other donors; (b) whether a determination has been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of projects funds (dollars or local currency generated therefrom). NA

CRITERIA APPLICABLE TO ECONOMIC SUPPORT FUNDS ONLY NA

1. **Economic and Political Stability** (FAA Sec. 531(a)): Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA?

2. **Military Purposes** (FAA Sec. 531(e)): Will this assistance be used for military or paramilitary purposes?

3. **Commodity Grants/Separate Accounts** (FAA Sec. 609): If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

4. **Generation and Use of Local Currencies** (FAA Sec. 531(d)): Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106?

5. **Cash Transfer Requirements** (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund," and Sec. 575(b)). If assistance is in the form of a cash transfer:

a. **Separate account:** Are all such cash payments to be maintained by the country in a separate account and not to be commingled with any other funds?

b. **Local currencies:** Will all local currencies that may be generated with funds provided as a cash transfer to such a country also be deposited in a special account, and has A.I.D. entered into an agreement with that government setting forth the amount of the local currencies to be generated, the terms and conditions under which they are to be used, and the responsibilities of A.I.D. and that government to monitor and account for deposits and disbursements?

c. **U.S. Government use of local currencies:** Will all such local currencies also be used in accordance with FAA Section 609, which requires such local currencies to be made available to the U.S. government as the U.S. determines necessary for the requirements of the U.S. Government, and which requires the remainder to be used for programs agreed to by the U.S. Government to carry out the purposes for which new funds authorized by the FAA would themselves be available?

d. **Congressional notice:** Has Congress received prior notification providing in detail how the funds will be used, including the U.S. interests that will be served by the assistance, and, as appropriate, the economic policy reforms that will be promoted by the cash transfer assistance?

DRAFTER:GC/LP:EHonnold:4/11/91:2169J

ANNEX D

Republic of Yemen
Ministry of Planning and Development
Economic and Technical Cooperation Sector

Ref. No. 3375
Date: 09.22.1991

The Director of USAID Esq.

After compliments;

With reference to the general population strategy paper and to the exchanged correspondences and meetings.

We are pleased to convey to you our interest in continuing cooperating with you in this respect. We thank you in anticipation for what you has done in preparation for the family care options project, which is expected to be signed during September 1991 in a total amount of US$ 18 Millions and the duration of 8 years.

Accordingly we would like to inform you that the Yemeni government will fulfill its obligation depending on potentialities.

Abdul Wali Abdulla Al-Aghil
Deputy Minister for
Economic and Technical
Cooperation

ANNEX D

بسم الله الرحمن الرحيم

الرقم : ٣٣٧٥

التاريخ : ٢٢/٩/٩١

الموافق :

الجمهورية اليمنية

وزارة التخطيط والتنمية

قطاع التعاون الاقتصادي والفني

الادارة العامة للتعاون مع الدول الصناعية

ادارة امريكا - اليابان والدول الاخرى

الموضوع :

SEP 1991
RECEIVED

السيد / مدير الوكالة الامريكية للتنمية الدولية المحترم

بعد التحية :-

اشارة الى اعداد ورقة الاستراتيجية العامة للسكان في الجمهورية اليمنية وكذلك الى اللقاءات والخطابات المتبادلة .

يسرنا ابلاغكم برغبتنا في الاستمرار في التعاون معكم في هذا الشأن ، ونشكركم سلفا على ماقطعتموه من تحضير لمشروع خيارات لرعاية الاسرة والذي من المتوقع ان يتم التوقيع عليه خلال شهر سبتمبر ١٩٩١م ، بمبلغ ١٨ مليون دولار ولفترة ٨ سنوات .

وبناء عليه نود ابلاغكم بان الحكومة اليمنية ستفي بالتزاماتها حسب الامكانيات . وهذا بناء على طلبكم ..

وتقبلوا تحياتنا !!!!!!!!

وكيل الوزارة

التعاون الاقتصادي والفني

الولي عبدالله العاقل

١٩٩١/٩/٢٢

٠٤٤٢ن

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ANNEX E

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ANNEX E

Project Analyses

1. Technical Analysis

Yemen is at a turning point in its history. In May 1990, the northern and southern governorates were united, bringing together the relatively more economically-developed Arab Republic of Yemen and the relatively more socially-progressive Peoples' Democratic Republic of Yemen. The process of standardizing systems of administration, policy-making, and education is expected to take at least two more years.

Shortly after unification, the Gulf Crisis erupted and a majority of Yemeni citizens working in the Gulf region have returned home in search of employment in the local economy. Absorbing the large number of returnees (estimates range from 450,000 to 1,000,000) and coping with the associated decline in remittances are two of the immediate challenges to the new nation.

In addition, the Republic of Yemen has begun to address the implications for future development of its high population growth rate. At the current annual growth rate of 3.1%, the population size will double in less than twenty years. A population policy has been drafted that includes the specific goal of enhancing women's participation in economic and social activities.

Uncertainty of what the future holds with regard to the structure and capacity of the public sector, the health of the economy, and the opportunities for women, requires that the population project described in this PP remain flexible in its expected achievements and innovative in its implementation. The project design ensures this adaptability through a rolling plan of implementation that emphasizes 18-month cycles of activities, target-setting, and evaluation.

The project will rely on buy-ins to central S&T/POP projects for technical assistance and training. This plan contributes to the need for flexibility in two ways: 1) by permitting the design of discrete activities of limited duration and facilitating access to a wide range of collaborating agencies and 2) by ensuring the participation of a wide range of host-country counterpart institutions. It also reduces the management burden on the Mission by transferring management oversight to S&T/POP CTOs.

The needs and resources identified by the "bridging" activities that the Mission currently supports (see Annex F) have provided, and continue to provide, valuable information about the family planning environment in Yemen: what works and what doesn't, the relative strengths and weaknesses of various CAs and local organizations, etc. These insights formed the basis for the choice of project activities.

Perhaps the most significant technical issue affecting the likelihood of accomplishing the project purpose is whether or not to include funds for A.I.D.-provided contraceptive. Originally the plan was not to include funds for contraceptives based on the assumption that contraceptive supply was not the major obstacle to expansion of family planning services in Yemen. During the development of the Mission's population strategy and the PID, it appeared that USAID would not need to provide funds for contraceptives.

A survey of contraceptive availability in pharmacies carried out in early 1990 concluded that the private sector was able to provide adequate and timely supplies of contraceptives at prices within reach of a large segment of Yemeni society, especially those who would be the most likely contraceptive users. However, by mid-1991 the situation has changed somewhat. Informal surveys of pharmacies indicate that prices for the most widely used contraceptives have increased significantly due to growing shortages created by current foreign exchange problems. If the current problem continues for any appreciable length of time, it will have serious consequences for the commercial marketing component of the project. USAID has modified its original procurement plan by including funds for annual procurements of IUDs and limited amounts for other contraceptives. Although not finalized, there is a strong likelihood that YEDCO will be able to arrange for direct procurement of oral contraceptives at highly favorable prices from the manufacturer. USAID would assist YEDCO to obtain necessary foreign exchange for contraceptives by paying for certain local project expenditures in dollars, rather than in Rials. As a fall-back, particularly in the early years of the commercial marketing activity, USAID could increase its purchase start-up supplies of contraceptives using part of the contingency fund.

The Options for Family Care project has the potential to make a significant contribution to building a foundation for a sustainable family planning program in Yemen. The project is designed to meet needs across the range of program components and the implementation plan ensures the flexibility to modify project activities as the situation warrants.

The potential for project success is good, based upon the growing concern within the ROYG that continued rapid population growth is a major obstacle to economic growth. The MPD has taken the lead in preparing the national population policy and in coordinating the roles of other ministries in expanding family planning services. Approval of a national population policy in the fall of 1991 should encourage each ministry to participate in the development of training, service delivery and public awareness progrmas. By collaborating closely with ROYG officials in the development of the PP, there appears to be solid agreement on most, if not all, issues, including ROYG counterpart funds and staff to be allocated to the project.

2. Financial Analysis

A.I.D. Handbook 3, Appendix 3D notes that projects designed for improving socio-economic infrastructure often generate little or no revenue to cover the cost of the project. Thus, financial justification of the project in terms of internal rate of return is not possible and is unnecessary. Rather, the preferred approach is cost-effectiveness analysis which usually is finding the best trade-off between costs and effectiveness. This analysis is especially useful where benefits are hard to quantify due to lack of data or uncertainty about cause and effect relationships.

From studies carried out in a number of developing countries over the past decade, family planning projects have yielded a high internal rate of return, based on savings to families and societies from each birth averted. The annual internal rates of return, according to these studies, is in the range of 15-50%. The initial analysis for Yemen, described below in the economic analysis, indicates an annual internal rate of return of 20 percent, quite consistent with findings from other developing countries. It is important to note, however, there is limited data upon which to base an analysis for Yemen.

The Project will utilize the buy-in mechanism to on-going world-wide projects of the S&T Bureau's Office of Population for most planned activities, especially during Phase I which will continue many of the activities initiated with central funds prior to and during the "bridging" period. There are several financial advantages to USAID in using the buy-in mechanism compared to seeking an institutional contractor under competitive bid. First, it is unlikely that one contractor could provide all of the diverse requirements of the project. Second, it is the intention of USAID to make this a Yemeni project as much as possible and avoid the presence of high cost long-term foreign technical advisors. Third, some of the overhead costs of the S&T/POP cooperating agencies are borne by central funds, thereby giving USAID "a bigger bang for a buck". Fourth, the cooperating agencies, with S&T/POP approval, have already or are willing to provide some of their central funds for activities in Yemen. This is particularly true during the "bridging" period and during Phase I. The net result is a larger inflow of resources to Yemen than would be possible from just the bilateral project. Fifth, most of the S&T/POP projects have contractors chosen on the basis of competitive bidding which has resulted in high quality, but lower cost, services available to USAID/Sana'a.

The project cost estimates were developed using the known costs included in each of the intended Cooperating Agency contracts or cooperative agreements. While these contracts or cooperative agreements are due to terminate over the next few years, it is assumed that they will be renewed or a new organization will be contracted to undertake similar work in the future. Should this

not be the case, USAID would have to consider contracting for services directly. During the entire project, USAID reserves the option of seeking competitive bids for some elements of the Project if it appears to be the most effective and efficient way of obtaining needed services in a timely manner.

Costs of local hire contract staff are calculated on the basis of known salary and fringe costs for Yemeni professionals. Similarly, costs of local training and materials production are based on costs included in existing CA contracts with Yemeni organizations. Since most vehicles will be purchased in Part I, these costs, including shipping charges, are fairly well known. Computer hardware and software costs were based on current prices and shipping charges.

To guard against unanticipated project activities and to offset future cost increases, there is a contingency allowance included in the budget of $941,000, roughly five percent of total project funding. This contingency fund could also be used in the event that USAID needs to provide additional contraceptives to start the commercial marketing activity.

Over the life of the project the ROYG is expected to contribute the equivalent of $5,898,000 for local project expenses. Most of these funds are in-kind contributions of staff salaries of ministry, YFCA and YEDCO personnel, media production and air time and commodities. The anticipated host government costs have been reviewed by ROYG officials and accepted. These costs seem within the range of the capacity of the various ministries to provide. The planned evaluations at the end of each phase of the project will determine the extent to which the ROYG has met its commitments.

It is important to note that this project should be viewed as the first step in assisting the ROYG to develop a national family care program serving the large majority of the citizens. In most developing countries, the efforts to develop and achieve a demographically significant level of contraceptive prevalence have taken ten to twenty (or more) years of major donor support, even in countries where the governments have strong population policies and make large budget contributions for population/family planning programs. There is no reason to think that Yemen will be different. Thus, although the project purpose might be achieved, it is likely that future donor assistance will be required. This project will attempt to stimulate the private sector and individual couples to share a large part of the costs of the family planning program, thereby relieving the government of some budget costs. However, the ROYG is still expected to make a significant contribution.

3. Economic Analysis

Numerous economic benefits are associated with averting unwanted births and postponing mis-timed births. Some benefits, such as recurrent education costs, are more easily measured; others, such as reduced medical costs attributed to high-risk births (e.g., high parity and closely spaced births) are more difficult to quantify. Some benefits, such as school fees, are measured at the family level; others, such as recurrent health care costs, are measured at the national level. The present analysis compares the costs of expanding Yemen's family care program with the savings associated with reduced government expenditures in the education and health sectors.

The analysis is limited in a number of ways. Three are noted here. First, demographic data for the unified Republic of Yemen are limited; thus, this analysis was performed using separate sources for the northern and southern governorates and combining the information. Second, family planning costs are estimated without distinguishing sources of funding. Obviously, there are a number of sources, including international donors, the Ministry of Public Health, private sector organizations and individual couples. Third, savings associated with averted and postponed births are estimated for the Government of Yemen alone. Savings realized by families and private sector service providers through reduced health and education expenses are ignored. These limitations probably cause the results of the analysis to be more conservative than would be derived from a more comprehensive analysis.

The analysis compares two scenarios of fertility decline. The first assumes a moderate fertility decline where the total fertility rate (TFR) falls from 8.3 to 6.0 over the 25 year period (1990-2015). This is consistent with the ROYG goal of increasing contraceptive prevalence to 30 percent by 2015. The cost implications of this scenario are presented in the first panel of Table 1. The number of users required to achieve moderate fertility decline increases from 118,000 to 2.4 million over this period. The analysis assumes a constant annual cost per user of $30 throughout the period. The result is an increase in total family planning costs from $3.5 million to $76 million over the period. Education and health care costs also rise under this scenario, owing to increasing numbers of school-age children (aged 5-14) and MOPH clients (the number of mothers delivering plus the number of children aged 0-4). The education estimates assume a maintenance of current enrollment levels (44 percent for primary and secondary school) and a constant recurrent annual cost per student of $488. The health estimates assume a constant annual per client recurrent cost of $29.

The second scenario (shown in the second panel of Table 1) assumes no change in fertility over this 25 year period. Due to the effects of population growth, the number of family planning users

must rise in order to simply maintain the 1990 TFR of 8.3. Family planning costs are estimated to increase commensurately from $3.5 million to $10.2 million. Due to continuing high fertility, both education and health costs also rise considerably. Total education costs more than double and MCH costs almost triple.

The third panel of Table 1 compares the costs between the two scenarios. The marginal program costs of a moderate fertility decline (from 8.3 to 6.0 by 2015) are $6.9 million in 1995, $16.3 million by 2000 and $65.9 million by 2015. Savings do not accrue in the health and education sectors until 1998 when they are $3.8 million. These savings (shown as negative numbers in the table) increase rapidly to $17.3 million by 2000 and $364.6 million by 2015.

Thus, the "break-even" point, where annual savings equal annual costs occurs in 1998 and the "pay-back" point, where cumulative savings begin to exceed cumulative costs, occurs in 2001. In other words, within ten years of program initiation, total savings begin to outweigh the costs associated with a stronger program. These estimates, of course, ignore discounting, and in effect equate future with present values of both savings and costs. The annual internal rate of return (IRR), which is the discount rate that equates the present value of expected costs with the present value of expected savings, provides a single measure of return on investment. The IRR in this example is 20 percent annually. In other words, one would have to discount future benefits by 20 percent annually for the investment in family planning not to be cost-beneficial. Hence, the benefit-to-cost ratio for family planning in Yemen is quite favorable.

Table 1
Estimated Costs of Family Planning
and Associated Reductions in Public Sector Expenditures
in Education and Health Sectors: 1990-2015
(all estimates in millions) *

	Family Planning		Education		Health: MCH		Total Ed/Hlth Costs
Year	Users	Costs	Students	Costs	Clients	Costs	
Moderate Decline in Fertility							
1990	0.1	$3.5	1.3	$635	6.0	$173	$808
1995	0.4	$11.3	1.6	$786	7.3	$212	$998
2000	0.8	$21.7	2.0	$961	8.7	$253	$1,213
2005	1.3	$36.0	2.3	$1,134	10.5	$304	$1,438
2010	2.1	$54.3	2.7	$1,315	12.5	$363	$1,678
2015	3.1	$76.0	3.1	$1,518	14.7	$425	$1,943
No Change in Fertility							
1990	0.1	$3.5	1.3	$635	6.0	$173	$808
1995	0.1	$4.4	1.6	$785	6.8	$197	$982
2000	0.2	$5.4	2.0	$971	8.9	$259	$1,230
2005	0.2	$6.7	2.4	$1,192	11.0	$319	$1,511
2010	0.3	$8.3	3.0	$1,470	13.5	$391	$1,861
2015	0.3	$10.2	3.7	$1,828	16.5	$479	$2,308
Difference							
1990	0.0	0.0	0.0	0	0.0	0	0
1995	0.2	6.9	0.0	1	0.5	16	16
2000	0.6	16.3	0.0	-10	-0.2	-7	-17
2005	1.1	29.3	-0.1	-58	-0.5	-15	-73
2010	1.8	46.0	-0.3	-155	-1.0	-29	-183
2015	2.7	65.9	-0.6	-310	-1.9	-55	-365

* All costs are expressed in 1990 US dollars.

Assumptions used in Economic Analysis

The assumptions regarding the proximate determinants of fertility come from the 1979 YFC. The proportions of the population in various age groups were prepared by the Futures Group using DEMPROJ software. The starting year (1990) assumptions are:

Method mix: 47% vasectomy, 53% pill
TFR: 8.3
CPR: 3.1% of married women of reproductive age (MWRA)
Total population: 10.5 million
WRA (aged 15-49): 39% of total population
Percent married: 94%
Duration of Postpartum infecundability: 8 months
Sterility: 15% of WRA
Abortion: 0
Children age 0-4: 20% of total population
Children age 5-14: 28% of total population

In the moderate decline scenario the method mix changes to: 10% condoms, 3% injectables, 10% IUD, 20% vasectomy, 40% pill, and 18% rhythm by 2015 and CPR rises to 30% by 2015. Contraceptive prevalence rises to 30%. The other proximate determinants remain constant. Women of reproductive age as a proportion of total population rises to 42%, children 0-4 declines to 18%, and children 5-14 remains roughly constant. The total 2015 population is 25.5 million. In the no decline scenario, all proximate determinants including method mix remain constant. The proportion of women aged 15-49 also remains roughly constant. The proportion of the population aged 0-4 rises to 21% and the proportion aged 5-14 rises to 30%. Total 2015 population is 28.9 million. Because the only proximate determinant the changes between the two scenarios is contraceptive prevalence, the number of users required to achieve the fertility decline from 8.3 to 6.0 is enormous. In reality, it is likely that age at marriage and duration of post-partum amenorrhea would change as well, possibly canceling each other out or possibly resulting in achieving 30% prevalence with fewer users. These factors suggest that the cost estimates presented here are conservative and the probable savings from expanding the Yemen family care program are higher.

4. Social Soundness/WID Analysis

The social soundness and WID aspects of the Options for Family Care project are discussed throughout the Background and Rationale sections of the PP. That discussion is consolidated below.

In the space of 20 years, the governorates of northern Yemen (previously the Yemen Arab Republic) stepped out of the middle ages, leaving behind a millennium of feudal rule, and into the twentieth century. From 1918 to 1962, the country was essentially cut off from outside influences. Eight years of civil war followed. In the twenty years since, great progress has been made in developing systems of education, health, transportation, and communications.

Economic growth has been impressive. Annual GDP growth rates averaged 5.6% between 1980-87, exceeding those of other countries in the region such as Tunisia, Morocco, and Jordan. Per capita income is over $640 per year. Agriculture as a share of GDP has declined from 44% to 34% of GDP. Remittances from migrant workers in the Gulf states have been a major source of foreign exchange. Since the Gulf War, however, the majority of migrants have returned and the Government must now cope with increased demands for jobs and services.

The numbers of schools, health facilities, and health personnel in the northern governorates have increased extremely rapidly. Five thousand new primary schools have been built in the last 20 years. Between 1979 and 1988, the number of hospitals increased from 25 to 39, health centers increased from 93 to 297, and health care units increased from 97 to 361. The number of doctors and dentists increased six-fold between 1975 and 1985.

Despite economic growth and improvements in infrastructure, social indicators have been slow to change. Female literacy and school enrollment of girls remain low (3% and 6% respectively) (OPTIONS database, 1990). Infant mortality has declined from 160 deaths per 1000 live births 15-20 years ago (World Bank, 1990b) to 136/1000. Maternal mortality is 10/1000. The total fertility rate (TFR), around 8.9 children per woman, is among the highest in the world.

The southern governorates (previously the Peoples' Democratic Republic of Yemen - PDRY) have had a different history and present a somewhat different picture. What was the PDRY is comprised of the former British Crown Colony of Aden and Eastern and Western Aden protectorates. After becoming independent in 1967, the country followed a Marxist path marked by political instability and limited economic growth.

In general, the southern governorates have experienced less economic development than their northern neighbors. GNP per capita in 1988 was less than $450. Less than one percent of the land is

arable and industrial activity is still rudimentary. However, the 1970s brought relative prosperity as remittances from abroad increased with the rise in the price of oil. The government made development of human resources a priority (World Bank, 1990a). Numerous schools were built and literacy and enrollment rates for girls are higher than in the northern governorates (25% and 32%, respectively). Although the economic situation deteriorated significantly in the 1980s, the demographic picture remains slightly more optimistic than in the north. The 1988 census suggests an infant mortality rate between 105-120/1000 and a TFR of 6.7. Attitudes towards women are also somewhat more liberal in the southern governorates.

The northern and southern governorates were united into the Republic of Yemen (ROY) in May 1990. The process of unification will continue over the next several years as health and education systems are standardized and the two economies are integrated. An immediate economic challenge to the new nation is to absorb the large number of returnees from the Gulf.

Official government statistics show a total population size of 11.3 million and a TFR of 8.3. At the current population growth rate of 3.1% per year, the population will double in size in just 20 years. It is estimated that urban populations will double in the next eight years. It is not surprising that the Government has become concerned about the implications of rapid population growth, despite the fact that this has been a forbidden topic in the past. In addition, there is growing recognition of the implications of closely spaced births and high risk pregnancies for the health of mothers and children.

The demographic situation in Yemen is typical for a country at the beginning of its demographic transition. A recent study of the feasibility of farm irrigation (Hossain, 1991) nicely captures the demographic characteristics of rural areas in Yemen:

> "The farm family has 16 members comprising 3 adult males, 3 adult females and 10 children. Females are completely uneducated. Males, in general, can read and write. Only male children [go] to school, female children are not sent to school. Males are engaged only in agriculture, females are engaged both in agriculture and in household activities."

The situation in urban areas is slightly better but, on average, social indicators are among the lowest in the Arab world.

For the first time in its history, Yemen finds that the weight of population growth threatens continuing social and economic progress and the goal of improving family well-being. Yet, progress in the population sector is hampered by a number of societal and institutional constraints. Unification itself presents a challenge to the new project. The relative economic underdevelopment of the

southern governorates will place additional demands on the budget. However, social attitudes and higher educational attainment of women in the southern governorates are more favorable to the proposed type of initiative.

a. Status of Women

The major factors affecting family health and welfare and the contribution of women to economic production are the traditional separation of male and female worlds and the seclusion of women. In spite of tremendous advances in education, primary gross enrollment rates are only about 22% for females, compared with 67% for males (CSO, 1991). Female literacy averages less than 15% and women's basic health knowledge is limited. Lack of female mobility affects access to health services for both women and their children. Most providers of contraceptive services require the written consent of the husband. When women are allowed to attend health centers, they can only be examined by female health care workers. This further limits their access to care, since lack of education and mobility have prevented large numbers of women from entering the health professions in the past. Thus, lack of female mobility is a major factor contributing to the high maternal and infant mortality rates (10/1000 and 130/1000 respectively) and low life expectancy (less than 50 for both sexes). Attitudes towards women are changing, as evidenced by the fact that approximately 50% of all medical school students in Yemen are women and the first graduating class was predominantly women. Nonetheless, it is obvious that any program in Yemen aimed at women and children must also reach men.

Various studies have highlighted the potential contribution of women to economic development in Yemen (see for example RAPID, 1982; World Bank, 1990c). These note that key factors limiting women's participation are illiteracy and lack of education. The project will address these through incorporation of literacy training into its skills development activities, thereby opening the doors to other opportunities. The training activities in general also will provide women with marketable skills in the health/population field.

b. Religion

Religion is also an important factor influencing attitudes. The Quran can be interpreted as limiting the role of women to the home and condemning any restriction on family size. However, there are other interpretations of the Quran that recognize the value of women in society and the importance of maintaining a balance between family size and resources. Some religious leaders are beginning to make declarations in this direction and have been active participants in family life education activities in schools and in mobilizing support among the religious community, for example, for the Expanded Program for Immunizations (EPI). In

Taiz, the women's religious schools offer family care education and a female staff doctor provides family care services so that married students can complete their education. Given the high value that Islam places on the family, there is considerable potential in Yemen for increasing the acceptance of family care by promoting the health benefits of birth spacing and safe motherhood.

c. Geographic Isolation

Geographic isolation is another major barrier to development (including the delivery of basic services) in Yemen. Yemen has over 20,000 villages dispersed throughout the coastal desert plains of the Tihama and literally perched atop its rugged mountain ranges. However, two major networks provide opportunities for overcoming geographic and cultural isolation: the commercial networks of stores and shops, including pharmacies and drugstores, particularly in the north, and the mass media, especially television.

Yemen has an ancient tradition of commerce and trade. The Kingdom of Saba controlled the Gold and Incense Road, the critical link with the Orient and East Africa. Since the early 1960s, commerce has been fueled by remittances from migrant workers in the Gulf States, and now by oil. The array of consumer goods available in northern cities is extensive and many such goods can now be found in the most remote village shops.

An astonishing 85% of households have access to television. The successful use of television spots to promote the recent immunization campaign has shown how effective this medium can be for increasing awareness and utilization.

Both commerce and television affect the demographic transition in many ways. They provide new opportunities and create demand for all that the modern world has to offer. Many families are beginning to desire fewer children so that they can invest more in each child's future and participate more fully in the benefits of a growing economy. Commercial networks and television also offer direct potential for expanding access to and awareness of family care products to meet this growing demand.

d. Lack of Current Data

Because of the perceived sensitivity of family care, information on the subject is not at all widespread. According to data on the northern governorates from the 1979 Yemen Fertility Survey (YFS, 1983), only 22% of women had ever heard of any contraceptive method and only 3% had ever used any method. Approximately 19% of currently married, fecund women wanted no more children. This percentage ranged from 9% of those under 25 years of age to 51% of those over 45, indicating considerable unmet demand among women. Contraceptive prevalence may now be around 10% in some cities, but

it seems likely that women's demand has increased more rapidly than has their access. Information on the current demographic situation is sorely needed and collection and dissemination of improved demographic data will be a priority for the project.

e. Institutional Constraints

Another major constraint in terms of family care is that child spacing has not been a part of the curricula or job descriptions of health professionals in the past. Therefore, relatively few providers and facilities are able to offer family care services, nor do they see it as one of their responsibilities. Out of several hundred Ministry of Public Health (MOPH) facilities, it is estimated that only a small number actually provide family care services. At many of these delivery points, the acceptor rates are low due to a perceived lack of quality services. In-service training and short courses for existing personnel would greatly expand access to family care. In addition, every attempt will be made to ensure that family care is integrated into all existing health curricula and job descriptions.

The public health system faces serious constraints in terms of staffing (especially female personnel), management, and coverage. As mentioned above, there is potential for strengthening the existing MOPH system, particularly with regard to maternal/child health and family care, through technical and management training, and by increasing the number of female health personnel. Some centers and districts have been very innovative in their efforts to improve family care services by offering day care services, literacy training, and dormitory facilities to female trainees and employees. These centers have growing numbers of family care acceptors.

Opportunities outside the public sector are limited in the southern governorates, which, prior to unification, followed the socialist, non-market-oriented model for provision of goods and services. Nonetheless, the project will look for opportunities to expand and strengthen the private sector in these governorates. In the northern governorates, however, major opportunities do exist outside the MOPH system, in the very active and growing private health sector. The project will take advantage of this dynamic private sector. More than 217 pharmacies and 799 drugstores are potential or actual points of sale for birth spacing methods. Most of the approximately 1,000 Yemeni physicians have private practices. (In fact, Yemen officially recognizes the right of MOPH employees to have private practices and most work for the MOPH in the morning and conduct their private practice in the afternoon.) In addition to the profit-making enterprises of the private sector is the not-for-profit sector, particularly the Yemen Family Care Association (YFCA). This organization has implemented many pioneering efforts in the field of birth spacing and safe motherhood. The centers run by the Local Councils for Cooperative

Development (LCCD) are another resource. These are elected bodies whose clinics charge fees and provide higher quality services than government clinics in many cases.

This project is Yemen's first bilateral population project. While this is a constraint in terms of data, experience, and institutional capability, it also affords a unique opportunity to be innovative. In the midst of rapid change, Yemenis seem to choose rather pragmatically what they want from the modern world, while retaining their cultural identity and independence. This project, like most other Yemeni projects, will be non-traditional in nature and assume unique Yemeni characteristics.

5. Administrative Analysis.

A number of local institutions, from both the public and private sectors, will be involved in the implementation of the Options for Family Care project. These institutions, particularly the lead institution(s) for each project component, play an important role in ensuring that the project runs smoothly.

The Ministry of Planning and Development (MPD) will be the government agency responsible for signing project agreements, providing overall policy guidance and monitoring project implementation. The lead institution for each project component will be the primary point of contact for the Mission for that component and will be responsible for coordinating the activities within that component.

The Central Statistics Office (CSO) within the Ministry of Planning and Development will be the lead institution coordinating data collection and policy analysis activities. The CSO, and particularly the PSRC within it, have played an active role in the drafting of the National Population Policy. The project will build on their accepted leadership position to expand population policy activities.

The Ministry of Information (MOI) will coordinate awareness-raising/communications activities. Much of the success of the project hinges on the ability to raise awareness of the benefits of family planning and of the options available to Yemeni couples. The MOI is the logical lead counterpart for this effort given the intention of the project to rely heavily on the mass media for dissemination of family care messages. The YFCA will be responsible for the Centers of Excellence component of these activities.

The skills development/service delivery component will use a team of counterpart institutions: the Ministry of Public Health (MOPH), the Health Manpower Institute (HMI), and the University of Sana'a Faculty of Medicine (FOM). Technically, HMI and FOM are responsible to the MOPH. However, each operates fairly independently and has its own target group of training participants.

The Yemen Drug Company for Industry and Commerce (YEDCO) will be the lead institution for the commercial marketing component of the Project, supported by the Yemeni Physicians and Pharmacists Union (YPPU). YEDCO is the largest importer/distributor of pharmaceuticals in Yemen and is the only pharmaceutical manufacturer in Yemen. It is a company of mixed ownership; the Government owns 51% and the private sector owns 49%. YEDCO covers 60% of the total market for imported and locally manufactured drugs. It imports over 500 drugs from 33 international suppliers, including several oral contraceptives and IUDs. Its local coverage

is made possible through five branches located in the major cities of Sana'a, Taiz, Ibb, Hoedeidah and Haja, and more recently through the National Drug Company in Aden. The YPPU has branches in the governorates and its membership includes the majority of physicians and pharmacists working in the private sector.

When the multi-sector activities commence in Phase II, they will involve a range of Yemeni organizations, both public and private. If there is to be a lead agancy, it will be determined during the design of Phase II activities. A likely candidate is the Ministry of Social Affairs.

The mandates, strengths, and weaknesses of the counterpart organizations are detailed below in the Institutional Profiles.

A. MINISTRY OF PLANNING AND DEVELOPMENT (MPD)

The MPD will serve as the coordinating agency for the Options for Family Care project It is responsible for national economic planning and for all technical cooperation with donor agencies. The MPD is organized into three main sectors with responsibilities for Planning, Programming and Technical Cooperation. There are 20 departments headed by Directors General within the three sectors. The MPD has not had any direct involvement in population related activities, except in its role as coordinator of donor assistance.

The institutional strengths of the MPD are in planning and preparing economic strategies. There is a substantial need for staff training in most areas.

The main counterpart officials within MPD are:
- Dr. Faras Bin Ghanim, Minister
- Dr. Mutahar Al-Saidi, Vice-Minister

Other important contacts within the MPD for the Project are:
- Mr. Abdul Wali Al-Agil, Deputy Minister
- Dr. Ja'afer Haamid, Deputy Minister for Planning
- Dr. Ahmed Abdul-Saadiq, Deputy Minister for Programming

B. CENTRAL STATISTICAL ORGANIZATION (CSO)

Chief Executive(s)

Mr. Abdo Rabo Garadah, Chairman
Dr. Salem Ben Hummam, Deputy Chairman
Mr. Muhammad Ben Mas'oud, Asst. Under Secretary for Analysis and Publication

Other Contact Persons:

Mr. Ameen Ma'arouf al-Janad, DG for Population Studies and Research Center
Mr. Yahya al-Qaizel, DG for Data Collection and Entry
Mr. Abdul Malek al-Tahami, DG for CSO Aden Branch
Mr. Abdo Qubatti, Deputy Director, PSRC
Dr. Abdul Aziz Farah, UNFPA chief Technical Advisor
Mr. Hussein Ogaleh, DG of the Technical Office
Mr. Edward Jongstra, Associate Demographer for the Netherlands Interdisciplinary Demographic Institute (NIDI)

Type of Organization and Affiliation

Government agency responsible for national statistics and demographic indicators; it is accountable to the Minister of Planning and Development

Purpose

The CSO is the official organization for gathering, analyzing and disseminating national statistical and demographic data, acting as a major resource for planning, analysis and research to assist the central government in making national economic and development plans.

Organizational Structure: See attached organization chart

a. Decision Making and Management

CSO has total autonomy and its chairman has the status and the authority of a senior vice minister. However, in terms of protocol, CSO comes directly under the supervision of the Ministry of Planning and Development. The concept of decentralization in decision making is beginning to force itself on the CSO management. For example, General Directors can make

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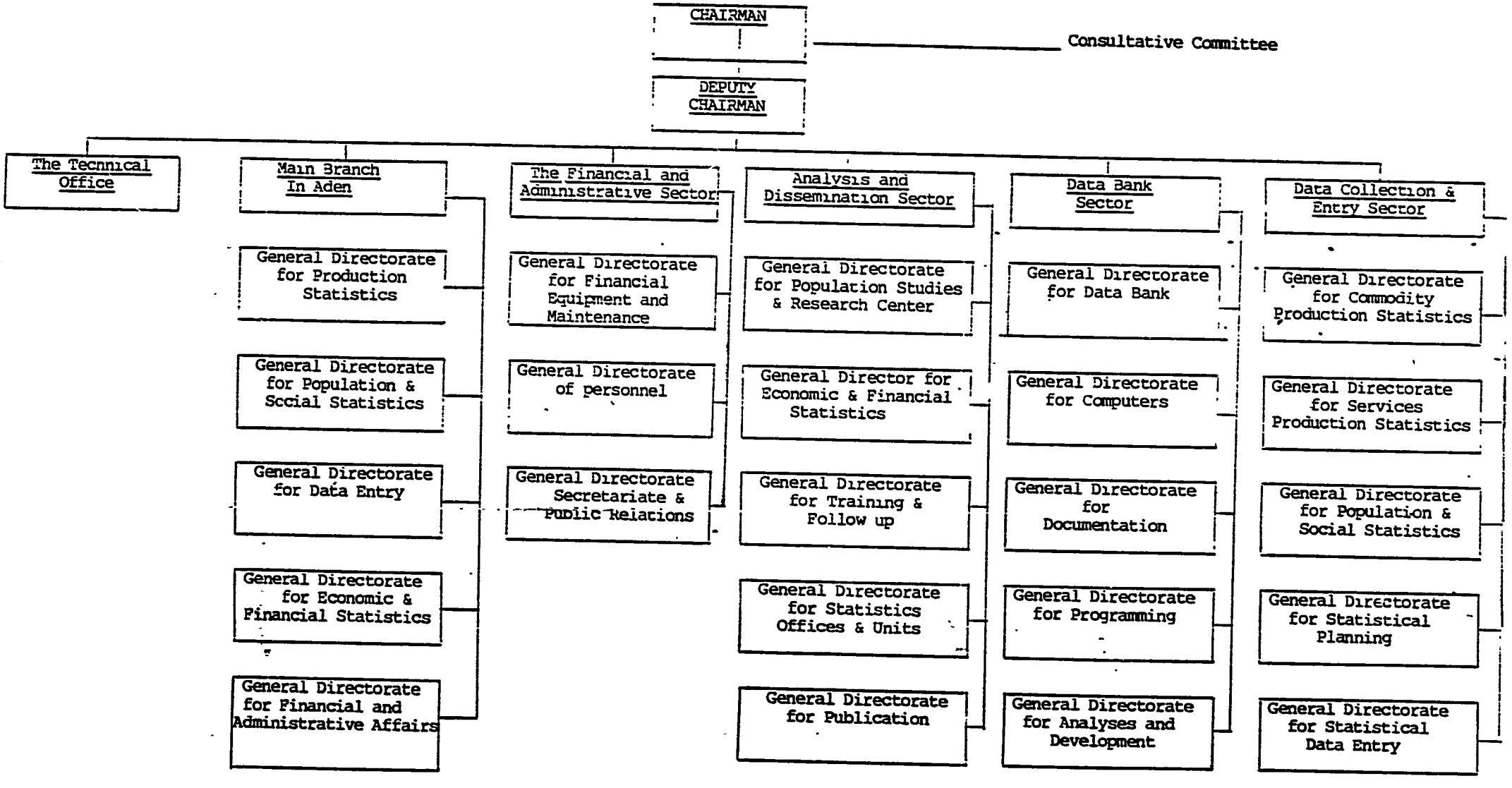
E-16 A
CSO Organizational Structure



decisions usually after conferring with either the Chairman or his Deputy. CSO, its main branch in Aden and offices in other governorates, has its separate budget allocated in the general budget of the ROYG.

b. Branch Structure

See attached organization chart (see CSO branch in Aden)

Main Activities

Data collection, entry, analysis, dissemination and research. Most importantly, CSO orchestrates all the census, survey, and secondary analysis done in the country. CSO also participates in developing and designing systems by which the central government can follow and monitor the implementation of the overall national development plan.

Staffing

There are four main sectors under the CSO with 23 general directorates, plus a technical office and a main branch in Aden. Each has its own divisions and staff. The total staff of CSO is more than 450.

Resources

Most CSO funding comes from central government. Other funds come from donor agencies such as USAID, UNFPA, NIDI, AGFund, the Canadian project and UNICEF.

Particular Involvement in Population Related Activities:

The CSO was established by Presidential Decree in 1990. Before unification, there was a General Directorate of Planning and Statistics in the Central Planning Organization, now known as the Ministry of Planning & Development. CSO has been involved in population activities since the 1970s when the first national census (1975) took place.

Population Studies and Research Center (PSRC)/CSO

PSRC was created in 1982 to conduct and serve as a source of technical expertise on population and demographic questions within the Government. It is an influential organization and has been active in sensitizing policy makers to population and development issues.

The PSRC has made presentations demonstrating the economic costs

of rapid growth (including RAPID presentation) and has been assigned the responsibility for formulating Yemen's population policy. Over the past year, the PSRC produced a draft of the National Population Strategy, held a series of meetings in various ministries to review the document, and will conduct a comprehensive program of activities leading up to a National Population Conference in October 1991 at which the final policy will be declared. In preparation for the Conference, key officials and agencies with responsibilities for implementing the goals of the National Population Strategy are assigned to task forces to ensure that these agencies are active participants in the population policy development. The task forces are preparing papers for the October Conference to identify important knowledge gaps and provide guidance on achievable and measurable policy strategies.

CSO prepares a Statistical Year Book and has analyzed the preliminary and final results of the 1975 and 1986 census data. Staff helped design a course on demography and population dynamics for use in the Departments of Sociology and Community Medicine (Sana'a University) in collaboration with UNFPA and WHO.

PSRC also assisted in the preparation of the 1989 national conference on Population Within the Framework of Islam in Sana'a.

USAID Funded Project/Activities

USAID has provided technical assistance from the U.S. Bureau of the Census for work on the two previous censuses. At present through bridging activities, USAID assistance is being provided for:

a. Yemen's Demographic Maternal and Child Health Survey to be executed in cooperation with the League of Arab States and the Demographic and Health Surveys Program implemented by the Institute for Resource Development, the Papchild Project and ROYG. USAID is providing $130,000 in regional funds and central AID projects provide $108,000 through IRD. The League of Arab States through Papchild is contributing $110,000.

b. A RAPID III program which is centrally funded and implemented by the Futures Group.

c. BUCEN technical assistance will help design and develop the listing operation for the upcoming two surveys: Labor Force and Family Income.

d. OPTIONS II project has provided assistance for

preparation of the National Population Conference.

Other Donor Funded Projects/Activities:

Financial and technical support for CSO is provided by several donors. UNFPA is by far the most active donor agency since October, 1988 and it is expected to continue its assistance to CSO through the next UNDP five-year program cycle starting in 1992. The project activities include staff development of PSRC through training. The UNFPA project YEM/87/P04 is executed by a chief technical advisor from the UN Department of Technical Cooperation for Development (UNDTCD).

CSO is also receiving assistance from the Netherlands Interdisciplinary Demographic Institute (NIDI) in the form of technical assistance from a Dutch demographic and computer equipment. NIDI also supports census and other survey analysis activities beside technical assistance to help in the preparation for the October Population Conference.

The Canadian Project on Maternal Mortality and Morbidity, and PapChild and DHS Projects, are other donor-funded activities in the CSO.

UNICEF has contributed and will be contributing in policy development through financial and technical support for pre-conference workshop and to policy task forces.

Institutional Strength:

Its independence in decision making, budgeting and staffing gives CSO a high position in the central government. The continuous endeavors to formulate the first population policy in Yemen, and to prepare for the October Population Conference is an indicator of CSO's commitment to the issue of population and its impact on development.

Institutional Needs/ Areas for Improvement:

For its major role and expanding involvement in the policy process, CSO has a shortage of adequately trained personnel, therefore, significant technical assistance to conduct all the activities necessary to successful policy development and constituency building will be required. Financial and logistic support is obviously needed, especially in the early stages of the population policy implementation.

C. MINISTRY OF INFORMATION (MOI)

Chief Executive(s):

Dr. Mohamed Ahmed Ghorhoum, Ph.D., Minister
Abdu Rahman Mohamed El Aqwa'a, Vice Minister
Motaher Ahmed Tuki, Deputy Minister
Ahmet Alim Souswa, Deputy Minister

Other Contact Persons:

Abdu Malek EsSindi, Director General, Public Relations
Intesar Omar, Assistant, Public Relations
Ali Ashak, Director General, Channel 1 TV
Ahmed Sheyani, Program Director
Ahmed Anoubi, Radio Chairman
Mohamed Dahwan, Program Director, Radio
Dr. Abdu Razak Mousad, Director General, Internal Coordination Department

Type of Organization and Affiliation:

Ministry responsible for national communications.

Purpose:

To relate national development to national policy by designing, implementing and monitoring activities of national and communications policy for all aspects of national and regional communications media, including TV, radio and the press.

Organizational Structure:

a. Decision Making and Management: Decisions are made, primarily, through a chain of command starting with the Minister and filtering down by rank. Some decisions are made at the Directorate level.

b. Branch structure: There are three main branches of the MOI covering TV, radio and the press. The branches have a total of 12 departments. Divisions are planned for each department, but do not yet exist.

Main Activities:

There are three main categories of activities in the Ministry:

a. Planning and development. Developing yearly plans and activities and enhancing the technical performance of the various communications departments and staff.

b. Implementation and Supervision. Implementing communications policy and the yearly activity plans.

c. On-going program support and development. Assisting the national campaigns of the Government to address such issues as health, education, tribal disputes and dowry issues.

Staffing:

The MOI has 12 departments, each with its own staff. A lack of funding and staff has prevented the development of divisions under each department.

Resources:

All funds for the MOI come from the central government. There are 17 communications offices under the existing departments. Each office has its own equipment, but additional equipment is needed. The goal of the MOI is to provide 5 cameras per office along with related equipment. However, each office now has one camera at best.

Particular Involvement in Population Activities:

There has been no MOI involvement in population activities. The MOI's first involvement will be in conjunction with the National Population Policy Conference to be held in late October 1991.

USAID Funded Projects and Activities:

The Options for Family Care Project will be the MOI's first collaborative experience with USAID.

Other Donor Funded Projects and Activities:

The MOI has participated in a few donor-sponsored activities, such as covering events at a 1991 UNDP conference on the environment; covering a WHO conference on the environment; and covering a UNICEF initiative on the state and solution to the problems of beggars.

Institutional Strengths and Weaknesses:

The primary strengths of the MOI are the amount of freedom of the

press it has allowed since unification in 1990 and the amount of diversity in the press. There are now three national newspapers and at least 33 governorate and local papers, evidence of a growing free press.

The primary weakness of the MOI is that it does not yet focus on the total development process but is rather steered by political considerations and agendas.

Institutional Needs and Areas for Improvement:

The MOI needs to develop greater technical expertise, both in terms of personnel and equipment. It also lacks the transportation required to cover national events.

D. YEMEN FAMILY CARE ASSOCIATION (YFCA)

Chief Executives(s):

Dr. Al Babli, Executive Director

Other Contact Persons:

Dr. Ismail Al-Sana'ani, Director, Taiz
Ms. Jamila al-Sharie, Director, Sana'a
Dr. Ali Fakira, Director General, Hodeidah
Ms. Na'imah Mujam, Director, Hodeidah
Maha al-Kumain, Communications Office

Type of Organization and Affiliation:

YFCA, an affiliate of the International Planned Parenthood Federation, was established in 1976. It is primarily responsible for the private voluntary agency family planning program in Yemen. YFCA provides family planning services through its own clinics in Sana'a and Hodeidah as well as through MOPH and LCCD-supported clinics. YFCA provides contraceptive supplies and service and training equipment to the 45 health centers in Sana'a and three Sana'a hospitals: Al-Thowra, Al-Saba'aen and Al-Kuwait. YFCA/Taiz has formal ties with the Taiz Health Office and works closely with several rural and urban health facilities.

Purpose:

To provide complete family planning and MCH services to the people of Yemen.

Organizational Structure:

a. Decision Making and Management

A volunteer Board of Directors of the General Assembly of YFCA approves programs and plans. There are approximately seven Program Officers. There is a hierarchical decision-making structure for all activities in the Taiz, Aden and Sana'a branches. In the Hodeidah branch there is a Committee for Educational Programs.

b. Branch Structure

There are currently four branches of YFCA, located in Sana'a,

Taiz, Hodeidah and Aden.

Main Activities:

YFCA is involved with all aspects of providing family planning services in Yemen, including training; provision of contraceptive services and family planning counseling; ante-natal and post-natal care, immunization and other PHC services; referral; and development and distribution of IEC materials.

Staffing:

The Sana'a clinic is staffed by one woman physician, two nurses, two midwives, an accountant, a public relations coordinator, a computer specialist, a program coordinator and a guard/janitor. The staff is under the direction of the Executive Director.

The Taiz clinic staff consists of a female physician (a general practitioner with three years of residency in OB/GYN but no formal family planning training), a midwife, a public relations coordinator who also acts as the supplies coordinator and a janitor.

Resources:

IPPF finances 90% of YFCA's annual expenditures. The remaining 10% comes from various donor agencies and YFCA income-generating activities.

Particular Involvement in Population Related Activities:

YFCA is a family planning/MCH agency.

USAID Funded Projects and Activities:

USAID support to date for YFCA has been through Pathfinder and AVSC grants.

AVSC sponsors a training project with YFCA that began in 1988 and ends in 1992. The project targets service providers and provides them with local and third country training.

Pathfinder International provides technical assistance to YFCA to enhance its organizational capacity through a computerized accounting system. In addition, Pathfinder provides funds to YFCA to support IEC activities and to assist in publishing a bi-annual report and a quarterly newsletter. Pathfinder is also working on strengthening YFCA's management information system

(MIS) capability.

Other Donor Funded Projects and Activities:

The Arab Gulf Fund supported YFCA women's development projects by sponsoring the work of Women Guides who conduct educational activities with rural women on a variety of social and health issues. IPPF has considered supporting these activities also.

The Dutch Project organized a workshop in collaboration with YFCA in 1990 on infant and child mortality. This served as an introduction to the Canadian IDRC project.

The Canadian IDRC project will start at the end of the on-going DHS survey and is expected to be implemented in early 1992. Studies from the workshop organized by the Dutch Project will be used by the IDRC project, jointly with YFCA, to design a field study on the causes of infant and child mortality in selected governorates.

UNFPA is supporting a 45 day technical consultancy in strategic planning. YFCA is the first IPPF affiliate in the Arab region selected to begin strategic planning activities.

Institutional Strengths and Weaknesses

YFCA has well-functioning clinic and training programs. YFCA is the major supplier of family planning services through its own clinics and by supplying contraceptives to other Yemeni clinics. Management systems have been established that include counseling and educational procedures.

Institutional Needs and Areas for Improvement

Additional and refresher training for staff is needed, particularly for outreach workers. Additional equipment is needed for all branches and financial support is needed to improve and extend services at existing clinics and to develop new branches and clinics.

E. MINISTRY OF PUBLIC HEALTH (MOPH)

Chief Executive(s): Dr. 'Awadh Bamattraf, Vice Minister
Dr. 'Abdulla As-Sa'idi, Deputy Minister for Planning & Statistics and Follow Up Sector
Dr. Ahmad Makki, Deputy Minister for General Health Services

Other Contact Persons: Mr. Muhammad Gharamah, Director General Planning, Statistics and Follow Up Sector
Dr. Mu'atassim Sabri, Director General Mother & Child Health Department
Dr. Abdul Haleem Hashem, Director General, Primary Health Care Directorate

Purpose:

The MOPH is responsible for providing health care in general and basic MCH and PHC services in particular.

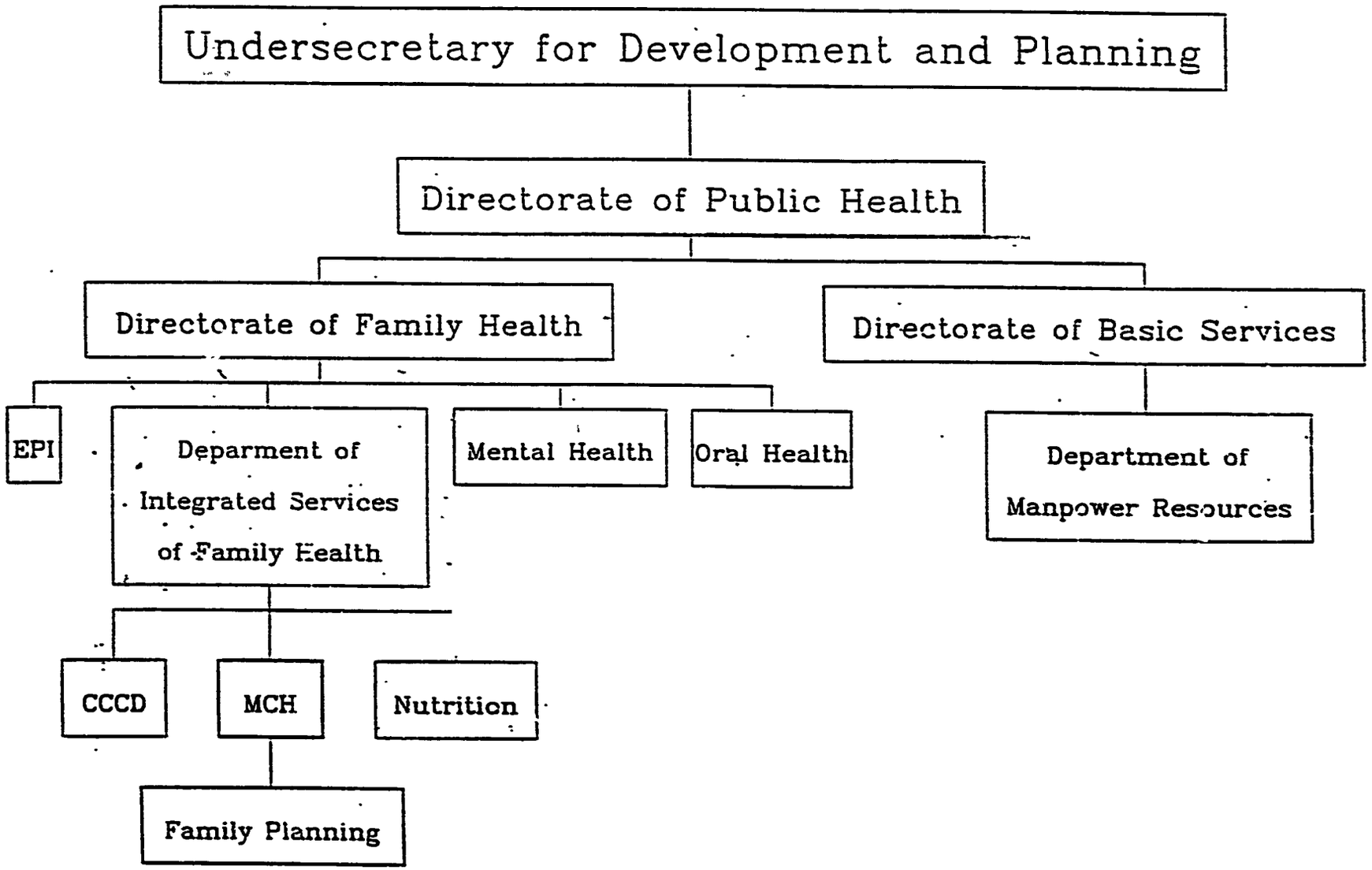
Organizational Structure:

Within the MOPH, birth spacing is the responsibility of the Department of Maternal and Child Health which is included in the Department of Integrated Family Health Services in the Directorate of Public Health. (See organization chart.)

The Directorate of Planning and Statistics (DPS) is responsible for health planning throughout the MOPH, including human resource planning and in-service training plans.

Governorate health directors are responsible for overall health services with their respective governorates, including PHCW and in-service training activities. Although planning is still performed at the central level, the responsibility for decisions regarding health budget expenditure was recently delegated to the governorate level (July 1991). Some of the governorate health offices have a well developed structure and adequate staffing levels (e.g. Hodeidah), while others are still underdeveloped. Consequently, plans for decentralized activities cannot be uniform throughout the country, but have to be based on the resources available to each governorate.

MOH Organizational Structure
Location of MCH Department



Health care delivery structures:
MOPH facilities, together with clinics established by the Local Councils for Cooperative Development (LCCD) constitute the entire network of public-sector health facilities in Yemen. The 1988 statistics showed a total of 39 hospitals, 297 health centers and 361 primary health care units (PHCU) in the northern governorates. Health center staff usually supervise a number of PHCUs and are referral centers for the latter, although there is sometimes a sub-center between the PHCU and the health center. Some health centers have beds for in-patient care and are in fact rural hospitals. Health centers refer patients to hospitals when necessary.

Health centers are to be staffed by several professionals, including a physician-chief health officer, a midwife when available, one or more nurses, an X-ray technician and a pharmacist assistant. PHCUs are supposed to be staffed by a male and female primary health care worker (PHCW). Health centers and PHCUs are usually only open in the mornings and most have fairly low attendance rates, one of the reasons being the lack of female health workers. Seventy health centers are designated as training centers for PHCWs. It is estimated that only 40% of the population is covered by the primary health care system.

There seems to be no clear system of coordination between the different levels and elements within the system, although the health manpower survey currently planned by the MOPH should bring this issue to the forefront for discussion and action.

Birth spacing services
The MOPH began to provide birth spacing services in 1986. Currently, services are available at most provincial hospitals and, in principle, also at health centers. In reality, however, it is considered that only about one third of health centers provided MCH services and even fewer provide birth spacing (perhaps 100 delivery points in the public health delivery system). Few health workers have been trained in birth spacing service delivery, and the little training that has been provided is usually limited to clinical knowledge and does not include client education, interpersonal communication or counseling skills. The oral contraceptive is generally the method provided, unless there is a female practitioner trained to insert IUDs. Where female service providers are available and well trained, there is a considerable demand for services.

Constraints to the provision of PHC and birth spacing services
The major constraints are lack of trained health workers, particularly women; lack of skilled supervision; staff

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absenteeism in many PHCUs; and poor inventory/supply management. All of these constraints need to be addressed in order to improve the quality of service delivery and make health care services accessible to women in the areas covered by the PHC system.

Health Planning:

As mentioned above, the DPS is responsible for health planning. According to the 1991 Health Plan, planning is centralized and implementation decentralized. The DPS is currently planning a situation analysis of the health care system in Yemen, involving a health manpower survey, which will include a survey of all health establishments. The MOPH's 1991 continuing education program calls for the formation of a task force to visit each governorate to review current training processes, identify the participating institutions and determine training needs. This will result in a plan for each governorate.

USAID Funded Projects and Activities:

USAID/Sana'a provides support to the MOPH through the ACCS project.

Other Donor Funded Projects and Activities:

UNFPA provides contraceptive supplies, office supplies, vehicles and equipment. It has also provided Sudanese trainer/supervisors and midwives, who are gradually being replaced by Yemenis. In addition, UNFPA provides short-term and long-term training fellowships in management and supervision, with special emphasis on family planning; logistics; information and statistics; and referral systems.

WHO provides limited technical assistance, some fellowship grants and is planning to provide catalytic funds for management and planning activities.

World Bank has provided one loan for expansion of primary health care, including training of staff and construction of health facilities. A second loan for primary health care is now under discussion between Bank and ROYG officials.

The Netherlands a project in Dhamar which supports five health centers including separate training centers for male and female PHCWs. The project in Rada supports an integrated rural development project which includes health education and a PHC clinic. The Hodeidah project provides funding for two urban health clinics in poor districts and training of urban PHC workers.

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F. HEALTH MANPOWER INSTITUTE (HMI)

Chief Executive(s):

Director: Mr. Ahmed Abdul Qahir
Deputy Director: Mr. Abdulwahab Al-Kohlani
Director of Hodeidah HMI: Mr. Abdel Hakeem

Other Contact Persons:

Mr. Naji Assamawi, Head of Medical Assistant Department
Ms. Tahra Mohamed, Head of Midwifery Department

Type of Organization and Affiliation:

Health training institute, accountable to MOPH

Purpose:

The HMI (Sana'a and branches) trains health workers and auxiliaries for the public health system.

Organizational Structure:

HMI's main institute is in Sana'a, with branches in Hodeidah, Taiz, Dhamar and Hajjah. A new branch will open in Ibb at the end of 1991 and the goal is to have branches in each governorate. (A counterpart structure for the southern provinces is based in Aden but is not discussed here. Its characteristics will have to be examined during Phase I.) (See attached organization chart.)

Main Activities:

HMI was established in 1972 to train paramedical and auxiliaries entering the public health system. HMI Sana'a offers a wide variety of courses (see attached table) including nursing, midwifery, medical and pharmacy assistants and trainer/supervisors. HMI Sana'a also provides the MOPH with technical assistance for the training of primary health care workers (curriculum design and some training). HMI centers in Taiz, Hodeidah, Dhamar and Hajjah offer nursing training, while Taiz and Hodeidah also train midwives. Except for the midwifery course, the majority of students are male (see table), although HMI statistics do show a gradual increase in female students in nursing and other areas. This increase in female students is partly due to the provision of accommodations at the regional HMI

centers.

The courses shown in the table are each three years in duration, although practical nursing in Dhamar and Hajjah is only a one-year course. However, HMI reports high dropout rates on some courses. For example, in 1988 only 13 out of an original 44 midwifery students graduated. The overwhelming majority of midwifery students are urban and the demand for the course in Sana'a is increasing: out of 70 requests in 1989, 40 were accepted. The number of midwives in Sana'a has now reached such a level that there will be no student intake to this course for the academic year 1991/92, according to the HMI Director.

HMI provides a one-year training course for trainer/supervisors. The students in this course are nursing or midwifery graduates with at least one year of field experience. Upon completion of their training, the trainer/supervisors are responsible for training and/or supervising primary health care workers.

Admission requirements:
HMI admission requirements include General Secondary Education (High School) or Preparatory Education (Junior High School). Currently, preparatory education is a requirement for midwifery and female nursing students, as opposed to primary education only a few years ago when there were not enough female candidates. However, with the increasing school enrollment of girls, HMI is gradually able to raise its entrance requirements. In five years there will be a uniform admission requirement of secondary education. There is also an increased demand for admission into the midwifery department.

Training methods and capabilities:
In all HMI divisions, the curriculum is 60% theoretical and 40% practical training. Practical training takes place either in hospitals or at the HMI practical training site. HMI midwifery students occasionally receive training in family planning service delivery skills at the YFCA/Sana'a clinic.

HMI does not use a systematic approach to design instruction. The resource materials are not adequate for the different levels of trainers although the training materials are technically correct. The staff of some departments are experienced in materials development. However, HMI does not make these materials available to other agencies, either through donations or sales. The training curricula do not reflect a skills-based approach. Job descriptions do not exist for training staff and are not used in designing instruction.

Clinical service delivery training in birth spacing is fair, whereas the non-clinical service delivery training is not adequate. There is a need to expand the counseling training component of the HMI midwifery curriculum, including training in the use of IEC materials for client education.

HMI does not evaluate training and does not use evaluation as a tool for improvement. HMI does not maintain a training information system.

Equipment used by HMI during training includes 16 mm films, flip charts, overhead and slide projectors. It has its own half inch PAL/SECAM VHS VCR.

Staffing:

HMI has a total faculty of 73 around the country (see table for breakdown). All HMI Sana'a staff are Yemeni. HMI appoints at least one instructor/teacher from among its graduates every two years. Each instructor/teacher does a one-year post-graduate study covering his/her specialty and teaching methodologies. In the past, one-year fellowships were offered by the World Bank. However, this is no longer the case. Now a six-week training course is offered to all instructor/teachers to prepare them as qualified lecturers.

USAID Funded Projects and Activities:

Pragma Corporation worked with HMI faculty to develop a two-volume birth spacing module which is used as part of the training curriculum for midwives and nurses. The module is taught over a two year period and is also used as a base for teaching birth spacing to other HMI students as part of the health education course.

Pathfinder Fund provides technical assistance and training to strengthen the institutional capacity of the midwifery training program of HMI Hodeidah. A new curriculum has been developed and implemented and guides for teachers and students will be published during 1991/1992. Curriculum revision workshops are also scheduled with the participation of ten midwife tutors.

Pathfinder will also support (1991/92) an in-service training activity with HMI, aiming at upgrading the skills of six supervisors and 55 male and female primary health care workers in the governorate of Marib.

Other Donor Funded Projects and Activities:

WHO supported the establishment of HMI in 1972. It provides support through the purchase of books, reference materials and manuals. WHO also provides short-term fellowships for staff and assists in both conducting the medical assistant training and in completing its curriculum. However, WHO financial assistance has been temporarily suspended.

The World Bank is funding the construction of the new HMI Ibb facility. The Bank formerly provided one-year training fellowships for HMI faculty, but this has been discontinued.

UNFPA has worked with HMI to develop a training curriculum for female primary health care workers. UNFPA also supports a community health course for midwives and female nurses. The only course thus far runs from November 1990 to November 1991.

The Swedish project supports a one-year pediatrics nursing training at the Taiz HMI. The course runs from November 1990 to November 1991.

The Dutch project in Dhamar provided training equipment for nursing training and provided financial support for participants to be trained for three years in Sana'a as nurses and midwives.

COURSES OFFERED BY HMI CENTERS THROUGHOUT YEMEN

Course	Sana'a	Hodeidah	Taiz	Hajjah	Dhamar
Nursing	x	x	x	x	x
Midwifery	x	x	x		
Medical Asst.	x				
Pharmacy Asst.	x				
Laboratory Asst.	x				
Technical Asst.	x				
X-ray technician	x				
Anesthetist	x				
Equipment maintenance	x				
Sanitarian	x				
Trainer/supervisor	x				

STUDENT LEVELS ON SELECTED COURSES

Total Students					
Nursing					
female	31	34	27		2
male	93	102	64	20	38
Midwifery	53	53	28		
Medical Asst.					
female	6				
male	89				
Pharmacy Asst.					
female	3				
male	88				

STAFFING LEVELS

Staffing patterns (total faculty)	50	13	13	2	3

Source: HMI statistics

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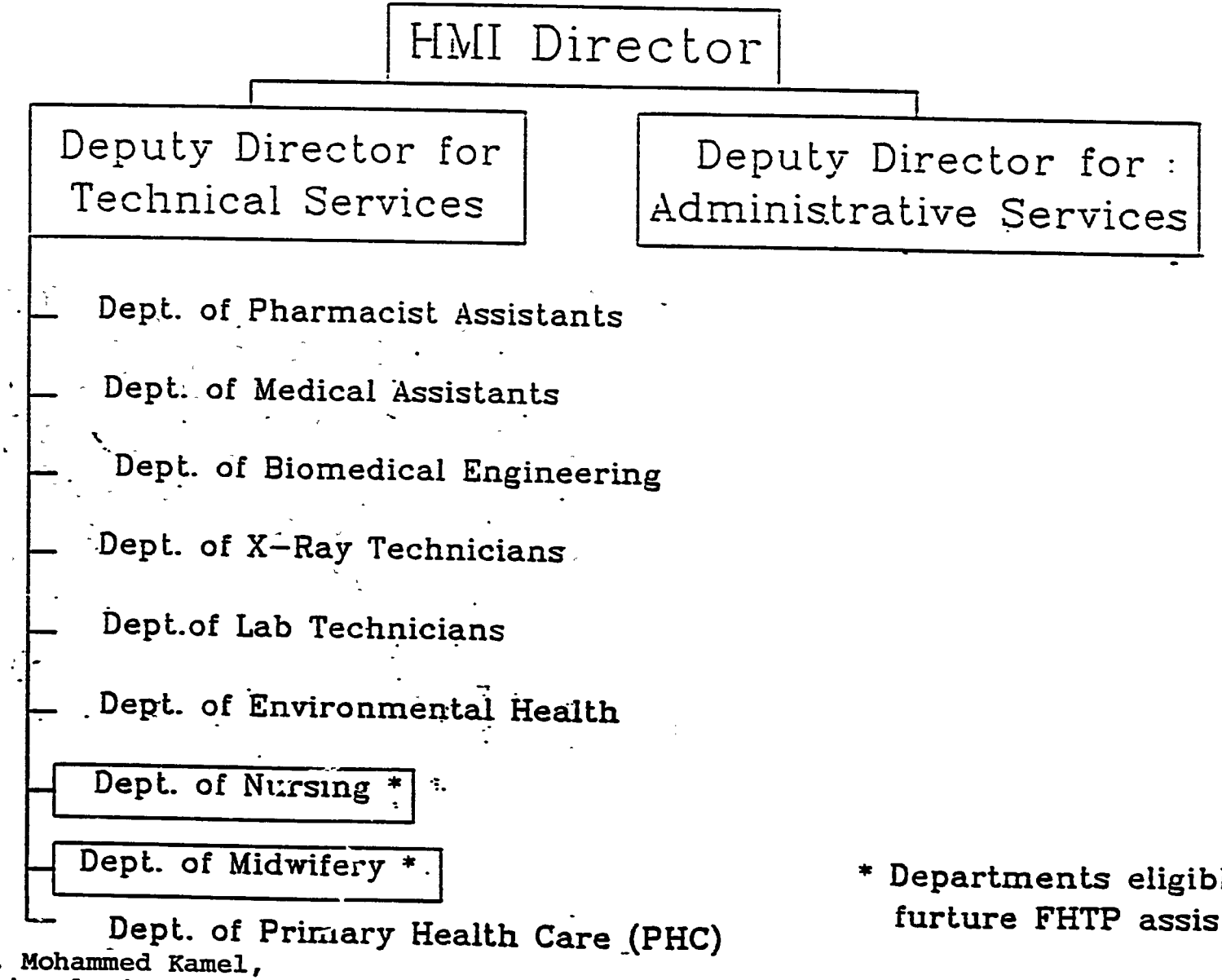
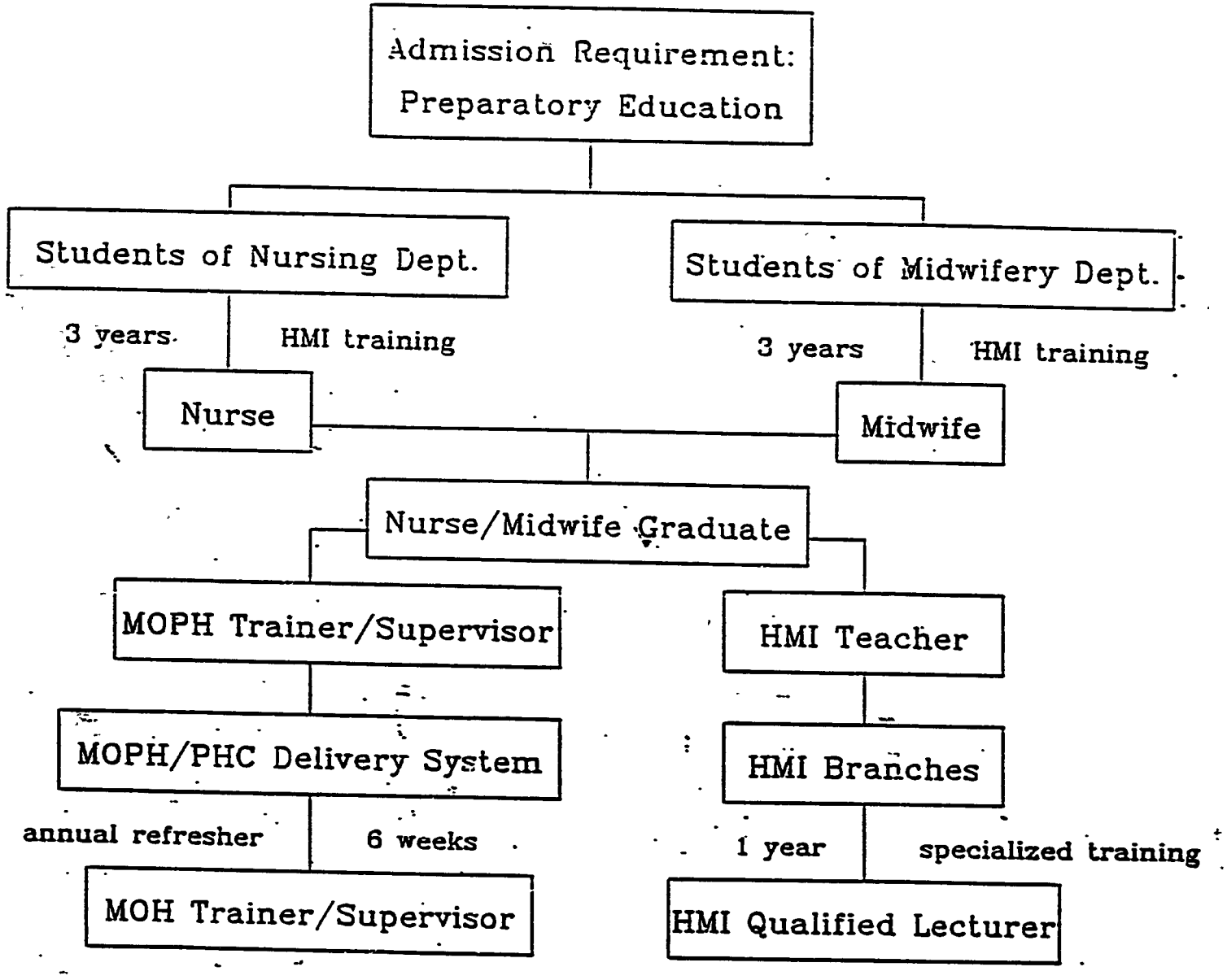
HMI Organizational Chart



* Departments eligible for furture FHTP assistance

Source: Dr. Mohammed Kamel,
Regional Director, PAC IIB -

HMI PRE-SERVICE TRAINING FOR NURSES & MIDWIVES



Source: Dr. Mohammed Kamel,
Regional Director, PAC IIB

G. UNIVERSITY OF SANA'A - SCHOOL OF HEALTH SCIENCES

Chief Executive(s):

Dr. Abubakr Al-Qirbi, Vice-Rector
Dr. Abdullah Al-Huraibi, Dean of the Faculty of Medicine

Other Contact Persons:

Type of Organization and Affiliation:

Pre-service training institute, accountable to the Ministry of Higher Education.

Purpose:

The School of Health Sciences trains physicians, pharmacists, registered nurses and medical technicians who work in the public and private sectors upon graduation.

Organizational Structure:

See attached organization chart.

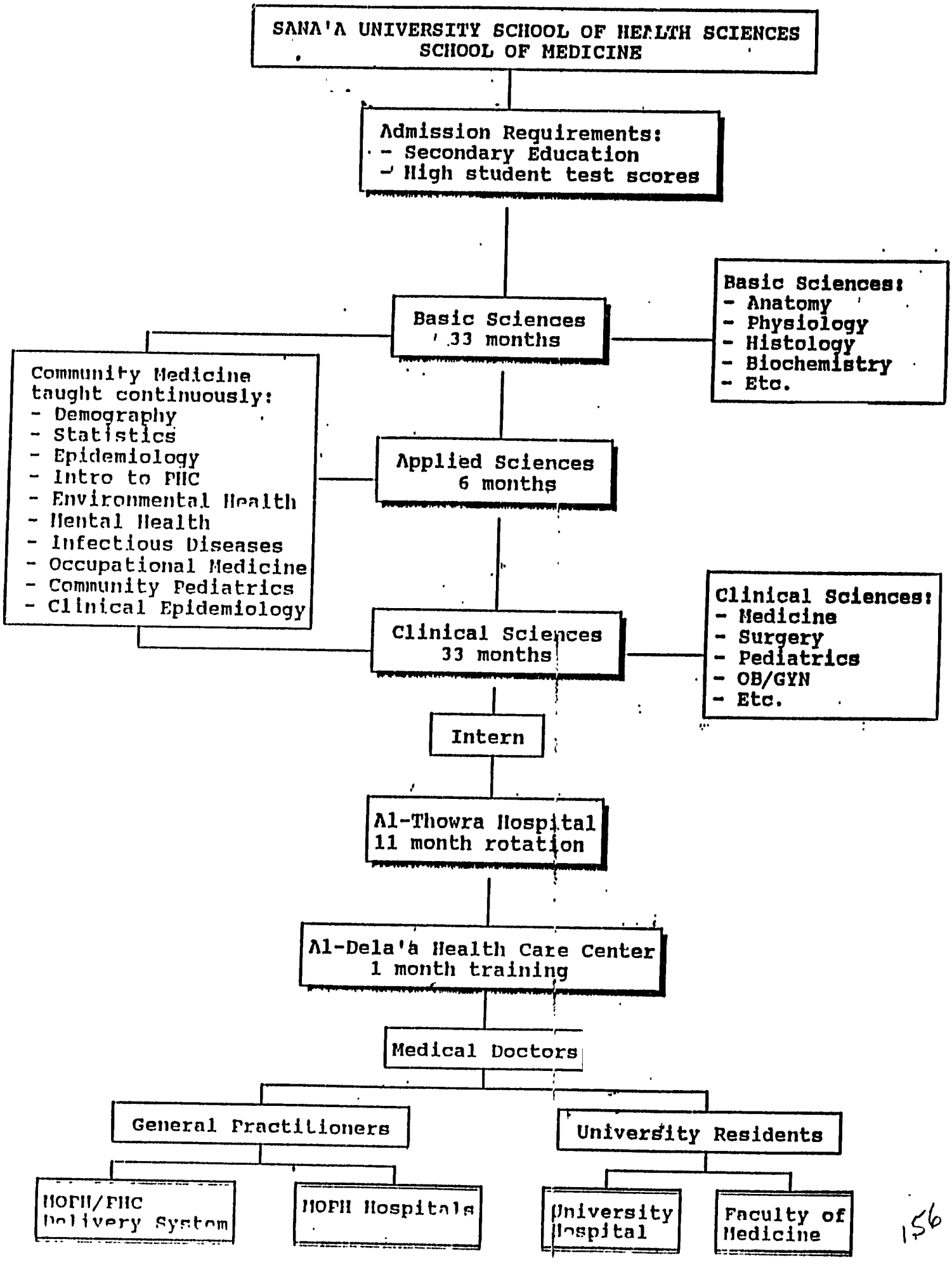
The School of Health Sciences has four faculties: medicine, pharmacy, nursing and medical technology.

Activities:

The **Faculty of Nursing** is a four-year program that leads to a B.Sc. in Nursing. Students are admitted after completing secondary education. The school is new and will commence its third year of activity in October 1991. There are 40 students (majority male) in each of the first two classes admitted so far. Upon graduation, students work in hospitals and other tertiary level of care facilities. They will have greater responsibilities than nurses graduating from the HMI. Birth spacing is not included in the nursing curriculum as yet, although the faculty seem open to the idea of developing modules.

The **Faculty of Medical Technology** graduates medical technicians with higher professional status than HMI graduates.

The **Faculty of Pharmacy** has three classes with 30 students in each. Birth spacing is not included in the teaching curriculum.


SANA'A UNIVERSITY SCHOOL OF HEALTH SCIENCES
SCHOOL OF MEDICINE
Admission Requirements:
- Secondary Education
- High student test scores
Basic Sciences
33 months
Basic Sciences:
- Anatomy
- Physiology
- Histology
- Biochemistry
- Etc.
Community Medicine taught continuously:
- Demography
- Statistics
- Epidemiology
- Intro to PHC
- Environmental Health
- Mental Health
- Infectious Diseases
- Occupational Medicine
- Community Pediatrics
- Clinical Epidemiology
Applied Sciences
6 months
Clinical Sciences
33 months
Clinical Sciences:
- Medicine
- Surgery
- Pediatrics
- OB/GYN
- Etc.
Intern
Al-Thowra Hospital
11 month rotation
Al-Dela'a Health Care Center
1 month training
Medical Doctors
General Practitioners
University Residents
MOPH/PHC Delivery System
MOPH Hospitals
University Hospital
Faculty of Medicine

The **Faculty of Medicine** has graduated three classes (July 1991). It is a seven-year medical school with over 50% female students. A total of 431 medical students (all Yemeni except for 34) were enrolled at the faculty during academic year 1987/88. Students are admitted to the medical faculty after obtaining a secondary school certificate, based upon their performance and exam results.

The medical curriculum consists of 33 months of basic sciences, 6 months of applied sciences, and 33 months of clinical sciences. Community medicine is taught to all students throughout the medical curriculum. After completion of the medical curriculum, students become interns and have an eleven-month internship at Al-Thowra Hospital and one month at the Al-Dela'a Community Health Center, which belongs to the faculty. Subsequent to their internships, interns graduate as medical doctors and become either general practitioners or university residents. General practitioners are employed in the MOPH/PHC service delivery system, while university residents are employed at the University Hospital or in the Faculty of Medicine.

Birth spacing is included in the faculty of medicine teaching curriculum, although no copies of the curriculum were available to assess the content matter. The Department of Community Medicine follows the skills-based and community-oriented approaches in its teaching, which includes demography, statistics, epidemiology, primary health care, environmental health and other subjects. While studying clinical sciences, medical students are introduced to the following community medicine topics: mental health, infectious diseases, occupational medicine, community pediatrics and clinical epidemiology. The Community Medicine Department is interested in introducing birth spacing issues into its curriculum and also wishes to use the Al-Dela'a Health Center as a practical training site where students can observe and practice the provision of high quality services.

Note: Aden University also has a medical faculty. It is not discussed here but its characteristics will be reviewed during the curriculum assessments in Phase I of the Project.

<u>Staffing</u>:

Faculty of Medicine: 40 Yemenis and 60 expatriates (1990)

Al-Dela'a Health Center: 7 physicians, 2 nurses, 1 nurse-midwife (Sudanese health visitor), and other support staff as well as visiting professors from the faculty of medicine.

USAID Funded Projects and Activities:

Under the bridging activities for the Options for Family Care project, USAID and JHPIEGO are sponsoring fellowships for ten faculty of medicine staff in the family planning training course at JHPIEGO's regional training center at Ain Shams University, Cairo. This training will be implemented in 1991/1992.

Other Donor Funded Projects and Activities:

UNFPA sponsored a two-year project to support the introduction of family planning and population studies into the curriculum of the faculty of medicine. The UNFPA project organized a workshop for instructors and faculty members of all departments. Issues discussed related to family planning and population dynamics. The project also sponsored the travel of a staff-member on a long-term fellowship to obtain an M.Sc. in Demography and Statistics. In addition, the project sponsored short-term regional training fellowships.

H. YEMEN DRUG COMPANY FOR INDUSTRY AND COMMERCE (YEDCO)

Chief Executive(s): Chairman, Engineer Haazem Baaker

Managing Director

Other Contact Persons: Dr. Ali Saleh al-Hamdani, General Manager
Dr. Ali ad Douwah, Manufacturing Director

Type of Organization and Affiliation:

YEDCO is the largest importer/distributor and the only pharmaceutical manufacturer in Yemen.

Purpose:

Established in 1964 to provide drugs for the Yemeni people at affordable prices.

Organizational Structure:

YEDCO is mixed public-private company with 51% Government and 49% private ownership. Distribution is managed by five YEDCO branches located in the major cities of Sana'a, Taiz, Ibb, Hodeidah and Haja, distribution stores in Dhamar and Al-Mahwit, YEDCO public pharmacies in Sana'a, Hada, Hodeidah, Haja, Sa'ada and Al-Mahwit and by the publicly owned National Drug Corporation in Aden. A local pharmaceutical manufacturing plant located in Sana's began production in 1983.

Main Activities:

YEDCO covers 60% of the total market needs for imported and locally manufactured drugs. It imports over 500 pharmaceutical drugs from 33 international companies and produces locally antibiotics, analgesics, vitamin capsules, elixirs, anti-histamines and cough syrups, anti-malaria and amebiasis drugs. Among its current imports are several brands of oral contraceptives and an IUD.

Staffing:

The company is run and managed entirely by Yemenis.

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USAID Funded Projects and Activities:

There are no USAID projects with YEDCO at present.

Other Donor Funded Projects and Activities

YEDCO has a project funded by UNICEF to pack and distribute ORS.

ANNEX F

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ANNEX F

Summary of Bridging Activities & CA Capabilities

1. Name of Project: **Family Planning Service Expansion and Technical Support (SEATS)**

Name of Contractor: John Snow, Inc.

Counterpart Institution: See description of individual activities

Duration: See description of individual activities

Summary of Bridging Activities:

A. Clinic Improvement Project/Cafeteria Approach: The objective of this activity is to improve the performance of 10 public, NGO, and private sector clinics and health centers delivering MCH/family planning services. Through a series of workshops and self-assessment activities, clinic staff will be trained in clinical and managerial techniques to improve their planning, implementation, and monitoring systems. The centerpiece of the activity is identification and provision of a "menu" of assistance tailored to the specific, self-identified needs of each clinic or health center. (Counterpart: Ministry of Planning and Development. Duration of Activity: October 1990-April 1992)

B. Training Workshop for General Practitioners and Pharmacists: The objective of this activity is to promote the practice of family planning in Yemen. The focus is on increasing the scientific knowledge and skills of physicians and pharmacists to help them provide adequate and appropriate information and counseling about family planning methods to their clients. (Counterpart: Union of Yemeni Physicians and Pharmacists. Duration: September 1990-February 1992.)

C. Production of an MCH/FP Flipchart: The purpose of the flipchart is to provide health practitioners with a tool to educate families about the family care choices available to them. The chart will include sections on counseling couples, safe motherhood, child health practices, and family planning methods. (Collaborators: YFCA, Health Education Department, UNICEF, and AVSC.)

D. Traditional Community Leaders KAP Survey (tentative): This activity is designed to gather sound information on perceived socio-cultural barriers to family planning service deliver in Yemen. The data gathered can then be used to design activities to address these barriers. (Counterpart: Population Studies and Research Center.)

2. Name of Project: **Association for Voluntary Surgical Contraception (AVSC)**

Name of Contractor: AVSC

Counterpart Institution: Yemen Family Care Association

Duration: July 1989-June 1992

Summary of Bridging Activities:

Voluntary Surgical Contraception Program: The objective of AVSC activities is to assist the YFCA in strengthening its capacity to conduct IE&C and training activities for medical and health care personnel with regard to family planning, including voluntary surgical contraception.

3. Name of Project: **Pathfinder Fund**

Name of Contractor: Pathfinder Fund

Counterpart Institution: See description of individual activities

Duration: See description of individual activities

Summary of Bridging Activities:

A. Curriculum Enhancement and Integration of Child Spacing Component into Midwifery Training (ACCS activity): This activity is designed to assist the HMI of Hodeidah in strengthening the institutional capacity of its midwifery training program. The intended output is an increase in the quality and quantity of trained midwives providing MCH services in the Tihama region. (Counterpart: Health Manpower Institute - Hodeidah. Duration: March 1989-June 1992.)

B. Institutional and Program Support to YFCA: This activity is intended to support the program activities and management capability of YFCA by investing in equipment, contraceptives supplies for 40 NGO and MOPH clinics, training, and IE&C. (Counterpart: Yemen Family Care Association. Duration: September 1990-June 1992.)

C. Refresher Training for Primary Health Care Workers: The objective of this activity is two-fold: 1) to strengthen the training capacity of the HMI through training of trainers, and 2) to develop and implement a training program for primary health care workers to increase their effectiveness in providing family planning education and services. (Counterpart: Health Manpower Institute. Duration: January 1991-June 1992.)

4. Name of Project: **Demographic and Health Surveys (DHS)**

Name of Contractor: Institute for Resource Development

Collaborating Institution: Population Studies and Research Center

Duration: August 1989-January 1992

Summary of Bridging Activities:

Yemen Demographic and Child Health Survey: In collaboration with the Arab League, this project is providing training and related services to develop the capabilities of employees within the PSRC and other appropriate agencies to conduct demographic, population, and health surveys and studies. A demographic and health survey will be carried out in the winter of 1991/92. The main objectives are: 1) to measure levels and determinants of fertility and infant, child, and maternal mortality and morbidity; and 2) to measure rates of contraceptive knowledge and contraceptive prevalence rates.

5. Name of Project: **Resources for the Awareness of Population Impacts on Development (RAPID III)/Options for Population Policy (OPTIONS II)**

Name of Contractor: The Futures Group

Collaborating Institution: Population Studies and Research Center/Central Statistics Organization

Duration: July 1989-October 1991

Summary of Bridging Activities:

RAPID/OPTIONS: These two activities are designed to strengthen the abilities of the PSRC/CSO to undertake policy analysis and presentations through training its staff, providing computers, updating relevant data, and developing a planning model that can be adopted at both the national and governorate levels.

6. Name of Project: **Population Communication Services (PCS)**

Name of Contractor: Johns Hopkins University

Counterpart Institution: Health Education Department, Ministry of Public Health

Duration: July 1990-October 1991

Summary of Bridging Activities:

Readiness Campaign for Male Leaders, Married Women, and Clinics: This activity has two objectives: 1) to increase male decision-makers understanding and acceptance of family planning and set the stage for implementation of a comprehensive IE&C program, and 2) to strengthen awareness among providers and users.

Production of the focus group research on attitudes of women and male opinion leaders on family planning. (August 1991)

Production of a documentary TV spot for decision makers on the urgency of adopting family planning as a national policy in Yemen. The spot will be shown during the National Population Policy Conference in late October 1991. (August-October 1991)

Production of an information booklet on family planning for decision makers which will be distributed to participants of the National Population Policy Conference. (August-October 1991)

Organize a family planning information center at the National Population Policy Conference, in collaboration with UNICEF, to sensitize participants to the theme of family planning and the role of IEC in promoting the concept and the services. (August-October 1991)

7. Name of Project: **Program for International Education in Gynecology and Obstetrics (JHPIEGO)**

Contractor: Johns Hopkins University

Counterpart Institution: Faculty of Medicine, University of Sana'a

Duration: June 1990-May 1992

Summary of Bridging Activities:

Reproductive Health Training Program: This project provides support for up to 14 physicians and two nurses to participate in 4-6 week training courses in family planning for service providers. The objective of the training is to develop a group of resource persons for the medical community by upgrading and updating family planning skills and knowledge for both classroom and clinical settings.

8. Project Name: **Contraceptive Social Marketing II (SOMARC)**

Contractor: The Futures Group

Duration: July 1-14, 1991

Summary of Activities:

Contraceptive Supply Assessment: As part of the PP design process, the Mission asked SOMARC to sponsor and undertake an assessment of the contraceptive distribution system in Yemen. The assessment team examined the legal and regulatory structure governing supply and distribution of contraceptives, the current status of the public and private sector systems of supply and distribution, the capability of the private sector to the be primary source of supply, and the kinds of activities the Mission should support to work most effectively with the private sector. The team's findings form the basis of the design of the commercial marketing component of the project.

9. Project Name: **Family Planning Training for Paramedical, Auxiliary, and Community Personnel (PACIIb)**

Contractor: Development Associates/Pathfinder Fund

Duration: May 12-29, 1991

Summary of Activities:

Training Needs Assessment: The purpose of this activity was to conduct a detailed training needs assessment that would provide input for the design of the skills development/service delivery component of the project. The consultant met with a variety of organizations in the public and private sectors that conduct training activities in the health/population field and with other donors. Several of the activities described in the skills development/service delivery section (Section IV.C.3) of the PP have been designed to respond to the needs identified by the consultant.

10. Project Name: **Demographic Data Initiatives (DDI)**

Contractor: U.S. Bureau of the Census (BuCen)

Counterpart Institution: Central Statistics Organization

Duration: October 1990 - March 1992

Summary of Activities:

Small Research and Investigative Studies: Through the ANE Regional Population Project, BuCen is providing assistance with a number of small, focused research activities. In particular, BuCen is providing training in sampling techniques and TA with a labor force survey and a family budget income survey. Other studies may include an analysis of urbanization trends in Yemen; internal and external migration; population, employment and health surveys at the governorate level; urban KAP surveys; male attitudes concerning family health and population problems; and sociological surveys in small rural villages to obtain data on health, family welfare, employment, education and women's status to help in planning rural development programs.

ANNEX G

WORKPLAN FOR OPTIONS FOR FAMILY CARE PHASE I ACTIVITIES
October 1,1991 - September 30,1993

OBJECTIVE & IMPLEMENTATION ACTION	ACTION DATE	LEAD AGENCIES
A. General		
1. Authorize Project Paper	Sept. 1991	USAID
2. Sign Agreement/Obligate FY91 funds	Sept. 1991	USAID/MPD
3. Agree on initial scopes of work	Sept. 1991	USAID/MPD/Implementing Agencies/CAs
4. Prepare PIO/Ts for Phase I buy-ins	Oct. 1991	USAID
5. Conduct initiation seminar for project and meetings with all CAs	Jan. 1992	USAID/MPD
6. Sign Agreement/Obligate FY92 funds	Feb. 1992	USAID/MPD
7. Sign Agreement/Obligate FY93 funds	Feb. 1993	USAID/MPD
8. Collect data for evaluation workshops	Feb. 1993	Implementing Agencies/CA's
9. Conduct evaluation workshop for Phase I draft Phase II workplan plan	April 1993	USAID/MPD/CA's
10. Agree on Phase II workplan/scopes of work	May 1993	Implementing Agencies
11. Prepare PIO/T's for Phase II	June 1993	USAID
B. Data Collection and Policy Analysis Objectives		
1. Complete DHS and secondary analyses		
a. Complete DHS fieldwork (bridging)	March 1992	CSO/CA
b. Complete preliminary DHS analysis	May 1992	CSO/CA
c. Define framework for secondary analysis	June 1992	CSO/CA
d. Complete and publish final DHS report	Sept. 1992	CSO/CA
e. Complete 3 secondary analyses of DHS	Sept. 1993	CSO/CA
2. Train five staff in statistics and MIS		
a. Identify 2 persons for 11 mo.BUCEN course on Sampling and Statistical methods	Dec. 1991	CSO

OBJECTIVE & IMPLEMENTATION ACTION	ACTION DATE	LEAD AGENCIES
b. Identify 1 person for 9 mo. BUCEN course on Health Manpower Information Systems	Dec. 1991	MOPH
c. Enroll candidates in local English Language training as needed	Jan. 1992	USAID/CSO/MOPH
d. 3 participants depart for U.S.	July 1992	USAID/CSO/MOPH
e. Identify 2 more participants	Aug. 1992	CSO/MOPH
f. Enroll in English classes as needed	Oct. 1993	USAID/CSO/MOPH
g. 1st group returns from U.S.	June 1993	USAID/MOPH
h. 2nd group departs for U.S.	July 1993	USAID/CSO/MOPH
i. Identify 3rd group of participants if if evaluation workshops call for continuation in Phase II	Aug. 1993	CSO/MOPH
j. 2nd group returns from U.S.	June 1994	USAID/CSO/MOPH
3. Initiate implementation plan for policy analysis		
a. National population conference held	Oct. 1991	MPD/CSO/PSRC
b. National population policy approved	Oct. 1991	ROYG
c. Develop policy implementation plan	Nov. 1991-Jan. 1992	MPD/CSO/PSRC, other Ministries/CA
d. Initiate implementation of plan	Feb. 1992	"
e. Tracking system for policy implementation in place	June 1992	MPD/CSO/PSRC/CA
f. Plan policy workshop/opinion leaders	June 1992	MPD/CSO/PSRC/CA
g. Conduct workshop	July 1992	MPD/CSO/PSRC/CA
h. Collect data on policy progress for evaluation workshops	March 1993	MPD/CSO/PSRC/CA
i. Plan policy workshop/trade, contraceptive commodity importation	May 1993	MPD/CSO/PSRC/CA/other Ministries
j. Conduct workshop	July 1993	"
C. Awareness-raising and Communications		
1. Increase data base for IE&C development		
a. Initiate KAP and media habits surveys	Jan. 1992	MOI/CSO/CA
b. Surveys&analyses completed&published	Aug. 1992	"

OBJECTIVE & IMPLEMENTATION ACTION	ACTION DATE	LEAD AGENCIES
2. Initiate discussions to improve awareness and support of opinion leaders		
a. Organize and conduct project orientation workshop for media officials and opinion leaders (same as A.5.)	Jan. 1992	MOI/MPD/USAID/CA
b. Organize and conduct 2 workshops for governorate leaders	Oct. 1992	MOI/CA
c. TV & news coverage of population issues and provision of background material for reporting	ongiong	MOI/CA
d. Plan & begin research on TV messages	Nov. 1992	MOI/CA
e. Training course for print and media reporters on population/family planning issues	Dec. 1992	MOI/CA
f. IE&C evaluation seminar for governorate leaders	Sept 1993	MOI/CA
3. Develop materials to improve awareness and support of family care providers		
a. Initiate testing of existing materials for use by providers	Feb. 1993	MOPH/CA
b. Initiate development of new materials (video/print) for use by providers	Oct. 1993	MOPH/CA
4. Develop materials to improve awareness of potential users		
a. Initiate development of logo	Oct. 1991	MOI/MOPH/CA
b. Start pre testing of logo	Jan. 1992	MOI/MOPH/CA
c. Produce logo for distribution	Dec. 1992	MOI/MOPH/CA
j. Initiate development of family care song	Dec. 1992	MOI/MOPH/CA
k. Test song	Jan. 1993	MOI/MOPH/CA
l. Initiate research for development of generic TV messages	Jan 1993	MOI/MOPH/CA
i. Initiate research and script development for TV drama(s)	April 1993	MOI/MOPH/CA

OBJECTIVE & IMPLEMENTATION ACTION	ACTION DATE	LEAD AGENCIES
5. Initiate development of Centers of Excellence for family care		
a. Select 2 YFCA clinics	March1992	MOPH/YFCA
b. Complete plans for development of Centers of Excellence (CEs)	June 1992	MOPH/YFCA/CA
c. Complete assessment of training needs of CE staff and develop training plan	Aug. 1992	YFCA/MOPH/CA
d. Conduct survey of CE equipment needs	Aug. 1992	YFCA/MOPH/CA
e. Start Procurement of equipment and supplies for CEs	Sept 1992	USAID
f. Start training staff at Centers	Dec. 1992	YFCA/MOPH/CA
g. Initiate materials testing (existing) and development (new)	Feb. 1993	YFCA/MOPH/CA
h. Develop plan for outreach worker recruitment and training	June 1993	YFCA/CA
D. Skills Development and Service Delivery		
1. Define needs for improving pre-service training for family care		
a. Conduct survey of training institutions for existing curricula on birth spacing and maternal health	Nov. 1991	MOPH/HMI/ Universities/CA
b. Distribute draft report for comments	Jan. 1992	"
c. Plan and conduct meeting of donors present findings and secure donor support for future interventions	April1992	"
2. Train 10 additional faculty/trainers in Family Care Provision		
a. At least 10 faculty/trainers go for training at JHPIEGO Regional Center in Egypt ("bridging" funds)	Oct.& Nov. 1991 Jan.& Apr.& June 1992	Universities/YFCA/ CA
b. Monitor and evaluate trainees	Aug. 1992	"
c. Select 10 additional faculty/trainers for JHPIEGO Regional Center in Egypt	Oct. 1992	"
d. Participant training in Egypt	various 1993	"

OBJECTIVE & IMPLEMENTATION ACTION	ACTION DATE	LEAD AGENCIES
3. Train 30 female practitioners in IUD insertion		
a. Identify 30 female practitioners for 3-week training course in IUD insertion in Tunisia	Dec. 1991	MOPH/HMI/YFCA
b. First 15 participants trained	Feb. 1992	USAID/CA
c. Second 15 participants trained	March1992	USAID/CA
d. Monitor trainees and conduct evaluation of training	July 1992-ongoing	MOPH/HMI/YFCA/USAID/CA
4. Provide in-country family care training for 20 midwives		
a. Evaluate bridging midwife training activity and refine program accordingly	Aug. 1992	HMI/YFCA/CA
b. Identify participants and venue	Oct. 1992	HMI/YFCA/CA
c. Conduct two @ 4 day workshops (10 midwives in each)	Feb. 1993	HMI/CA
d. Monitor trainees (bridging and new)	ongoing	HMI/CA
e. Evaluate training and start to identify participants and venue for refined activity if project evaluation calls for continuation.	May 1993	HMI/YFCA/CA
5. Provide supervisory and PHCW family care skills training in two governorates		
a. Assess training completed in bridging activity in Marib and refine program accordingly	June 1992	HMI/CA
b. Identify two governorates and do assessment visits	July 1992	MOPH/HMI
c. Start training	Sept 1992	HMI/Gov. Health Office(GHO)/CA
d. Monitor trainees in three governorates	ongoing	HMI/Gov Health Office
e. Evaluate training	March1993	HMI/GHO/CA
f. If evaluation calls for continuation identify two more governorates and refine program appropriately for Phase II	May 1993	MOPH/HMI/CA

OBJECTIVE & IMPLEMENTATION ACTION	ACTION DATE	LEAD AGENCIES
6. Introduce concept of Governorate training team approach in three governorates		
a. Complete program plan, venue and participants selection	April1993	MOPH/HMI/Governorate Health Office(GHO)/CA
b. Conduct 3 introductory workshops in three governorates	July 1993-Aug 1993	HMI/GHO/CA/YFCA
7. Refine and expand clinic improvement program (cafeteria approach)		
a. Implement workplans produced at bridging workshop(Aug'91) for initial clinics	Oct 1991 March1992	MOPH/GHO/CA
b. Identify 10 additional clinics and 3 local trainers of OJT	Jan 1992	MOPH/HMI/YFCA/CA
c. Evaluation workshop for initial clinics	April1992	MOPH/CA
d. Pre-workshop clinic assessments	May 1992	MOPH/GHO/CA
e. Conduct clinic improvement workshops	June 1992	MOPH/CA
f. Start implementation of workplans	July 1992	MOPH/GHO/CA
g. Monitoring of all program clinics	ongoing	MOPH/GHO/CA
h. Evaluation workshop for 2nd round of clinics	Jan. 1993	MOPH/CA
i. If evaluation calls for continuation identify 10 new clinics and refine program appropriately	April1993	MOPH/HMI/YFCA/CA
8. Provide in-country family care refresher courses to 100 physicians		
a. Complete agenda, venue and development of technical and counseling materials for workshops for physicians	April1992	YPPU/CA
b. Conduct @2 day workshops in 5 different locations (@10 physicians each)	July 1992	YPPU/CA
c. Evaluate workshops (duration, material, and agenda) an refine appropriately	Aug 1992	YPPU/CA
d. Identify 5 locations and participants for next round of workshops	Sept 1992	YPPU/CA
e. Conduct 5 additional workshops	Oct. 1992	YPPU/CA

OBJECTIVE & IMPLEMENTATION ACTION	ACTION DATE	LEAD AGENCIES
f. Evaluate impact of workshops and refine program accordingly	Jan 1993	YPPU/MOPH/CA
g. Identify additional venues and participants if continuation called for by project evaluation	April1993	YPPU/CA
9. Strengthen USAID capacity to monitor training programs		
a. Begin procurement of vehicle	Nov. 1991	USAID
b. SOW for training officer approved	Nov. 1991	USAID
c. Position advertised	Feb 1991	USAID
d. Candidates interviewed and ranked	April1991	USAID
e. Candidate selected and hired	July 1991	USAID
E. Commercial Marketing		
1. Initiate planning of commercial marketing program and assess viability		
a. Develop questions for inclusion in KAP survey to test market preferences	Jan. 1992	CA
b. Conclude agreement with YEDCO for implementation of commercial marketing	Jan. 1992	CA/YEDCO
c. Plan and conduct evaluation of commercial marketing program	April1993	USAID/YEDCO/CA
d. Design workplan for Phase II activities	June 1993	USAID/YEDCO/CA
2. Train 100 pharmacists in family planning methods		
a. Design training courses for pharmacists	April1992	CA/YPPU
b. Develop and test training materials	May 1992	CA/YPPU
c. Identify training locations, local trainers and pharmacists	June 1992	CA/YPPU
d. Conduct training of trainers workshop	July 1992	CA/YPPU
e. Ten one day workshops for pharmacists completed	Dec. 1992	CA/YPPU

OBJECTIVE & IMPLEMENTATION ACTION	ACTION DATE	LEAD AGENCIES
f. Evaluate training program	April1993	CA/YPPU
i. If evaluation calls for continuation, identify additional locations, pharmacists and revise program accordingly	June 1993	YPPU/USAID
i. Develop training plan for Phase II	Sept.1993	CA/YPPU
3. Develop advertising campaign for Commercial Marketing		
a. Develop advertising strategy	Feb. 1992	YEDCO/CA
b. Develop point of purchase materials for sellers and customers	March1992	YEDCO/CA/UNICEF
c. Test and refine materials	May 1992	YEDCO/CA
d. Produce and distribute materials	June 1992	YEDCO/CA
e. Develop other advertising materials for mass media use	March1992	YEDCO/CA
f. Test and refine materials	May 1992	YEDCO/CA
g. Produce materials	June 1992	YEDCO/CA
h. Initiate mass media advertising	Aug. 1992	YEDCO/CA
i. Evaluate advertising campaign	Aug. 1993	YEDCO/CA
j. If evaluation calls for continuation refine program appropriately and prepare advertising strategy for Phase II	Sept 1993	YEDCO/CA
4. Develop contraceptives sales plan		
a. Complete survey of pharmacy stocks of contraceptives	March1992	YEDCO/CA
b. Develop procurement, detailing and packaging plan for contraceptives	April1992	YEDCO/CA
c. Design contraceptives packages and inserts	July 1992	YEDCO/UNICEF/CA
d. Test and produce packages & inserts	Aug. 1992	YEDCO
e. Order initial supply of IUDs	Oct. 1991	USAID
f. Order contraceptives through commercial channels	continuing	YEDCO

OBJECTIVE & IMPLEMENTATION ACTION	ACTION DATE	LEAD AGENCIES
g. Distribute contraceptives to participating pharmacies	continuing	YEDCO
h. Product launch	Dec. 1992	YEDCO
i. After reviewing DHS preliminary results order 1993 supply of A.I.D. contraceptives	March1992	USAID
j. Conduct store audits, order 1994 supply of contraceptives	March1993	USAID

F. Multi-sectoral Linkages

No activities are planned for Phase I.

Annex H

Suggested areas of Investigation for Mid-term Evaluation

Mid-term evaluation questions important in determining whether Part II of Options for Family Care project should be funded.

1. What are the prospects for increasing the average birth interval by six months by the end of Part II? Is there evidence that the birth interval has been extended at all since the beginning of Part I? If yes, Is there any evidence that the project contributed to this change, or was it due to exogenous factors?

2. What are the prospects for reducing the proportion of high risk pregnancies by 25 percent by the end of the second part of the project? Is there evidence that the proportion of high risk pregnancies has been reduced since the beginning of Part I? If yes, is there any evidence that the project contributed to this change?

3. What are the prospects for realizing a 25-percent decline in infant and maternal mortality by the end of Part II? Is there any evidence that such mortality has been reduced at all since the start of Part I? If yes, what has been the project's contribution to this reduction?

4. What is the likelihood of achieving a 20-percent contraceptive prevalence rate in urban areas by the end of Part II? Is there any evidence of CPR increase in urban or rural areas since the start of the project? If yes, what has been the project's contribution to this increase?

5. What are the prospects for reducing the total fertility rate from 8.3 children per woman at the beginning of Part I to 6.5 by the end of Part II? Is there any evidence that the TFR is declining at all? If yes, can the project's activities be related to this decline? How?

6. What is the likelihood for doubling in Yemen the awareness of methods, sources, and advantages of family care (family planning) by the end of Part II? Has there been any change in this regard since the start of Part I? If yes, what has been the project's contribution to this increase?

7. The Outputs for each component of the project are explicit. Which ones have seen progress towards their realization since the beginning of Part I? What are the prospects for achieving all or some of the Outputs by the end of Part II?

8. Has the Mission adequately managed the project? What changes are appropriate to facilitate success by the end of Part II?

9. Has the rolling 18-month evaluation and restructuring procedure operated satisfactorily during Part I? Is more or less implementation flexibility appropriate?

10. Has the Yemeni Government shown full commitment to the project and its policy underpinnings? If not, what can the Mission do to improve the situation? Are there any Yemeni Government actions or inactions which are fatal or seriously debilitating to important aspects of the project or threatening their successful completion by the end of Part II?

ANNEX I. BIBLIOGRAPHY

aron, Albert R., Elizabeth Bennour, and Nancy P. Harris. August 1990. roposed USAID/Yemen Population Strategy Statement. Arlington, VA: Dual an ssociates.

entral Statistics Office. 1991.

estler, Harriett, et al. November 1990. Preparing for the Twenty-first entury: Principles for Family Planning Service Delivery in the Nineties. ashington, D.C.: Family Planning Services Division, Office of Population, U.S. gency for International Development.

arah, Abdul Aziz M. April 1991. Towards Population Policy Development in emen. Sana'a, Yemen: Population Studies and Research Center.

ossain, Md. Mukarram. May 1991. "Economic Potential of Introducing ppropriate Irrigation Systems at the Farm Level: A Case Study." Paper resented at the Seminar on Economic and Social Issues in Water Resources a evelopment in Yemen. Sana'a, Yemen.

PTIONS Database. May 1990. Washington, D.C.: Population Reference Bureau

RAPID. 1982. Women in Yemen: Increasing the Labor Potential. Washington, D.C.: The Futures Group.

World Bank. 1990. Republic of Yemen Human Resources: Development, Issues and Prospects. Washington, D.C. (1990a)

World Bank. 1990. Social Indicators of Development. Baltimore: Johns Hop Press. (1990b)

World Bank. 1990. Yemen Arab Republic: Utilizing Women for National Development. Washington, D.C. (1990c)

Yemen Arab Republic Fertility Survey 1979. 1983. (Volume I: Survey Design and Findings). Sana'a, Yemen: Central Planning Organization.

World Bank. 1991. Republic of Yemen: Human Resources Sector Survey. Washington D.C..

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