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**CENTER FOR INTERNATIONAL DEVELOPMENT
RESEARCH TRIANGLE INSTITUTE**

***LIMITED SCOPE
HEALTH SECTOR ASSESSMENT
FOR THE USAID MISSION TO YEMEN***

March 19 - April 25, 1992

LIMITED SCOPE HEALTH SECTOR ASSESSMENT
FOR THE USAID MISSION TO YEMEN

A Report Prepared for
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by the

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ACRONYMS AND GLOSSARY

ACCS	Accelerated Cooperation for Child Survival (USAID Project)
CS	Child Survival
CDD	Control of Diarrheal Diseases
CSO	Central Statistical Organization
DG	Director General
EPI	Expanded Program for Immunization
FC	Family Care (as used in the report synonymous with Family Planning)
FPHCW	Female Primary Health Care Worker
HE	Health Education
HEALTHCOM	Health Communication. Academy for Educational Development (Buy-in contractor under ACCS Project)
HIS	Health Information System
HMI	Health Manpower Institute
IEC	Information - Education - Communication
KAP	Knowledge, Attitudes and Practice
LCCD	Local Council for Cooperative Development
LBA	Licensed Birth Attendant
MCH/FC	Maternal and Child Health/Family Care
MPHCW	Male Primary Health Care Worker
MOI	Ministry of Information
MOPH	Ministry of Public Health
NEDS	National Epidemiologic and Disease Surveillance Program (under the ACCS Project)
OFC	Options for Family Care (USAID Project)

PACD	Project Assistance Completion Date
PASA	Participating Agency Services Agreement
PDRY	People's Democratic Republic of Yemen (presently Southern Governorates)
PHC	Primary Health Care
PHCUnit	Primary Health Care Unit
REACH	Resources for Child Health (John Snow, Inc. Buy-in contractor under ACCS Project)
ROY	Republic of Yemen (Unified Nation)
SEATS	Family Planning Service Expansion & Technical Support (John Snow, Inc. Buy-in contractor under Options for Family Care Project)
TA	Technical Assistance
TBA	Traditional Birth Attendant
TOT	Training of Trainers
VHC	Village Health Committee
WID	Women in Development
YAR	Yemen Arab Republic (presently Northern Governorates)
YEDCO	Yemen Drug Company
YFCA	Yemen Family Care Association

EXECUTIVE SUMMARY

In its 1992-97 Management Implementation Plan, the USAID Mission to Yemen has reconfirmed its commitment to the health and population sector. In March, 1992 this commitment was further strengthened with the posting of an experienced, Health-Population-Nutrition Officer as a resident member of the Mission staff. In addition, there are two foreign service nationals in the project support office.

As part of this commitment, USAID arranged for this Limited Health Sector Assessment.

On the basis of three intensive weeks of interviews, literature review and observations in the field, the Team identified a number of critical issues which have a bearing on the final recommendations, along with the strategies and structure needed to implement them.

In all, 16 issues were identified. They are discussed in Section 5 of this report. Following each discussion, conclusions are stated.

RECOMMENDATIONS

Below are the more important recommendations. Each is based on whether it will require: (1) policy decisions, (2) structural (or institutional) change, and/or (3) programmatic change.

1. Integration of Maternal and Child Health with Family Care

Thirteen interventions are recommended to integrate Maternal and Child Health with Family Care. This integrated approach is workable, efficient and effective in all areas: training, health education, logistics and supply, health information, village health committees, planning and budgeting, team management and supervision, or marketing commodities through the private sector. Both MCH and FC share the same target groups. Health managers and providers can effectively deal with them as one.

Implementation of this approach, will require policy decisions on the part of the Government, and structural and programmatic change within the implementing ministries and linkages among them.

2. Accessibility to Mother, Child and Family Care Services

Accessibility is important, especially in Yemen. A number of barriers limit the Yemeni people from gaining access to their health system. These are: (a) physical barriers (the rough mountainous terrain, scattered settlements), (b) technical barriers (overtaxed, under trained health providers), (c) management barriers (lack of health/management information, lack of supervision, inadequate supply system), and (d) cultural barriers (lack of adequate numbers of female health workers to serve women and children and high illiteracy, particularly among rural women).

Therefore, USAID in its new Management Implementation Plan has set an objective to "increase access to and participation in MCH and family care programs".

This approach conforms to existing government policy, structure and programs.

3. Decentralization

The present USAID Child Survival Project (ACCS) is concentrating at the Governorate level, rehabilitating Health/Training Centers and training Primary Health Care Workers which has proven effective. It has been adopted by other donors including UNICEF which is allocating 23% of its \$21.5 mns budget for 1993-97 to four Governorates.

The Team recommends that work be concentrated in five Governorates (the present four, plus one in the southern Governorates). The village level interventions should involve only a small number of villages.

Implementation of this strategy will require programmatic change, and the delegation of authority.

4. Alternative Resources for Health

Due to the severe limitations placed on government finances, new mechanisms for funding health and other social services are needed.

Yemen has a long and proud tradition of independence and self-help. The Local Councils for Cooperative Development have shared 50% of the cost of building most of the Primary Health Care Units in the northern governorates. In the southern governorates, there is a long tradition of volunteerism. There is a growing interest in fees-for-service and health insurance for government employees. The private health sector is dynamic and growing.

The Team members believe that health care starts with the individual, then the family, followed by the community, and

finally the health system. Therefore, the recommended interventions are designed to tap this potential within the people. These include Village Health Committees, training and supporting Licensed Birth Attendants, volunteer Health Guides, and alternative financing schemes at the local level.

Policy-level decisions by Government will be necessary to adopt this approach.

5. Sustainability

Given the high rate of inflation (reportedly 39%), plus the high population growth rate, compounded by the returnees, the Government capacity to absorb and maintain donor proposals is limited. Thus the Team considered sustainability a major factor in its decision-making, and an important criterion in selecting the interventions.

Government budgetary policy will be required to commit the recurrent funds required to sustain each intervention after foreign assistance is phased out.

6. Management

With the myriad of problems facing the health services of Yemen and the complexity of government itself, the Team recommends improving the managerial capability of the MOPH. Concern about management was expressed in every Team interview.

In recognition of this need, the Team recommends six management interventions. These include the design and implementation of a simple, standardized, Health Information System which will include Epidemiologic Surveillance. This is perhaps the most ambitious intervention. It will require a national framework before it can be implemented at the governorate level. It is essential to the health services, since without reliable information, no rational planning and decision-making can take place.

This will require structural change within the MOPH.

IMPLEMENTATION

How can the recommended interventions be effectively and efficiently implemented? The Team spent much time working with the new Health-Population-Nutrition Officer in designing a management model which is based on a strategy and organizational structure.

With current USAID contractual commitments in Child Survival coming to an end, and with the new Options for Family Care Project just beginning, this appears to be the ideal time to move forward with the fully integrated approach recommended above.

(See the structural diagram in Section 6).

This integrated MCH/FC strategy has three main parts:

Part I:

A shift away from the present practice of utilizing numerous short-term consultants to using resident specialists ("Associates") is recommended. Following the transitional period, five long-term associates are recommended: a Senior MCH Associate/Team Leader with associates for Management, Nursing/Midwifery, Health Education and HIS/Disease Surveillance. These long-term associates will not necessarily serve for five years. The Team Leader will serve five years, the Management Associate four years, and the others three years each. This amounts to a full-time equivalent of 3.6 persons. There would also be three Governorate Associates (to serve 5 governorates) who would share both technical and managerial responsibilities and serve as counterparts to the DG of the Governorate Health Office. The number of short-term consultants would be kept to a minimum.

This approach makes more efficient use of resources, and facilitates management.

Part II:

Create a balance between Child Survival and Family Care activities. Under the proposed strategy the Family Care work will be reduced in scale and phased over time. The present plan for the Options for Family Care Project is clearly a serious overload. With the resident associates noted above, much of this work can be assumed by them. When special services are required (for example, the RAPID III presentation and the demographic work planned by the U.S. Bureau of the Census) they can be arranged under the direction of the resident associates. Whenever possible all work will be on an integrated (MCH + FC) basis.

Focus will be on service delivery.

Part III:

Starting with the transitional period (beginning 1 July 1992) one contractor with one senior Team Leader as "Chief of Party" will be responsible for management, with USAID retaining a firm monitoring and evaluation role.

As an essential aid to implementation, a workplan will be drafted, which will be coordinated with the implementing ministries, NGOs, and other donors.

THE INTERVENTIONS

The Team is recommending 13 specific interventions: four in training, three in the community and six in management. (One of the training interventions and one of the management interventions are also at the community level - Training of LBAs and Alternative Financing). The Team members believe that all of the interventions are achievable within a 3 to 5 year time frame. They have been assigned priority rankings so that adjustments can be made when the cost of each has been determined and the workplan formulated.

Basic concepts underlining the choice of the interventions include (1) focus on the Governorate level to strengthen services delivery, and (2) facilitation of community participation to help build a strong community base for primary health care and family planning within the family, home and village.

Each intervention states the Mission's Program Objective and Sub-Objective, and lists Activities, Performance Indicators and Impact Indicators. A budget outline has been prepared for each, but the budget figures are not provided. These should be developed during workplan formulation. And most importantly, an estimate of the amount of the recurrent budget impact is called for, to measure the cost of sustaining the intervention following phasing out of foreign assistance.

Manpower Interventions

1. Training of Primary Health Care Workers (especially females)
2. Training of Midwives (with emphasis on supervision)
3. Training of Licensed Birth Attendants (with emphasis on the community)
4. In-Service Training for existing PHCWs, midwives and LBAs (an identified need)

Community Interventions

1. Village Health Committees (in 40 villages)
2. Health Guides (in 40 villages)
3. Community-based Health Education (in 40 villages)

Management Interventions

1. Management Technology Transfer among Governorates (18 Governorates)
2. Team Management and Supervision (5 Governorates)
3. Logistics and Supply System (5 Governorates)
4. Decentralized Planning and Budgeting (5 Governorates)
5. Health Information System (national and 5 Governorates)
6. Alternative Financing for Primary Health Care (communities served by 5 health centers)

ملخص تنفيذي

ضمن خططها الادارية التنفيذية للفترة ١٩٩٢-١٩٩٧ اكدت بعثة الوكالة الامريكية للتنمية الدولية لدى اليمن ارتباطاتها في قطاع الصحة والسكان. وفي مارس ١٩٩٢م تم تعزيز هذا الارتباط من خلال تعيين ضابط صحة-سكان-تغذية مؤهل كعضو مقيم من افراد البعثة. علاوة على ذلك هنالك اثنين من الموظفين المحليين المتعاقدين للخدمة الخارجية ضمن مكتب مساندة المشروع.

وكجزء من هذا الارتباط قامت الوكالة الامريكية للتنمية الدولية بتجهيز هذا التقييم المقتصر على القطاع الصحي.

من خلال اعمال مراجعة استمرت ثلاثة اسابيع بشكل مكثف ومراجعة الوثائق والملاحظات الميدانية تمكن الفريق من تحديد عدد من القضايا الهامة المؤثرة على التوصيات النهائية والاستراتيجيات والتكوينات المطلوبة لتنفيذها.

وقد تم تحديد مجمل ١٦ قضية تم ايضاحها في القسم ٥ من هذا التقرير حيث تم اعطاء الاستنتاجات عقب كل ايضاح.

التوصيات

أدناه اكثر التوصيات اهمية وفصلت على اساس مدى تطلبها لكل من: (١) قرارات سياسية، (٢) تغيير هيكل أو مؤسس و/أو (٣) تغيير برامجي.

(١) دمج صحة الامومة والطفولة مع رعاية الاسرة:

يومي بادخال ثلاثة عشرة نشاطا لدمج صحة الامومة والطفولة مع رعاية الاسرة. ويعد هذا النهج التكاملي عمليا وذو كفاءة وفعالية في كل من المجالات التالية: التدريب، الصحة، التعليم، الامداد والتمويل، المعلومات الصحية، جمعيات القرى الصحية، التخطيط والموازنة، الادارة والاشراف وتسويق السلع عبر القطاع الخاص.

يشترك كل من برنامجي صحة الامومة والطفولة ورعاية الاسرة في نفس المجموعات المستهدفة. ويمكن لمدراء الصحة ومقدمي الخدمات التعامل معهم بفعالية كجهة واحدة.

لتنفيذ هذا النهج يتطلب اتخاذ قرارات تنظيمية من قبل الحكومة وادخال التعديلات الهيكلية والبرامجية ضمن الوزارات المنفذة وعمل الروابط بينها.

(٢) الحصول على الخدمات الصحية للام والطفل ورعاية الاسرة:

تعد امكانية الحصول على الخدمات هامة وبشكل خاص في اليمن. فهناك عدد من الموانع التي تحد من امكانية وصول الفرد اليمني الى النظام الصحي. وهذه الموانع هي: (١) موانع طبيعية تتمثل في (التضاريس الجبلية الوعرة، تشتت وتباعد المنشآت) (ب) موانع فنية وتتمثل في (الاجهاد البالغ، ضعف تدريب مقدمي الخدمات الصحية) (ج) موانع ادارية وتتمثل في (الافتقار الى المعلومات الصحية/الادارية، ضعف الرقابة، عدم ملائمة نظام التمويل) و (د) موانع ثقافية تتمثل في (الافتقار الى الاعداد الكافية من عاملات الرعاية الصحية لخدمة المرأة والطفل وارتفاع نسبة الامية خصوصا بين المرأة الريفية).

ولذلك قامت الوكالة الامريكية للتنمية الدولية ضمن خطتها التنفيذية الجديدة برصد هدف «زيادة نسبة الحصول على الخدمات والمشاركة فى برامج صحة الام والطفل ورعاية الاسرة».

يتوافق هذا النهج مع سياسة وهيكل والبرامج الحالية للحكومة.

(٣) اللامركزية:

يركز المشروع الحالى للتعاون المعجل لانقاذ الطغل التابع للوكالة الامريكية جهوده بمستوى المحافظات على مراكز اعادة التأهيل الصحية/التدريبية وعلى تدريب عمال الرعاية الصحية الاولى وقد اثبت ذلك فعاليتها. كما تبنت الجهات المانحة الاخرى ذلك النشاط بما فيها منظمة اليونيسيف والتي رصدت ٢٣% من ميزانيتها البالغة ٢١٥ مليون دولار للاعوام ١٩٩٣-١٩٩٧ لعدد اربعة محافظات.

يوصى الفريق بتركيز العمل على خمس محافظات (الاربعة محافظات الحالية اضافة الى احدى المحافظات الجنوبية). ويجب ان تشمل الانشطة بمستوى القرى عددا قليلا فقط من القرى.

يتطلب تنفيذ هذه الاستراتيجية ادخال تغييرات برامجية واعطاء السلطة للتنفيذ.

(٤) موارد بديلة للتمويل الصحى:

نظرا للتحديات الحادة على التمويلات الحكومية، فهناك حاجة الى مرونة حركة التمويل الصحى والخدمات الاجتماعية الاخرى.

تفخر اليمن بتفاليدها المستقلة واعتمادها الذاتى فقد ساهمت المجالس المحلية للتطوير التعاونى بنسبة ٥٠% من تكلفة بناء معظم وحدات الرعاية الصحية الاولى فى المحافظات الشمالية. وفى المحافظات الجنوبية هناك تقليد مستمر من التطوعية. ويوجد اهتمام متناهى لغرض رسوم مقابل الخدمة وإدخال نظام التأمين الصحى لموظفى الحكومة. رعليه فالقطاع الصحى الخاص يعمل بحيوية وفى حالة نمو متزايد.

يؤمن افراد الفريق بان الرعاية الصحية تبدأ من الفرد ثم الاسرة يليها المجتمع واخيرا النظام الصحى الكامل. ولذلك فقد تم تصميم الأنشطة الموصى بها للطرق لهذا الاعتقاد الذى يراود الناس. ويشمل ذلك اقامة الجمعيات الصحية بمستوى القرى، وتدريب ودعم الدايكات الحاصلات على تراخيص، والمرشدين الصحيين المتطوعين، وانظمة التمويل البديلة على المستوى المحلى.

سيكون من الضرورى الحصول على قرارات حكومية على المستوى السياسى لتطبيق هذا النهج.

(٥) الاستمرارية:

تعد الاستمرارية قضية هامة من منطلق ارتفاع معدل التضخم (معلن ٣٩%) اضافة الى النسبة العالية للنمو السكانى علاوة على عودة المفتربين، ومعزدية قدرة الحكومة على استيعاب والعمل بمقترحات الجهات المانحة. ولذلك فان الفريق يعتبر ان الاستمرارية تعد عاملا رئيسيا فى اتخاذ قراراته ومعيارا هاما فى اختيار الأنشطة.

سيطلب من انظمة الموازنة الحكومية ربط الاعتمادات الدورية المطلوبة لاستمرار كل نشاط بعد انتهاء المساعدة الخارجية.

(٦) الإدارة:

بوجود المشاكل المعقدة التي تواجه الخدمات المحية في اليمن وتعقيبات الاجراءات الحكومية نفسها، يوصى الفريق بتحصين القدرات الادارية لوزارة المحية العامة. فقد تركزت الاهتمامات حول نظام الادارة في كل تقرير قدم من الفريق.

تجاوبا مع هذا الاحتياج يوصى الفريق باذخال ستة أنشطة ادارية تشمل تصميم وتنفيذ نظام معلومات صحية مبسط وقياسي يتضمن نشاط رقابة الوبئة. والذي قد يكون اكثر تلك الأنشطة طموحا. وهو يتطلب اطار عمل وطني قبل البدء بتنفيذه على مستوى المحافظة. فمن الضروري توفر معلومات موثوقة بالنسبة للخدمات المحية حتى يمكن اجراء التخطيط المنطقي واتخاذ القرار الملائم.

سيطلب هذا اجراء تغيير هيكلية ضمن وزارة الصحة العامة.

التنفيذ

كيف يمكن تنفيذ الأنشطة الموصى بها بكفاءة وفعالية؟ امضى الفريق وقتا طويلا في العمل مع ضابط الصحة والسكان والتغذية الجديد في تصميم نموذج اداري يركز على التكوين الاستراتيجي والتنظيمي.

مع الارتباطات الحالية للوكالة الامريكية في مشروع انقاذ الطفل الذي يشارف على الانتهاء ومع بدء مشروع خيارات رعاية الاسرة الجديد يبدو ان هذا هو الوقت الامثل للمسير قدما في تبني النهج الموحد الموصى به اعلاه. (انظر الرسم التخطيطي للهيكل في القسم ٦).

تتضمن هذه الاستراتيجية الموحدة لصحة الام والطفل/ورعاية الاسرة ثلاثة اجزاء:

جزء ١:

يوصى بالابتعاد عن الممارسة الحالية لاستخدام العديد من المستشاريين على المدى القصير الى استخدام الاختصاصيين المقيمين ("متخصصين").

يلى الفترة الانتقالية يوصى بتعيين خبذة اختصاصيين على المدى الطويل: زميل متخصص في صحة الام والطفل/رئيس فريق مع زملاء للادارة، تدريج/قبالة، ارشاد صحي ونظام معلومات صحية/رقابة الوبئة. وليس من الضروري ان يعمل هؤلاء الاختصاصيين لمدة خمس سنوات. سيعمل رئيس الفريق لمدة خمس سنوات، والاختصاصي الاداري لمدة اربعة سنوات، أما البقية فيعمل كل منهم لمدة ثلاثة سنوات. ويحسب هذا بما يعادل الوقت الكامل لمعدل ٣٦ شخص. كما سيكون هناك ثلاثة اختصاصيين (للمعمل في ٥ محافظات) والذين سيشاركون في المسؤوليات الفنية والادارية ويعملون كنظراء للمدير العام بمكتب الصحة بالمحافظة. وسيتم الحد من الامتثاريين للمدى القصير الى الحد الأدنى.

يتيح هذا النهج استخداما اكثر فعالية للموارد ويؤدي الى تسهيل الاعمال الادارية.

جزء ٢:

خلق توازن بين أنشطة انقاذ الطفل. ووفقا للاستراتيجية المقترحة سيتم تخفيض حجم عمل رعاية الاسرة وتنفيذها على مراحل بمرور الوقت. من الواضح ان الخطة الحالية لمشروع خيارات رعاية الاسرة تتضمن جهدا كبيرا. حيث سيتم القيام بمعظم هذه الاعمال من قبل الاختصاصيين المقيمين الموضحين اعلاه. فعندما تكون هناك حاجة الى خدمات خاصة (مثلا، عند تقديم برنامج رابعد ٣ والعمل البيومفرايس المخطط من قبل مكتب الاحماء الامريكي) يمكن ترتيب ذلك تحت توجيهات الاختصاصيين المقيمين. وسيكون القيام بالعمل وفقا للاسلوب الموحد (صحة الام والطفل + رعاية الاسرة) بقدر الامكان.

سيتم التركيز على مجال امداد الخدمات.

جزء ٣:

عند استهلال الفترة الانتقالية (التي تبدأ في ١ يوليو ١٩٩٣) سيتولى احد المقاولين الى جانب رئيس فريق اساس المسئولية الادارية مع احتفاظ الوكالة الامريكية للدور الرقابي والاشرافي.

كمساعدة ضرورية للقيام بالتنفيذ سيتم صياغة خطة عمل بالتنسيق مع الوزارات المنفذة، الجهات غير الحكومية والجهات المانحة الاخرى.

الانشطة

يوصى الفريق بادخال عدد ١٣ نشاط: ٤ منها في مجال التدريب، ثلاثة في المجتمع وستة في مجال الادارة. (كذلك يقع احد الانشطة التدريبية واحد الانشطة الادارية ضمن مستوى المجتمع - وتدريب القابلات المحليات و يمكن تحقيقهما خلال ٣ الى ٥ سوات من الوقت. وقد تم وضع الاولويات حتى يمكن اجراء التعديلات عندما يتم تحديد تكلفة اي منها واجراء الصياغة الرسمية لخطة العمل.

شمل الافكار الاساسية التي تحدد الاختيار للنشاط (١) التركيز على مستوى المحافظة لتمييز امداد الخدمات (٣) تسهيل مشاركة المجتمع للمساعدة في بناء قاعدة اجتماعية متينة للرعاية المحية الاولى وتنظيم الاسرة ضمن اطار الاسرة الواحدة والبيت والقرية.

يوضح كل نشاط اهداف برنامج البعثة والاهداف الفرعية الاخرى ويبين قائمة الانشطة ومؤشرات الاداء والتاثيرات. تم اعداد بيان موازنة لكل نشاط ولكن لم يتم اعداد ارقام الميزانيات. ويجب ان يتم القيام بذلك اثناء صياغة خطة العمل. والاهم من ذلك، ان يتم الحصول على المبلغ التقريبي لنتائج الموازنة الدورية لقياس تكلفة استمرارية النشاط عقب انتهاء المساعدة الخارجية.

انشطة القوى العاملة:

- (١) تدريب عمال الرعاية المحية الاولى (خاصة الاناث)
- (٢) تدريب القابلات (مع التوكيدات على الاشراف)
- (٣) تدريب الدايات المرخص لهن (مع التوكيدات على المجتمع)
- (٤) تدريب اثناء الخدمة لعمال الرعاية المحية الاولى والقابلات والدايات (احتياج محدد).

انشطة المجتمع:

- (١) اللجان المحية القروية (في ٤٠ قرية)
- (٢) مرشدين صحيين (في ٤٠ قرية)
- (٣) ارشاد صحي للمجتمع (في ٤٠ قرية)

انشطة ادارية:

- (١) نقل التقنية الادارية بين المحافظات (في جميع ال ١٨ محافظة)
- (٢) الادارة والاشراف على الفريق (في ٥ محافظات)
- (٣) نظام الامداد والتموين (في ٥ محافظات)
- (٤) تخطيط وموازنة لامركزية (في ٥ محافظات)
- (٥) نظام المعلومات المحية (وطنيا في ٥ محافظات)

(٦) تمويل جديد للرعاية المحية الاولى (في المجتمعات التي تتضمين ٥ مراكز صحية).

(١) بيان بالاعمال والتنظيم

يتضمن بيان الاعمال لهذا التقييم توصيات جديدة للوكالة الامريكية للتنمية الدولية ووزارة الصحة العامة حول:

"انشطة انقاذ الطفل الاكثر ملائمة مع مساعدات الوكالة الامريكية للتنمية الدولية والتي يمكن ادارتها بفعالية واستمرارها بموجب ميزانية التشغيل المتوفرة من قبل الجمهورية اليمنية، والقدرات الفنية والادارية المتاحة مع التركيز على وجه الخصوص على أنشطة انقاذ الطفل". (انظر الملحق ١).

يقدم التقييم توصيات ليتم تجسيدها في عنصر قطاع الصحة والسكان بالخطوة الادارية للتنفيذ الخاصة بالوكالة الامريكية للتنمية الدولية/اليمن والتي سيتم رفعها الى واشنطن في اوائل مايو ١٩٩٢م.

علاوة على قضايا برنامج انقاذ الطفل المبينة في نطاق العمل فقد طلب مدير البعثة من فريق التقييم فحص واعطاء التوصيات حول الدمج المحتمل لمشروع التعاون المعجل لانقاذ الطفل مع المشروع الجديد لخيارات رعاية الاسرة. نتج عن ذلك توسيع المجال من أنشطة انقاذ الطفل فقط الى أنشطة موحدة لمحة الام والطفل ورعاية الاسرة. وقد تم تطوير البرامج الاساسية والبرامج الغيرية لكل نشاط في خطة التنفيذ الادارية الخاصة بالوكالة الامريكية للتنمية الدولية.

قام بالتقييم فريق تم تعيينه وتشكيله ودعمه من قبل المركز الدولي لتطوير البحوث، نورث كالورينا بالولايات المتحدة بموجب شرايط محددة الكمية مع الوكالة الامريكية للتنمية الدولية.

اعضاء الفريق كالتالي:

- البرت آر نيل، وزارة الصحة العامة (الصحة الدولية)
مستشار في ادارة الصحة الدولية
ساكسون ريفر، فيرمونت ٥١٥٤ الولايات المتحدة
رئيس الفريق
- روز جالا ماكيولي، وزارة الصحة العامة (دكتوراه)
إختصاصية محة الامومة والطفولة
دورام ، نورث كالورينا ٢٧٧٠٧ الولايات المتحدة
- عائشة عباد جمعان، وزارة الصحة العامة (دكتوراه) (رقابة اوبئة)
محاضرة (زمالة تدريسي) وإختصاصية بحوث
كلية الطب، جامعة صنعاء
صنعاء-الجمهورية اليمنية
- زين أحمد زين، دكتوراه
مستشار، وزارة الصحة العامة
صنعاء-الجمهورية اليمنية
(٩ أيام)
- احمد غرامة، دكتوراه (إختصاص علوم طبية)
مدير البحوث والدراسات الطبية
وزارة الصحة العامة
عدن، الجمهورية اليمنية

- احمد الكحلانى، ماجستير (التخطيط الصحى ورقابة الاوبئة)
نائب مدير عام التخطيط والاحصاء والمتابعة
وزارة الصحة العامة
 صنعاء-الجمهورية اليمنية

- عبدالعزيز قائد
اختصاصى برامج، موظف خدمة محلى
بعثة الوكالة الامريكية للتنمية الدولية باليمن

- شارلز اي هابيس
ضابط صحة وسكان وتغذية
بعثة الوكالة الامريكية للتنمية الدولية باليمن

حددت فترة ثلاثة اسابيع لاكمال التحريات بما فى ذلك الزيارات الميدانية تليها فترة اسبوعين للمراجعة وتنقيح وتجهيز المسودة النهائية. عمل الفريق بعضويته الكاملة لفترة الثلاث اسابيع الاولى مع بقاء رئيس الفريق لاكمال فترة الاسبوعين الختاميين للتعيين. كما منح اسبوع اضافى من قبل الدكتورة/ عائشة جمعان خلال الاسبوعين الختاميين. وكانت هناك مشاركة مستمرة من قبل الدكتور/ غرامة والدكتور/ الكحلانى على اساس وقت جزئى فى حين منح الدكتور/ هابيس واليد/ عبدالعزيز قائد، جل وقتهم للمساعدة فى اكمال التقييم. عند قرب الانتهاء تقدر تمديد فترة رئيس الفريق لاربعة ايام اضافية حتى ٢٥ ابريل ١٩٩٢م.

بدا العمل فى ١٩ مارس. وطور الفريق خلال اليومين الاولين استراتيجيه القيام بالتقييم، وتم تجهيز جدول عمل والتقسيم الى مجموعات فرعية. وقد شمل جدول العمل التالى:

- اسبوع ١ -	جمع البيانات ولقاءات فى صنعاء
- اسبوع ٢ -	زيارات ميدانية الى اربعة محافظات
- اسبوع ٣ -	مراجعة وتطوير الاستنتاجات والحصول على مدخلات بحسب اللازم وصياغة التقرير الاول.

تزامنت فترة الثلاث اسابيع الاولى مع شهر رمضان وعيد الفطر مما اعاق من أنشطة الفريق الى حد ما. حيث لم يكن من الممكن اجراء بعض اللقاءات وكانت ساعات العمل متباينة.

اختصرت الزيارات الميدانية للضرورة الى اربعة ايام. وكان من الممكن استفلال وقت اطول فى اللقاءات الميدانية والملاحظات ولكن نظرا لشهر رمضان وقصر الوقت الاجمالي، شعر الفريق باهمية العودة الى صنعاء لتصنيف البيانات والبدء بصياغة التقرير. وقد اتضح لاحقا بان هذا القرار كان حكيما حيث كانت هناك حاجة الى وقت كبير لتطوير البنية واستراتيجية التنفيذ، واهداف البرامج الاساسية والفرعية والانشطة التى من شأنها امداد المساهمات فى المواعيد الملائمة بالنسبة لخطة التنفيذ الادارية للاعوام ١٩٩٢-١٩٩٧م.

فى الختام تم تحرير ملخص تنفيذى وترجمته الى اللغة العربية.

1. STATEMENT OF WORK AND ORGANIZATION

The Statement of Work for this assessment provides for new recommendations to USAID and the Ministry of Public Health on:

"the most appropriate child survival interventions for USAID assistance which can be effectively managed and sustained with available Republic of the Yemen operating budget, technical and management capacities - particularly focussing on child survival." (See Appendix A).

The Assessment is to provide recommendations to be embodied in the health and population sector component of the USAID/Yemen Management Implementation Plan to be submitted to Washington in early May, 1992.

In addition to the child survival issues called for in the Statement of Work, the Assessment Team was requested by the Mission Director to examine and make recommendations for the possible integration of the ACCS Project with the new Options for Family Care Project (OFC). This resulted in broadening the scope from solely child survival interventions to integrated child survival and family care interventions (MCH/FC). Program and sub-program objectives were developed for each intervention for the USAID Management Implementation Plan.

The assessment was conducted by a team recruited, fielded and supported by the Center for International Development of the Research Triangle Institute, Research Triangle Park, North Carolina, U.S.A., under an IQC contract with USAID.

The Team members were as follows:

- o Albert R. Neill, MPH (International Health)
Consultant in International Health Management
Saxtons River, Vermont 05154, USA
Team Leader
- o Rose Jallah Macauley, M.D., MPH
MCH Specialist
Durham, North Carolina 27707, USA
- o Aisha Obad Jumaan, MPH, PhD (Epidemiology)
Lecturer (Associate Professor) and Research
Specialist
University of Sana'a Medical School
Sana'a, Republic of Yemen

- o Zain Ahmed Zain, MD, MPH
Consultant
Sana'a, Republic of Yemen
(9 days)
- o Ahmed Ghorama, MD, Medical Specialist
Director of Research and Medical Studies (Aden Branch)
Ministry of Public Health
Aden, Republic of Yemen
- o Ahmed Al-Kohlani, Masters (Health Planning
and Epidemiology)
Deputy Director General
Planning, Statistics and Follow-up
Ministry of Public Health
Sana'a, Republic of Yemen
- o Abdul Aziz Kaid
Program Specialist, FSN
USAID Mission to Yemen
- o Charles E. Habis
Health, Population and Nutrition Officer
USAID Mission to Yemen

Three weeks were allotted for completing the investigation, including field visits, followed by two weeks for review, revision and preparation of the final draft. The Team functioned with a full membership for the first three weeks, with the Team Leader remaining to complete the final two weeks of the assignment. During the final two-week period, an additional week was provided by Dr. Jumaan. There was continued participation by Dr. Ghorama and Mr. Al-Kohlani on a part-time basis, while Dr. Habis and Mr. Aziz Kaid devoted a major share of their time to help complete the Assessment. Toward the end it was agreed to extend the Team Leader an additional four days through April 25, 1992.

Work started on 19 March. During the first two days the team developed a strategy for approaching the assessment, prepared a work schedule and divided into sub-teams. The schedule provided for:

- o Week 1 - data collection and interviews in Sana'a
- o Week 2 - field trips to four representative Governorates
- o Week 3 - review, develop findings, obtain additional inputs as needed, draft first report

The first three weeks coincided with Ramadan and Eid Al-Fitr and this constrained team activities to some degree. It was not possible to make some appointments, and working hours were erratic.

Of necessity, the field trips were shortened to only four days. More time could well have been spent in field interviews and observations but due to Ramadan and to the shortness of time overall, the team felt obliged to return to Sana'a to compile data and start drafting the report. This turned out to be a wise decision as considerable time was needed to develop the structure and strategy for implementation; the program objectives and sub-objectives, and interventions that were to make a timely contribution to the Missions's Management Implementation Plan for 1992-97.

Finally, an Executive Summary was written and translated into Arabic

2. METHODOLOGY AND APPROACH

In general, the Team undertook three main areas of investigation:

1. Identification of needs and priorities (in PHC and family planning)
2. Assessment of the delivery of health services - existing status, lessons learned, future plans by the Government, USAID and other donors
3. Assessment of the capacity for management and sustainability of health and family planning services delivery

On the basis of these investigations, the Team identified specific, discrete interventions which can be realistically achieved within the resources and management capability of both the USAID and Government of Yemen.

The Team members developed a list of questions to use in obtaining information during a series of interviews and data gathering with government officials, health providers, donors, NGOs and PVOs agencies and contractor personnel at national, governorate, district and local levels. Discussions and observations at the local level included health providers in selected Health Centers and Primary Health Care Units. (See Appendix B for list of persons contacted and Appendices D and E for field trip reports, and Appendix F for a report of interviews with female health providers).

These contacts were scheduled to progress from the center - outward so that information obtained at one level could be verified at subsequent lower levels.

In conducting this research, the Team took a broader view of child survival and family planning needs, priorities, activities and plans than just those of the two USAID projects.

During the course of the investigation, a number of issues surfaced which the Team identified. These issues have a bearing - positive and negative - on the outcome of the Assessment and the specific interventions recommended. Due to their importance they are discussed in some detail and occupy a large section of this report. (Section 5).

All the inputs from reviewing documents, interviewing government officials, donors, and NGOs, and observations in the field - fortified by the individual team members' background, knowledge and experience - formed the basis for the recommendation of a structure

and strategy for implementation, followed by the specific interventions.

In reaching their conclusions, the Team members were repeatedly challenged to be creative, to contribute their own original thinking and ideas, and not merely regurgitate and feedback what they had been told in interviews. In view of the constraints, monetary, managerial, and cultural, the team philosophy was to "think big but act small" and "to work incrementally toward the big picture".

The recommended interventions are contained in the body of this report, with a step-by-step action plan and indicators for each. Time did not permit constructing budgets and estimates of the costs of sustainability (Recurrent Budget of the ROY), and this should be done as part of the transitional work plan.

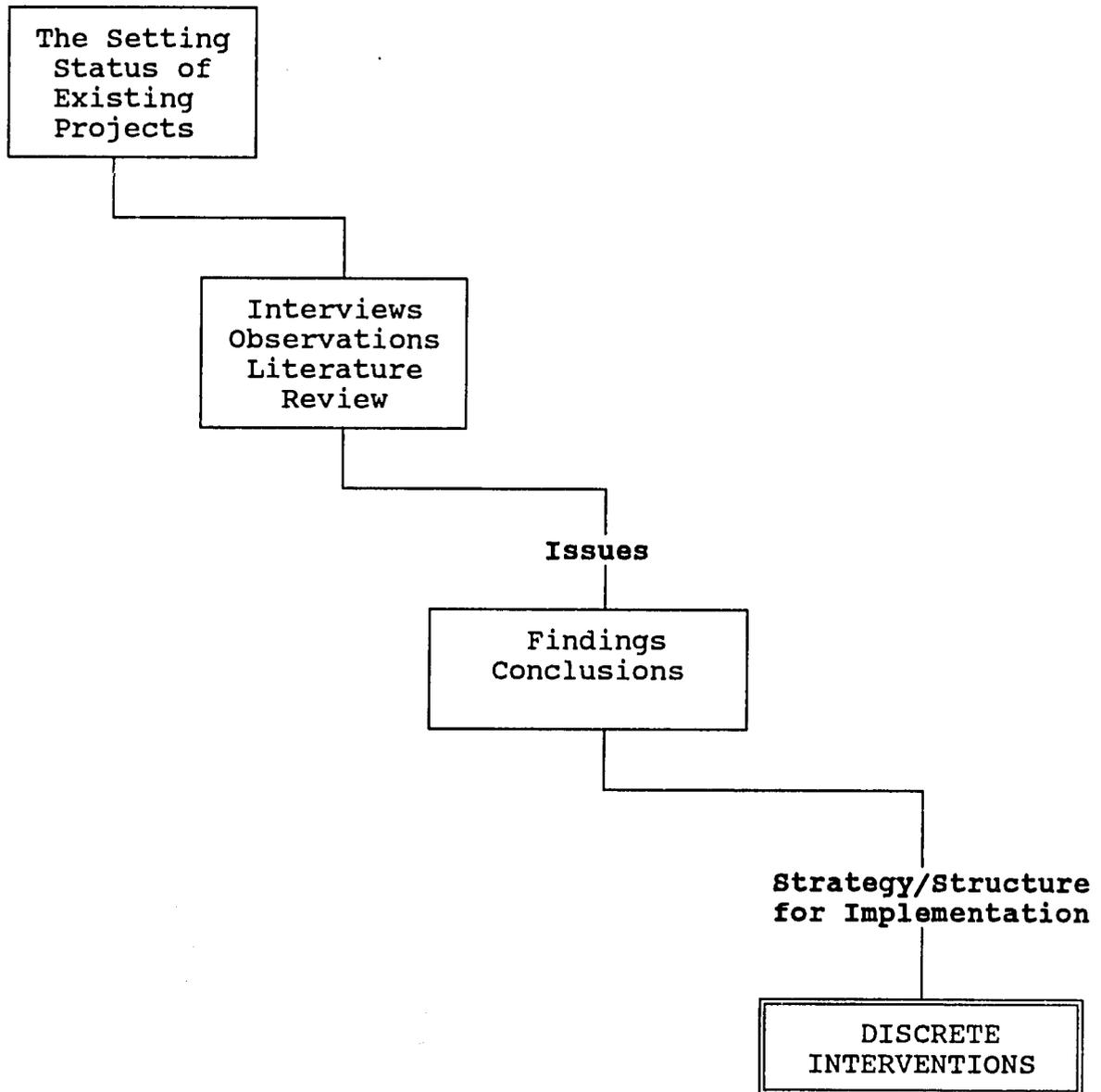
Thirteen interventions were identified. They were then put through a review process to rank them in order of priority. They are contained in Section 7.

Of special importance is the opportunity to combine the on-going work of child survival with the new Options for Family Care Project. Institutional arrangements and strategies are proposed that will make it possible to continue the momentum of the child survival activities, integrate mother and child care with family planning, and facilitate the operational aspects of the combined project.

There are problems inherent in this approach, and much time was spent in developing what is considered to be the best option. The alternative is "business as usual", that is, continuing with a variety of separate contractors and "buy-ins" and relying to a large degree on short-term consultants. The Team members feel this would be dysfunctional and, particularly that the family planning components of the program, tend to overburden the absorptive capacity of the Government and run the risk of a cultural backlash.

The methodology followed by the Team members can be shown in a diagram form as follows:

**LIMITED HEALTH SECTOR ASSESSMENT
METHODOLOGY**



3. THE SETTING

The Republic of Yemen was formed on the 22nd of May, 1990, by unification of the former YAR and the PDRY. The total population is 11.6 million, with 72% living in rural scattered villages connected by rough roads. The newly formed country faces many of the problems found in most LDCs, including high population growth, poor health, high illiteracy rate, poor environment, lack of resources, and severe shortage of trained manpower.

According to the latest statistics published by the Central Statistical Organization (1991), the total population of the Republic was 11.6 million. Fifty-two percent were under 15 years of age and 19.8% were under 5 years of age. The population growth rate is 3.2%, an increase from the 2.3% previously reported for 1965-1980. The crude birth rate is 5.4% and the crude death rate is 2.2%. Life expectancy at birth is 51 years and total fertility is 8.4 live births per mother. About 28% of the population is urbanized. Annual growth rate of the urban population is 10% (CSO, 1990).

The basic indicators of the new Republic are not optimistic, and are evidence that much remains to be done to improve the health and well-being of the population. Under-five mortality is 190 per 1000 and infant mortality 131 per 1000 (CSO, 1991). Total literacy is 32% for both sexes, with 54% literate men and 15% literate women. The enrollment in primary school between 1986-1988 was 86%. The GNP in 1988 was \$480. Some improvements in education were reported; but, they are far from satisfactory, especially among women. The adult literacy rate increased from 14% in 1970 to 47% in 1985 for males and from 3% to 15% for females. Illiteracy among women in the rural areas is estimated as high as 91%. Thirty-one percent of the children completed primary school in 1985-87 (UNICEF, 1992).

The majority of the population does not have access to basic health services, especially in rural areas. Access to safe water during 1985-88 was limited to only 45% of the total population; 97% of the urban population and 26% of the rural population. The reported population access to the health services ranges from 38%-50%. Based on the Assessment Team's findings, it is important to qualify these figures. Access for the most important groups at risk, women and children, is clearly well below 38%-50%, and access does not assure utilization!¹ Although immunization coverage increased

¹ When referring to access it is important to qualify what access refers to. Access differs wildly among target groups and among services. In particular, access for women of child-bearing age and under-fives in the rural areas, is very limited. According to the Assessment Team's observations this access to the formal

between 1981 and 1988-89 against the six childhood diseases (TB 14% to 71%, DPT 21% to 53%, Polio 21% to 53% and measles 33% to 45%), the increase is still below the 80% coverage reported by the MOPH. Tetanus immunization for pregnant women still lags behind at 8%. Present immunization coverage is estimated by UNICEF at 62%, and due to the lack of sustained effort, is expected to drop to 50% before resources can be mobilized to bring it back up.

In 1989, the ROY started producing ORT packages at the Yemen Drug Company (YEDCO) in Sana'a and over two million packages have been distributed. This is expected to increase the use of ORT from the 8% utilization reported in 1987-88.

Malnutrition is a serious health problem for children under five years of age. Between 1980-1988 breastfeeding declined steadily with age; 74% of the infants breast feed up to three months of age, 66% up to six months of age, and 34% up to one year of age. Between 1980-1989, 15% of the children 12-23 months of age were wasted and 61% of the children 24-59 months of age were stunted (UNICEF, 1992).

Yemen has one of the highest fertility rates in the world - 8.4 live births per mother. The main reason has been attributed to the low status of Yemeni women, with only 15% of the adult females literate. The contraceptive utilization rate in the period 1980-1987 was very low, ranging from 1% to 3%. Only 12% of births were attended by trained health personnel (1983-1988). The maternal mortality rate is 10/1000 and this is surely an underestimate as many deaths are not reported, especially in the rural areas.

UNICEF has estimated the socioeconomic benefits for the Yemen EPI program in 1990 as follows: US \$2.3 million were invested in health interventions (EPI and ORT) resulting in savings due to averting cases costing US \$227.6 million and US \$279.6 million in disabilities and deaths, based on a healthy-days-of-life lost formula. The total estimated net savings was US \$507.2 million.

health system (MOPH) must be extremely limited, in some cases non-existent.

REPUBLIC OF YEMEN - BASIC INDICATORS

	Yemen	Jordan	Mexico
Total Population (1990)	11.7Million	4.0	25.0
Population Under 15 years of Age	52.2%	--	--
Population Under 5 years of Age	19.8%	--	--
Crude Birth Rate	5.4%	--	--
Crude Death Rate	2.2%	--	--
Pop. Growth Rate (1980-90)	3.5%	3.2	2.6
Total Fertility	7.7%	5.8	4.5
Percent of Pop. Urbanized (1990)	29.0%	68.0	48.0%
Annual Growth Rate of Urban Population	10.0%	4.4	4.1
Life Expanctancy at Birth	51 Yrs.	67 Yrs.	62Yrs.
Infant Mortality (1990) under 1	114 per1000	52	75
Under-Five Mortality (1990)	187 per 1000	40	112
GNP per capita (1989)	\$480	1640	880
Total Literacy for Both Sexes (1990) UNICEF	32%	80%	50%
Literate Men (1990) UNICEF	47%	89%	61%
Literate (Women (1990)	21%	70%	38%
Primary School Enrollment (1986-89)	87%	99%	67%
Percent Children Completed Primary School 1985-87 (UNICEF, 1992)	31%	96%	67%
Access to Safe Water (1988-90) UNICEF	38%	99%	61%
Urban Population	56%	100%	100%
Rural Population	30%	98%	25%
Access to the Health Services (1985-90) UNICEF	38%	97%	70%
Immunization Coverage (1989-90) UNICEF			
TB	71%	--	96%
DPT	53%	92%	81%
Polio	53%	92%	81%
Measles	45%	87%	79%

Tetanus	08%	23%	64%
ORT Use (1987-89) UNICEF	07%	58%	14%

	Yemen	Jordan	Morocco
Breastfeeding (1980-91) UNICEF			
Up to 3 months	74%	93%	87%
Up to 6 months	66%	80%	77%
Up to 12 months	34%	61%	59%

Malnutrition (1980-91) UNICEF			
12-23 months (Wasted)	15%	--	6%
24-59 months (Stunted)	61%	--	34%

Source: The State of the World's Children - 1992, UNICEF, New York.
 Immunization coverage, Breastfeeding and Malnutrition figures are from the UNICEF office in Yemen.

Note: Where the figures in the text differ from this table they are taken from the Central Statistical Organization of Yemen and are generally for the latest year obtainable, 1991. In particular, there is a discrepancy in the Fertility Rate, 8.4% according to the CSO, and 7.7 according to the UNICEF report. (Added by the Team Leader, 26 May, 1992 for report submitted to the Research Triangle Institute).

4. CURRENT USAID HEALTH AND POPULATION PROJECTS

Currently USAID is funding two projects in Health and Population, the Accelerated Cooperation for Child Survival Project (ACCS), now well along in implementation, and the Options for Family Care Project, in the initial stage. Details follow.

ACCELERATED COOPERATION FOR CHILD SURVIVAL

Project Period:	FY 1986 - 1994
PACD:	September 29, 1994
<u>As of November, 1991</u>	
USAID funding, LOP:	\$12.7 mns
Obligated to date:	\$7.0
Pipeline:	\$3.9

The original project period of five years was extended to seven with Grant Agreement No. 4, December 31, 1989. The figures indicate that as of November, 1991 only approximately 30% of the project had been achieved, in terms of monies spent!

Although the ACCS Project Agreement was authorized on August 25, 1986, it was not until December 31, 1989 that it actually got off the ground. At that time, Amendment No. 4 to the Project Grant Agreement was signed. It extended the Project Assistance Completion Date from 9/30/92 to 9/29/94 "in recognition of delays in implementation in the early stages of the project." ²
The Project Goal and Purpose were amended to read:

Goal: "To ensure the quality of life of the Yemeni population through improving family health status"

Purpose: To strengthen the delivery of basic health services in up to seven governorates, particularly for the population at greatest risk, mothers and children, through the further development and institutionalization of a system to deliver primary health care services to the target population."

There are four main elements of the project:

- o Expanded and upgraded primary health care for child survival
- o Accelerated immunization services

³ The output analysis, prepared by the USAID Project Support Office is on file in the HPN Office.

- o Improved health education
- o Special activities

For all practical purposes, the accelerated immunization services have been combined with the PHC element.

REACH

Under a buy-in to the REACH project (John Snow, Inc.) work has been underway on the first and second elements - PHC and immunization services.

An analysis of achieved outputs against those planned,³ highlights the following achievements against the last contract with REACH for the period 8/7/91 through 3/31/92. 166 PHC workers have been trained in three governorates and six health/training centers furnished and equipped in four governorates. In addition, 180 health workers have attended in-service training workshops in 4 governorates. An EPI/disease surveillance system has been designed, and a manpower assessment made. However, there is no reported progress on the construction or identification of fixed sites for 90 Primary Health Care Units. Technical studies of the cold chain have been completed, but the planned training for cold chain maintenance has yet to begin. There has been no achievement in project team management at the governorate level. However, a contract has been entered into with the Hodeidah Governorate (November 11, 1991) for carrying out the full package of REACH activities including rehabilitating health/training centers, training, assessment of the PHC system, review of fees-for-service at the Al-Thorah Hodeidah Hospital, and development of a disease control and surveillance system for EPI.

² The delays alluded to in Grant Agreement No. 4 have been identified by the REACH Chief of Party as: (1) Ownership: Since the MOPH as the implementing ministry was not a signatory to the Project Agreement, and disagreed on a number of points in the Agreement, they were reluctant to accept responsibility. (2) Salary Supplements: Under the earlier Thiama Project, incentives were paid to the Yemeni MOPH staff by topping-up their salaries as much as 90%. In the new ACCS Project, this was a point of disagreement until finally clarified with an amendment to the Project Agreement, and although the rationale was understood by the concerned parties, it delayed the ACCS Project implementation until settled. (3) PL 480 Funds for Construction: The MOPH has been unable to reach a satisfactory arrangement with the Ministry of Planning and Development for the allocation of PL 480 Funds for the provision of work sites for newly-trained PHC workers. It remains undetermined how and when the necessary work sites will be made available. The delays surrounding the release of funds has set back the project, according to the REACH Chief of Party.

The REACH project component has sponsored 20 short-term consultancies for a total of 26 person-months in the past two years alone! They have been largely concerned with PHC development, training, manpower, and Health Information/EPI (See Appendix K). The Assessment Team questions this use of short-term consultants. Taken together, they have submitted hundreds of recommendations which have not been implemented for a variety of reasons. (See Trip Report, Hodeidah Governorate, Appendix D).

HEALTHCOM

The HEALTHCOM component of the ACCS Project was initiated in September, 1988 and transferred to HEALTHCOM II on August 19, 1991. The HEALTHCOM inputs were designed to concentrate in three Governorates, Hajjah, Marib and Al-Beida. The objectives were: (1) Establish within the MOPH a health education system based on research, planning, pretesting, production of audience-centered materials, and monitoring effectiveness, and (2) to implement communication activities for control of diarrheal disease in pilot projects at the governorate level that demonstrate ways to change behavior among the critical target population.

HEALTHCOM has conducted focus groups research with mothers in 16 villages in the catchment areas of eight health centers. On the basis of this, a mini-project has been designed to identify and train "Rural Caring Mothers" to provide village-level health education. This research has been questioned by the GD Health Education. The concern is that the data presented are incomplete. The differences are presently being worked out.

HEALTHCOM has conducted three assessment-planning workshops on health education with officers from seven governorates. As a result, a health education plan for each of the seven governorates has been devised. In all seven governorates the control of diarrheal disease has been chosen as the program priority, the central intervention of HEALTHCOM.

The project is also helping to develop a training module for health workers to improve their communication skills, especially at the interpersonal and community levels. Pre-service training curricula have been discussed with the Director of the Health Manpower Institute.

Two short-term consultants have been used for conducting a study in four governorates and validating the data. Two others assisted with a workshop in Aden to develop and finalize governorate health education plans and prepare a health workers' training module.

SPECIAL PROJECTS

NEDS

The National Epidemiologic and Disease Surveillance Program (NEDS) started December 15, 1991 with the arrival of an Epidemicologist/Team Leader on a PASA arrangement with the Centers for Disease Control, Atlanta, Georgia. The Team Leader will be resident in Yemen for two years with a possible extension for a third year. A workplan has been drawn up for the two-year period and is pending approval by the MOPH. Meanwhile, a data gathering and analysis system has been initiated through the Central Laboratory in Sana'a based on out- and in-patient data from selected hospitals and health centers in the Sana'a area. Data from these sources has been analyzed for major infectious diseases. The plan is to extend it next to the Hajjah Governorate.

This work is to be combined with the EPI program surveillance system being devised by REACH; and one, simple, standardized Health Information/Disease Surveillance System is proposed under NEDS. This is the objective of one of the proposed interventions. (See Section 5, Issue 5.12, and Section 7, Management Intervention for HIS).

Health Financing

Two studies have been completed on health financing: (1) A study of Health Care Options in Yemen, by C. Ross Anthony, September, 1990. (2) Health Care Financing/Health Insurance Potential, by Paul R. Torrens, August, 1991.

OPTIONS FOR FAMILY CARE

Project Period:	FY 1991 - 1999
PACD:	September 30, 1999
<u>As of November, 1991</u>	
USAID funding, LOP:	\$10.6 mns
Obligated to date:	\$500,000
Pipeline:	\$500,000

The Options for Family Care Project is in its infancy. The Grant Agreement was signed September 23, 1991. It is an eight year project with total authorization of \$10.6 mns. The pipeline as of November, 1991 was \$500,000, merely adequate to undertake certain "bridging activities".

The purpose of the project is to improve the awareness of broad population issues and to increase the access to a wide range of family care services in order to expand opportunities and options available to families. The project is divided into five 18-24 month phases. Phase I includes four interrelated project

components: (1) data collection, analysis and policy, (2) awareness raising and communication, (3) skills development and service delivery, and (4) commercial marketing of contraceptives. (See diagram, Appendix L).

Some thirteen institutions ("Cooperating Agencies") will supply services through "buy-ins" to centrally funded contracts for technical assistance and training for seven Yemeni institutions.

Bridging activities either completed or currently underway include:

- o Training of young men and women in six training centers in the Taiz area on awareness for disease prevention and benefits of health care (PRAGMA).
- o Research and demonstration of population dynamics which was started in 1986 and ended in October, 1991 at the National Population Conference (The Futures Group - RAPID II and III).
- o Provision of medical supplies and training for voluntary sterilization. Worked with physicians and health providers, hospitals and the Yemen Family Care Association. (Association for Voluntary Surgical Contraception - AVSC).
- o Curriculum development and training for service delivery. (Pathfinder Fund).
- o Training in reproductive health in Rabat and Cairo. (Program for International Education in Gynecology and Obstetrics, Johns Hopkins University - JHPIEGO)
- o Planning for an IEC program (Population Communication Services, Johns Hopkins University - PCS)
- o Training needs assessment for service delivery (Family Planning Training for Paramedical, Auxiliary and Community Personnel, Development Associates and Pathfinder - PACTIIB)
- o Service delivery, using a "cafeteria approach" in 15 clinics (Family Planning Service Expansion and Technical Support, John Snow, Inc. - SEATS)

5. ISSUES AND CONCLUSIONS CONCERNING CHILD SURVIVAL POPULATION AND RELATED PRIMARY HEALTH SECTOR PROBLEMS AND PRIORITIES

During the course of its investigation the Assessment Team members surfaced a number of issues which have a bearing on the final recommendations for interventions and the strategies and structure required to implement them. Some of these issues were identified in the Statement of Work; others have been added. Each of the issues is discussed in this section. Conclusions are stated at the end of each issue discussion. Throughout the report references are made to these statements, and the conclusions are embodied in the Team's recommendations.

5.1 ISSUE: THE CHILD SURVIVAL/FAMILY CARE FRAMEWORK - POLICIES AND GOALS

The Assessment Team members feel it is essential that all their recommendations and proposed interventions conform to and support ROY national policies and goals for the health and population sector. And further, that all donor agencies subscribe to the same goals.

These goals have been stated in the Action Plan adopted at the First National Population Policy Conference held in Sana'a 26-29 October 1991. The fourteen goals are based on the World Summit for Children Declaration; they represent a high level of political commitment on the part of the Yemeni Government.

The conference was well attended and addressed recommendations emanating from 17 task forces in the areas of (1) Community Health, (2) Human Resources, (3) Economic Development, and (4) Institutional, Legislative and Information Arrangements.

UNICEF has adopted the conference goals for its upcoming five-year program for 1993-97.

The fourteen goals (for the period 1991 to the year 2000) as summarized by UNICEF are:

- o Reduction of the infant mortality rate from 130 to 60 per 1000 live births
- o Reduction of the under-5 mortality rate by 50%
- o Increase in the coverage of immunization among children under one year of age to 85% and more, and expansion of coverage of immunization against tetanus among women of reproductive age

- o Reduction by 50%, compared with the 1990 levels, in the deaths of children due to diarrhoea
- o Halving of severe and moderate malnutrition among under-5s
- o Reduction by 33%, the mortality of under-5s due to acute respiratory infections
- o Reduction of maternal mortality from all causes by 50%
- o Increase in the life expectancy at birth from 46 in 1991 to 60 years
- o Reduction of the total fertility rate from 8.4 to 6 live births
- o Increase in the contraceptive use rate from around 3%-5% to 35%
- o Increase of primary health care coverage to 90% as compared to 40% in 1990
- o Expansion of basic education to reach an enrollment ratio of 85% and more among the relevant school-age population
- o Reduction of the adult illiteracy rate to less than 30% among males and 50% among females
- o Increased access to clean (safe) water to reach 80% of the households as compared to 48% in 1991

It is noted that nine of the 14 goals are directly concerned with health. All are compatible with the amended goal and purpose (December, 1989) of the ACCS Project. However, in the opinion of the Assessment Team members, they are overly-optimistic, and no matter how desirable, it is doubtful they can be reached by the year 2000. The link between the population/health and education goals is a positive one; as well as the population/health goals dependency on economic development. Without ever-increasing literacy rates and a rising standard of living, the goals will very likely remain beyond reach.

In formulating the recommendations and interventions contained in this report, the Assessment Team has reviewed each in terms of these goals, and have determined that all of them support the goals.

Conclusions:

It is important that the government and all its donors support the same goals for health and development. The Assessment Team has judged all of its recommendations on the basis of the goals adopted by the October 1991 National Population Policy Conference.

5.2 ISSUE: COMPLEXITY OF THE GOVERNMENT OF THE REPUBLIC OF YEMEN AND EXTERNAL AID

With the unification of the two Yemeni nations in May, 1990, the public service ballooned in numbers and the bureaucracy became over-burdening as sections, directorates and general directorates increased in numbers; and duplicate, often incompatible, regulations and procedures fell under one central government.

Before unification, the PDRY (South Yemen) had an estimated 225,000 public servants. The Yemen Arab Republic (North Yemen) had 75,000 public servants. Today, the total of the two, 300,000, are employees of the new unified Republic of Yemen, a ratio of one public servant to every 39 men, women and children! The unified Ministry of Public Health has a total of 18,000 employees. According to the preliminary results from seven Governorates of the December 1991 Health Manpower Survey, 35% up to 51% of health manpower occupy administrative positions (those other than medical, nursing or technical). See table under Section 5.11 on Manpower.

The MOPH is top-heavy with a multiplicity of positions at the central level. This has given rise to compartmentalism of functions and redundancy with very little coordination. (See Appendix J - Organizational Chart, Ministry of Public Health).

These problems are apparent in various donor-supported health activities, including Health Education, Health Information and Epidemiological Surveillance, and the administration of Primary Health Care, MCH and Family Care.

Beyond the Ministry of Public Health, other ministries and governmental agencies involved in Child Survival and Family Care activities include the Ministry of Information, Ministry of Planning and Development, Ministry of Local Administration, National Population Council, Central Statistical Organization, Health Manpower Institute, Sana'a University Faculty of Medicine, Dr. Nasher's Health Institute in Aden, the YFCA, and Social Insurance Corporation, to name the more prominent. (See Appendix L - Options for Family Care Project Chart of Implementing and Contracting Agencies).

Elsewhere in this report the Team has listed the strengths and weaknesses of the system within which all must work. Underlying the typical litany of problems and shortages facing the nation in the health/population sector, the basic issue is how the young nation will overcome a variety of social, political and economic obstacles during the coming months as it goes through elections and makes the transition to a more open democratic society.

Conclusions:

The challenge facing USAID is to determine the best point in this complex system to inject funds, commodities and technical assistance where the resources can be absorbed, managed and sustained in the most cost effective way.

5.3 ISSUE: SUSTAINABILITY AND ROY MANAGEMENT CAPACITY

Underlying the potential for sustainability of this and other assistance programs, is the general economic situation coupled with the adjustments inherent in unification. While Government officials are optimistic that the next two years will produce an economic turn-around, there is no assurance of this (such as re-establishment of economic aid from the Gulf States and the discovery and production of new oil reserves).

Recent trends in the health budget are not encouraging. Clearly, the government is in serious financial straits and this is reflected in the capacity of the government to achieve its objectives in the health and population sectors. For example, there is a definite limit to the numbers of health providers that can be recruited and trained and then absorbed on the government's rolls. At present there are 60 health workers trained by the REACH project who remain unemployed in one Governorate (Hajjah).

As further example, the Primary Health Care Units built with aid in the Tihama Project have not been maintained and are in a poor state of repair. While staff continue to function, the quality of care has been noticeably lowered.

In view of this, the Team has looked closely at the conditions for sustainability for the recommended interventions. For each, estimates are to be prepared for the recurrent budget necessary to carry on following the removal of external assistance. In appropriate cases, the Team recommends that USAID consider "phasing out" assistance, so the impact on Yemeni resources will be gradual. Similarly, when dealing with the issue of sustainability, USAID project design should take into account "phasing in" so that the government's capacity can be gradually built up to absorb the inputs. In this regard, REACH consultant Rachel Feilden in her assessment of the lessons learned from the Tihama Project, observed

that as is so often the case donor ambitions exceed local capability.

"In future it will be important for donors to coordinate their own project ambitions (with those of the host nation)." (Feilden, 1/92). This may well have been the underlying cause of many of the troubles that beset the Tihama Project. It is a telling message, and a lesson that has to be learned over and over again. It must not be repeated with the proposed new alignment of the ACCS and OFC Projects.

Conclusions:

The importance of sustainability of project inputs cannot be overemphasized. Each intervention undertaken should be carefully examined for its future recurrent costs and commitments obtained from the ROY to sustain the activity following the withdrawal of foreign assistance.

5.4 ISSUE: SHORTAGE OF RESOURCES AND LIMITED ACCESS TO HEALTH CARE

Clearly, with the present financial crisis the Government is not in a position to take on additional health service costs of any significant magnitude. The need far outweighs the ability to pay!

As noted in the issue paper on private sector initiatives (Appendix G), private health care is a growing industry in the urban areas, now providing for an estimated 15% of the urban population. There are over 1,000 private practitioners and approximately 1,100 pharmacies in Yemen. Most all MOPH physicians operate private clinics in the afternoon in addition to their public duties in the morning.

Nonetheless, this leaves the great majority of the people with little recourse to health services. Based on its brief field experience and other investigations, the Team questions the official estimate of 50% coverage. In many areas there is a complete void of health services, particularly for women and children - the two primary groups-at-risk - due to cultural barriers preventing male providers from serving them. There are

30,000 villages in Yemen and only 900 Primary Health Care Units. The Team is using 40% as a more realistic global coverage figure in designing the interventions.

With this in mind, the Team members have looked hard to identify ways and means to improve health status with little financial input from the public sector.

This has led the Team to examine the potentials of the people themselves. In what ways can individuals, families and communities support themselves (with modest outside assistance) to bring about change for improved health status? There have been significant strides in this direction in other nations. The concept is to emphasize maintaining wellness rather than simply providing for cure. Health care starts with the individual, then the family, next the community and finally the health system.

Thus, the Team is recommending simple, low-cost interventions at the community level. These include, the formation of Village Health Committees, the adoption (and adaption) of the volunteer "Health Guides" which have proven so successful in the southern Governorates, and the training of Licensed Birth Attendants (LBAs) and female PHCWorkers. Emphasis in these interventions will be on health education to introduce behavioral change, simple preventive and curative applications (ORS, chloroquine tablets, aspirin and the like), pre-natal care, nutrition, child spacing, environmental sanitation, and motivation to increase accessibility to the health services (such as mobilization for vaccination campaigns).

These options are examined in detail under the interventions section.

This approach is not without precedence. The Yemeni people have demonstrated strong motivation in constructing local infrastructure projects through the LCCDs and it is expected they will continue this support for Primary Health Care Units planned through the REACH Project.

(For further discussion see Issue No. 5.5 - Health Care Financing).

Conclusions:

The Government of Yemen is in a severe financial crunch. Resources are inadequate to meet even the basic needs of health, education and social services. One source of resources for health care is the people themselves. Thus the Team is recommending that the health care system should place more emphasis on the community and the motivation of the people to develop their own potentials for self-family-and-community health care.

5.5 ISSUE: HEALTH CARE FINANCING

In all health systems throughout the world, the search is on for health care financing mechanisms to ease the burden on the public purse. With the severe financial problems facing the Government of Yemen, the need is all the more apparent here. Fee-for-service, national social insurance schemes, health insurance for government employees, capitated health service systems (HMOs), and revenue sharing at the LCCD level are all under consideration.

Until very recently the Yemen constitution provided for free health care for all. However, the new constitution, adopted by referendum in May, 1991, is silent on the point.

While it has not been possible to check into the details, it is known that a form of health insurance has existed for some time in the former PDRY.

The Minister of Health has publicly supported private sector initiatives in health and recently on national television encouraged the private sector to invest in health services.

A Health Insurance Planning Committee has been authorized by decree from the Prime Minister and Minister of Insurance and Social Affairs. This Committee has been meeting and has developed a plan for a health insurance program for government employees.

The draft strategy paper written for the first health plan for the ROY (1993-1997) supports the need for new financing mechanisms. The paper proposes a social insurance scheme for specialized care (for those persons with ailments lying outside the government's definition of basic health care), a YR 0.1 increase in the Zakat (religious tax) to be used wholly for preventive health projects at the first level of the LCCD, and a financing partnership between the MOPH and LCCDs to support all health facilities (MOPH to pay 60-80% of the budget of a health institution, with the LCCD to pay the remainder 20-40%, or even more).

The private sector is viable and is currently providing for about 15% of the urban population. (See Appendix G - Private Sector Initiatives).

Funds spent outside the country for health care approved by the Ministry of Finance amounted to \$4.6 mns in 1990. But according to external consultants, the total amount spent outside the country may run as high as \$60 mns a year. (Torrens, 8/91).

Al-Thorah Hospital in Hodeidah is presently experimenting with a fee-for-service scheme.

And the Revolution Hospitals in the Ibb and Hodeidah Governorates (both about 300 beds), in the past have received voluntary contributions of some significance used for maintenance, equipment and building construction. The funds have come from visitors, suppliers, and occasional patients. This practice was stopped by the former YAR because there was no legislation allowing public institutions to receive private monies. But following unification this voluntary concept could well be reinstated.

With this background of private, public and voluntary support and recognition of need, there appears to be an increasing interest for taking steps to find alternate means to finance health care. (See also, Hodeidah Field Trip Report, Appendix D).

However, there are many problems to overcome including the complete lack of a data base for planning and administering insurance programs. Clearly, any national program for alternative health financing is beyond the purview of the proposed CS/FC Project. There may, however, be more immediate potential for financing through fee-for-service arrangements and LCCD cost-sharing at the local level.

Therefore, the team is recommending one intervention to be in the form of a study to investigate these two potentials, with small pilot projects.

There is one over-riding caveat. Previous experience has shown that revenues generated by the public health sector go directly to the Ministry of Finance and have not been used for the benefit of health. If this situation is not corrected there will be little incentive for alternative financing schemes.

Of special interest in this regard is the experience with the surtax on cigarettes. Specifically called a "health tax" (rasam sehi), the 1 rial per pack tax yields about YR 25 mns annually to the national coffers, but none of it is specifically allocated to health.

Conclusions:

There is interest and there is potential for developing health financing schemes in Yemen, and the private sector offers many opportunities for providing health care. The Team is recommending some small pilot projects for community-level health care financing.

5.6 ISSUE: THE ROLE OF DONORS IN HEALTH AND POPULATION IN YEMEN

Looking back, most of the Government's resources in the health sector have gone toward the provision of curative services, where none existed 20 years ago. Large-scale donor assistance has been provided by Saudi Arabia, Kuwait and various Arab funds in constructing, equipping, staffing and operating hospitals and clinics.

Many international agencies, have worked in health in Yemen since the early 1980s, especially in the Northern part of Yemen. These included the Americans, Dutch, Germans, Italians, British, Swedish, Australian, French and Norwegians. However, no formal coordination of efforts was established between these agencies.

Most of these efforts have addressed Primary Health Care, Maternal and Child Health, Health Education, the provision of basic and medical health services, and training of health manpower.

Presently, the Canadians, Chinese, Russians, French and Italians provide medical assistance to hospitals in the form of personnel. The Germans, Dutch, Japanese, Americans, Swedish, British and the UN Agencies (UNICEF, UNFPA, WHO) provide assistance to PHC concentrating on MCH services, training of PHCWs, developing curricula, control of communicable diseases, health education and environmental health with special emphasis on water and sanitation.

UNICEF has been a major contributor to improving the health status of mothers and children in Yemen. It was instrumental in assisting the Government to establish a PHC program in the early 1980s and improving child health in general. Most recently one of UNICEF's primary foci has been on expanding and improving immunization.

The new UNICEF five-year program for 1993-97 totals \$21.5 mns of which \$11 mns is devoted to health, and of this amount \$3.0 mns is to be area-specific (in four governorates). The three major priorities of the 1993-97 plan are:

1. Child Survival, Development and Protection
2. Maternal Survival
3. The Girl Child

Past efforts have succeeded in increasing health services coverage to a significant portion of the population where there was none before. But the lesson that everyone has learned is that once the donor agencies left a project, the project could not be sustained. And there are projects going on today (for example, the Dutch in Rada and Hodeidah, and in all likelihood even the new Peace Corps project) where a repeat performance is highly likely.

Despite the large input in the health sector from donor agencies, cost effectiveness appears low. Most projects collapse or the donor input is stopped. This is primarily due to the heavy involvement of foreign technical assistance, topping-up local salaries, funding the running costs, lack of counterparts and providing hands-on operating assistance.

USAID's principal experience in PHC was the Tihama Project which operated from 1980 to 1990. This project was a traditional "full service" activity involving long-term technical assistance and commodity support. Catholic Relief Services was the first contractor, later replaced by Management Sciences for Health. The Mission has concluded that this was not a cost-effective activity in the Yemeni context.

Today, USAID is involved in three health/population activities:

- (1) the Accelerated Cooperation for Child Survival Project
- (2) Options for Family Care Project
- (3) Women in Development (health program component)

These are discussed in some detail in Section 4.

Typically donors do not have open lines of communication nor do they coordinate programs among themselves. It is expected that the MOPH should assume a more active role in coordinating external assistance.

In January, 1990, UNDP attempted to coordinate donor input by sending out a questionnaire and arranging for a meeting at the Central Planning Organization. Twenty-seven organizations responded to the questionnaire, and most attended the meeting representing the agencies working in the country, except the Saudis, Kuwaitis, Chinese and Russians.

The participants formed five working groups to meet and discuss development topics in the health sector. However, due to changes brought about by unification, these groups never met.

In August 1991, USAID in collaboration with the Ministry of Public Health organized a donors' meeting at the Ministry and a questionnaire was sent out to the major donors. Eleven agencies

responded and identified the following problems faced in implementing their project programs.

1. Lack of qualified counterparts
2. Absence of functional coordination
3. Poor administrative system
4. Excessive bureaucratic process
5. Delays or non-delivery of government contributions
6. Absence of clear MOPH mandate or framework for activities

Recently, UNDP started donors meetings in preparation for the Round Table Conference to be held in Geneva in the 2nd quarter of 1991. The issues are divided into different topics with one agency heading each sector; for example UNICEF heads the health sector, UNFPA heads the population sector, FAO heads the agriculture sector and so on.

The Round Table Conference meeting is a preliminary one in which the Yemen Government representatives will meet with the major donors to discuss development priorities for the country's next development plan. Once these are set, another meeting will be held in which the amount of contributions from each donor agency will be announced.

The MOPH has developed two papers for the conference which will be discussed with the donors in Yemen at the end of April for refinement before submitting them to the Geneva Conference.

Conclusions:

Sustainability is a major concern for the Yemeni Government as well as for the donor community. No project should be started unless it can be sustained!

With the variety of donor activity taking place in Yemen it is essential that proposed new initiatives be thoroughly cleared with the Government and other donors to avoid overlap and duplication.

5.7 ISSUE: DECENTRALIZATION AND FOCUS ON THE GOVERNORATE LEVEL

As a smaller unit of government, the Governorate is clearly more manageable and health officials are in a better position to respond more directly to the needs of the people. Implementation of service delivery becomes more effective as management decisions are made closer to the point of contact between provider and client.

In the new unified Yemen, there are 18 governorates of a size ranging from 40,000 to 2,500,000 population. These are divided into 227 districts, 2,520 sub-districts, and 30,000 villages. The village is the smallest unit and may be made up of a number of scattered settlements. The Local Councils for Cooperative Development (LCCDs) have no political boundaries.

A recent development has been to focus donor inputs at the Governorate level. In health, the ACCS Project through REACH has inaugurated a training program for renovating health centers into training sites and has trained 166 primary health care workers in four governorates - Hajjah, Marib, Sada'a and Hodeidah.

Similarly, HEALTHCOM has contracted with the three Governorates of Marib, Al-Beida and Hajjah to train health workers to work in selected communities to recruit and support "Caring Rural Mothers" to promote health education focused on diarrhea/ORS and breastfeeding. YR 42,501 has been made available to each governorate through a contract to initiate this work at the village level.

The Peace Corps is also starting a new program utilizing volunteer nurses, midwives, health administrators, lab technicians and health statisticians for a comprehensive PHC approach focused in eight specific sites.

The new UNICEF draft five-year plan for 1993-1997 provides for area-specific programs in water, health and education totaling US\$ 6 mns in four governorates out of a total five-year budget of approximately US\$ 21.5 mns. The Governorates are yet to be selected.

There are other programs concentrating at the local level. In health these include the Swedish, Dutch, German, and British, clinic-level activities.

As a further point, by focusing on Governorates, donors can select areas in need so as to avoid overlap with other assistance programs. Approval and support of the central ministry is a must in all cases.

The decentralization approach is acceptable to Government, and is a much-discussed subject. Recent legislation gave official endorsement to decentralization, and starting in 1993 budgets will be allocated to the Governorates. The Director General of the Governorate Health Office will have authority to expend funds according to budget, and will be involved in a planning process which originates the identification of needs and priorities at the Governorate level.

Of course, in many project initiatives, it would be a mistake to concentrate solely at the Governorate level and ignore the center.

For example, in strengthening the Health Information/Disease Surveillance System it is envisioned that substantial progress can be made in installing effective systems Governorate-by-Governorate, but this must be done within a national framework; the national system and governorate sub-systems must be compatible and interchangeable.

Similarly, the Team members see opportunities to move forward with management training. Management training at the Governorate-District level can prove effective in the more finite managerial environment close to the provider-client point of contact. This is where it all comes together, where managers must be resourceful and where intersectoral collaboration can be made to work. At the same time, some progress should be possible at the national level through management training in functional areas, such as personnel, finance, planning and budgeting, logistics and supply, and transport and communication.

However, the donor community should be well aware that short of a major overhaul and restructuring of government at the central level, little progress can be expected in managerial reform. Nonetheless, the Team members believe, even under existing conditions, the effort (and financial inputs) will be worthwhile in the overall context of health and family care, and considering the serious plight of the Yemeni people.

Conclusions:

The Government is supporting the concept of decentralization. A number of donor agencies have adopted this approach. Working at the Governorate level holds promise of more effective absorption of donor inputs. The Assessment Team accepts this concept, and whenever applicable the recommended interventions are designed to be implemented at the Governorate level and below.

5.8 ISSUE: PROJECT MANAGEMENT BY USAID AND ITS CONTRACTORS

With the present and proposed level of staffing in the USAID Mission, it is clear that USAID is not in a position to directly manage and coordinate project activity. Rather, USAID should retain a monitoring/evaluation function to ensure that project objectives are met within budget.

For the ACCS Project, the USAID Mission has retained the monitoring and coordinating function, but it is severely handicapped in performing these functions due to the "buy-in" arrangements. Under ACCS, USAID now has two contractors on a buy-in basis - REACH and HEALTHCOM - plus a PASA specialist for Disease Surveillance

(NEDS). During the course of this assessment one glaring problem surfaced between two of these implementation entities (REACH and NEDS) concerning the coordination of the Health Information and Epidemiological Surveillance systems. If all work were done under one contractor these kinds of problems would not arise. There is also no apparent coordination between REACH and HEALTHCOM.

The lack of a strong coordinating function (either by a contractor or by USAID) has resulted in a number of problems in the administration of the three ACCS implementing entities. It is noted that on occasion they have asked for workshops in a governorate involving the same participants at or near the same time. Further, there is no need to have a coordinator in a governorate for each project module. These duplications and other inefficiencies could be reduced with one set of field coordinators.

With the OFC Project, the Team members see the need for a strong contractor management function, including the purchase of commodities. Realistically, the OFC Project cannot be effectively managed and coordinated with the multiplicity of actors (governmental and private agencies, and contracting agencies) that are planned. The OFC Project should be streamlined for (1) better management, and (2) more effective impact. This is discussed in some detail under Issue No. 5.15 and in Section 6 on Strategies and Structure for Implementation.

Other means for project management include direct funding of multi-lateral agencies (e.g. UNICEF and WHO), and NGOs or PVOs. For the mid-term future (5 years), the only viable choice in this regard is the possibility of granting funds to UNICEF for immunization. USAID must determine if such a move would best support its program and would be more effective than implementing it on its own or through its contractors. Under the OFC project (to be combined with child survival) support of the non-governmental agency, YFCA is planned.

The REACH contractor, John Snow, Inc., has a three-person administrative staff at its central location in Sana'a and four field coordinators, one in each of the Governorates in which it is working. While it is recognized that there are a myriad of administrative procedures and bureaucratic obstacles to overcome (on both the U.S. and Yemen side), in relation to outputs achieved, this has all the appearances of a top-heavy organizational structure. The Team has not identified any technical work undertaken by this staff; it is all administrative, including the role of the Governorate Coordinators who appear involved in "busy work", and limiting their work to administration, logistics and providing a communication link with the central staff. Further, the Chief of Party largely limits his role to a coordinating one, facilitating the work of a battery of consultants, with no time left for technical work.

The Team recognizes that the field coordinator role can be an effective one. To increase this effectiveness the coordinator's job can be broadened to include technical responsibilities. Also, consideration should be given to appointing coordinators who are officials of the MOPH (that is, a strong, full-time counterpart), and who would be compensated for extra time spent and per diem when on field duty. This will help provide a close link with the MOPH and its on-going work in the Governorate, make it possible to attract more senior persons to the position, and avoid the problem of training project staff who are lost to the MOPH or other projects when the project ends. (This was one of the "lessons learned" from the Tihama Project. See Feilden, 1/92).

It would be counter-productive to top-up the salaries of these counterparts (another "lesson learned" from the Tihama Project). However, incentives could be made available by sponsoring the Coordinators in a US-based management training short course such as those offered by MEDEX, Boston University and Management Sciences for Health, if present restrictions on participant training are lifted.

Further, for USAID to maintain an adequate monitoring function it will be important to have frequent and timely progress reports from the contractors. These should be against a workplan. If there are to be active programs at the Governorate level, there should be sub-workplans for each Governorate. In the past REACH has had such workplans, and also submitted quarterly reports, but this practice has fallen behind. It is important that it be maintained. Workplan formulation should use a "bottom-up" approach so that MOPH officials at the District and Governorate levels make early inputs to the planning process.

Conclusions:

Present staffing levels at USAID do not allow for adequate project oversight, and due to the contractor buy-ins, the local USAID Mission has little control; the responsibility of the local contractors is to the mother project in Washington (John Snow - REACH, and AED - HEALTHCOM).

In the future, it will be important to have strong contractor management in Sana'a with an effective, but streamlined monitoring/evaluation function by the USAID Mission, which should include clear performance indicators and regular reporting against the indicators.

5.9 ISSUE: DURATION AND CONTINUITY OF USAID FOREIGN ASSISTANCE

The Team members feel it is important to maintain a continued presence in the health/population sector and to carry out to satisfactory completion the work started (provided, of course, that it is judged to have positive outcomes). The Team members also believe that duration is important; experience has demonstrated that it takes an inordinate length of time to reach a satisfactory level of productivity in project implementation in Yemen, but this does not mean the attempt shouldn't be made. Rather, realistic time frames must be established.

While both the REACH and HEALTHCOM components of the ACCS Project have fallen far short of planned outputs, the Team recommends that certain activities that have been started should be continued. This is addressed in Section 6 on Strategies and Structure for Implementation. The desired continuity can be provided through an integration of the ACCS and OFC Projects. The advantages and disadvantages of this integration and the Team's recommendations are contained in Issue No. 5.15. And the structure and strategy to achieve the integration of MCH/FC activities is contained in Section 6.

Conclusions:

Child Survival activities financed under the ACCS Project should be integrated/merged into the Options for Family Care Project as quickly as possible during the remaining life of the ACCS Project which currently ends in September, 1994. Realistic time frames must be allowed for impact. Reducing the scope of work is another means of compacting time. (That is, specific, discrete interventions achievable within 2 to 3 years)

5.10 ISSUE: FUTURE PROJECT ASSISTANCE FOR THE SOUTHERN GOVERNORATES

Following the field trip to Abyan Governorate, it became apparent to the Team that significant differences are evident in the health systems of the former North and South Yemen, and that the two areas of the new unified nation can benefit from each other.

As noted in the Trip Report (Appendix E), some of the significant differences are:

The Southern Governorates:

- o have a Health Information System (although it is not fully operational)

- o utilize volunteer Health Guides at the community level
- o have stronger supervision
- o have better trained health personnel, and more females
- o require mandatory military service for men and mandatory social service (health and education) for women
- o population has a higher level of education in general and a higher literacy rate among women in particular
- o Directors General at the Governorate level have the authority to redistribute and post health personnel according to need

The Northern Governorates:

- o have a tradition of community development through the LCCDs
- o have a leaner public service
- o have private sector involvement in the health sector
- o some Northern Governorates have reached a level of 80% coverage of under-5s in the EPI campaign
- o some hospitals have received voluntary contributions for maintenance, equipment and construction (see Issue 5.5 on Health Care Financing)

The Team recommends that future health programs sponsored by USAID should include at least one Southern Governorate. For the proposed integrated CS/FC Project, the Team also recommends that work be focused on five governorates, one of which would be a southern Governorate. The four governorates where ACCS is presently active would be retained (Mareb, Hajjah, Hodeidah and Saad'a).

By adding a southern Governorate, USAID will -

- o gain valuable knowledge and experience from the southern Governorate
- o be in a position to promote and encourage technology transfer among the governorates, including North-to-South and South-to-North (see Interventions)
- o demonstrate support for the new unified Yemen

Conclusions:

For the reasons stated USAID should include at least one southern Governorate in its future health and population assistance programs.

5.11 ISSUE: HEALTH MANPOWER DEVELOPMENT

Although the number of trained health personnel has increased in recent years, there remains a severe lack of health manpower in Yemen, especially females. This lack of females limits the accessibility of the health services to the most vulnerable groups in the society, women and children.

In the Northern Governorates PHCW training was established for graduates of a sixth grade education to increase the accessibility of health services to remote rural areas. Different donor agencies (the Dutch, Germans, Swedish, UNFPA, etc.) have conducted training for PHCWs, men and women.

However, due to cultural constraints, few women have been trained. In the northern governorates of the unified ROY the PHCW is required to perform an array of outreach, health education, and curative services. Supervision is often lacking for the worker and he/she is usually unable to fulfill the many requirements of the job. PHCWs often do not know how to plan or carry out health education or how to use opportunities in the community to their advantage.

In the ROY's Southern Governorates, the PHCW system is somewhat different than in the north. There are many trained para-medical such as medical assistants, professional nurses, lab technicians, public health inspectors, community midwives, etc. Most of these cadres were trained at Dr. Amin Nasher's Institute in Aden. The Institute reports show a total of 4,014 para-medical trained between 1970 and 1990. Therefore, there was no need for training PHCWs. However, in places with no health facilities, Health Guides who are volunteers in health but serve as government employees in other ministries such as Education and Agriculture are trained for 3 to 6 months to deliver basic health services at the village level. There are approximately 1200 Health Guides in the south at present.

In the northern part the Health Manpower Institute (HMI) is responsible for training health personnel. There are branches in some of the Governorates. However, the number of graduates is limited.

The next one to three years will be a transition period for the health sector as the two previously separate health care systems and policies are integrated and standardized.

In most rural health centers, there is no structured MCH care program and no female MCH personnel. Society's strong aversion for women to seek or accept services from male health care providers results in few women coming to the health center/clinic to seek treatment or other health care services such as immunization or prenatal MCH care. There are few trained female PHCWs and a severe

lack of trained TBAs, midwives and nurses to assist pregnant or delivering women.

**BASIC STATISTICS
HEALTH MANPOWER AND FACILITIES IN YEMEN**

	1986 (North)		1989 (North & South)		1990 (Est.)	
	Yemeni	Total	Yemeni	Total	Yemeni	Total
Doctors	633	1233	1794	1884	2573	2663
Nutritionists	2	16				
Lab Technicians	92	157				
Nurses	487	1415		6117		6422
Trained Midwives	48	165				
Health Clinic		209		296		296
Hospitals		35		72		72
Health Center		80		94		94
HCUs		399		811		818

Source: Central Statistical Organization, Statistics Yearbook, 1990

Preliminary analysis of seven Governorates from the Health Manpower Survey conducted in December, 1991 (Mareb, Sada'a, Hajjah, Hodeidah, Jauf, Baida, and Dhamar) showed the following:

PERCENT OF STAFF IN MAIN CATEGORIES

	Medical	Nurses	Tech.	Other
Mareb	4%	39%	5%	53%
Sada'a	14%	37%	9%	40%
Hajjah	9%	52%	7%	35%
Hodeidah	12%	45%	7%	35%
Jauf	4%	46%	2%	47%
Baida	10%	47%	5%	38%
Dhamar	6%	46%	6%	4%

- * Medical: refers to doctors, dentists and pharmacists
- * Nursing: refers to professional nurses, TBAs and PHCWs
- * Technical: refers to laboratory, x-ray, dispensary staff, etc.
- * Other: refers to administrators, clerks, cooks, laundry staff, guaras, etc.

From the above table, it is seen that the proportion of the other staff is extremely high relative to the remaining categories, followed by nursing personnel, with a majority of them being PHCWs. Technical staff on the other hand are the minority in all governorates surveyed.

The proportion of female staff employees as reported in the December, 1991 Survey is shown below:

PERCENT OF FEMALE STAFF IN MAIN CATEGORIES

	Medical	Nurses	Technical	Other	Total
Mareb	0%	25%	0%	4%	12%
Sada'a	9%	35%	14%	13%	21%
Hajjah	12%	35%	3%	16%	25%
Hodeidah	18%	38%	14%	31%	31%
Jauf	0%	25%	0%	0%	12%
Baida	6%	38%	6%	19%	26%
Dhamar	0%	27%	0%	12%	18%

As expected Mareb and Jauf governorates have the lowest overall percentage of female staff, as these two governorates are the most conservative in the country. Hodeidah has the highest percentage of female staff which supports the findings of the field trip. Finally, the percentage of the females in the nursing staff is highest compared to the other categories. The analysis also found Jauf and Sada'a governorates to have the highest percentage of non-Yemeni staff, 83% and 77% of the medical staff; 61% and 59% of the nursing staff; 67% and 62% of the technical staff respectively.

For additional information on the female health provider, see the report of interviews conducted on the field trip to Hajjah and Hodeidah Governorate, Appendix F.

Conclusions:

A severe lack of trained manpower for health persists in Yemen.

The manpower profile:

- o **Over-reliance on expatriate health workers**
- o **Over-abundance of administrative personnel**
- o **Inadequate numbers of female health workers**

5.12 ISSUE: HEALTH INFORMATION AND EPIDEMIOLOGICAL SURVEILLANCE SYSTEM

One of the major managerial problems facing the Ministry of Public Health is the weakness of the health information system. The lack of data for planning and decision-making is a widely-recognized constraint in the health services.

There are numerous departments and projects within the health services using different information systems and procedures. They are collecting and analyzing data on their own and using their own forms and registers. These departments and projects include:

- o **Department of Health Statistics**

This is the main department in the MOPH responsible for data collection, analysis and reporting.
- o **Expanded Program for Immunization (EPI)**

EPI has its own system for collecting data on the EPI target diseases and vaccinations
- o **Department of MCH**

During 1986, in cooperation with WHO, this department designed and established an information system to cover all the activities provided by most health facilities in the country.
- o **National Epidemiologic and Disease Surveillance Program (NEDS)**

This is a recently-established program working with the MOPH and located at the Central Laboratory in Sana'a to collect and analyze information on infectious diseases.

- o Health Facilities

Various health facilities - general and rural hospitals - maintain different medical records. There is no uniform system.

- o Northern and Southern Governorates

Despite the country's unification and legislation passed to unify the health system, the information systems remain separate.

Awareness of the importance of a unified and effective HIS is increasing among health workers. In the northern Governorates, however, the system suffers from many problems. These include:

- o Unavailability of records and reports

Many health facilities do not have supplies of these essential materials. Some devise their own, handmade records. Availability is helped in places where there are donor programs, but typically, the donors devise their own forms, thereby compounding the problem. Availability at the governorate level is severely lacking. The EPI has its own HIS forms which are reasonably available at all levels. These consist of a daily register, tally sheets and monthly reports.

- o Poor quality of data

The majority of health personnel have not been trained in filling out forms. When the forms do exist, most records are incomplete. The interpretation of information varies. Monthly records do not agree with daily tallies. There are frequent mis-diagnoses, especially for diseases requiring laboratory confirmation. There is duplication of data between the EPI HIS and MCH/PHC HIS.

- o Lack of procedures for transmitting information up the system

This was improved by linking the transmittal of reports with staff salaries, but this then resulted in fabricated reports. Little attention is given to reports because it is generally believed the quality is poor.

Transmittal requirements to more than one department in the MOPH causes confusion and increases the workload at the Governorate level.

- o Lack of information processing and analysis

Figures are usually compiled as totals with no denominator, which greatly reduces the value of the data.

- o Non-use of information for planning and decision-making

There has been no MOPH statistics book published since 1987 due to the lack of funds. Feedback is nonexistent. Health information is not used for management and decision-making purposes because of poor quality and lack of such information.

- o Lack of training and supervision

The Southern Governorates:

In the southern governorates, the HIS is decentralized. It is comprehensive, well designed and provides a framework for action-oriented management. Nevertheless, implementation of this system shares the same problems of the northern governorates.

Manpower:

Personnel in the Statistics Departments in the Southern governorates and at central level are adequate. But material resources are meager. In the majority of the northern governorates there is a severe shortage of trained statistical personnel.

There are three institutions which provide HIS training: the Health Manpower Institute in Sana'a, Dr. Amin Nasher's High Institute for Health in Aden, and the Central Statistics Office. But the local training facilities are limited and need significant development. A lack of trained trainers persists. Training is needed at all levels, to information providers, data processors and analysts.

Donors:

The donor community, especially in the northern governorates, has supported the development of HIS at the local level (that is, in given health facilities - the Dutch in Hodeidah, Rada and Dhaher, the Germans in Ameran, Swedish in Taiz, etc.), but there is limited support for the governorates (intermediate level) and the MOPH (central level). Presently German volunteers are helping in the development of the HIS for EPI at the central level, but this support is limited.

The National Epidemiologic Diseases Surveillance program (NEDS), supported by USAID under the ACCS Project, is presently supporting data collection and analysis of infectious diseases in Sana'a Governorate covering five health centers and three major hospitals. The Project plans to expand to four more governorates in the near future.

Another ACCS-sponsored activity, under REACH, has designed a HIS/surveillance system for the Expanded Program for Immunization (EPI). These two systems must be merged. (See Interventions).

Conclusions:

There should be one, unified, standard, but simple system for health information and epidemiologic disease surveillance. As the MOPH is the main body for data collection, reporting, processing and analysis, support for the design and development of the system at the national level is vital. However, while a national framework is essential, the HIS can be installed in the governorates, one-by-one, within the national framework.

It is also important to coordinate external support to avoid duplication and the proliferation of non-standard statistical forms as is the present case where multiple health information systems exist.

The time has come for one good, simple, functional system to support all health and population work in Yemen. The Assessment Team considers it a high priority.

5.13 ISSUE: COMMUNITY PARTICIPATION

Community participation can and should be a major component of the PHC services program in Yemen. PHC is strengthened through community participation and the spread of community awareness. Community participation activities are visible and viable, especially in rural Yemen, where many communities have taken on major responsibilities for development since the early seventies.

Local councils have a long experience in community participation and organization of community work, especially in the health sector. Community development committees (Local Councils) have organized themselves to deal with development issues related to health. At the district and local levels, the Local Councils for Cooperative Development (LCCDs) are important partners with MOPH. Most of the PHC Units in rural Yemen have been constructed with 50% community funding. Furthermore, the Local Councils contribute financially to the cost of health by recruiting and providing financial support to trainees and employees in health.

In recent years, a move toward centralizing the functions of the LCCDs has resulted in a reduction of contributions by the communities since the government's bureaucratic procedures hindered the use of funds when needed. Most Councils have had to employ a person for contacting central level to get their contributions back for development purposes.

Since unification, a Ministry of Local Administration (MLA) has been established complicating the procedures and making it even harder for communities to get the needed funds. Moreover, the current economic depression and the return of immigrants (meaning greatly reduced remittances) have resulted in even lower community contributions. Despite the above, communities are still providing materials for constructing health units/centers and manpower.

In the southern governorates, community participation has been in the form of services provided, i.e., volunteer Health Guides, mobilization of communities for immunization, health education, and recording of vital statistics for the communities through the Population Defense Councils (PDC). The General Yemeni Women's Union (GYWY) had a wide membership and participated in increasing awareness among women regarding MCH, conducted training for volunteer health workers and held many seminars and workshops for disseminating health information.

Conclusions:

Yemen has a long, and strong, tradition of community self-help. Community participation (financial and in-kind) should be a component of all future health/population programs.

5.14 ISSUE: HEALTH EDUCATION

Health education is a critical element for improving the health status of the population. This is particularly true in Yemen because of the high illiteracy rate (especially among women who are the primary care-takers of the members of the family) and the limited access to health services, particularly in the rural areas.

Health education messages covering the important determinants of health and especially MCH/FC, such as nutritional practices, breastfeeding, personnel hygiene, environmental sanitation in the home and the community, safe water supplies, proper child care and child spacing can have a major impact in improving the health status of the population and have a positive influence on the reduction of maternal, infant, and child morbidity and mortality.

The Health Education Department in the Ministry of Public Health supports many departments and programs such as MCH, FC, EPI, CDD, infectious diseases, nutrition, and general and home accidents.

The Department utilizes a number of channels to reach the population through mass media: television, radio, mosques, schools, women's groups, etc.

Presently, the health education messages are aired through the mass-media including radio and television. However, no studies have been conducted to assess the impact of these messages in changing people's behavior. It is accepted, however, that a large percentage of the target audience watches or hears the messages, but this does not necessarily mean that people understand them or act as advised since the dialect used may not be appropriate for all groups in Yemen.

A major concern for the health education messages is the time of day these messages are aired. Since most villages have electricity only during the night and since most village women go to bed early because their working day typically starts at dawn, it is believed that many of the women in the rural areas miss the messages. Therefore, finding the right time for airing the messages is important.

UNICEF and the Ministry of Information in collaboration with the Health Education Department have developed many printed health education messages as they relate to immunization, breastfeeding, and control of diarrheal diseases. Most of these materials are in the form of posters and stickers with a few lines for the message. These messages are self-explanatory and illiterate people can understand them as well. A Health News Letter is also published and distributed to health facilities. Recently, UNICEF has cooperated with the Ministry of Information in developing radio and TV health education programs.

Many other organizations, internal and external, conduct health education activities at either the central or local level. These include the Yemen Family Care Association, which conducts health education in schools, factories, and cultural centers. YFCA also has a yearly school competition for health and family planning messages in the form of drawings, poetry, songs, etc. The Dutch, Germans, Swedish, UNFPA, Japanese, British and Americans also use health education messages in their projects at the local level.

The ACCS Project through a buy-in with the HEALTHCOM project of the Academy for Educational Development has been assisting the MOPH with the design and development of health education messages and programs. A current activity is the organization of health education in the community through "Rural Caring Mothers". This project, on a small pilot basis, is included as one of the recommended interventions in this report. It is expected that it can be implemented within the next six months.

The HEALTHCOM contract will end 30 June, 1992. It is planned to recruit a Health Education Specialist (for three to six months)

during the transitional period (1 July 1992 - 31 July 1993) to help implement this intervention, carry it through to completion and conduct an evaluation. In concert with the Department of Health Education, MOI, and UNICEF, this specialist will also prepare an IEC component for the combined MCH/FC program.

Health education efforts need to be strengthened in two dimensions:

- (1) As a "cross-cutter" HE is an important component of much of the on-going work of the MOPH in mother, child and family care. It will be a part of most of the interventions proposed by the Assessment Team. These include all the training interventions, all the community interventions, and some of the management interventions, including HIS, Logistics and Supply, and Planning and Budgeting. Equally, it will be a significant part of the planned Family Care Interventions.
- (2) Vertically in the health system, it is important to strengthen HE activities at the Governorate level and below. At the local level much can be accomplished using local materials in the local dialect, taking into account local customs and beliefs.

With the integrated approach to MCH/FC new opportunities are presented for health education. Messages and methods can be combined to reach the same target audiences. KAP surveys and focus group surveys can also be integrated.

Training of staff is an important function of the health educator. This should be at all levels, reinforced through supervision, and incorporated in the curricula for the three training interventions proposed by the Assessment Team - for PHC Workers, Midwives and Licensed Birth Attendants.

Conclusions:

As an important component of most all program activities, health education should be emphasized and strengthened, especially at the Governorate level. It should be part of all training curricula and supervisory responsibilities. Local materials can be effectively used in the villages, PHC Units and Health Centers. IEC (in research, media and methods) can be effectively applied to the integrated MCH/FC approach.

5.15 ISSUE: THE ROLE OF HEALTH GUIDES/COMMUNITY HEALTH WORKERS

A major health problem in the Republic of Yemen is that of making basic health services available to the rural population. To address this need various projects, including the ACCS Project in

collaboration with the Government, have embarked on building Primary Health Care Units and training Primary Health Workers to staff these units.

Many PHCUnits built thus far are physically inaccessible to the target population (women and children). Some villagers have to walk 15 or more kilometers to the nearest unit. In the absence of a regular public transport system, women find it difficult to attend these facilities.

Of even more consequence accessibility is denied these two groups because many of the PHCUnits are staffed only by male PHC workers.

Also, if the current trend of using only "highly trained primary health care workers" continues, it will be difficult to recruit women to be trained as health care workers. Such training will require the trainee being away from home for at least 9 months (PHCW training course). The male heads of household are unwilling to have their wives and daughters be away for such an extended period of time. Further, the majority of the few women who have been trained as primary health care workers are young and unmarried, and are often not well accepted by the older women.

Therefore the training of female Health Guides who will be willing to volunteer their time (with perhaps some modest remuneration from the village or LCCD, with no additional financial responsibility to the central government), offers a viable alternative. This is also more likely to be sustained after external funding phases out.

The Health Guides would be selected by the community and trained for nine months at the village or district level. Supervision will be provided by the Health Center or PHCUnit. The full participation of the community will address the present problem of the acceptability of the trainees; and training female Health Guides will help lower the barrier to health care for women and children.

With time and more training, the Health Guides will be able to provide basic MCH/FC services in their villages, such as treating diarrheal diseases with ORS, malaria with chloroquine, counseling on nutrition and family planning, and identifying cases to be referred to the health system.

This strategy is also congruent with government policies on decentralization and can be integrated with the Options for Family Care Project for the provision of family planning services at the village level.

The use of community Health Guides is a tradition in the Southern Governorates, where it has worked well to extend basic health services.

For a description of the methodology for recruiting, training and deploying Health Guides, see Appendix I.

Conclusions:

The concept of Health Guides or community health workers will help to strengthen community-level health awareness and delivery of simple preventive and curative measures. The Health Guide approach should be promoted more widely. The volunteer aspect which has proved so successful in the Southern Governorates in the past, may necessarily be adapted to include remuneration from the community (but not from the Ministry of Public Health).

5.16 ISSUE: INTEGRATION OF ACCS AND OFC PROJECTS

The team has examined the feasibility of integrating the CS Project with the OFC Project. Advantages and disadvantages have been identified. Among them:

Advantages

- o Facilitates project management by USAID and the government, and collaboration with other donors.
- o Supports the integration of CS and FC activities in service delivery.
- o CS components will strengthen service delivery helping to place emphasis on implementation at the governorate, district and local levels.
- o CS and FC activities share the same target population.
- o CS and FC activities will engage many of the same counterparts in the ministries, thereby minimizing confusion, overlap and possible competition. Separate projects will compete for the time of the same officials (this situation often occurs within one project).
- o Makes it possible to continue and strengthen CS activities presently underway, and offers a means for the FC components to "piggyback" on the grass roots approach being put in place by the CS project management.

- o Provides flexibility by making it possible to emphasize or de-emphasize various components during the project life on the basis of the 18-month rolling plan to be used in the OFC Project.
- o Supports the National Population Goals

Disadvantages

- o Runs the risk of subsuming and minimizing CS activities, and setting back CS progress.
- o Invites delay and management problems through engagement at the central level.
- o Adds to the complexities of an already complex project design (OFC).
- o Creates funding source problems in project administration. (Over the life of project funding for ACCS, USAID must establish clear guidelines and mechanisms to avoid co-mingling of funds for accounting purposes).
- o May be publicly or politically challenged due to the conservative and unpredictable attitude toward family planning in a country such as Yemen. (Party newspapers have already labeled the USAID population project a conspiracy against the Islamic peoples).

The team has examined various options which would serve to maximize the advantages and minimize the disadvantages.

To achieve effective integration the OFC Project should be redesigned to incorporate the following:

- o Trimming back the number of short-term consultancies, and providing for adequate long-term technical assistance. Expertise should include Health Education, Midwifery, and Management Development. There should be a strong training component in all three.
- o Integrating the CS interventions identified in this assessment with the OFC workplan. This will require a review and revision of TA (both in nature and duration), and commodities.

While it may be important to upgrade FP skills and services in much the same way it is done for other components of Maternal and Child Health (immunization, control of diarrheal diseases, acute respiratory infections, ecc.), this work of service delivery can be fully integrated. That is, the combined project would provide integrated Maternal and Child Health and Family Planning services. The Project could be renamed "Options for Maternal, Child and Family Care" - or simply "MCH/FC".

Similarly, training, health education and health information can be integrated.

- o It will be important to streamline the combined project in order to achieve realistic objectives.

Clearly, on the basis of what the Assessment Team has learned, the present complex and overburdened structure of the OFC Project will encounter insurmountable obstacles and delays. Just as the Assessment Team has been charged to narrow down and focus on discrete and achievable child survival interventions, the structure of the combined project must be narrowed-down and focused.

In doing this, emphasis should be placed on service delivery at the Governorate level. Over involvement at the center with broad concepts of population policy is likely to prolong and delay service delivery implementation.

The HPN Officer has formulated revised project organization and staffing proposals to achieve this. The Assessment Team has assisted in this work and fully subscribes to it. (See Section 6 - Strategies and Structure for Implementation).

- o With the focus on service delivery the OFC project elements can "piggy-back" on the CS initiatives now underway at the Governorate level. New interventions recommended in this Assessment will further focus on the Governorate level and will serve to substantially strengthen approaches in the community itself to draw on the resources of the people.

Conclusions:

The Assessment Team is recommending that the two projects be combined. When doing so, the scale of the population

activities should be modified to make them more realistically achievable while stretching them out over time. The focus should be on integrated MCH/FC delivery where it is expected that results can be achieved in training and implementing family care interventions along with maternal and child health. Responsibility assigned to one contractor will facilitate management of the combined project.

The ACCS Project is scheduled to end September, 1994 (with the possibility of an extension to September, 1996 with strong justification). It makes sense at this time to provide for continued attention to CS activities under the clear ROY Policy Statement on Population and the longer term of the OFC Project (eight years)

6. STRATEGIES AND STRUCTURE FOR IMPLEMENTATION

The strategy for implementation calls for integration of the two current health and population projects, ACCS and OFC. The combined projects are constructed as one program calling for a fully integrated approach to Maternal and Child Health/Family Planning.

This strategy provides for a 13-month "bridging" period (1 July 1992 - 31 July 1993). The existing contract dates are as follows:

- o REACH 1 April - 31 July 1992
 4 month no cost extension
- o HEALTHCOM 30 June 1992
 End of buy-in contract
- o NEDS Started 1 January 1992
 PAFA Epidemiologist from CDC under
 a 24 month contract with the possibility
 of a 12 month extension
- o SEATS Buy-in contract expires 30 September 1992

For the bridging period a contractor will be selected to provide two long-term technical specialists: a Senior MCH Associate/Team Leader and Senior Management Associate, both for the full 13 months. A third specialist, a Health Education Associate, will serve for approximately six months in order to carry to completion the proposed intervention for Community-Based Health Education and to prepare a plan for the future IEC components of the integrated program. The NEDS epidemiologist will work with these three in a team role.

A workplan will be developed and weekly team meetings held. Quarterly reports showing progress against the workplan and monthly financial statements will be submitted to the USAID Mission in Sana'a.

There will be one support staff, and common vehicles and drivers. The field coordinators will serve all functions equally.

A Project Support Office of two FSN officers will function in the USAID Mission under the direction of the HPN Officer.

Following the transitional period the program will shift to a more permanent structure. A new workplan will be designed to essentially implement the interventions recommended in this report. Obviously, following a 13-month experience, changes will be in order for the work content, but the management structure should continue as a fully integrated one, under one contractor and one

manager (Senior Associate), with effective mechanisms in place for monitoring by the USAID Mission in Sana'a.

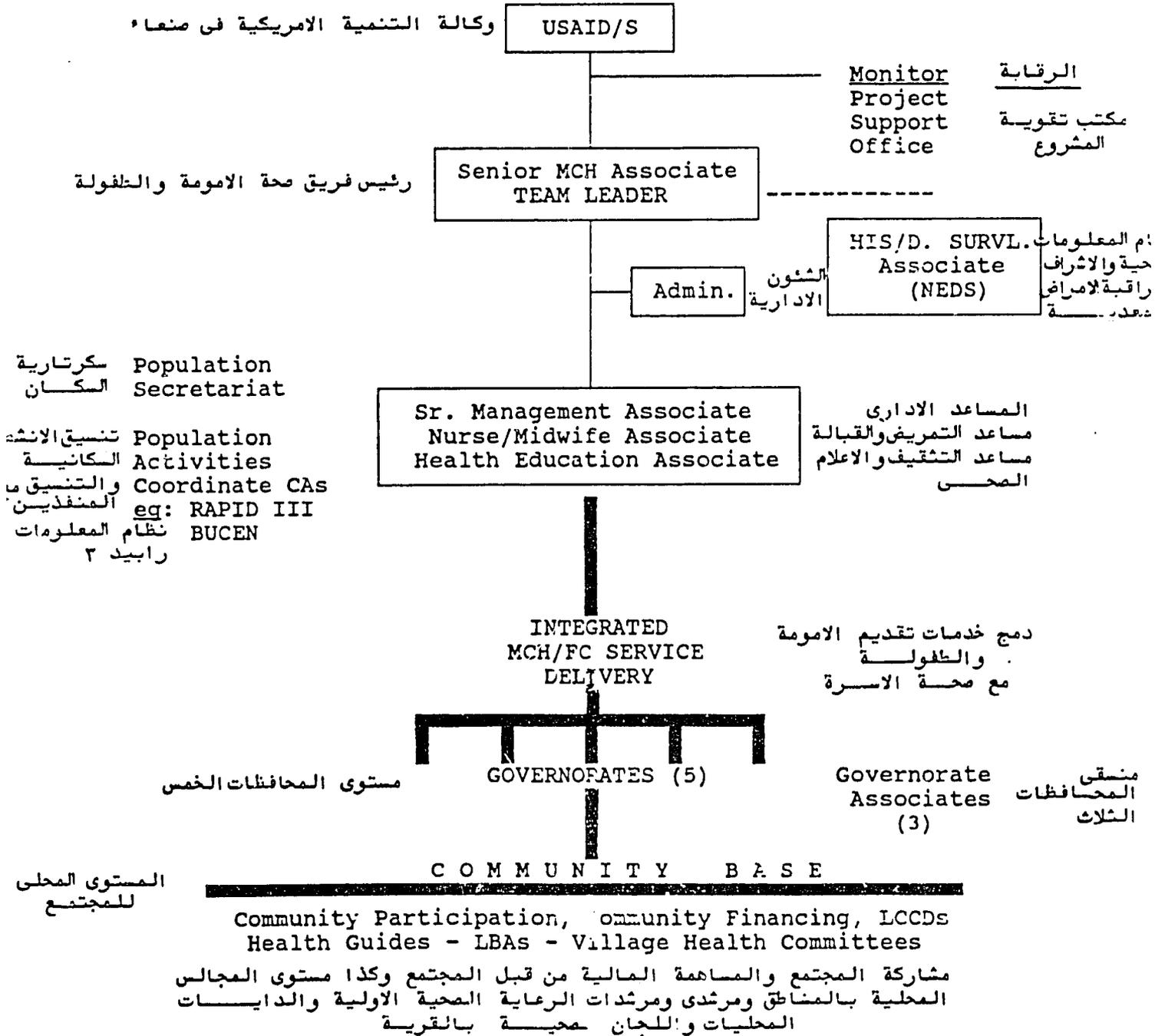
The Workplan

The workplan will not only serve as a management tool but will also be the means by which all parties - the implementing ministries, NGOs, the other donors, USAID and its contractor - can coordinate with and support the overall effort. The workplan should include specific guidelines for the development of governorate level management and service delivery; and identify the governorates in which USAID will function.

The proposed organization structure is on the following page:

نظام مشروع انقاذ الطفل وبرنامج صحة الاسرة الموحد
STRUCTURE OF COMBINED ACCS AND OFC PROJECTS

ادارة الفريق
TEAM MANAGEMENT
Starting 1 August 1993
اعتبارا من أول اغسطس ١٩٩٣



This scheme calls for five long-term associates with the following roles. The length of time for each is the total time including the 13-month transitional period):

(1) Senior MCH Associate (5 years)

Team Leader, MD. Responsible for policy, program implementation/coordination, team management. Provides technical input to all MCH/FC interventions and population activities. Reporting responsibilities to USAID/Sana'a HPN Officer.

(2) Senior Management Associate (4 years)

Coordinates population Contracting Agencies (CAs), provides support for National Population Secretariat, collaborates in management and implementation of MCH/FC service delivery, and designs, implements and evaluates management interventions.

(3) Nurse/Midwife Associate (3 years)

Designs, implements and evaluates maternal and child care components of MCH/FC interventions; supports training and supervision of midwives, LBAs and PHCWorkers; supports community-level interventions; and collaborates on management interventions.

(4) Health Educator Associate (3 years)

Designs, implements and evaluates IEC components of all MCH/FC interventions in close collaboration with the other associates.

(5) Health Information System/Disease Surveillance Associate (3 years)

Designs, implements and evaluates combined Health Information/Disease Surveillance System in close collaboration with the other associates.

The time of these five long-term associates, taken together, is the full-time equivalent of 3.6 persons for the five year period.

Governorate Associates

Three Governorate Associates will support the Governorate-level activities. Two will be posted in the northern governorates (one each for two governorates). The third will be in charge of the southern governorate.

The Governorate Associates will be responsible for coordinating the design, implementation and evaluation of all training, service delivery and management interventions at the governorate and local level. In this role, they will support and collaborate with the other associates who will provide specialized expertise in midwifery, family care, health education, health information and management. They will work on a daily basis with the Director General of the Health Office and his staff, with the Governorate Health Manpower Institute, the LCCDs and community leaders. Their chief counterparts will be the Directors General of the Health Offices.

The heavy solid line in the diagram represents the main thrust on service delivery which focuses on the Governorate level and serves to facilitate strong community participation. All of the long-term Associates will serve to design and implement interventions, including training. All will work on integrated MCH/FC activities.

One Southern Governorate will be added, bringing the total number to five where program activities will be focused.

The contractor will be responsible for all Project logistics and commodity procurement.

The contractor will be given full authority to manage the program, but there will be strict requirements for effective monitoring by USAID/Sana'a. A workplan will be required, with quarterly reports measuring progress against the workplan. Periodic progress meetings will be held with all contractor associates with the HPN Officer and support staff. Monthly financial statements will be submitted to USAID/S.

The cost of the long-term associates can be shared between the ACCS and OFC Projects. For example, the Senior Associate/Team Leader and the Senior Management Associate could be charged to OFC, with the Nurse/Midwife Associate and Health Educator Associate charged to ACCS. The HIS/Disease Surveillance Associate is presently under a PASA arrangement with CDC-Atlanta, funded through the ACCS Project.

NB: The present design of the Options for Family Care Project provides for a number of USAID Contracting Agencies (CAs). These include:

- o Family Planning Service Expansion and Technical Support (SEATS), John Snow, Inc.
- o Association for Voluntary Surgical Contraception (AVSC)
- o Pathfinder Fund

- o Institute for Resource Development (Demographic and Health Surveys)
- o Population Communication Services, Johns Hopkins University
- o Program for International Education in Gynecology and Obstetrics, Johns Hopkins University
- o Contraceptive Social Marketing II (SOMARC), The Futures Group
- o Family Planning Training for Paramedical, Auxiliary and Community Personnel (PACTIib), Development Associates/Pathfinder Fund
- o Demographic Data Initiatives (DDI), U.S. Bureau of the Census

Three of these groups plan to have full-time coordinators resident in Yemen (SEATS, Pathfinder and Johns Hopkins).

Conclusions:

In view of past experience, and the desirability of implementing a balanced MCH/FC program for Yemen, the Assessment Team members believe this is a serious overload!

First there should be no resident representatives other than the long-term team associates recommended in the diagram above.

Secondly, as specialized services are required from these or other contractors and agencies, consultancies can be arranged. These consultancies will be under the direction of the resident associates, and terms of reference will require a fully-integrated approach so that single-focused "outside experts" will not unduly upset what the team considers to be a delicate balance in population and health activities in order to gain acceptance in the Yemeni context.

7. RECOMMENDED CHILD SURVIVAL/FAMILY PLANNING INTERVENTIONS

This section contains 13 discrete and specific child survival and family care interventions. The Assessment Team members believe each can be effectively managed and sustained within the available resources and management capacity of both the ROY and USAID. But taken together they could amount to an overload. Therefore, a priority ranking has been attached to each to assist the USAID Mission in selecting the most appropriate workload for the new Mission Management Implementation Plan. The interventions have been assigned to three groups: "A" for the highest priority, "B" for next highest, and "C" for the third highest. The Team members believe that all are needed and achievable, but the Mission may well need to reduce the level of effort in consideration of its total portfolio.

Criteria used in assigning the priorities were (1) need, (2) ease of implementation, and (3) national and USAID priorities.

The interventions are based on the findings of the assessment. In response to the Statement of Work, they are designed as discrete tasks that can be achieved within a reasonable time frame (2 to 3 years).

Of importance, every one of the proposed interventions serves to integrate child survival activities with family planning activities in line with the recommendation to combine the ACCS and OFC Projects.

Each intervention supports the USAID Mission's 1992-1997 Management Implementation Plan Goal, and Program and Sub-program Objective for the Health and Population Sector.

For each, the Team has stated (1) the Program and Sub-program Objectives, (2) Activities, and (3) Performance and Impact Indicators. In order to finalize priorities and draft the new workplan for the transitional period, two additional steps are necessary:

First: Budgets should be developed. (1) an Implementation Budget (by the Project), and (2) a Recurrent Budget (that will be required for the ROY to sustain the intervention following withdrawal of external assistance.

Second: The interventions should be reviewed with the other donors to assure a good fit with the overall assistance program for health and population.

A budget outline is presented for each intervention, but the figures have not been entered. This can be done when the transitional workplan is developed.

One means of reducing the scope of the interventions was to limit them to selected Governorates and then to further focus them on a limited number of sites within the Governorates. This is noted for each intervention under "coverage".

The Target for each intervention is expressed with a population denominator to provide a general measure of impact. This measure is necessarily global at this early planning stage. At a later stage, when the Governorates and Districts are identified, more specific and more accurate denominators can be developed for the target population groups. The present global figures assume a 40% coverage rate.⁴

The criteria or factors (discussed in the section on Issues) which influenced the selection and ranking of the interventions, included the following:

- o supports the USAID Mission's goal, sub-goal and strategic objective for health and population in the Implementation Plan for 1992-1995
- o supports the national population goals (see Section 5)
- o discrete and capable of producing reasonable achievement within 2-3 years

⁴ In order to calculate the population denominators the Team made a number of assumptions. The first was that the five Governorates chosen will be the four in which the ACCS Project is currently working (Hajjah, Hodeidah, Marib, and Sada'a) plus the southern governorate of Abyan. This, of course, is subject to change and agreement with the MOPH. The census figures of 1986 for the northern governorates were then increased by 3.2% per year to 1992. For Abyan, the 1988 census was increased by 2.8% per year to 1992. An estimated 600,000 was then added for the returnees in these governorates. 40% of the resulting total of 3,258,000 was then taken to arrive at an estimated population coverage of 1,400,000 for the five governorates.

The MOPH planning ratios for health facilities were used. The population to be served by a PHCUnit is 2,250 and for a Health Center, 25,000. Here again, a 40% coverage ratio was applied.

The population of villages varies greatly. For planning purposes a village population of 800 was used, assuming full coverage.

- o within the technical and management capabilities of the MOPH and of a reduced USAID Mission staff
- o sustainable
- o in support of decentralization, with focus on the Governorate level
- o integrates with PHC service delivery, including family planning
- o readily integrates into the OFC Project
- o increases accessibility and utilization of PHC/FC services
- o facilitates access of women to PHC/FC services
- o culturally acceptable and culturally workable
- o provides for the optimal use of resources
- o builds on and extends worthwhile activities already started (to provide bridging to the proposed combined PHC/FP program)
- o complements other donor inputs

Private sector initiatives are also supported in recognition of this dynamic dimension of the Yemeni economy.

Thus, many of these interventions serve to tap resources outside the public sector - the community and the private sector - both of which have demonstrated viability.

Finally, in recognition of the critical need for female health providers to reach the two most important (and neglected) groups at-risk, mothers and children, the interventions serve to increase both the numbers and quality of female health workers (supervising midwives, PHC workers and LBAs).

The Strategic Objective for the USAID Mission and the Program Objectives for the Health and Population Sector of the Mission Management Implementation Plan for 1992-1994 are as follows:

MISSION STRATEGIC OBJECTIVE

Increase the responsiveness of systems and practices in selected democratic and social development institutions.

HEALTH AND POPULATION PROGRAM OBJECTIVES

- (1) Increase access to and participation in MCH and Family Care programs.
- (2) Improve performance and responsiveness of selected MCH/FC services.

Supporting the Program Objectives are Sub-Program Objectives. These are listed under each intervention that follows.

The Interventions are organized into four groups.

INTERVENTIONS

GROUP I: MANPOWER

1. Training of Primary Health Care Workers
2. Training of Midwives
3. Training of Licensed Birth Attendants
4. In-service training for existing PHCWs, midwives and LBAs

Rationale:

These cadres are the backbone of MCH/FC delivery. To increase the accessibility of women and children to these services the emphasis on training female providers will be continued.

The PHCWorker serves to deliver the key preventive/curative services of EPI, ORT, ARI (in the future) and contraceptives. The Female PHCWorker is trained to identify cases at risk and complications to be referred. Training should emphasize child and mother care. Presently the PHCWorkers (especially the males) concentrate on the curative aspects, diagnose cases and dispense medication.

The Midwife is trained to handle emergency cases and complications. She also fulfills the vital role of supervisor for the PHCWorkers and LBAs.

The LBA reinforces family planning within the community and in many cases can be instrumental in community mobilization efforts. She is trained to provide healthy child delivery practices and identify cases-at-risk. The impact on the reduction of maternal and infant mortality can be significant.

The numbers of these cadres that can and should be trained in the coming three to five years are dependent on a variety of factors including the resources of both donors and the government, cultural factors, availability of women to train, availability of trainers, high illiteracy among women, the capacity to supervise and support those trained, and the lack of in-service training.

GROUP II: COMMUNITY

1. Village Health Committees
2. Health Guides
3. Community-Based Health Education

Rationale:

The team members believe that community participation is an essential element for the success of any program. This is especially true in health and population.

Proper health practices start in the home. The majority of the diseases leading to the high infant, child and maternal morbidity and mortality in Yemen can be prevented through simple, low-cost measures undertaken by the family and community. Further, community awareness and understanding can serve to open the door to increased utilization of health and population services.

These three proposed interventions are experimental and limited in scope. Their success will differ from one area to another, and in varying degrees depending on the economy of the village; and the traditions, attitudes and practices of the people. Therefore, the interventions are purposely designed to be modest and discrete.

It is anticipated that by approaching community participation in these three modes, the program will be in a position to learn through success and failure, and modify and develop a model (or perhaps more than one model) for expansion and replication. Each intervention will have a strong evaluation component for this purpose.

Constraints:

The Village Health Committees may become dominated by men and the health issues of women and children run the risk of being neglected. If the membership is limited solely to women, there will be limitations due to the high illiteracy rate among women. Given the cultural setting of Yemen, it is almost impossible to have committees with both men and women members, especially in the

Governorates where the AUCS Project is currently working. The acceptability of the VHC will vary according to the governorate.

With these constraints in view, it will be important to approach the community in such a way that the motivation comes from within the community, not imposed from without. Community members have to say they want! the way they want the committee to be formed! and who are to be the members! Further, the type of activities in which they will engage should not be dictated, but rather self-determined.

The Health Guides concept has worked well in the southern part of Yemen before unification. However, due to the economic hardship the people are undergoing, the system is in trouble. Health Guides are insisting on payment similar to the Primary Health Care Workers. One way to get around this could be the recruitment of TBAs who can be given three-months of training similar to that of the Health Guides, and who are remunerated for their services. Therefore, in this intervention the voluntary concept of the Health Guides will be necessarily modified.

Community-Based Health Education is another means for gaining entry at the community level through schools, mosques, women's gatherings, and the like. This provides basic training for community thought-leaders such as school teachers, religious leaders and elderly women.

Constraints are the complexity of training, understanding local cultural practices, in particular the willingness of religious leaders to participate, and how the community perceives its needs and priorities (in many places the expressed need is for water, little else).

GROUP III: MANAGEMENT

1. Management Technology Transfer among Governorates
2. Team Management and Supervision
3. Logistics and Supply System
4. Decentralized Planning and Budgeting
5. Health Information System
6. Alternative Financing for Primary Health Care

Rationale:

The need for strengthening health management was cited in most all the interviews conducted by the Team. Given limited and diminishing resources (financial and manpower) available for health, the rapid increase in population, the dispersion of the population, the difficulty of access due to the harsh terrain, and an overburdened bureaucracy, management becomes a priority.

Further, most health officials, whether physicians or not, lack management skills.

These interventions have been selected based on identified need, the intent to support decentralization, and the opportunity to introduce basic management methods and procedures at the Governorate level. Two of the interventions are general in nature (Technology Transfer and Team Management/Supervision), and three are directed towards specific system development (Logistics/Supply, Planning/Budgeting and HIS). The sixth and last one is designed to explore alternate sources of resources from either fees-for-services and/or community contributions.

Constraints:

The two general interventions are recommended although direct impact will be hard to measure. Difficulties will be encountered in breaking down barriers among the Governorates, with personality conflicts and, in the case of the Team Management, in delegation of authority (a societal phenomenon whereby leadership and authority is generally retained by the designated leader). This intervention will also address a critical element of health management, supervision.

The Technology Transfer intervention may be frustrated by the unwillingness of the Governorate leaders to enter into a cooperative, sharing relationship.

The three interventions aimed at strengthening specific systems can result in more immediate impact, but they require manpower (including a redistribution of manpower), financial resources and a willingness to learn and adapt to new ways of doing things. Also, at present the systems are diffused (for example, HIS forms vary and are provided from different sources at different levels), and some operate independently of one another. The lack of standardization and of control are major constraints in need of correction.

Further, concentration on individual systems in individual governorates could suffer from a "pilot project syndrome" whereby these systems and governorates would receive extra inputs to make them work resulting in an artificial environment. Replication without these external inputs may become difficult.

The final intervention, Alternative Financing for Primary Health Care, will be constrained by economic hardship and the centralized control over LCCD funds resulting in a reluctance to make local contributions (not knowing how the funds will be administered). In the southern governorates the concept of fee-for-service will meet opposition as the people are used to free health care.

GROUP IV: POPULATION

All the afore-mentioned interventions serve to integrate MCH and Family Care activities. In addition, there are to be interventions directly concerned with population issues. These interventions are being developed by the USAID staff and will be available in the very near future.

They will support the following Sub-Program Objectives:

- (1) Develop database for use and distribution of ORS, Vitamin A and Contraceptives (includes MCH)
- (2) Increase awareness of demographic and FC concerns to policy makers, media and NGOs
- (3) Develop MCH/FC training materials
- (4) Conduct KAP and media habits surveys (includes MCH)
- (5) Train staff of National Population Council
- (6) Establish DHS Analysis System
- (7) Develop Population Policy Plan
- (8) Develop market plan for YEDCO (includes MCH)

Constraints:

Although it has been approved by the Prime Minister's Office, the actual formation of the National Population Council has not taken place (from October, 1991). It is perceived that there are major differences in terms of membership, functions, and advisors for the Council, and little seems to be accomplished in terms of resolution of these problems.

Is this hiatus an indication of things to come?

Social marketing will present problems in Yemen due to the strong private for-profit motivation of the Yemeni's. It will be difficult to control overcharging and exploitation.

The support of private health providers will require controlled distribution to get contraceptive and health supplies into the proper hands (e.g., TBAs, PHCWorkers, midwives, local pharmacists, physicians, etc.).

It may be necessary to consider price control measures.

INTERVENTIONS - GROUP I

MANPOWER

PRIORITY B

INTERVENTION: TRAINING OF PRIMARY HEALTH CARE WORKERS

PROGRAM OBJECTIVE: Increase access to and participation in MCH and Family Care programs

SUB-PROGRAM OBJECTIVE: Train primary health care workers

ACTIVITIES:

Coverage: 4 Governorates
200 sites
Catchment area population - 180,000
Population per 1 PHC Worker - 2,250

Duration: 30 months

In collaboration with Governorate branches of HMI -

1. Select target population sites on basis of criteria including:
 - o Governorate can provide supervision
 - o need exists to expand accessibility
 - o female PHC Workers are most needed
 - o PHC Units exist with male workers and can be supplemented with female workers
 - o LCCD can lease Unit if not constructed
2. Identify assigned supervisor for each site
3. Obtain LCCD commitment for cost-sharing for each site (50% of training stipend will be paid by Project)
4. Assist HMI to institutionalize training. Include practical field training, with assigned supervisors participating (to reinforce concept of trainer/supervisors). <Assumption: present HMI curriculum is suitable, but may require additional field training>.
5. Recruit trainees by Governorate (target: 70% females, 30% males)
6. Conduct training by HMI-Governorate

7. Post trainees
8. Reinforce supervisory system to support new trainees
9. Evaluate training

PERFORMANCE INDICATORS:

1. Sites selected
2. Supervisors identified
3. HMI curriculum in place
4. Trainees recruited
5. Training completed
6. Supervisory schedule completed
7. Trainees performing in assigned PHCUnits one year following completion of training
8. PHCUnits case load increased for women and children

IMPACT INDICATORS:

1. Trained PHCWorkers contributing to improved health status of the catchment area as measured by reduction in immunizable diseases, reduction in diarrheal episodes, reduction of malnutrition (acute and chronic), and increased use of contraceptives (mid-term).

<assumes sufficient base data>

IMPLEMENTATION BUDGET:

	<u>USAID</u>		<u>Others</u>		<u>Yemen</u>
	YR	\$	YR	\$	YR
Revision of HMI curriculum		x			
Trainees		x			X
Cost of training					
Trainers		x			
Materials		x			
Accommodations		x			
Facilities					x
Field Work					
Transport		x			
Per diem		x			
Evaluation		x			

TOTAL:

Yemen YR
Project YR US\$

Cost per Governorate:
per PHC Unit:
per trainee:
per capita:

RECURRENT BUDGET ESTIMATES (ROY):

INTERVENTION: TRAINING OF MIDWIVES

PROGRAM OBJECTIVE: Increase access to and participation in MCH and Family Care programs

SUB-PROGRAM OBJECTIVE: Train midwives

ACTIVITIES:

Coverage: 5 Governorates
Catchment area population - 1,400,00

Duration: 48 Months

In collaboration with Governorate branches of HMI -

1. Establish training schedule, arrange logistics, employ trainers and review curriculum
2. Identify districts in need and select trainees
3. Conduct training (36 month course)
4. Mobilize supervisory program, identify supervisors, draw up supervisory schedules and supervisory check-lists. (Involve supervisors in final phase of training).
5. Post trainees
6. Reinforce supervisory system to support new trainees
7. Conduct evaluation of training and performance of new trainees

PERFORMANCE INDICATORS:

1. Training plan and arrangements completed
2. Districts and trainees identified
3. Supervisors identified
4. Training course completed
5. Trainees posted
6. Follow-up and evaluation with supervisors completed
7. Trainees performing according to training standards one year following completion of training

8. Case loads increased for women and children

IMPACT INDICATORS:

1. Trained midwives contributing to improved health status of the catchment area as measured by reduction in maternal morbidity and mortality, increased rate of tetanus immunizations, reduction in immunizable diseases, reduction in diarrhoeal episodes, reduction in malnutrition (acute and chronic), increased use of breastfeeding, reduction in complicated births, decreased rate of pertusis, established referral system for at risk deliveries, and increased use of contraceptives (mid-term).

<assumes sufficient base data>

IMPLEMENTATION BUDGET:

	<u>USAID</u>		<u>Others</u>		<u>Yemen</u>
	YR	\$	YR	\$	YR
Revision of HMI curriculum		x			
Trainees		x			x
Cost of training					
Trainers		x			
Materials		x			
Accommodations		x			
Facilities					
Field Work					x
Transport		x			
Per diem		x			
Evaluation		x			

TOTAL:

Yemen	YR	
Project	YR	US\$

Cost per Governorate:
 per PHC Unit:
 per trainee:
 per capita:

RECURRENT BUDGET ESTIMATES (ROY):

PRIORITY A

INTERVENTION: TRAINING OF LICENSED BIRTH ATTENDANTS

PROGRAM OBJECTIVE: Increase access to and participation in MCH and Family Care programs

SUB-PROGRAM OBJECTIVE: Train licensed birth attendants

ACTIVITIES:

Coverage: 5 Governorates
Catchment area population - 32,000

Duration: 24 months

In collaboration with Governorate branches of HMI -

1. Select target villages on basis of criteria including:
 - o Need
 - o Health Center and PHCUnits can provide supervision
 - o Local community demonstrates interest and support
2. Identify assigned supervisor for each village
3. Obtain village and/or LCCD commitment for cost sharing
4. Conduct training by HMI-Governorate with full involvement of supervisors
5. Reinforce supervisory system to support new trainees
6. Conduct evaluation of training and performance of new trainees

PERFORMANCE INDICATORS:

1. Training plan and arrangements completed
2. Health Centers/PHCUnits and Villages identified
3. Supervisors identified
4. Baseline surveys completed
5. Training course completed

6. Trainees posted
7. Follow-up and evaluation with supervisors completed
8. Trainees performing according to training standards one year following completion of training
9. Case loads increased for women and children

IMPACT INDICATORS:

1. Trained LBAs contributing to improved health status of the village as measured by reduction in maternal morbidity and mortality, increased referral of complicated cases, decreased birth complications, reduction in pertusis among new-borns, increased breastfeeding, increased tetanus immunization, reduction of immunizable diseases, reduction in diarrheal episodes, reduction in malnutrition (acute and chronic), and increased use of contraceptives (mid-term).

<assumes sufficient base data>

IMPLEMENTATION BUDGET:

	<u>USAID</u>	<u>Others</u>	<u>Yemen</u>
	YR	YR	YR
	\$	\$	
Curriculum development and training plan	x		
Baseline surveys	x		
Trainees	x		x
Cost of training			
Trainers	x		
Materials	x		
Accommodations	x		
Facilities			x
Field Work			
Transport	x		
Per diem	x		
Evaluation	x		

TOTAL:

Yemen	YR	
Project	YR	US\$

Cost per Governorate:
per trainee:
per capita:

RECURRENT BUDGET ESTIMATES (ROY):

INTERVENTION: IN-SERVICE TRAINING FOR PRIMARY HEALTH CARE WORKERS, MIDWIVES AND LICENSED BIRTH ATTENDANTS

PROGRAM OBJECTIVE: Increase access to and participation in MCH and Family Care programs

SUB-PROGRAM OBJECTIVE: Conduct in-service training for primary health care workers, midwives and licensed birth attendants

ACTIVITIES:

Coverage: 5 Governorates
Catchment area population - 1,400,000

Duration: 24 months

In collaboration with Governorate branches of HMI -

1. Conduct competency-based performance survey of existing PHC Workers, Midwives and LBAs
2. Design training modules, identify training sites, procure training materials
3. Select trainees and prepare training schedule
4. Conduct training (involve supervisors)
5. Follow-up with supervisors, evaluate performance on-the-job
6. Reinforce supervisory system to support strengthened and new skills learned by trainees
7. Conduct evaluation of training and performance of new trainees

PERFORMANCE INDICATORS:

1. Competency-based performance survey completed
2. Training courses designed
3. Trainees and supervisors identified and logistics in place

4. Trainees recruited
5. Training completed
6. Follow-up and evaluation with supervisors completed
7. Trainees performing according to training standards one year following completion of training
8. Case loads increased for women and children

IMPACT INDICATORS:

1. Re-trained health workers contributing to improved health status of the catchment area as measured by reduction in immunizable diseases, reduction in diarrheal episodes, reduction of malnutrition (acute and chronic), and reduction in maternal morbidity and mortality and increased use of contraception (mid-term).

<requires sufficient baseline data>

IMPLEMENTATION BUDGET:

	<u>USAID</u>		<u>Others</u>		<u>Yemen</u>
	YR	\$	YR	\$	YR
CB Performance survey	x				
Curriculum design					
Trainees	50%				50%
Cost of training					
Trainers	x				
Materials	x				
Accommodations	x				
Facilities					
Field Work					x
Transport	x				
Per diem	x				
Evaluation					

TOTAL:

Total budget for .. trainees:

Yemen	YR		
USAID	YR	US\$	
Others	YR	US\$	

Cost per Governorate:

per PHC Unit:

per trainee:

 PHC Worker:

 Midwife:

 LBA:

RECURRENT BUDGET ESTIMATES (POY):

INTERVENTIONS - GROUP II

COMMUNITY

PRIORITY B

INTERVENTION: ORGANIZATION OF VILLAGE HEALTH COMMITTEES

PROGRAM OBJECTIVE: Increase access to and participation in MCH and Family Care programs

PROGRAM SUB-OBJECTIVE: Develop and install Village Health and Midwife Committees

ACTIVITIES:

Coverage: 5 Governorates
20 PHC Units
40 Villages
Catchment area population - 32,000

Duration: 36 months

1. Select organizer/facilitator (Yemeni)
2. Identify and train 5 key FPHC Workers/community mobilizers in 5 Governorates
3. Obtain input from villagers. Discuss with village leaders the potential role and members of a Village Health Committee (VHC) and the way they like to see it operate.
4. Assist in organizing VHCs
5. Assist in conducting baseline surveys of community needs.
6. Work with VHCs on a sustained basis (mobilizers with backup from facilitator) to identify major health problems in the community and introduce basic health interventions such as health education, nutrition and breastfeeding, immunization, CDD, child spacing and basic sanitation and hygiene. Provide linkage with the PHC Unit. (Flexibility required; villagers must identify their own needs to gain receptivity).
7. Train and support PHC Units in sustaining VHCs by facilitator

8. Conduct post surveys to measure performance and impact of Village Health Committees (after two years)

PERFORMANCE INDICATORS:

1. Number of VHCs formed and still functioning after 2 years
2. Number of volunteer hours spent by VHC members
3. Increased immunization coverage
4. Increased use of ORS
5. Implementation of growth monitoring
6. Increased use of contraceptives and child spacing methods
7. Improved sanitation and hygienic practices and conditions
8. Increased utilization of the PHCUnit by villagers, especially women and children

IMPACT INDICATORS:

1. VHCs contributing to improved health status of the village as measured by reduction in immunizable diseases, reduction in diarrheal episodes, reduction of malnutrition (long-term), reduction of major diseases in the community, and increased use of contraceptives (mid-term).

IMPLEMENTATION BUDGET:

	<u>USAID</u>	<u>Others</u>	<u>Yemen</u>
	YR	YR	YR
	\$	\$	
Facilitator (Yemeni)	x		
36 pm			
Village surveys (40)	x		MOPH
Baseline			
Post			
Training and HE materials	x		
Trans/Supervision	facilitator		MOPH
(vehicle required)	x		supr
Health and population supplies			x
(vaccines, ORS, contraceptives)			PHCUnit
Village clear-up/improvement projects			LCCD

TOTAL:

Yemen	YR	
Project	YR	US\$

Cost per village:
per capita:

RECURRENT BUDGET ESTIMATES (ROY):

INTERVENTION: VILLAGE HEALTH GUIDES

PROGRAM OBJECTIVE: Increase access to and participation in MCH and Family Care programs

SUB-PROGRAM OBJECTIVE: Train village health guides

ACTIVITIES:

Coverage: 5 Governorates
20 PHC Units
40 Villages
Catchment area population - 32,000

Duration: 36 months

1. Select organizer/facilitator (Yemeni)
2. Identify assigned supervisor for each village
3. Obtain input from villagers. Discuss with village leaders the potential role of the Health Guide and candidates for the position (often a TBA, LBA or traditional medicine practitioner)
4. Obtain village and/or LCCD commitment for providing modest stipend for Health Guides
5. Recruit Health Guide candidates
6. Conduct training by HMI-Governorate with full involvement of supervisors, in village, PHC Unit or Health Center/Training Center. (3-6 months)
7. Conduct baseline survey of community needs (can be done as part of training)
8. Reinforce supervisory system to support new trainees
7. Conduct evaluation of training and performance of new trainees

PERFORMANCE INDICATORS:

1. Training plan and arrangements completed

2. Health Centers/PHCUnits and Villages identified
3. Supervisors identified
4. Communities committed, stipends arranged, candidates identified
5. Baseline surveys completed
6. Training course completed
7. Follow-up and evaluation with supervisors completed
8. Trainees performing according to training standards one year following completion of training

IMPACT INDICATORS:

1. Trained Health Guides contributing to improved health status of the village as measured by reduction in maternal morbidity and mortality, increased tetanus immunization, reduction of immunizable diseases, reduction in diarrhoeal episodes, reduction of malnutrition (acute and chronic), and increased use of contraception (mid-term).
2. Community satisfied with and utilizing Health Guide services

IMPLEMENTATION BUDGET:

	<u>USAID</u>	<u>Others</u>	<u>Yemen</u>
	YR	YR	YR
	\$	\$	
Facilitator (Yemeni)			
36 pm	x		
Curriculum development			
and training plan	x		
Baseline surveys	x		
Trainees	x		
Cost of training			x
Trainers	x		
Materials	x		
Accommodations	x		
Facilities			x
Field Work			
Transport	x		
Per diem	x		
Evaluation	x		

TOTAL:

Yemen	YR	
Project	YR	US\$

Cost per Governorate:
per trainee:
per capita:

RECURRENT BUDGET ESTIMATES (ROY):

INTERVENTION: COMMUNITY-BASED HEALTH EDUCATION

PROGRAM OBJECTIVE: Increase access to and participation in MCH and Family Care programs

SUB-PROGRAM OBJECTIVE: Expand community-based health education in 40 villages

ACTIVITIES:

Coverage: 3 Governorates
4 Health Centers
40 Villages
Catchment area population - 32,000

Duration: 6 months

Working through the Governorate team (DG Health Office, Director Primary Health Care, Health Education Officer, one Medical Officer, one Midwife, PHC Workers from the catchment area's Health Center) ...

1. Conduct a situation analysis of each project site for baseline
2. Select women leaders, one from each village
3. Organize and conduct training for the health educators, midwives and women leaders in each Health Center (initial training, 3-5 days, follow-up 1-2 days every two months)
4. Mobilize social support through community and special groups in schools, mosques, and other community places
5. Organize women's group meetings in the villages
6. Design messages and appropriate local media, especially posters for use in training and community/interpersonal diffusion activities
7. Pre-test designed messages
8. Organize mass media programs for the local area

9. Hold competitions on best messages, songs, composition, poetry, posters, etc. on breastfeeding, CDD, nutrition, etc.
10. Conduct regular counselling sessions in the Health Center by the trained midwife, educator and/or health worker
11. Conduct regular monitoring and supervision of the project activities
12. Conduct post evaluation, and draft recommendations for modification and replication of the project

PERFORMANCE INDICATORS:

1. Collection of baseline data
2. Completion of selecting and training women leaders
3. Number of households visited and number of mothers receiving health education
4. Number of mothers supplied with ORS
5. Number of families supplied with contraceptives
6. Number of persons attending community/school/mosque meetings
7. Post evaluation completed

IMPACT INDICATORS:

1. Increased level of awareness of mothers on child care and family planning practices
2. Increased number of children cured from use of ORS
3. Increased number of women breastfeeding according to recommended practice
4. Increased number of families practicing family planning according to recommended practices

IMPLEMENTATION BUDGET:

	<u>USAID</u>	<u>Others</u>	<u>Yemen</u>
	YR	YR	YR
	\$	\$	
Training of health workers (15 for 3 days)	YR		
	30,000		
Research	10,000		
Community programs in schools, mosques, home visits	9,000		
Orientation of women leaders/ women's programs	60,000		
Development of media, dis- tribution	60,000		
Equipment costs/repair/ maintenance	60,000		
Song competitions	12,000		

Other, including supplies
and communication 9,000
Technical assistance -

TOTAL: 270,000

Yemen YR
Project YR 270,000 US\$

Cost per Governorate:
per Health Center:
per village:
per capita:

RECURRENT BUDGET ESTIMATES (ROY):

INTERVENTIONS - GROUP III

MANAGEMENT

PRIORITY C

INTERVENTION: MANAGEMENT TECHNOLOGY TRANSFER AMONG GOVERNORATES

PROGRAM OBJECTIVE: Improve performance and responsiveness of selected MCH/FC services

SUB-PROGRAM OBJECTIVE: Transfer management technology among governorates

ACTIVITIES:

Coverage: 18 Governorates
90 key health staff

Duration: 36 months

1. Conduct pre- limited management audit in selected Governorates
2. Organize semi-annual conferences for all Directors General of Health Offices and their key PHC staff (for two year period, four conferences)
3. Arrange exchange of key personnel among Governorates to serve as "consultants" to assist Governorates design, install and implement improved management systems and procedures
4. Conduct post- limited management audit in selected Governorates

PERFORMANCE INDICATORS:

1. Number of conferences held with "?" participants
2. Number of key personnel exchanged for "?" person/days of "consultation"

IMPACT INDICATORS:

1. Governorate management cadres performing at improved level of productivity

IMPLEMENTATION BUDGET:

	<u>USAID</u>	<u>Others</u>	<u>Yemen</u>
	YR	YR	YR
	\$	\$	
Governorates conferences (90 participants x 3 days x 4)	x		
Exchange program for Governorate "consultants" ... consultancies, av. of 2 weeks each, per diem	x		
Support to manage program over 24 months	x		
Evaluation (pre- and post- limited mgt. audits in selected Governorates) Shared with other management interventions, nos.	x		

TOTAL:

Yemen	YR	
Project	YR	US\$

Cost per Governorate:
per health official:

RECURRENT BUDGET ESTIMATES (ROY):

INTERVENTION: STRENGTHENING TEAM MANAGEMENT AND SUPERVISION

PROGRAM OBJECTIVE: Improve performance and responsiveness of selected MCH/FC services

SUB-PROGRAM OBJECTIVE: Strengthen team management and supervision

ACTIVITIES:

Coverage: 5 Governorates
100 key health staff

Duration: 30 months

1. Conduct pre- limited management audit in selected Governorates
2. Assist Director General of the Health Office to organize work through a management team. Develop work plans and other management tools for effective team management
3. Assist the DG on a regular consulting basis in team management
4. Design supervisory structure, draft role descriptions, clarify reporting relationships. Working with supervisors, draft supervisory schedules and checklists. Help identify and solve supervisory problems
5. Train supervisors and support them in following new procedures
6. Monitor team management and supervisory system over time (18 months)
7. Conduct post- limited management audit in selected Governorates

PERFORMANCE INDICATORS:

1. Team management and supervisory systems and procedures designed and installed
2. All staff adequately trained
3. Systems functioning according to design

IMPACT INDICATORS:

1. Governorate management cadres performing at improved levels of productivity
2. Governorate management team achieving workplan objectives
3. Health providers motivation enhanced and productivity improved

IMPLEMENTATION BUDGET:

	<u>USAID</u>	<u>Others</u>	<u>Yemen</u>
	YR	YR	YR
	\$	\$	
Design, installation and training of team management			
Materials and supplies	x		
Training costs (largely on-the-job)	x		
Evaluation (pre- and post- limited mgt. audits in selected Governorates)	x		
Shared with other management interventions, nos.			

TOTAL:

Yemen	YR	
Project	YR	US\$

Cost per Governorate:
per health official:

RECURRENT BUDGET ESTIMATES (ROY):

INTERVENTION: STRENGTHENING THE LOGISTICS AND SUPPLY SYSTEM

PROGRAM OBJECTIVE: Improve performance and responsiveness of selected MCH/FC services

SUB-PROGRAM OBJECTIVE: Strengthen the logistic and supply system

ACTIVITIES:

Coverage: 5 Governorates
Catchment area population - 1,400,000

Duration: 30 months

1. Conduct pre- limited management audit in selected Governorates
2. Design improved systems and procedures for logistics and supply
3. Install improved systems and procedures, and train personnel in their use
4. Monitor performance over time (18 months)
5. Conduct post- limited management audit in selected Governorates

PERFORMANCE INDICATORS:

1. Systems and procedures designed and installed
2. All staff adequately trained
3. Systems functioning according to design including transport and cold chain

IMPACT INDICATORS:

1. Supplies delivered and stocked at points of delivery adequate to sustain PHC activities (vaccines, drugs, ORS, dressings and medical supplies, contraceptives, HIS forms, growth charts, etc.)

IMPLEMENTATION BUDGET:

	<u>USAID</u>	<u>Others</u>	<u>Yemen</u>
	YR	YR	YR
Design, installation and training			
Hardware, software, materials/supplies			
training costs (largely on-the-job)			
Evaluation (pre- and post- limited mgt. audits in selected Governorates)	x		
Shared with other management interventions, nos.			

TOTAL:

Yemen	YR	
Project	YR	US\$

Cost per Governorate:
per Health Center:

RECURRENT BUDGET ESTIMATES (ROY):

INTERVENTION: DECENTRALIZED PLANNING AND BUDGETING

PROGRAM OBJECTIVE: Improve performance and responsiveness of selected MCH/FC services

SUB-PROGRAM OBJECTIVE: Support decentralized planning and budgeting

ACTIVITIES:

Coverage: 5 Governorates
50 key health staff
Catchment area population - 1,400,000

Duration: 30 months

1. Assist Director General of the Health Office to design systems and procedures for decentralized planning and budgeting
2. Assist DG to install the systems and procedures and train staff
3. Provide consultative services to the DG and the management team to implement the new systems and procedures
4. Monitor the new systems and procedures on a sustained basis (24 months)

PERFORMANCE INDICATORS:

1. Systems and procedures designed
2. Systems and procedures installed and staff trained
3. Systems and procedures functioning according to design

IMPACT INDICATORS:

1. Governorate resources being managed for optimum efficiency and effectiveness

IMPLEMENTATION BUDGET:

	<u>USAID</u>		<u>Others</u>		<u>Yemen</u>
	YR	\$	YR	\$	YR
Design, installation and training					
Hardware, software, materials/supplies					
training costs (largely on-the-job)					
Evaluation (pre- and post- limited mgt. audits in selected Governorates)					x
Shared with other manage- ment interventions, nos.					

TOTAL:

Yemen	YR		
Project	YR	US\$	

Cost per Governorate:
per health official:

RECURRENT BUDGET ESTIMATES (ROY):

PRIORITY A

INTERVENTION: PHC HEALTH INFORMATION AND EPIDEMIOLOGICAL SURVEILLANCE SYSTEM

PROGRAM OBJECTIVE: Improve performance and responsiveness of selected MCH/FC services

SUB-PROGRAM OBJECTIVE: Install HIS/ESS system

ACTIVITIES:

Coverage: 1 National System
5 Governorates
.. health facilities
.. health personnel
Catchment area population - 1,400,000

Duration: 36 months

1. Conduct survey of all existing data collection, processing and utilization mechanisms (not limited to the above 5 Governorates)
2. Based on survey, on a national basis, redesign system, forms and procedures to create one unified standard, simple system including epidemiological surveillance
3. Conduct pilot testing for the newly designed in the five Governorates
4. Train personnel at all levels to implement the combined system at central level and in the 5 Governorates
5. Install system and follow-up on a sustained basis at central level and in the 5 Governorates. Evaluate periodically and ensure provision for feedback and utilization of information for planning and decision-making

PERFORMANCE INDICATORS:

1. System redesigned and forms standardized
2. System approved by central and governorate level officials
3. Personnel trained in use of system

4. System installed and functioning

IMPACT INDICATORS:

1. Corrective action being taken by health personnel on basis of health and epidemiological information

IMPLEMENTATION BUDGET:

	<u>USAID</u>		<u>Others</u>		<u>Yemen</u>
	YR	\$	YR	\$	YR
Survey					
Redesigning system and conducting field trials		x			
Equipment					
Hardware		x			
Software		x			
Printing of forms, training materials		x			
Training					
Central level		x			
Governorate Health Office		x			
Health Facilities		x			
Sustained monitoring and evaluation		x			

TOTAL:					
	Yemen	YR			
	Project	YR		US\$	
Cost per Governorate:					
per health facility:					

RECURRENT BUDGET ESTIMATES (ROY):

INTERVENTION: ALTERNATIVE MEANS OF FINANCING PRIMARY HEALTH CARE

PROGRAM OBJECTIVE: Increase access to and participation in MCH and Family Care programs

SUB-PROGRAM OBJECTIVE: Develop Community-level financing of MCH/FC Services

ACTIVITIES:

Coverage: 5 Governorates
5 PHC Units
5 Health Centers
Catchment area population - 50,000

Duration: 36 months

1. Conduct research on feasibility of fees-for-service and LCCDs cost-sharing
2. On basis of research findings, organize and conduct pilot interventions
 - 2.1 Design interventions, including evaluation protocol, obtain approvals in selected Governorates, and obtain counterpart support
 - 2.2 Select representative PHCUnits and Health Centers (five of each)
 - 2.3 Train staff and install procedures
 - 2.4 Conduct pilot interventions over time (2 years)
 - 2.5 Conduct evaluation and prepare proposals for modification and replication

PERFORMANCE INDICATORS:

1. Research study completed
2. Pilot interventions designed and implementation initiated
3. Pilot interventions completed
4. Evaluation and proposals completed

IMPACT INDICATORS:

1. Additional funding available for PHCUnits and Health Centers administered to improve the quality of and accessibility to MCH/FC services in those facilities and their catchment areas

IMPLEMENTATION BUDGET:

	<u>USAID</u>	<u>Others</u>	<u>Yemen</u>
	YR	YR	YR
	\$	\$	
Research study			
Local TA (University or Public Acctg. firm?)			
Design of interventions	Contract		
Conduct pilot interventions			
Training			MOPH
Install procedures	TA for training/		
Supervise and Monitor	installing and monitoring		
Evaluation of interventions, proposals for replication	Contract		

TOTAL:			
	Yemen	YR	
	Project	YR	US\$
	Cost per site:		
	Cost per capita:		

RECURRENT BUDGET ESTIMATES (ROY)

ATTACHMENT NO. 1**STATEMENT OF WORK
for a
LIMITED SCOPE HEALTH SECTOR ASSESSMENT****I. BACKGROUND:**

USAID/Yemen assistance to the Republic of the Yemen's (ROY) health sector was initiated in 1980 under the Tihama Primary Health Care Project. This project ended in 1990 at a cost of \$10.5 million. The ongoing Accelerated Cooperation for Child Survival (ACCS) project was initiated in 1986 with authorized life of project financing of \$12.7 million and is scheduled for completion in 1994. Technical assistance is provided under contracts with HEALTHCOM, PATHFINDER and CDC. REACH, HEALTHCOM and PATHFINDER contracts will terminate in 1992. The REACH activity will be extended through March 31, 1993, to allow completion of ongoing activities and to continue momentum during the replanning period. The project activities complement and/or relate to UNICEF, Dutch, Swedish and other donor health assistance in the sector.

Progress to Date:

The Tihama and the ongoing ACCS projects provide resources for technical assistance, commodity support and training. The significant investments in institutional development, infrastructure and services of the Tihama project have seriously deteriorated because of lack of maintenance and/or operating budget. In addition, the ongoing ACCS project is seriously behind schedule because of bureaucratic delays during the initial two years and more recently because of lack of counterpart resources. Reports indicate that other donor-assisted programs (Dutch, Swedish and UN agencies) in the health sector are also experiencing similar difficulties.

The deterioration of past USAID investments and the current ACCS implementation and operating problems require a serious review of the project objectives, what can productively be completed in the remaining period and new management mechanisms. The new plan will need to consider USAID/Yemen's reduced staffing/management limitations and related A.I.D. policy of concentration on very discrete elements for improved management and sustainability.

Of the \$12.7 million planned life-of-project funding, \$7.0 million has been obligated. The \$5.7 million balance may be made available in the remaining period for well-designed and discrete

child survival-related activities that can be effectively implemented and managed.

II. PURPOSE OF THE ASSESSMENT:

The assessment is intended to provide new recommendations to USAID and the MPH on:

the most appropriate child survival interventions for USAID assistance which can be effectively managed and sustained with available Republic of the Yemen operating budget, technical and management capacities - particularly focussing on child survival.

The recommendations will provide the basis for amendment of the ACCS project paper. Recommendations will also be incorporated in the health sector component of USAID's FY 1992-94 Management Plan to be submitted to Washington in late April 1992, in conjunction with USAID's Annual Budget Submission.

In this regard, it is important to note that the operative requirement of all USAID/Yemen's assistance will be on **program and project concentration**; i.e., the focus will be on a limited number of program objectives/project activities that have the full commitment of the ROY and that can be sustained for the long term with available ROY resources. The interest in concentration is to also improve management and the implementation of project activities to achieve better long-term development results.

In the health sector, USAID's interest will continue to be on the more limited aspects of child survival and related primary health care. Accordingly, the assessment is not intended to be a comprehensive health sector assessment but will focus on the more discrete elements of child survival.

III. SCOPE OF WORK:

The field assessment will be conducted beginning o/a March 1, 1992. It is estimated that the field work and interviews can be completed in two weeks. A draft report and recommended action plan will be completed by April 1 for review and comments by USAID and the MOPH.

Recommended action steps:

In Washington:

- A. Review background documents related to the project including the 1990 Country Development Strategy

- Statement and ACCS Project Paper. (Documents will be made available by Near East Bureau Washington offices).
- B. Meet with Near East Bureau/Development Resources Office (NE/DR) and A.I.D./Research and Development (R&D) staff for background briefing on Bureau/Agency health/population sector strategies, issues and central resources available to support Mission programs.

In the Yemen:

- A. Meet with USAID management and Health, Population and Nutrition (HPN) technical staff for briefing on overall Mission program strategy, HPN sector programs and to review contractors draft strategy for undertaking the field assessment.
- B. Meet with MOPH counterparts to:
- discuss MOPH draft health sector plans including decentralization plans, budgetary resources and planned allocations;
 - review progress on manpower assessment and analysis;
 - review other donor assistance training programs, technical assistance and commodity support;
 - discuss MOPH institutional strengths and weaknesses and perceptions of problems and performance of ongoing USAID and other donor-assisted health programs in such programs as the expanded program for immunization (EPI), disease surveillance, primary health care training and communication activities.
- C. Meet with UNICEF, WHO, Dutch, and Swedish technical and program planning staff to review/discuss their perception of priorities, their program plans, policy and operational issues and their recommendations for improved child survival and primary health care programs.
- D. Revise assessment plan and schedules as appropriate and discuss with USAID and MOPH.
- E. Undertake field visits to representative health care sites in 3-4 governorates.
- F. Review preliminary findings with USAID, MOPH and other donor representatives for comments and clarification as necessary.

- G. Prepare draft report and recommendations for discussion prior to departure of team leader.

IV. THE FINAL REPORT:

The contractor will prepare a final report that will discuss/comment on key child survival issues including, among others:

- decentralization of child survival and related health delivery services;
- technical and management capacities and training requirements;
- strategies/opportunities for private sector initiatives;
- approaches for sustained immunization coverage;
- disease surveillance;
- education and communication modalities;
- integration of child survival and related primary health care service delivery in complementary population, Women in Development and primary education programs.

The report will provide:

- A. Recommendations of discrete and achievable child survival targets of opportunity where USAID resources can be concentrated and most productively utilized carefully considering the MOPH's and ROY's (more generally) institutional and budgetary capacity.
- B. To the extent possible, each recommended project intervention should be broken into achievable sub-units with scheduled end points and identified/detailed performance indicators for periodic assessment of progress.
- C. An objective analysis of resource requirements including budget, equipment and personnel that can be reasonably met by the ACCS project and counterpart institutions.
- D. An outline of the responsibilities and authorities of each of the parties; i.e., ACCS project, MOPH, local councils and others such as cost sharing; (A matrix of responsibilities and authorities together with budgetary responsibilities must be included in the revised project agreement to assure proper management and attention to implementation.) Recent experience

may recommend deviation from the practices and/or location of authority now in place.

- E. Complementarity of the recommended project activities with the planned investments/efforts of key donors to increase the overall impact.
- F. Options for management of the project under grants, arrangements with other multilateral donors; e.g., UNICEF.

The report will also provide recommendations for other research and/or other lines of inquiry that will be necessary for project paper amendment and/or strategy development.

Format of the report:

The report should contain the following sections:

- A. An executive summary outlining
 - a brief overview of the objectives and general methodology of the assessment;
 - significant findings including issues, institutional strengths, opportunities and limitations for improved child survival and related primary health care; and
 - recommendations by priority.
- B. An overview of child survival and related primary health sector problems and priorities.
- C. Institutional arrangements, responsibilities and related issues.
- D. The resource requirements for improved child survival and related primary health care services.
- E. Recommended ACCS project interventions by priority with
 - appropriate analysis supporting the recommendations;
 - tables, charts, and means-ends diagrams to highlight input requirements for each proposed output; and
 - performance indicators for each intervention.
- F. Conditions/requirements for successful project intervention and project implementation including

budgetary and personnel resources, revised institutional arrangements, etc.

Report Preparation:

Before leaving Yemen, the contractor will prepare a draft report, including recommendations, for discussion with USAID/Yemen personnel and members of the host government. The contractor will provide USAID/Yemen with 15 copies of the final report within two weeks following the completion of it work in Yemen.

V. TEAM COMPOSITION AND LEVEL OF EFFORT:

The assessment team will be composed of four external consultants (contractors) supplemented by USAID/Yemen HPN office staff. Ideally, all of the contract staff will have operating experience in the Yemen and have some knowledge of Arabic.

A. Team Leader: (Five person weeks)

The team leader should be an **experienced health planner** with significant experience in management of child survival programs in developing countries. The team leader will have strong leadership and negotiation skills and excellent writing ability. Experience in working with USAID-assisted health care programs would be beneficial.

The team leader will spend up to two working days in Washington reviewing background documents and meeting with NE/DR and R&D staff.

B. Public Health Specialist: (Three person weeks)

The public health specialist will have extensive **technical experience** in primary health care delivery systems and more specifically experience in child survival field experience including EPI, ORT, primary health care, logistical support and systems management. Working experience in the Yemen would be ideal.

C. Training and Institutional Development Specialist: (Three person weeks)

The training and institutional development specialist will have extensive field experience in **primary health care management and organizational development**, training and related resource budgeting and planning. Work experience in

the Yemen would be ideal.

D. Local Yemeni Health Specialist: (Three person weeks)

A consultant (from outside of MPOH) who must be familiar with the issues and provide objective assessment inputs.

E. Yemeni Counterparts:

The Ministry of Public Health will provide two counterpart staff to work with the team (per diem only).

APPENDIX B

LIST OF PERSONS CONTACTED

MINISTRY OF PUBLIC HEALTH - SANA'A

Dr. Abdulla Al-Saadi, Undersecretary for Planning
and Health Development
Dr. Abdul Halim Hashim, Director General
Primary Health Care
Dr. Ahmed Al-Hamly, Director General, Health Education
Dr. Salih Dobahi, Director, Family Health
Dr. Adel Barakat, Director, Diarrheal Diseases
Dr. Mutasem Sabri, Director, MCH
Dr. Mohamed M. Hajar, Public Health Advisor
and Director, EPI
Dr. Nader M. Sultan, Director, Nutrition
Dr. Mahdi Abdulla, Deputy Director, MCH

MINISTRY OF PUBLIC HEALTH - GOVERNORATES

Hajjah

Dr. Abdul-Karim Nasar, Director General, Health Office
Dr. Ismail Humaid, Director, Primary Health Care
Dr. Ahmed Abbas, Deputy Director, Primary Health Care
Ahmed Al-Hugari, REACH Coordinator

Hodeida

Dr. Ali Fakira, Director General, Health Office
Dr. Ali Alshuraai, Deputy Director, Primary Health Care
Asia Aishibani, Director, MCH
Dr. Zainab Shiathal, Director, Medical Research
Sharaf Al-Hamly, REACH Coordinator

Abyan

Dr. Salem Naser Gaber, Director General, Health Office
Abdulla Hussin Gaber, Asst. DG, Health Office
Salem Mahamed Ali, Director, Health Office, Koufir District

(See Trip Reports, Appendices D and E for names of persons
seen in health centers and units)

OTHER MINISTRIES, INTERNATIONAL AGENCIES, DONORS AND NGOS

Ali Al-Hlaly, Deputy Governor of Hajjah

Dr. Farouk Partow, Acting Country Representative, WHO
Stewart McNab, Country Representative, UNICEF

Joel Renserom, Assistant Resident Representative
for Programs, UNDP

Thomas Kencht, Program Officer, United Nations
Volunteer Program

Dr. Hedia El-Ghouayel, Country Director, UNFPA
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APPENDIX C

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APPENDIX D

LIMITED HEALTH SECTOR ASSESSMENT
FIELD TRIP REPORT
HAJJAH AND HODEIDAH GOVERNORATES

28 - 31 MARCH 1992

Team Members:

Mr. Ahmed Al-Kohlani	MOPH
Dr. Aisha Jumann	Consultant/USAID
Mr. Charles Habis	HPN/USAID
Mr. Albert Neill	Consultant/USAID

HAJJAH GOVERNORATE

Itinerary:

Saturday, 28 March 1992

1200 hours Arrive Hajjah
Meeting with:
Dr. Abdul-Karim Nassar, Director
General, Health Office
Dr. Ismail Humaid, Director, PHC
Dr. Ahmed Abbas, Dpty. Dir. PHC
Mr. Ahmed Al-Hugari, REACH Coordinator

1330 hours Meeting with Mr. Ali Al-Hlaly, Deputy
Governor

1400 to 2400 Observation visits to Qalat Humid PHC
hours Unit and Al-Shagadra Health Center

Sunday, 29 March 1992

1100 hours Conference with DG and staff. Detailed
review of REACH/ACCS workplan and
management issues

1330 hours Depart Hajjah. Stop at Kholan PHC Unit

Characteristics:

Population	1,000,000
Zones	5
Districts	33

Different topographic and climatic conditions from high mountainous areas to the seacoast, including five small islands.

Mountain disease patterns: hepatitis, bilharzia

Coastal disease patterns: malaria, tuberculosis

Hospitals 4 rural. New 50-bed hospital in Hajjah city to open May, 1992. Expandable to 200 beds.

Health Centers 7

PHC Units 20 permanent, 60 temporary
15 permanent Health Units will be constructed in 1992 and another 15 in 1993.

The health services in the Governorate have improved greatly in the past ten years when there were only four doctors, one hospital and two health units.

Planning ratio for health facilities: 1 PHC Unit/5000 population. (this would require staffing by both a female and male PHC Worker).

The Ministry of Civil Service has a quota for employing PHCWs in each governorate. In the 1992 plan, the Governorate proposed posts for 74 PHCWs, only five have been employed and the MOPH has agreed to employ the 60 new graduates of the ACCS Project. It is important to look for other sources to fund the PHCWs. In 1989, 125 TBAs were trained by BOCD in Aslam and Abbs districts, however, due to the lack of supervision and follow up, there is no information on their performance. The Governorate has 6 trainer/supervisors. There are 30 PHCUs; each has one male and one female PHCW. However, supervision and follow-up needs more than just cadre, it needs vehicles, petrol, maintenance, and per diem. The allocated funds per health center is YR 2500. To maximize the use of the supervisors, it is important to integrate all PHC activities; at present, one supervisor can not supervise all activities. The EPI program has its own budget for transport and supervision, while all other activities have one budget that comes in nine months instead of the scheduled three months. It is important to team up the EPI, MCH, and PHC supervisors to travel together in one vehicle, or use one supervisor to follow up all the activities.

The Project trained 4 supervisors and planned many refresher courses in and out of the country, but only one fellowship (in Hawaii) was implemented. Refresher courses will be needed for the present working staff and in the future for the new graduates. Management courses will also be needed for central level staff and the directors of the health centers. External sources for training may be needed. The Health Office submitted training plans to REACH with a schedule for each course, the numbers of trainees, and the area of support nine months ago. REACH agreed, yet, nothing has been implemented.

The Governorate has seven health centers, two are supported by REACH. Most of the items mentioned in the REACH Workplan were not implemented, except a workshop in August, 1991 for supervision and follow-up for ten days in Sana'a. The LCCD participated in that workshop.

Training of FPHCWs in the governorate started in 1985. Sixty have been trained by REACH, 13 of whom just finished training last month. REACH started discussing the ACCS Project in 1987, however, nothing was done until 1990. Two sites were selected for REACH activities and to start training PHCWs; these were Aflah Al-Sham and Al-Shagadra. REACH signed the agreement in February, 1990. Trainees were selected and sites for building 30 health units were identified. In September, 1990 training started in the sites. So far, 47 MPHWCs and 13 FPHCWs have been trained in Aflah Al-Sham; 10 FPHCWs are still in training in Al-Shagadra. They will complete their training in May, 1992. The sixty trained PHCWs are still awaiting appointment as government employees. REACH has provided the two sites with two vehicles and two small generators.

Cadre building and furnishing the health centers have been the two major successes in implementing the ACCS project. The hope is to emphasize MCH services in the future. Plans are to have a FPHCW in each health center and provide MCH services in all health centers and units in the 33 districts in 5-6 years. Currently there are 65 FPHCWs, 125 TBAs, and 132 MPHWCs. In 1993, the plan calls for training 30 FPHCWs. The ACCS Project aims at covering 50% of the governorate with health services.

It is expected that the ACCS Project will strengthen immunization, supervision, and follow-up activities. It states that it will train 140 PHCWs (70 have been trained) and 6-7 trainers/supervisors. Currently the Governorate has 6 trainers/supervisors, four of whom were trained by the ACCS Project. HEALTHCOM will start a plan for combating diarrhea and encouraging breast feeding in June, 1992.

Oalat Humid Health Unit, Magrabit Binian - Population 9,000

This health unit is a temporary one and is rented at YR 8,000/year. It lacks all basic furniture and equipment. It has two newly graduated MPHWCs, who have not been employed yet. Services are very poor with no women and few children attending for services. Children come for immunization and people who have traveled from as far as 15 km away have been turned away, forced to look elsewhere due to the shortages of vaccines and medicines. Malaria is endemic, yet the unit has no chloroquine. As the population is scattered in very rough, mountainous area, health workers have to walk to reach the population, especially since the health unit has no transport facility. The average number of service seekers is 18/day. A cholera epidemic hit the area at the end of February incurring 8 fatalities. PFCWs go to the homes of cholera patients

and distribute drugs to those who come in contact with the patient as a preventive measure. Supervision and follow-up to the health unit is poor. The reporting system is also poor. Data collected is not analyzed, nor sent in a form to those concerned at the Health Office. Women receive health services from a traditional women practitioner since no other women are trained in this area in providing health care service.

Al-Shagadra Health Center

Four administrators and ten technicians work with a Sudanese physician who has been there for five months. There are ten trainees. Population in the area served is 50,000.

The Health Center, supported by the ACCS Project, provides preventive and curative services. It has an EPI Room, MCH Room, a Lab, a Nutrition and Growth Monitoring Room and an Emergency Care Unit.

The Center charges patients for some of the services offered. There is a YR 5 registration fee; students and emergency cases are exempted from this. Of the YR 5 fee, one rial goes to MOPH, and one rial is for the Yemeni Red Crescent. Medical reports cost YR 300 and dressing of wounds cost YR 50. Lab procedures cost YR 10. All funds are sent to MOPH. The center serves approximately 3,000 patients per month.

Training is coordinated with the Health Manpower Institute. The trainees get YR 1,000 per month; YR 500 paid by the ACCS Project and YR 500 paid by the LCCD. Training is divided into two parts, a theoretical part conducted at the center and a practical part conducted at the hospital in Hajja city. For the MPH CWs, Yemeni trainers conduct the training; for the FPH CWs, a female Sudanese trainer conducts the training. Examination of the trainees is done by the staff of the MCH department at the MOPH and HMI. Thirty MPH CWs participated in training; 27 graduated and 3 failed. Currently, ten FPH CWs are under training. They are expected to graduate in May, 1992.

The Center's most important activities are immunization and health education. Health education relates to hygiene and is conducted at the Center, in the schools and at homes. People respond to immunization. The Center selected ten schools where HE lectures on personal hygiene are presented once a month as a special program to combat cholera. Diarrhea is ranked as the number one problem in the Governorate.

Khowlan PHC Unit

The unit was built by the community and UNICEF in 1986/87, costing a total of YR 65,000. The unit has two rooms, one for immunization and the other for check-ups. It serves three villages with a total

population of 6,000. Cholera is prevalent with 16 cases and five deaths between 15 March and 28 March 1992. No water is available. The unit only serves men and children. For cholera cases, the advise is to isolate the case and give medicine to contacts, however, no medicine is available for the children. EPI Supervisor comes once every three months to look at statistics and the cold chain. PHCWs walk for outreach immunization and HE activities. There are difficulties with the community demanding drugs that are usually not available. At times children coming for immunization have had to be turned away because it is impractical to one vial of vaccine to immunize one child.

Statistics are reported in a book, gathered at the end of the month and taken by one of the PHCWs to the Health Office in Hajja. The LCCD has 38 members. They help in gathering people for immunizations and HE outreach activities.

Problems include scattered population with rough roads and cultural barriers for women.

Observations and Findings:

1. Accessibility and utilization is very low due to a number of critical barriers:

Physical Barriers: Settlements are scattered throughout a very rugged mountainous terrain. Villages are located on mountain tops. Roads are unpaved. There is no public transport other than private taxis which are high cost (YR500 per ride).

Cultural Barriers: Strict Islamic customs preclude males from providing health care to females, not even for health education. The lack of female health providers severely limits accessibility for the two most important groups--at-risk, women and children. In many locations this results in no health services for these groups at all.

Technical Barriers: Health providers are expected to do more than they are trained for. They actually have a narrow role; they diagnose and dispense drugs. The communities give lower priority to maternal care than to ambulatory curative services. The PHCWorkers are presently visiting homes to advise on safe hygienic practices because of the cholera outbreak.

PHCWorkers do not appear to be doing ORT on a regular basis. There is no ORT education. Physicians in the health centers also complained about the lack of skills in the PHCWorkers. Overall there is low utilization, with little or no provision of MCH services.

Management Barriers: There is no supervision, no refresher courses (to date). Costs for maintaining vehicles inhibits supervision and supply. While registers are maintained in the health facilities, there is no standard HIS recording and reporting, with the exception of vital statistics.

Cost of maintaining a Health Center (excluding personnel and drugs):	YR 2,500/month
Cost of maintaining a PHC Unit:	YR 666/month.
Cost of building a PHC Unit:	YR 65.000.

2. Training

Learning is typical of Yemen system; students learn by rote and are incapable of responding to special needs and problems. The emphasis is on classroom training, when practical experience is needed.

Female trainees are forced to remain in the area where they live. This can result in a maldistribution of health workers.

Use of Sudanese women as trainers has resulted in some problems. But female Yemeni trainers are too liberal in their outlook to work in remote areas like Hajjah. Higher salaries for Yemeni trainers might provide the motivation needed. In future, selected PHC workers can be upgraded to become trainers.

Midwifery training is a priority need. There are presently only two midwives in the entire Governorate. Can train at Hajjah branch of HMI, 3-1/2 year course. Problem is recruiting candidates and then absorbing them on MOPH rolls. Midwives can become trainers of TBAs.

Governorate requested refresher courses from REAC. 5-6 months ago, but no response.

3. Service Delivery

In preventive care, all that is basically done is immunization. Other programs could "piggy-back" on EPI, such as ORT and malaria prophylaxis.

4. Management

Management at the Governorate level is clearly in need of strengthening. There are no plans of action, no management nor health information, no workplan to support the REACH workplan (last one in 1989) there appears to be no delineation of roles and responsibilities, no job descriptions, no procedures manuals, no protocols, no supervisory schedules, no supervision checklists, etc.

There is no model to follow for planning and management. Governorate priorities differ from the central Ministry, e.g. in the allocation of resources for Primary Health Care.

There are six supervisors in the Governorate; four were existing, four trained by REACH. But two have left, leaving the six remaining. One Health Center is to supervise 30 PHC Units.

Technical support for strengthening management could prove a worthwhile intervention for foreign assistance. Suggest long-term technical assistance for management development, not workshops. (Workshops could supplement the sustained support, but are no substitute for it).

5. Manpower

What is required to reach 50% coverage. As a general rule-of-thumb, according to the formula of 1 PHC Unit/5000 population, for 1,000,000 people this would require 2,250 PHCWorkers. Since both male and female workers would be required, the number comes to 2,250 males and 2,250 females. 2,250 Units would be required. There are presently 20 permanent and 60 temporary units.

6. REACH Workplan

The team reviewed the FY1991 REACH/ACCS Workplan with the Director General and his staff in some detail.

They had not seen the workplan, nor did the Governorate have a sub-workplan to support it. Most activities have not been carried out, and most outputs not achieved. REACH activity has been largely limited to the training of PHCWorkers. None of the Management objectives (Objective No. 4) have been met. (The Minute of the Meeting held between REACH and the Governorate Health Office on 29 January 1992, does cover some of the more critical components of the workplan. This type of review on a periodic basis would strengthen project management).

Specific Interventions to be considered based on Hajjah Observations and Findings

- a. Training of midwives
- b. Development of midwives for training TBAs
- c. Refresher courses for PHCWorkers (as a supplement to supervision)

- d. Cold chain maintenance
- e. Training of female training supervisors
- f. Technical assistance for management development
- g. Strengthening of the Health Information System, install, train personnel, develop information for planning and management decision-making
- h. Strengthen REACH Coordinator role. Use management by workplans. Formulate workplans from the "bottom-up" with participation of the DG and staff.

HODEIDAH GOVERNORATE

Characteristics:

Population: 1.2 mns.

Hodeidah City	177,000 (14%)
Other cities	157,000 (13%)
Rural	881,000 (73%)

Health Centers:	24 (21 rural)
PHC Units	99 to 105 (16 have female staff)
Training Facilities	2
To be added by REACH	3

There are 15 trainer/supervisors, 103 MPHCWs, 21 FPHCWs, 6 LBAs and 54 TBAs

Hodeidah ratio for planning facilities: one unit per 2500 to 3000 population.

Disease patterns (in order of magnitude):

TB, Pertussis, Measles, Tetanus, Diphtheria, Polio
(per David E. Bevan, 3/92)

Malaria, Respiratory, Diarrhoea, Dressings, Anaemia, Malnutrition (per Rachel Feilden, reports by PHCUnits and HCs, 1990, p. 65)

Itinerary:

Sunday, 29 March 92
1730 hours Arrive Hodeidah
Monday, 30 March

1100 hours	Meeting with Director General, Health Office, Dr. Ali Omar Fakirah Dr. Ali Al-Shuraai, Dpty. Director PHC Asia Alshibani, Director MCH Dr. Zaineb Shiathal, Medical Research Director
1100 - 1600 hours	Observation visits to Tahreer Health Center, Qhuleil Health Center (Dutch supported), Hais Health Center
2000 - 2200 hours	Extended discussions with Director of Medical Research re: the woman's role in health and development and the potential of women's health committees
 Tuesday, 31 March	
1000 hours	Conference with DG to cover numerous questions based on observations and review of reports

Observations and Findings:

1. Contrast with Hajjah: Stark contrast, flat land, better accessibility, better management, higher ratio of murshidaat (female PHC health workers), substantial influx of muqtaribeen (returnees), more urban population.
2. Management: DG has workplan. Handicapped by severe shortage of funds. Necessary to juggle funds among departments to keep things going.
3. Tihama Project: Built 100 PHCUnits which are still functioning. But not sustainable at initial level; have had to scale them down resulting in a reduction in quality of care. While shortage of time did not allow the Team to survey these units, they are reportedly in a bad state of deterioration.

Lessons Learned (from Feilden Assessment, 1/92):

- o Management systems training worked and had lasting impact
- o Did not train enough females
- o Hired local staff who were not Health Office employees so they were lost after the Project
- o Purchased overly desirable vehicles (rather than utilitarian) which were later taken over by high officials
- o Gave salary supplements to MPH staff (25% after one year, 50% after two years) which could not be sustained

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- o Lacked integration with the Health Office and other agencies
- o Consultants reports were in English, not translated into Arabic, so were lost to many counterparts
- o Donor ambitions greater than can be realistically expected to be absorbed."

No mention of how facilities and services have been maintained, but the Team's information is that both are very poor.

4. EPI: Supply problems.
5. Training: Need for emphasis on practical, "hands-on" training. Governorate has 6 trainers, all Yemenis. There has been an overwhelming response from female recruits (over 1000 applicants for 55 positions). Families need the income (YR1000 per month during training and continuing). But there is no career ladder for PHC Workers. It would be possible to upgrade the better ones to supervisors and trainers.
6. Management Technology Transfer: Consider USAID-sponsored program to transfer management technology among governorates through organizing conferences of DGS, exchanging Department Heads, and the like).
7. Technical Assistance: Fewer consultants and consultants reports. More direct management development assistance such as strengthening the Health Information System and EPI logistics. Set practical performance levels!
8. Vehicles: REACH has inventoried vehicles and recommended six be repaired. DG's position is that it would be better to purchase three new vehicles for the same cost of repairing six, and being newer they will last longer.
9. Financing HC/T Repairs: The Zaidia HC will require YR 2,600,000 to be financed 1/3 REACH, 1/3 ICCD, 1/3 MOPH. Government has no funds in the immediate, the community has yet to come up with its share. DG requests work proceed with MOPH paying in six months upon completion of repairs. But there are no guarantees.
10. PHC Supervision: Monthly to each unit. Cost of petrol an increasing problem. After Ramadan will combine supervisors so they visit together in same vehicle. (NB: Feilden Assessment survey indicated that more than half of PHCWs and LBAs had not seen a supervisor in 6 months, p. 99).

11. Health Information System: Reliability is questionable. Need training for central statistics staff and for all staff in facilities.
12. REACH Consultants: "We know our problems. Some solutions are in our hands; for others, we need help. Feilden recommendations are unworkable. Recommendations for whom? the Health Office, the Project, the MOPH? For example, EPI is a national program; it is not in the Governorate's hands." (DG).
13. Women's Village Health Committees: Could be approached in a cautious, low-profile way. Do not bring in outside consultants. (Not been done in this area before; but we have learned the Dutch have organized Village Health Committees - with men and women members - in Baydah Governorate).
14. Dutch Urban Health Project (Ghuliel HC): This is a model project, but has required time (6 years) and resources including three expat staff (now down two). 24,000 urban poor population. This approach, while exemplary, is clearly unsustainable!
15. Family Planning: SEATS Project has been to Hodeida and selected two sites for introduction of FP interventions integrated with other health services. The DG states he is in full support of these initiatives.
16. Utilization: Team was told average attendance at PHC Units is 100 per day. This contrasts markedly with Feilden analysis of Monthly Activity Reports indicating about 115 per month! We must factor in the attendance at curative facilities (private with doctors and/or nurses).
17. Rachel Feilden Assessment (July-August 1992): Contains a great deal of information, much of it based on survey data and interviews in 33 facilities. Numerous recommendations on all aspects of PHC. These could be reviewed to select interventions on a priority basis.
18. Coordinator's Role: Coordinator may be more effective if he were a MOPH employee (counterpart).
19. There is a lack of accessible services to mothers and children, particularly in the rural areas. Reliance on male PHCWs appears to be the most important cultural barrier to accessibility for these two key target groups.
21. Training of PHCWs with major emphasis on female workers has proven to be an important contribution to PHC services availability.

22. Community participation appears to be affected by village-level socio-cultural customs impeding decision making in health. Local councils with male membership address all community issues.

Specific Interventions to be considered based on Hodeida Observations and Findings:

- a. Mushidaat training - get on with it
- b. HIS training
- c. Repair/replace vehicles
- d. EPI support (supplies and distribution)
- e. Women's Village Health Committees
- f. Management technology transfer: Governorate-to-Governorate
- g. Technical Assistance: fewer consultants more direct support (problem with sustainability here; must ensure good counterparts and training components)

ADDITIONAL FINDINGS/RECOMMENDATIONS

(From Dr. Jumaan's Field Notes)

General:

All FPHCW trainees met by the team in Hajja and Hodeidah expressed interest in working in deliveries and Health education only, when asked about the most favorite activity. This raises a concern regarding the other PHC activities including immunization, diarrhea control, nutrition, prenatal care, etc.

Most deliveries in Hajja and Hodeidah are done at home; for which PHCWs get incentives. This practice should be encouraged so as not to overwhelm the already weak public health structure as well as promoting a "fee-for-service" approach.

A referral system for complicated deliveries and risk cases does not exist; a woman may die before reaching a health center where trained personnel may assist. In Hajja, the only four deliveries at the center for the 12 months of training, were ones that had stayed at home for delivery, and only when it became apparent to everyone that trained help was needed, were these women taken to the center. In many cases, it may not be possible to move these

women to the health center on such short notice.

Warning signs for difficult cases and complicated pregnancies must be stressed in training. Health workers should encourage women to attend the HU or HC for prenatal services, so these women know what to expect during delivery. Also, in this way at risk cases can be identified at an early stage.

A fee for service concept is implemented in one form or another. These include: 1) fees (incentives) for deliveries as noted above; 2) charges for ORS packages (in Hajja, it was reported that people paid as much as YR 35 per package); 3) charges for drugs; 4) charges for basic services such as dressing of wounds, laboratory tests, etc. People seem to accept it as a fact. A useful way is needed to channel the funds. Presently, the funds go to MOPH. This should be decentralized. These funds could be used to purchase necessary drugs and equipment for the health facility or some of it may be used as incentives for health care workers. The factory approach may be used, the more people that come to the center for health services, the high the incentive may be!!

Most MPH/CWs, all over Yemen, act as physicians, diagnosing diseases and prescribing drugs with little attention paid to preventive measures and health education. This issue has to be dealt with during training and through regular supervisory and follow-up visits.

Poor skills of health personnel at all levels is observed. Upgrading the skills of these workers through refresher courses, in-service training or long term training should be addressed.

Hajja:

As it is difficult to recruit females as PHCWs and as most deliveries take place in the homes, it may be important to recruit TBAs for short term training. These women are older and freer in their movements, respected by their society, have access to people's homes and have the basic knowledge. Therefore, they would not need long term training. Training should include prenatal care with recognition of warning signs for referral using adult learning methods and building on previous experience. These TBAs can then be provided with certificates and delivery kits. they may also be important in the distribution of contraceptives and ORS packages.

From communication with people working in Hajja, it was apparent that the skills of the health workers are not satisfactory, Therefore, it is important to initiate refresher courses to improve the quality of the health workers performance. This will be needed for all health workers in the country, especially since most of these workers never get supervisory visits and may work alone.

Training of FPHCWs should be adopted to the realities of the

community where the training is conducted; when interviewed, these workers tended to repeat what they had memorized during training. Teaching methods should also be improved to get away from the memorization style that presently exists. It was observed that most of the training of the FPHCWs concentrates on midwifery as the Sudanese trainers are trained midwives, lacking a strong background in PHC. This explains the students' desire, whether in Hajja or Hodeidah, (both had Sudanese trainers) to perform deliveries and health education activities only after graduation. Future training should also stress the other PHC components which may be done by other trainers while the delivery and HE part can still be done the Sudanese trainers, if necessary.

The Health Center in Al Shagadra did not have HE material, no posters were seen anywhere in the center. This was especially important because it is heavily involved in HE activities related to the prevention of cholera. Locally-made HE messages should be encouraged in the training of PHCWs. These should not be costly, local dialects can be used on posters that target special problems of the local community. Most HUs and HCs depend on supplies from Sana'a. However, since the logistical system in the MOPH is poor, locally made materials should be encouraged.

The REACH coordinator seems to be doing administrative work only with little involvement in technical matters. He also appears to have no control or even a say in any of the decisions regarding the project. The coordinator could be trained during this period on project management, so that when the project phases out, this person is not lost. Salary of the coordinator should be compatible with MOPH salaries with some incentives for traveling purposes and additional work in excess of normal government duties.

Hodeidah

The Dutch urban project does not seem to be sustainable, since the running cost of the center is paid for by the Dutch. The project prints its own mother and child cards which are different from the ones used by the MOPH, creating a parallel HIS adding to the already confused HIS. Transport, petrol, maintenance of equipment is all done by the project. These will not be picked up by the Government once the project phases out.

Home visits are good and need to be encouraged; yet it is costly and time consuming; it was stated that on average 4-6 families are visited per day. A mechanism for sustaining this activity needs to be developed, especially for logistics.

The center seemed to be overstaffed with FPHCWs; this was also true of the REACH-supported center. OXFAM is also training 12 FPHCWs from the same area which is within the city of Hodeidah. A maldistribution of FPHCWs is apparent. A policy should be introduced to limit the number of trainees from each area, and give

opportunities to other women from remote areas. The same needs to be considered for the ACCS Project since in the three training centers, the women come from the same area where the center is located. This should be reconsidered and women from other places should be brought in for training. Priority in training should be given to places where there is a severe shortage of FPHCWs. Since Hodeidah governorate is one of the least conservative governorates, it is possible to have women come from different villages for training purposes. This is already practiced by HMI in Hodeidah.

It was stated by the D.G. of the Health Office, that the pool of women returnees is huge and that many women who applied for training either for the ACCS Project or the HMI training courses had to be turned down. These women may serve as a good source for female workers to be taken to other governorates where there is a severe shortage of women recruits.

As the civil service is limiting the number of hired PHCWs per governorate, the community may be approached for supporting the salaries of the already graduated workers who cannot be hired until the following year through:

- a) monthly contributions from all community members and especially those who are well off
- b) fee-for-service concept. Fees may be taken for registration, drugs, immunization, ORS and so forth. A certain amount of these funds can be used to support the salaries of the PHCWs.

Health education messages should be practical and adapted to the community realities and available resources.

APPENDIX E

LIMITED HEALTH SECTOR ASSESSMENT
FIELD TRIP REPORT
BAYDAH AND ABYAN GOVERNORATES

28 -31 MARCH 1992

Team Members:

Mr. Aziz Yahya	Project officer, USAID
Dr. Ahmed Ghurama	MOPH
Dr. Rose Macauley	Consultant/USAID

Itinerary:

Day 1 (Saturday, 28 March 1992):

The team departed Sana'a at 9:30 AM and arrived in Rada, Baydah Governorate at about 11:30 AM on the same day.

Activities: Met and held discussions with the Dutch PHC project team and the director of the hospital/health center. The Team toured the old and new health centers in Rada.

Day 2 (Sunday, 29 March 1992):

The team departed Rada at 9:00 AM and arrived Aden at about 4:00 PM.

Activities: On Sunday, appointments were made since we were told that messages sent from Sana'a concerning our trip were not received.

Day 3 (Monday, 30 March 1992):

The team departed Aden at 9:00 AM and arrived Abyan about 10:00 AM and held discussions with health officials of the Abyan governorate. The team proceeded to a health center, built by the Swedish in 1988, made observations and held discussions with the staff.

The team was then taken to a government health unit in Gaar for observations and discussions.

The team returned to Aden at about 4:30 PM on the same day.

Day 4 (Tuesday, 31 March 1992):

Visited the Amin Nasher High Institute in Aden and met with Mr. Shaboot for about 2 hours beginning at 10: AM.

The team then departed Aden at about 12:35 and arrived Sana'a at 6:30PM.

Rada--Dutch primary health care project:

Persons contacted:

Dr.Ahmed Abd El-Rahman	Team leader, PHC Rada
Wilhelmina Giessen	Public health nurse
Marjan Terwey	Health educationist
Karla Hofman	Public health nurse
Bouwe-Jan Smeding	Public health nurse
Nassa Ahmed Al-Ahmar	Hospital administrator

The project was initiated by the Swedish in the 70's and later taken over by the Dutch in 1988.

Objective of the Project:

(General) To improve the health of Yemenis through integrated primary health care at the District level, by training primary health care workers, (mainly females), improving managerial capabilities and building primary health care units.

Targets:

1. Fully mobilize the communities to identify their own needs, identify possible solutions and to be fully involved in working out the solutions.
2. Build 15 PHCUs in several villages
3. Train enough FPHCWs to staff the PHCUs and the health center
4. Build the management capacity among the nationals to take over the programs initiated by the project when the funding period ends in 1993.
5. Build and furnish the health center in Rada

Achievements to Date:

1. 60 FPHCWs trained, 50 already hired by government. Other 10 are working in the health center and health units but compensated by the project while awaiting to be hired.
2. 3 PHCUs nearing completion
3. The health center in Rada is completed awaiting furniture from the Netherlands. This center should hopefully be ready for use by the end of June, 1992.

Problems as per Dr. Ahmed Abd El-Rahman:

1. Shortage of trained personnel to serve as counterparts to

the team members

2. Lack of management experience among the nationals
3. Lack of female supervisors
4. Lack of collaboration between the D.G. for health services in Baydah and director for health services in Rada.

Steps taken to resolve the above problems:

1. Two females have been sent to Aden to have training in management in addition to advance training in their area of interest, eg. health education.
2. Plans are under way to train eligible FPHCWs as supervisors
3. There have been couple of meetings between the D.G. and the director to iron out their differences. Relationship between the two has improved greatly .

Sustainability:

1. Recurrent cost for all activities is currently been paid for by the ROY.
2. Construction of PHCUs is equally shared by the LCCDs, and the project.
3. Nationals are been trained to take over the management of the project.
4. Village health communities could and are willing to support the FPHCWs from their respective villages.

Lessons Learned:

1. Work directly at the district level
2. Strong mobilization team is crucial
3. Work to gain the confidence of the communities
4. Traditional organizations can be very helpful, though some may serve as barriers.
5. Only one donor organization should be allowed to work in any District (per hospital administrator)
6. A mobil team can serve two purposes: (1) to mobilize the communities, and (2) to increase health care coverage.

ABYAN GOVERNORATE

Persons contacted:

Dr. Salem Naser Gaber	D.G., Health Office
Mr. Aboulla Hussin Gama	Asst. D.G., Health Office
Mr. A. M. Shaboot	Dr. Amin N. Nasher's Institute for Health Sciences
Dr. Ibrahim Mohmed Abdel Rahim	WHO Consultant Amin Nasher Institute

Population	375,000
# of Districts	4
# Hospitals	8
# of health centers	35
# of health units	85
# of medical assistants	88
# of dentists	3
# of dental assistants	12
# of Yemeni doctors	24
females	2
# of non-Yemeni doctors	21
females	8
# of health guides	225 ¹
females	25
# of TBAs (all females)	75

Major Diseases:

- Diarrhea
- Parasitic diseases
- Acute respiratory infection
- malaria
- Hepatitis
- Other tropical diseases
- Motor vehicle accidents

¹ All health guides are people in different professions, eg. teachers, farmers, etc., who volunteer their service.

Duration of health guide training: 4 weeks with frequent refresher courses

Content of training: Health Guides are trained to give first aid and to treat common illness such as; diarrhea, malaria, etc. They are also trained to conduct health education on water and sanitation, recognize risk signs in pregnancy, and referral procedures.

Supervision:

There are three levels of supervision in the Abyan Governorate:

- Central (governorate level), level
- District level
- Area or health center level

The central level supervises the district level once every three months, picking-up reports, replenishing drugs, and supplies where necessary and available, etc. The district level does the same for the area level once every three months. Each district is divided into 3 areas for supervisory purposes. The health centers in turn supervise the health units and the two together supervise the health guides in the villages on a monthly basis. The supervisory team at central and district levels is composed of people from the following areas: MCH, EPI, PHC, Health education.

Content of health guide's monthly report:

- Number of cases seen
- Types disease (complaints)
- Type of treatment given
- Outcome
- Number of health education sessions held and topic discussed during each session

Reports at higher levels may include more information depending on the level.

Problems:

- Finances
- Feedback --"MOPH in Sana'a does not supervise us, we send reports but never get feedback. We too are getting lazy now."
- Health guides are now requesting for compensation since they heard that PHCWs in the Northern governorates are being paid.

Donor assistance is greatly needed in the following areas:

- Family planning
- CDD
- PHC
- Malaria control
- Sanitation

GAAR HEALTH UNIT

Persons contacted:

Mrs. Mahdia Saleh Midwife

Mr. Salem Moh'd Ali Lab.Tech. and Director of the Health Unit

The unit provides both preventive and curative services.

Intake is drastically reduced this month because of Ramadan. Usual daily attendance is about 100-150

Services utilization is about 90%. Most women come for prenatal care in the first or second trimester.

Staff:

- 3 medical assistants
- 4 midwives
- 7 nurses, 5 of whom are females

FINDINGS

People were found working in every office and health facility visited, during Ramadan, both men and women. The Team found more female health workers in each of the health facilities visited who were open and willing to talk with the team members.

Is there a role for health guides/motivator in the villages of the northern Governorates? Can TBAs be recruited for this? The problem seems to be to find the right trainers for illiterate trainees.

In Abyan there was an attempt to train TBAs, but they did not respond! The foreign trainers were unable to cope.

The Undersecretary for Health Planning and Development (in the Team interview) alluded to the role of volunteer health guides.

Characteristics of the Health System in the Southern Governorates:

1. The health system appears to be more of a "bottom-up" system with community involvement and community health workers (Health Guides) - to a greater extent than that found in the Northern part.
2. Health manpower appears not to be a problem. There are adequate trained health manpower as per the D.G. of Health Services.
3. Recruiting female health workers is no problem either. There are over 200 females willing to be trained as health workers.
4. Supervisory system is in place, though not practiced regularly now because of logistics problems.

5. Majority of the health guides (volunteers) are still willing to work as per their original mandate. A few are now requesting compensation as the word has gotten around that PHCWs are paid in the Northern governorates.

(Note: For a list of distinctive characteristics between the southern and northern governorates, see Issue No. 5.10, "Future Project Assistance for the Southern Governorates").

POSSIBLE INTERVENTIONS BASED ON THE SOUTHERN GOVERNORATES EXPERIENCE

1. Train health guides in the villages with emphasis on females with appropriate modifications.
2. Institutionalize training (so that each project doesn't have to go about it on an ad hoc basis). Also ensures standardization of curricula, and places training in the hands of a local institution.
3. Use the Amin Nasher High Institute in Aden to train mid-level managers for the northern governorates. This training could be an incentive for the FPHCWs. The Rada PHC PROJECT has sent two to be trained and are quite satisfied with the results.
4. Consider the organization of mobile teams for community mobilization and supervision.

APPENDIX F

INTERVIEWS WITH FEMALE HEALTH PROVIDERS

By Dr. Aisha Jumaan, Member Assessment Team

Note: During the field trip to Hajjah and Hodeida Governorates, Dr. Jumaan took the opportunity to interview all female health providers and trainees with whom she came in contact. She took extensive notes, which are recorded in this appendix. The role of the female health provider, her attitudes and motivations are deemed to be critical ingredients of the Yemeni health system.

HAJJAH GOVERNORATE - 28-29 MARCH 1992

Al-Sghadra Health Center:

Fatima Naji, Trainee:

Fatima started training on 15 April 1991. All trainees are rotated to serve one week in each of the following sections: EPI, Medical Doctor, MCH, Diarrhea Control. The two months practical midwifery training will start in May after the return of the trainer from Sudan. The trainees have conducted some outreach activities to four villages around the health center. The services provided include EPI, health education and home visits.

The most popular activities among all female PHCWs interviewed were delivery and health education. Health education messages concentrate on personal hygiene, importance of clean drinking water, and prenatal care, especially in regard to nutrition and immunization. Schools for girls and women's gatherings are used for tetanus immunization.

Iman Abdulrahman, Trainee:

Iman works in the Delivery Room. Most deliveries are conducted at home with TBAs attending except for emergency cases that are brought to the center. Since May, 1991, only four deliveries have been conducted at the center; all were emergency cases and one resulted in the death of the newborn. Women do not usually come in for prenatal services. Health education is provided on breastfeeding, hygiene, washing of vegetables, and environmental health. Some women refuse to listen to the FPHCWs because of their young age and lack of experience. Multiparity is high. They try to do some FP counselling in the center. However, the acceptance of

the FP concept is low. During one year of work, only three women came in for FP services and only 5-6 came in for prenatal services. Outreach activities are done once a month with a team of three FPHCWs, three MPFCWs and the immunization supervisor. Microphones are used to inform people of meeting places.

Takia Alshargi and Amani Alansi, Trainees:

Takia and Amani work in the Maternity Room. Prenatal care includes common questions about parity, family size, numbers of pregnancies, age, and if there have been any abortions. Advice is given if the mother's weight is below normal. When food was distributed many women attended. Once the food distribution stopped few women came. Most people come to the center for curative services only and refuse any preventive measures such as immunization or health education messages. TV messages on immunization have increased people's awareness and demand for immunization services. The recent TV message on diarrhea motivated the people to clean the streets.

Kawkab Naji and Saida Naji, Trainees:

Kawkab and Saida work in the Nutrition and Diarrhea Control Room. Health education is done on breastfeeding and weaning foods. Children are weighed but they do not have any growth monitoring charts. Sick children are referred to the physician. An average of five diarrhea cases are seen per day.

HODEIDA GOVERNORATE - 30-31 MARCH 1992

Female recruitment is easy in Hodeidah. In Hais and Marawa, more than 100 women applied for the training posts. For HMI training about 1200 women applied, competing for 55 vacancies. Many of the applicants have finished secondary school. This large pool of applicants is due to the return of emigrants who have educated girls looking for job opportunities.

Tahreer Health Center (Urban):

Seven women work in the center. There are three public health nurses; one in the HE room, one in growth monitoring, and one in FP. There is one nurse working in first aid and 2 midwives in the Midwifery room. The center is only open during the day so few deliveries are conducted there. The average number of deliveries is 4 per month. The midwives are sometimes called to the women's homes for deliveries. One FPHCW works in the immunization room. The statistics officer prepares the monthly and yearly reports after taking the daily forms from the respective sections. One female General Practitioner works in the center. Drugs are scarce, especially those for pregnant women such as vitamins, iron tablets,

and antiacid.

Saud Ali, Midwife and Fatum Khzan, Health Educator:

Saud works in the Growth Monitoring Room. The children are weighed after immunization. A card is used for recording the immunizations and child's weight. Malnourished children are sent to the Health Education Room.

Most health education is done verbally, stressing the importance of using locally available material in preparing nutritious weaning foods. FP services are widely accepted with the pill being the most used method. On March 28th, 18 users came into the center for FP services, two were new and 16 had attended previously. Between 1 March 1991, and 29 March 1992, 647 women came for FP services. Eleven IUDs were inserted in February. Supplies are from the YFCA.

Fatima Baker, Midwife:

Fatima keeps daily and monthly records in the Maternity Room. There are no prenatal cards, but Fatima has established her own card system to record vital information including: name; age; weight; BP; month of pregnancy; date; and number of living children. The number of patients seen ranges from 2-30 depending on the day of the week. Saturday, Sunday and Monday are the most active because those are also the immunization days. The most prevalent health problem among pregnant women is anemia. They do blood and urine lab tests for pregnant women.

OXFAM FPHCWs Trainees:

OXFAM is conducting training for eleven FPHCWs from the Alrabsa area located about 3km from Hodeidah city. They have been in training for eleven months under a Sudanese trainer. They expect to graduate in April, 1992. Practical training is conducted in Althora Hospital, Health Centers, and at women's homes. They conduct field visits on environmental health, water, and garbage disposal. The trainees get YR 500 from OXFAM and they are supposed to get YR 500 from the LCCD, however, the LCCD has not paid. All trainees agree that deliveries and health education were their favorite topics.

Ohuleil Health Center (Dutch supported):

Six FPHCWs, one Yemeni midwife, one Dutch midwife and one nurse work in the Center. The rest conduct outreach activities. The PHCWs visit high risk-women in their homes on a monthly basis for follow-up. Three days per week are spent weighing children, delivering food and demonstrating the proper methods of preparing weaning foods, and delivering curative services. Four areas have been identified for these services. Each area is visited once a

month for three days. In each area there are 26 - 80 families. The remaining times is spent registering new families and referring mothers to the clinic. Vehicles are essential for these activities. Only four at risk families can be covered by one PHCW per day as these visits are time consuming. Five to six families can be visited per day for follow up and completing their files. Immunization and prenatal care services are provided and food is distributed to mothers during these field visits. Color coded cards are used.

Hanan Hussein, Nurse graduated from Jedda, PHCWs Fatima Abdulla and Elham Salem:

Hanan, Fatima and Elham work in the Nutrition Room. Duties include following children's growth, administering ORS. On the most active days between 27 and 42 children visit the Nutrition and Health Education Room.

Alia Ahmed, PHCW, Suad Ibrahim, PHCW:

Alia and Suad are rotated to cover weighing, immunization, nutrition, prenatal, and registry. Between 90 and 105 children are brought in for immunization per day from outside the area, especially after the return of the Yemeni emigrants.

Home visits are time consuming because some mothers refuse to open the door, others refuse to answer questions, and some refuse to come to the center as referred. Women who have appointments and do not show up at the center are visited at their homes to determine the reason for not coming. Immunization is the most accepted service among the population.

Fatima Omer, PHCW BOCD Trainee and Zaiton Hassan, Midwife from Aden:

Both Fatima and Zaiton work in the Maternity Room. Duties include prenatal care, post natal care, FP, tetanus immunization, home deliveries, and home visits for women after delivery. Cards are used to identify women who are at risk. Most deliveries are conducted at home. There are very few deliveries at the center.

Pregnant women's problems include anemia, dizziness, high BP, and the lack of money to purchase the necessary drugs. IUD insertion and at-risk cases are delayed until one of the three days in which Maroline, the Dutch Midwife, works in the center. Between 40-80 women attend the Maternal Room per day for prenatal care and family planning services. Other activities include follow-up for pregnant women and visiting women in their homes to encourage them to attend the center and conducting Health Education sessions. The pill is universally used.

A Dutch midwife works several days per week in the center and does outreach activities the remainder of the week. Most women come to the center during the days she works in the center. They have a good data collection method on immunization and growth monitoring. They use two growth charts; one is given to the mother and the other (a smaller one) is kept at the center. There is also a Nutrition Room for cooking demonstrations.

Hais Health Center:

Fatima Abdul Momen, Sudanese Trainer:

Fatima has been employed for training since November, 1991, but since training has not started, she is delivering health services at the center. The center has four physicians, two Yemeni and two Sudanese (a man and his wife). It also has two nurses, one physician's assistant and one PHCW for immunizations. We could not visit the center because we arrived after working hours.

APPENDIX G

Background, Strategies and Opportunities for Private Sector Initiatives in Health and Population

Contributed by Zain Ahmed Zain, MD, MPH
Consultant to Limited Health Sector Assessment Team

The private sector in the northern part of Yemen has traditionally been dynamic in all sectors of the Yemeni economy. The centrally planned economy pursued in the PDRY discouraged this sector, but following unification in 1990, it has began to flourish as well.

The health care delivery system in Yemen is a mixed private/public system. The private health sector is active and well developed. Three types of private health providers, the basis of delivery, can be identified in Yemen. These are:

1. **FOR PROFIT SECTOR:** These include private hospitals and clinics, private insurance companies, traditional healers/midwives, drug stores, pharmacies and shops.
2. **NON-GOVERNMENTAL ORGANIZATIONS:** These include foreign operated and local organizations. Many of the NGOs including various Red Crescent Societies operate clinics, health centers and hospitals with MOPH or alone, but there is a trend of handing over these facilities to MOPH. Of the local organizations, the Yemen Family Care Association specializes in family planning and MCH. The Local Councils for Cooperative Development (LCCD) have been instrumental in mobilizing significant community resources for primary health care in the former northern governorates. It is estimated that contributions of LCCD's amount to YR 120 million, equivalent to 30% of the total of Yemen's health care allocations, or 10% of the total third five-year health investment plan of the government.⁶
3. **SOCIAL MARKETING:** This is in its early stage of development, but is expected to play a significant role in the distribution of contraceptives and ORS in the coming years.

It is estimated that private clinics provide about 15% of care in the cities in Yemen with figures in the capitol much higher. Currently there are about 1100 pharmacies and drug stores and over 1000 general practitioners¹. The extent of public sector employees in private practice is not known. However, the MOPH allows its physicians to engage in private practice. Generally, most physicians in medical faculties and in health administration posts at MOPH headquarters and governorates engage in private practice. In urban areas, private hospitals and clinics equipped with

sophisticated diagnostic facilities offer a range of specialty and subspecialty services in group or solo practices. In rural and peri-urban areas, drug stores, paramedical and primary health workers, including traditional practitioners, provide medical care. The role of traditional health care is not well documented, but this form of care provided by Koranic specialists or herbalists, including birth attendants, is believed to be utilized by a significant percentage of the population⁷.

A study⁸ in four villages in 1988 reported that utilization of traditional healers was 1.1 per child per year in contrast to 1.4 for modern healers. A local practitioner known as the Sahi (a man who practices medicine using western drugs) has flourished in rural parts of northern Yemen in the last 20 years.

The charge to patients for private care at present is rather expensive by Yemeni standards (Table 1). Fees for surgery range between US \$83.00 to US \$250.00 with the overall operating fee amounting to double the physician's fee. The average fees for normal delivery, caesarian section and tubal ligation are US \$125.00, \$520.00 and \$374.00 respectively².

A 1989 study carried out in 20 villages of rural Taiz found that on average, the total cost of a health care visit was YR 422. Annual cost per year was YR 1182. The largest expense was for medications, which amounted to 49% of the total cost. The second largest cost was transportation, which amounted to 32%. According to this study, paying YR 1182, means families spend more than one fifth of their annual budget (estimated at YR 5396 in 1991) on health care².

It is estimated that about 10,000 Yemenis seek health care outside the country annually, at a total cost of US \$60 million⁹. Out-of-Country medical care costs the government (1989) about US \$4.6 million in direct hard currency subsidies. Although it is impossible to estimate how much people spend of their own funds, the total expenditure on foreign medical care (US \$60 million) is significant in a country of the size and resources of Yemen. Another recent phenomenon is the practice of arranging foreign specialists in ophthalmology and dentistry to provide care in mobile clinics. Patients are required to pay in hard currency for these services.

Alternative financing of health care through insurance for public employees has been under study since 1990, and a demonstration project based in Al-Thowra Hospital in Sana'a is proposed⁴. However, a follow-up consultancy report in 1991⁹, cautioned against implementing the proposal too soon and suggested a phased implementation and incorporating experiences gained in running a health insurance scheme in the former PDRY. The proposed government health insurance plan when implemented can reduce the present MOPH financial commitment to hospital care (now running at

80%) and serve to shift those funds into primary health care and disease prevention activities⁹. The insurance scheme, per se, does not include preventive services and family planning. And, it has been argued that the development of social insurance that focuses largely on hospital-based horizontal care with its technological focus could only further shift away the emphasis both in funding and in public psychology from PHC and disease prevention, leading to worsening the situation of the MOPH⁹.

Among the potentials of the private sector, which are planned to be exploited in Yemen is the distribution of contraceptives through pharmacies. The Options for Family Care Project (USAID) envisages strengthening the role of private pharmacies through training and social marketing. In view of the endemicity of iron deficiency (anemia) in Yemen, a study¹ of the food processing industry in this country (1988) reported the feasibility of wheat flour fortification with iron. Since the publication of this report, some evidence has emerged for the need to fortify salt with iodine and possible dairy products with vitamin A and D.

In its 1993-97 country program UNICEF has planned to increase the role of private pharmacies in the distribution of ORS and education of clients.

With regard to non-governmental organizations there seems to be a shortage of local NGOs. These can potentially play a significant role in WID in general and MCH/FP in particular.

The role of the Yemeni Family Care Association in family planning has been significant in the last twenty years. This is a major PVO which provides a range of MCH services. The Syndicate of Physicians and Pharmacists which includes 2600 members has untapped potential to contribute to safe motherhood and child survival. However, the potentials of the private sector in Yemen, especially in health insurance schemes, can not fully be realized unless the government adopts a policy for removing some of the barriers to this sector. These are:

1. **LEGAL:** The present constitution¹⁰ of the ROY has removed the provision of free medical care to the population. However, the government has maintained the practice of the previous constitutions of the YAR and PDRY which stipulate provision of free medical care. In some institutions a token fee for medical care is charged.
2. **INFLATION:** Currently running at 34%³ is not conducive to imports.
3. **MANPOWER:** Over half of the Yemeni health force is composed of expatriates from the Indian subcontinent, Egypt, Palestine, Somalia, Ethiopia, Eastern Europe, China and Cuba. The presence of a large expatriate force

is necessary in many institutions because of the lack of Yemenis to replace them. However, they represent a considerable source of foreign exchange drain. It is also alleged that the use of foreign health workers in the public sector has allowed Yemenis to spend more time on their private practices at the expense of public service. There is at present little regulation of private practice which is often at the expense of the public sector.

4. ATTITUDES TOWARDS INSURANCE: Article 6 of the new constitution¹⁰ states that the economic foundation of Yemen is "Islamic social justice in production and social relations", and Articles 2 and 3 state Islam is the religion of the state and that Islamic Law (Sharia) is the main source of legislation. Article 6 Section IV also stipulates the establishment of socialist relations based on the Islamic and Arab heritages.

The practical interpretation of these Articles remains to be seen. As the Islamic religion teaches that death and other vital events are God's will, there has been a negative reaction to insurance in general and life insurance in particular. Many people feel that insurance is prohibited by the teachings of the Koran. This belief would appear not to be relevant in the case of health insurance, but, intensive education and perhaps labelling the plan with some name other than "insurance" will be necessary for successful implementation of any future health insurance⁴ scheme. These fears may not be well founded, nor should they be discarded entirely.

Yemen is not new to insurance and indeed is pursuing the establishment of a health insurance system vigorously. In the PDRY there was a national health insurance scheme and in the YAR and ROY there is a ministry for "Social Insurance and Social Affairs" with a subdivision called "Social Security Corporation". In 1991, Republican Decree No. 35 authorized the establishment of a health insurance system.

5. DATA: In many fields data are lacking. A health insurance system requires a sophisticated information base. In this regard, the lack of actuarial data is a major obstacle to development of an insurance system.
6. MANAGEMENT: Lack of management skills are impediments for an efficient private health care system.

CONCLUSION:

In spite of the barriers mentioned above, the country has potentials that facilitate private sector initiatives. Yemen has

a tradition of private business running for centuries. Over the years, it has developed an efficient distribution system for goods based on the "suk" (small privately owned shops) network. The new constitution also guarantees private business. In addition, Yemeni business has ample assets in cash and investment capital. Appreciation for western technology, particularly American, is widely prevalent. A critical mass for private medical practice is already in place. There is also a core of Yemeni policy makers pushing for an insurance system.

The private sector in Yemen is dynamic. In the health sector, it is extensively involved in providing curative health care in urban settings. This sector is also involved in family planning and the distribution of contraceptives and ORS. However, the quality of its services and the fees it charges patients are not effectively controlled nor regulated by the government to permit consumer protection. Two other potential areas for private sector involvement which have been considered since 1988 are food fortification and a health insurance scheme. The latter has been authorized by a government decree in 1991 and its implementation is being pushed by the government. As well as being ambitious, it faces several barriers and its implications for the MOPH and PHC are also not well understood. As a short-term strategy (one or two years), close monitoring of the evolution of the health insurance system, supported by additional studies is recommended.

Selected References

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Table 1

FEES FOR PRIVATE MEDICAL CARE IN SELECTED FACILITIES IN YEMEN

	<u>Rials</u>	<u>US \$</u>
1. Physician visit*		
-specialist	100	8.30
-consultant	75	6.20
-GP	50	4.10
2. Surgical fees		
<u>Minor Surgery</u> (eg hernia)		
-surgeon	1000	83.30
-operating room	750	62.50
-anesthesiology	250	20.80
- <u>Total</u>	2000	166.60
<u>Intermediate Surgery</u> (eg appendectomy)*		
-surgeon	2000	166.70
-operating room	1500	125.00
-anesthesiology	500	41.60
-Total	4000	333.30
<u>Major Surgery</u> (eg gall bladder)*		
-surgeon	3000	250.00
-operating room	2250	187.00
-anesthesiology	750	62.00
- <u>Total</u>	6000	500.00
3. Radiology & Lab*		
--7 panel blood test	70-80	5.80-6.70
-routine X-ray	85	7.00
-barium x-ray	500	41.60
-ultrasound	350-400	29.10-33.30
4. Obgyn**		
-normal delivery	1500	125.00
-Caesarian section	5000-7000	458.00-583.00
-tubal ligation	4000-5000	333.00-416.00
5. Diarrheal treatment (rural areas)#		
-average cost per visit	264	22.00
-drugs	116	9.70
-transport	93.4	7.70
-exam	26.4	2.20
-lab/xray	13.2	1.10
-others	13.2	1.10

* Al-Iryani Clinic (Sana'a, 1990); Source reference 4

** Al-Shifa Clinic (1990); Source reference 2.

Taiz Diarrheal Survey (1991). Services include private and public health facilities. Source reference 2.

Note: All rial equivalents of the US dollar are calculated on the basis of the official rate of 1 US\$ = 12 Yemeni Rials. Current parallel market equivalent is 1 US\$ = 30 rials. The consumer price index (retail price) for medical expenditures in Sana'a rose from 1122 in 1989 to 1248 in 1990 (1977/1978=100). Source: Reference 5. Since 1990 prices have risen markedly for all goods and services in Yemen [See reference 5].

APPENDIX H

CHILD SURVIVAL AND RELATED PHC SERVICE DELIVERY IN POPULATION, WOMEN IN DEVELOPMENT AND PRIMARY EDUCATION

Contributed by Zain Ahmed Zain, MD, MPH
Consultant to Limited Health Sector Assessment Team

1.0 Current Status of Child Survival Programs

The Government of ROY has emphasized primary health care in all past Five-Year Development Plans. Its political commitment to child survival has been expressed in its signing of the declaration of the World Summit for Children and the adoption of a national population policy. The fourth Five-Year Development Plan due in 1993 is expected to pay special attention to the further expansion of health services.

While political commitments abound, the performance of the health services is far from adequate, particularly in the area of management. Decentralization of decision making, integration of vertical programs into existing basic health services, lack of a health information system and intersectoral collaboration leave much to be desired.

Within the health sector, the only viable child survival program is immunization. This program is vertical, but, following a decentralized approach and mobilization of communities and resources, it achieved an average immunization coverage of 80% in 1990 for BCG, OPV/Polio and measles. Moreover, immunization is the only program with a national monitoring system. The apparent success of this program has been largely due to the political support of the government, a successful communication and mobilization strategy and strong backing by donor agencies, notably UNICEF. The MOPH has also recently strengthened the administration of EPI at the national level.

One of the greatest challenges of this program at present is the sustainability of coverage so far achieved since district level PHC support is still weak. This is borne out by the decline of immunization coverage. In December, 1991, the average immunization coverage for all antigens dropped to 63.7% and for BCG, DPT3/OPV to 73%, 57%, and 62% respectively¹, indicating a crisis situation. This coverage is expected to decline further to 50% before resources are mobilized to reverse the downward trend.

The second child survival program is the national diarrhoeal diseases project. To date, it has conducted several training workshops on case management, and, in collaboration with UNICEF and the Department of Health Education, has been active in public

health education.

A national pharmaceutical company (YEDCO) has been established and started production of ORS estimated at 4 million sachets to date. However, the ORS access rate is 45% and its use in health facilities is only 15%. Physicians continue to over prescribe antibiotics.

The ongoing cholera epidemic, however, has revealed severe deficiencies in this project. The cholera case fatality rate has approached 20% - twenty times more than the accepted 1%. The administration of this project at the national level is weak; the department is run by a single project officer, who until very recently also combined the leadership of the Nutrition Department within the Ministry of Public Health.

UNICEF has programmed an ARI control project in its 1993/97 program of cooperation with the ROYG². When the project is launched it is expected to be integrated with EPI/CDD.

In the late 1970's and early 1980's, Yemen enjoyed a thriving nutrition activity and research. A substantial proportion of existing knowledge and information on the nutrition situation has come about as a result of activities carried out in this short period. Unfortunately, in the past 10 years, nutrition activities have come to a standstill, notwithstanding the seriousness and magnitude of malnutrition in this country. The reason for the decline is not apparent. Judging from the active support given to past nutrition activities and research by donor communities, it seems that lack of interest of donors may have been a factor.

The situation of MCH programs is no better. In common with other programs it shares a weak department at the national level and poor integration within the basic health services. Only 110 of the 392 (28%) health centers in the country offer MCH services³. Strong MCH components are, however, found in projects run by NGOs, for instance the Swedish Health Center in Taiz.

The decline of mortality in the past 30 years can not be guaranteed to continue. The possibility of infant and child deaths actually increasing can not be ruled out, given the current economic crisis in Yemen, and its rapidly growing population. Clearly, the goals of the government in child and mother survival are ambitious and require efforts and resources as well as good management above all.

2.0 Integration of Child Survival Programs in Population, Women in Development, and Primary Education.

Several aspects of Yemeni administration including programs within and outside the health sector require integration. The major national task confronting Yemen at present is integration of YAR and PDRY administrations including that of health. A second task is integration of programs across sectors. The third task is integration of vertical programs and projects within ministries. In the context of health, the desire for integration of vertical health programs, namely diarrhoea, immunization, and ARI at the national, governorate, and district levels within PHC, has been expressed in ROYG past and present policy pronouncements.

Towards this end, actual progress has been rather slow. Integration is not only intuitively appealing and desirable, it also allows rational use of scarce resources. However, experience in many countries suggests that the very human desires for influence, power, and money are some of the reasons for vertical programs; as well as a sincere belief that a specific objective is much more readily achieved through a specific and self-contained action⁴. These motives also operate in Yemen, to the impediment of the process of integration. All too frequently, vertical programs are also promulgated by donors. Thus, in the short term, integration may not be realistic.

2.1 Population Activities

The Yemen Fertility Survey (1979) has shown that IMR decreases from 204.1, when the mother's age is less than 20, to 144.9 when the mother's age is 30-34. The IMR begins to rise slowly to 172.9 when the mother's age is between 40-44. IMR also declines from 192.2 for first order births to 149.8 for births of orders 3-4, and it rises to 190.8 for births of order 7 or more⁵. This finding is the basis of the recent national population policy.

The broad objectives of the population policy⁶ are to increase awareness of the 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 to 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 multisectoral linkages. The strategy promotes private sector participation in delivery of health services and broader participation by women in the development processes. The national population policy has also spelled out critical child survival, safe motherhood and family planning intervention areas in

reducing mortality in Yemen. These include; immunizations, training of TBAs, expansion of PHC services, family planning, control of malnutrition, reduction of female illiteracy, control of diarrhoeal diseases and ARI, and measures to improve the status of women. However, the implementations of the plan of action of the national population policy was envisaged to be the establishment of a national population council and its secretariat. To date, these institutions have not been established.

A conference on "Population and Islam" in 1989, recommended the use of family planning methods on a voluntary basis to improve mother and child health, thus clearing some of the obstacles towards a population policy.

Several international donor agencies are also involved in supporting population activities in ROY. A recent USAID family care project (Project #279-00900)⁷ with a total planned funding of US \$18 million, is expected to assist the country in implementing its population policy. The project envisages the expansion of opportunities for women and the strengthening of health, education, and private sectors. Its counterparts include the Ministry of Planning and Development, Ministry of Information, Ministry of Public Health, Yemen Drug Company, Health Manpower Institute, Sana'a University Faculty of Medicine, and Yemeni Family Care Association. Other donors include: UNFPA, UNICEF, The Netherlands, and IPPF. Noteworthy is the absence of family planning in the curricula of the medical schools and health manpower institutes.

The proliferation of donors is not matched by coordination of their efforts in population and child survival activities. The USAID Family Care Project envisages coordination of the work of these donors through joint periodic meetings.

The present health system does not yet have a MCH program with a strong family planning component. Constraints are apparent in the shortage of contraceptives due to inefficient distribution networks and nonexistence of advisory/counselling services.

A pioneer in population activities in Yemen is the Yemen Family Care Association (YFCA), a private agency which was established in 1978. Besides family planning, the YFCA provides child care, pre and postnatal care and outreach activities with school girls, estimated at 9000 students in 1991.

There are however, exceptions. Some primary health care projects assisted by foreign NGOs, notably, Dutch PHC projects in Dhamar and Hodeidah, which have well integrated family planning services into urban and rural PHC, development and post-natal care, and immunization. Most of its funds come from IPPF and Pathfinder. In 1989, YFCA provided 18,000 couple-years of contraceptive protection which rose to 21,000 couple-years in 1991. Of the 21,000 couple-years of contraceptive protection given in Yemen, 17,000 were in

government health facilities, while 4000 were in YFCA clinics.

2.2 Women in Development Activities

The social policy pursued in the former PDRY has enhanced the position of women particularly their welfare, political participation, and legal rights. In the YAR, the government had taken steps to demonstrate its support for promoting WID. The National Charter, the Labor Laws (1970) and the establishment of several women's bureaus within ministries are some of the indications of the government's initiatives. The past few years have also seen the establishment of a number of women's organizations.

The high committee for women, population and development, a government organization established in 1989, has among its objectives, the preparation of educational materials on maternal and child health care and family planning. Similarly, a non-governmental organization, with independent branches, the Yemeni Women's Association (YWA) was founded in 1965 in Sana'a, Taiz, and in 1979 in Hodeidah⁸. Among its objectives are the provision of advice to women in family related problems in general and advice on mother and child care in particular. However, these organizations face numerous constraints and as such do not have specific activities to promote child survival. The USAID/Yemen Mission WID program has begun a program to strengthen the capacity of the YWAs and their branches in Ibb and Taiz. The family care project has in its plan the involvement of YWAs in Ibb and Taiz in the execution of outreach and training activities⁷. Prior to unification women's associations unified to form the Women's Union of the YAR. After unification, the latter amalgamated with its counterpart, the General Union of Yemeni Women (GUYW) of the PDRY to form the National Women's Association³. Nevertheless, the latter organizations are facing internal power struggles³ and it will take some time before they are strong enough to mobilize Yemeni women to improve their lot.

Several issues must be tackled before effective WID strategy can be developed. These are⁹:

1. High illiteracy and limited access to education.
2. Poor health, largely due to unsafe motherhood problems, unsanitary living conditions, and poor nutrition.
3. Extremely heavy work load in rural areas due to large families, lack of access to water and fuel, and inefficient farming practices and household devices.

4. Seclusion and limited mobility of Yemeni women, which affect travel to health facilities, schools and training courses.
5. Limited numbers of professionals, Yemeni or Foreign, available for WID work.
6. Cultural barriers, which perpetuate general ignorance about subjects affecting female and family well-being, and limit the effectiveness of WID interventions initiated by international donors.
7. Incomplete integration of women's programs into mainstream projects and inadequate investment for them.
8. The rural settlement pattern.
9. The absence of small scale credit mechanism.
10. Very limited means of transport in remote rural areas.

2.3 Primary Education Programs

Few sectors in Yemen show as much promise, yet suffer as much pressure as education. The education and training system is in deep crisis - overwhelmed by a surge in student enrollments, underfinanced because of government budget constraints, unable to keep up with the huge demand for qualified teachers, and grappling with the administrative complexities of unifying two formerly different systems.

In 1990, over 2.47 million Yemenis - about 22 percent of the total population, was enrolled in some form of schooling or vocational training. Over 60% of the 14.5% enrollment expansion in 1990/91 was due to growth in the school age population, and the remaining 40% to the influx of expatriate returnees.

Enrollment in primary education (grade 1-6) grew from 1.0 million in 1990/91, to 1.9 million. But, the education system is skewed in favor of boys, urban populations, and primary/intermediate levels.

In spite of the quantitative expansion of education, its quality is compromised by shortages of physical facilities (overcrowding), qualified teachers, and budgetary constraints. The potential of schools for health improvement is obvious, but at present is not exploited in Yemen. A school health service department exists. In 1991, it was involved in conducting goiter prevalence surveys of school children. Understaffed and with little funding, its impact

to date has been negligible.

3.0 Conclusions and Recommendations

The expansion of the physical health infrastructure (basic health facilities) in the past 30 years has not been accompanied by similar expansion of health programs. At present, critical child survival interventions, chiefly immunizations and diarrhoeal disease control, are provided.

Although some decentralization has been achieved for immunization programs, by and large, vertical programs dominate the health services.

Outside the health sector, the relationship between women's issues and health and population is increasingly recognized as evidenced by increased donor involvement and support in these areas. The population policy conference was a useful platform in that it brought together health and development sectors to address mortality reduction and child survival. Each sector had its proposed solutions, some of which were ambitious in the short term. Except for the health sector, there were few child survival components of immediate impact. Attempts to integrate child and mother survival were minimal.

Yemen is at present in the process of integrating the administration and health services of the former YAR and PDRY. Integration of child survival within PHC and across sectors, although recognized to be essential, will take some time to develop. It would, therefore, appear that in the immediate future child survival activities must be carried out using both existing vertical programs and integrated services.

Integration of child survival interventions with family planning is a typical and effective approach in most health systems and one which is also recommended here. Service delivery to women and children should contain integral family planning components. Thus, this report recommends the full integration of child survival and family care projects. This will take place in all aspects and at all levels of health care in training, health education, community participation, logistics and supply, health information systems, and provision of MCH/FP services through health providers at the community PHC unit and health center levels. As a strategy for integrating MCH/FP with child survival activities in Yemen, focus should be given to health centers at governorate level. Accordingly, MCH/FP services should be provided in all the 182 existing health centers that do not have an MCH service at present. These health centers will serve as first level units as well as training and supervisory units for lower echelons of PHC and community health services. The MCH/FP department in the MOPH at present is weak and therefore needs strengthening in manpower and management. In the interim, an MCH/FP technical team could be

formed to support expansion of MCH/FP services in health centers.

One of the major impediments to the expansion of MCH/FP is the shortage of health workers. An accelerated training program of community health workers should therefore be undertaken in collaboration with the community. The Yemeni Local Development Councils have been involved in supporting TBA training and therefore can be motivated to participate further. In the southern governorates, the health guide volunteers have been successful in providing PHC and outreach services at the community level. This category of health provider should therefore be utilized.

The training of TBAs, LBAs and health guide-volunteers should be carried out in such a way that they can deliver a range of services to address child survival, safe motherhood and family planning education. This will have to be reflected in the design of their curricula.

Integrated MCH/FP services calls for collaboration with others, among these, government and community services, including the private sector, notably the Yemen Family Care Association which can undertake expansion of its services to district and community levels.

Coordination of activities with NGOs is also vital to obviate duplication of services, since some NGOs have also planned expansion of MCH and PHC services to selected governorates.

While there may be opportunities to integrate child survival activities in both WID and primary education, recommending this strategy is not recommended at this time due to the necessity to narrow down the scope of the health/population program in order to focus on a few discrete achievable interventions of high impact.

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9. World Bank; 1990; Yemen Arab Republic: Utilizing Womenpower for National Development; Report #8883-YAR

APPENDIX I

HEALTH GUIDES IN THE COMMUNITY

METHODOLOGY

A. SELECTION CRITERIA

1. The individual must be selected by the community.
2. The person must be a female who commands respect in the village. In villages where there are traditional birth attendants/local birth attendants (TBAs/LBAs), the community should be encouraged to select them. A TBA/LBA may be more appropriate because:
 - a. She is female
 - b. She is respected in the community because of her status/role and age
 - c. She is usually the first person contacted when a women needs medical care or when a child is sick in the village
 - d. If she embraces the PHC concept, she can easily convince other women to use PHC services
3. She must be willing to function as a volunteer.
4. The community should be encouraged to decide on the kind of remuneration, and this should be documented.

B. TRAINING

1. Selection and Training of Trainers (TOT)

a. Selection

The Health Manpower Training Institute (HMI) in Sana'a already has a cadre of trainers who have been training primary health care workers at the governorate level. Three to five of these trainers could be selected based on their previous performance, experience, and willingness to live in the governorate or district during a training course. Trainers should be Yemeni women who understand the culture.

b. Training

Trainers together with PHC supervisor(s) at the governorate and/or district level should go through a training workshop on ADULT LEARNING METHODOLOGY. The supervisors should attend the TOT so that during their supervision, they know how to approach the Health Guides, using principles of positive reinforcement. This will also enable the supervisors to know what to expect from the Health Guides in terms of output, and to be able to give in-service/on-the-spot training based on findings during supervision.

DURATION OF TOT: 2 Weeks
LOCATION OF TOT: Governorate

2. Training of Health Guides

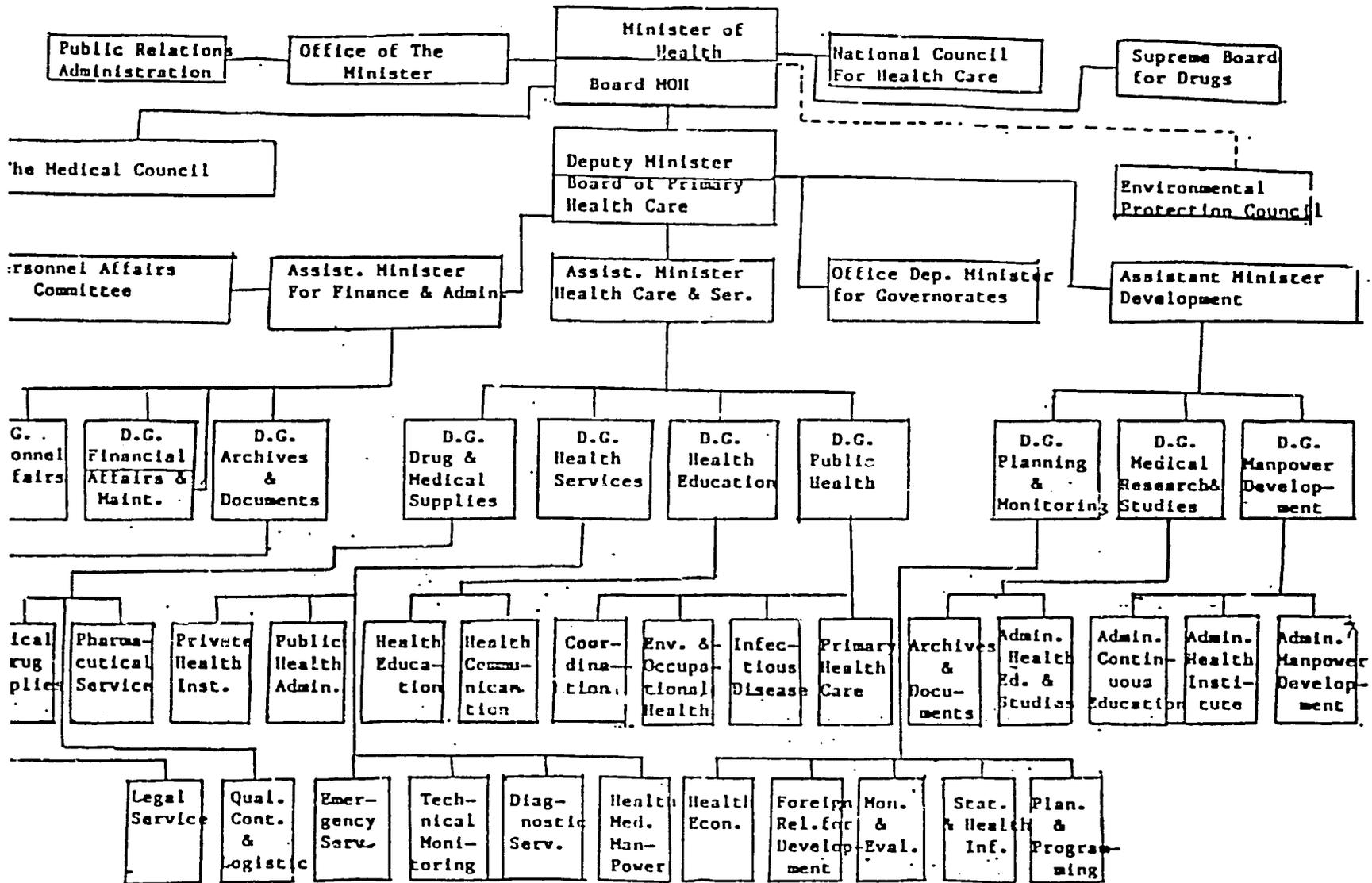
Participants from 4-5 villages which are located closely together could be trained at a central location, preferable at the nearest Health/Training Center or PHC Unit. This will help to create a close relationship among the trainees as well as between the trainees and the staff of the nearby facility. The participants will also know what their referral center looks like and how it operates. The supervisor(s) should participate in this training.

Training Objectives:

1. Treat simple cases of diseases, such as bilharzia, tuberculosis and malaria.
2. Treat diarrheal diseases with Oral Rehydration Therapy
3. Identify the stages of dehydration resulting from diarrhea and appropriately refer those children of moderate-severe dehydration.
4. Conduct interpersonal and group counseling on various health and sanitation issues with women in the village.
5. Recognize and teach care providers the importance of immunization in child survival.
6. Provide proper storage of drugs.

7. Basic recording and reporting using predesigned simple reporting forms. These forms can be pictorial, whereby the health guide will only need to circle the appropriate picture.
- o Duration of training: 3-6 months
 - o Location of training: village or community, PHC Unit or Health/Training Center
 - o Number of trainees per section: 6-8

ORGANIZATIONAL STRUCTURE
The Ministry of Health In Unified Yemen



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APPENDIX J

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APPENDIX K

ACCS SHORT-TERM CONSULTANTS
JANUARY 1986 - MARCH 1992

A. JSI/REACH CONSULTANTS				<u>Person Months</u>
1.	Carl Hasselblad	Management of Immunization and Disease Control	2/15-3/31/92	1.5
2.	Peter Shipp	Health Manpower Analysis	2/8-3/8/92	1.0
3.	Rachel Feilden	PHC Management Workshop	1/9-3/8/92	2.0
4.	Madeleine Taha	End-of-Term Training Assessment for Male and Female PHCWs	1/2-3/8/92	2.2
5.	Najawa Kasaifi	Teaching Methods for Male and Female PHCWs	2/1-3/1/92	1.0
6.	David Bevan	Computerized Disease Surveillance System	1/6-31/92	0.7
7.	Madeleine Taha	Mid-Term, Training Assessment for Male and Female PHCWs	1/4-2/15/91	1.4
8.	Peter Shipp	Health Manpower Analysis	1/18-2/22/92	1.2
9.	Carl Hasselblad	Management of Immunization and Disease Control	2/15-3/31/91	1.5
10.	Carl Hasselblad	EPI Program Planning	9/1-10/30/91	2.0
11.	Rachel Feilden	Tihama PHC Assessment	6/26-8/26/91	2.0
12.	Madeleine Taha	PHC Training Development	6/26-7/23/91	1.0
13.	Rachel Feilden	PHC Management	1/9-2/9/90	1.0
14.	David Pyle	Prepare REP Scope of Work	7/31-8/21/90	0.7
15.	Mark Grabowsky	Review of Coverage Data and EPI Experience for ACCS Project	7/31-8/20/90	0.7
16.	Carolyn Hart	Administrative Visit	7/31-8/21/90	0.7
17.	Sareen Thaddeus	PHC Training Development	5/9-8/6/90	3.0
18.	William Bowers	PHC Training Development	5/12-6/8/90	0.8
19.	Mickey Vanden	REACH Internal Audit	2/18-3/3/90	0.4
20.	Pierre Claquin	REACH Activities Review	1/25-31/90	0.2

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Person
Months

21.	Robert Steinglass	TDY (purpose not in file)	12/30-1/15/88	0.5
22.	Norbert Hirschorn	REACH Activities Review	9/1-9/23/86	0.8
23.	Zein Ahmed Zein ^L	Manpower Assessment	dates not in file	
24.	Ahmed Said ^L	EPI/Cold Chain	dates not in file	

B. AED/HEALTHCOM

1.	John Elder	Health Education Training	11/26-12/6/91	0.4
2.	Taher El-Amour	Research Training	9/12-10/6/91	0.8
3.	Anne Roberts	Workshop Training	9/12-10/6/91	0.8
4.	Lucine Tamian	Finalize Research Design and Data Collection Tools	6/26-8/12/91	1.6
5.	Anne Roberts	Development Workshop	7/12-26/90	0.5
6.	Will Show	Development Workshop	7/12-26/90	0.5
7.	Will Show	Health Education (purpose not explicit in file)	dates not in file	
8.	Roger Pereira	Evaluate Existing Health Education	4/1-5/6/86	1.2

C. SPECIAL PROJECTS

Health Financing

1.	C. Ross Anthony	Al-Thwara Health Care Financing	7/6-21/90	0.5
2.	Eleazer Andrews	Pre-Feasibility Study for Private Specialty Hospital	7/7-21/90	0.5
3.	Lawrence Carl	Same	7/7-21/90	0.5
4.	Scott Stupey	Same	7/7-21/90	0.5
5.	Eleazer Williams	Same	7/7-21/90	0.5
5.	Paul Torrens	Health Financing/ Insurance Schemes	8/4-18/91	0.5

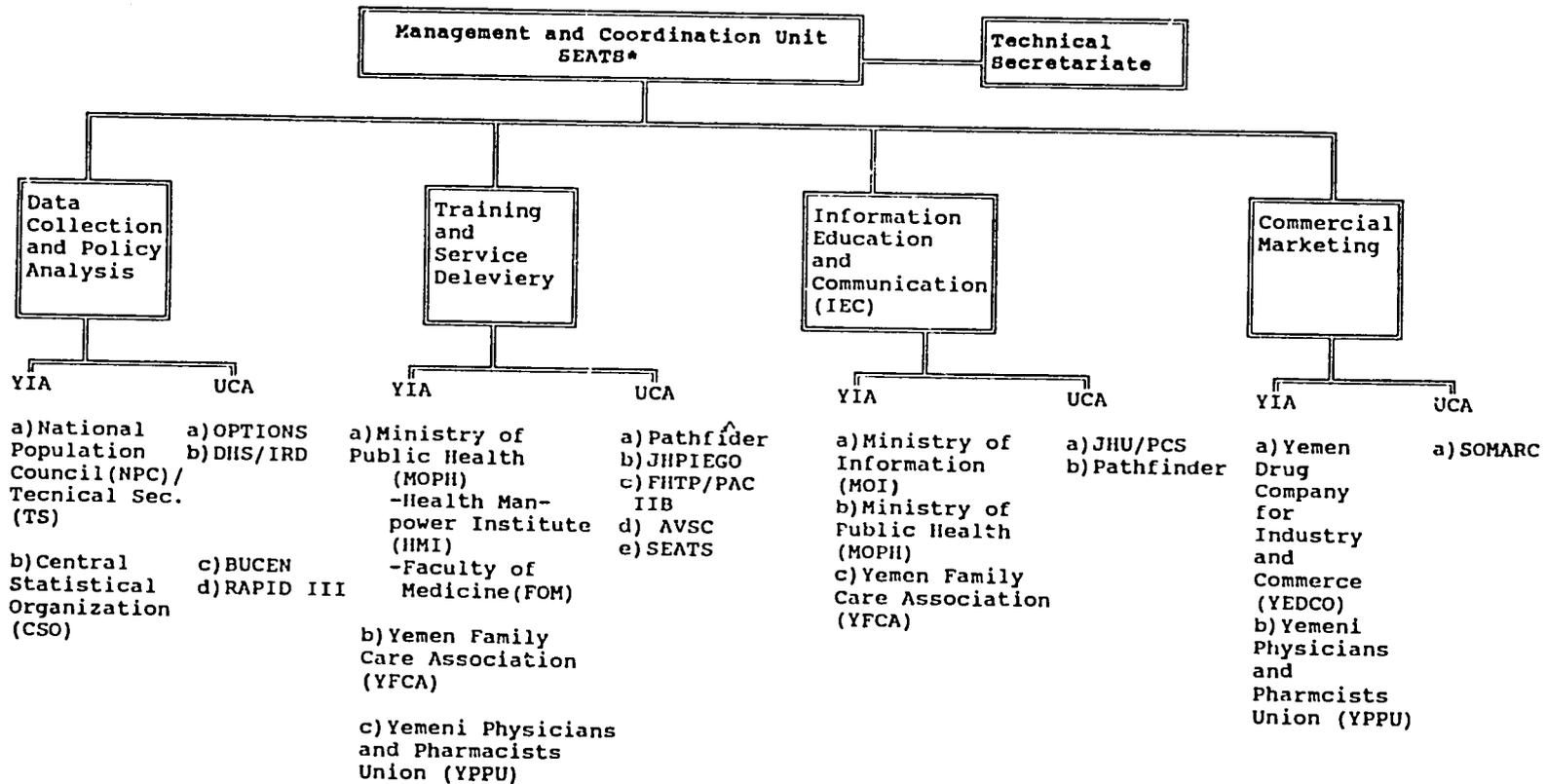
^L Local consultant

Person
Months

National Epidemiologic and Disease Surveillance Program (NEDS)

1.	Kelly Bussell	NEDS Information System Development	2/8-14/92	0.2
2.	Ralph Vaughn	NEDS Information System Development	2/10-16/92	0.2
3.	Stanley Foster	Review of NEDS Workplan	dates not in file	
4.	Edward Kassira	Review Disease Patterns	5/18-6/2/90	0.5
5.	Edward Kassira	Same	2/9-17/90	0.3

OPTIONS FOR FAMILY CARE PROJECT
 Strategies, Yemeni Implimenting Agencies (YIA) and
 USAID Contracting Agencies (UCA)



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APPENDIX L

*SEATS will manage, coordinate all activities under OFC Project