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ENHANCING GOVERNMENT EFFECTIVENESS IN YEMEN: AN ASSESSMENT OF THE MINISTRY OF PUBLIC HEALTH AND POPULATION

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This report was produced for review by the United States Agency for International Development. It was prepared by Dr. Riitta-Liisa Kolehmainen-Aitken.

ENHANCING GOVERNMENT EFFECTIVENESS IN YEMEN: AN ASSESSMENT THE MINISTRY OF PUBLIC HEALTH AND POPULATION



Management Systems International

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I. INTRODUCTION¹

Yemen's Strategic Vision 2025 is to raise the country from a 'least developed country' to a 'medium human development' status. The second Socio-Economic Plan for Poverty Reduction (2006-2010) is guided by this vision and provides a general framework for the national Poverty Reduction Strategy.² The government is now aligning its medium-term planning processes with the Millennium Development Goals and targets. The country, however, faces formidable challenges in reaching its vision for the future.

Yemen is the second poorest country in the Middle East and North Africa region. In 2005, it ranked 151st out of 177 countries in the UNDP Human Development Index. A notable gender disparity compounds the country's substantial problems of poverty, ill health, malnutrition and low educational achievement. The economy grew at a reasonable rate in the 1990s, but growth has stagnated in more recent years. GDP has remained at around \$530 per capita in real terms since 2002. The economy is highly dependent on oil, which provides 70% of government revenue. By 2003, two-thirds of known oil reserves were depleted and the search for new deposits has thus far brought disappointing results. Yemen faces the prospect of running out of oil in the next decade, without having other economic sectors to replace the lost oil revenue.

Yemen's population growth continues to be one of the highest in the world, estimated at 3.5% in 2006. The current population of 21 million will thus almost double to 40 million in the next 20 years. The public sector is not able to provide an adequate quantity and quality of health and education services to the current population. It will face very serious challenges in trying to do so to the future, much larger population.

Yemen confronts a worsening scarcity of fresh water, in addition to the economic and population-related challenges. The 2006 Yemen Development Policy Review points out that the sustainability of livelihoods is jeopardized at the present rate of depletion.³ Some towns and communities are already running out of domestic water, while farming has been abandoned or scaled down in other areas.

According to World Bank studies, Yemen's governance is among the weakest among its neighbors. Political power is concentrated in a very small group, which has been unable to bring substantial improvements in the governance of the public sector. Government effectiveness has declined since 1996. Transparency International ranked Yemen 103rd out of 159 countries in 2005. Corruption remains a very serious issue, despite recent Civil Service reforms, which eliminated large numbers of ghost workers, and other recent improvements in regulatory quality.

II. THE HEALTH SECTOR IN YEMEN

Yemen has a three-tiered health system with the Ministry of Public Health and Population (MOPHP) at the central level and governorate and district health offices at their respective local levels. The decentralization Law No. 4 of 2000 fragmented the system by devolving substantial public sector

¹ This report was prepared by Dr. Riitta-Liisa Kolehmainen-Aitken for the Enhancing Government Effectiveness (EGE) project. Dr. Kolehmainen-Aitken was a member of the EGE team that conducted an assessment of select government ministries in Yemen in February 2008. The views in this report are the author's and does not necessarily reflect the views of USAID.

² Yemen Socio-Economic Plan for Poverty Reduction (2006-2010). October 2006.

³ *Yemen Development Policy Review*. World Bank, November 2006.

responsibilities over planning and management of health services to local authorities. One donor representative went as far as claiming that “Yemen has no health system” any more.

Because of very low capacity at the local level, the MOPHP continues to manage several health programs centrally. These “vertical programs” include immunization, maternal and child health, family planning and several disease-control programs, such as TB, malaria and HIV/AIDS.

Yemen’s health indicators are very poor. In 2006, life expectancy at birth was estimated to be 62.1 years, while infant mortality was 59.9 per 1000 live births. The low-birth weight rate, 32%, is the highest in the world. Malnutrition rates are also high. Such dismal health indicators are not surprising considering the generally low accessibility and poor quality of health services.

Only 40% of the total population has access to public sector health facilities. Only 58% has access to any health services, public or private. In rural areas, this percentage drops to 20%. Due to social and cultural restrictions, women’s access is even lower. Health facilities are under-equipped, understaffed and suffer from persistent drug shortages.

The health system is severely underfunded. Most resources and staff are highly concentrated around urban areas. Table 1 shows the trends in government’s health spending from 2000 to 2006. Total public spending on health is among the lowest in the Middle East region and it is stagnating. In 2006, it was only 3.6% of total government spending and 1.3% of GDP. Health received YR50.1 billion of government revenue, while education received over 3.5 times that amount (YR184.9 billion). Defense, regulation and public security were allocated almost five times that amount (YR244.9 billion). Hospital care receives more emphasis than primary health services, including prevention and promotion. The private sector involvement in health is rapidly growing but unregulated.

TABLE 1: REPUBLIC OF YEMEN: SOCIAL SPENDING ON HEALTH, 2000–06

	2000	2001	2002	2003	2004	2005 ¹	2006 ²
Billions of Yemeni rials	20.3	24.2	23.8	30.5	46.6	37.6	50.1
% of total government spending	4.1	4.8	4.1	4.0	5.3	3.2	3.6
% of GDP	1.3	1.4	1.3	1.4	1.8	1.2	1.3

Source: Ministry of Finance’s Government Finance Statistics; and Fund staff estimates. Reported in IMF, Republic of Yemen, Statistical Appendix, August 17, 2007.

1. Preliminary
2. Budget, excluding the supplementary budget

The Public Expenditure Review of the health sector pointed out that cost sharing has become a very significant source of funding for government health services.⁴ Out-of-pocket expenditure on health has been growing substantially from 56.5% in 2003 to an estimated 81.0% by 2005. These figures do not include “under-the-table” payments, of which we heard much anecdotal evidence. Out-of-pocket expenditures at such a high level in a poor country are a very significant barrier to improving the population’s health status.

Given the bleak picture of government health service provision, it is not surprising that the general population has lost confidence in the health system. Utilization rates in government facilities are extremely low, while expenditure on overseas treatment is very high. According to the Yemen National

⁴ Fairbank, Alan. Public Expenditure Review, Health Sector, Republic of Yemen, 1999-2003. April 2006.

Health Accounts estimate, almost one half of all household spending was for overseas treatment in 2003.⁵ The cost of medical treatment in Jordan alone (app. \$184 million) was only 5% less than Yemen's total health budget. This represented a ten-fold increase from 1998. Out-of-pocket payments formed 91% of the expenditure for overseas treatment.

Health is not perceived by high authorities in the government as an essential ingredient in poverty reduction and economic growth. Rather, both the government and the people themselves are reported to consider health to be a purely private matter. National and more recently local authorities see health to be an investment opportunity, not a core set of basic services that a government should guarantee to its citizens. Local authorities have invested in capital construction of several new facilities. The ballooning investment spending has outpaced the government's capacity to staff them. A Public Expenditure Review points out that the new facilities would likely require increments in the government's recurrent budget at roughly two to three times the present rate.⁶ This assumes trained health workers are in fact available in sufficient numbers, which they are currently not. Such a rapid budget increase is clearly unrealistic in the present economic climate. Furthermore, the lifespan of the newly constructed infrastructure is shortened considerably by the very low allocations for maintenance and repair, only 3 to 4% of total recurrent spending.

III. MEASURING THE EFFECTIVENESS OF MOPHP

Defining measures to assess the effectiveness of a health ministry requires understanding the role of the ministry and the way in which responsibility and authority over health sector functions are distributed between the central and local level governments. Decentralization – or the lack thereof - has a direct impact on the role of the central ministry responsible for health. This role changes as soon as substantial functions over planning health services and acquiring and managing financial, human and material resources are transferred to local governments. The central-level ministry becomes the steward of the nation's health, rather than acting as a direct service provider as it did in the past. The Ministry's new role is to define policies, set standards, target health resources toward the achievement of national development goals and assure quality of service provision through regulation and by ensuring that the regulations are enforced.

The concept of governance or stewardship is relatively new in the health sector. The World Health Organization (WHO) defines it as “the careful and responsible management of the well-being of the population.” The U.S. Agency for International Development (USAID), in turn, describes effective health governance as the process of “competently directing health system resources, performance, and stakeholder participation toward the goal of saving lives and doing so in ways that are open, transparent, accountable, equitable, and responsive to the needs of the people.”⁷ There are currently few standardized indicators to measure stewardship in the health sector, as Islam et al. point out.⁸

USAID expressed a desire that the indicators of the Ministries' performance address key sector priorities, be useful across countries and comparable over time periods. In this regard, two different sets of

⁵ Fairbank, Alan. Yemen National Health Accounts: Estimate for 2003. PHRplus for USAID, June 2006.

⁶ Ibid.

⁷ U.S. Agency for International Development. 2006. “Health Systems 20/20: Request for Applications” (January 30, 2006, RFA Solicitation No. M/OAA/GH/HSR-06-189). Washington, DC: USAID.

⁸ Islam, M., ed. Health Systems Assessment Approach: A How-To Manual. Submitted to the U.S. Agency for International Development in collaboration with Health Systems 20/20, Partners for Health Reformplus, Quality Assurance Project, and Rational Pharmaceutical Management Plus. Arlington, VA: Management Sciences for Health. February 2007.

indicators were adopted for the Ministry of Public Health and Population. The first set measures outcomes or impact in maternal and child health in relation to Yemen's health Millennium Development Goals (MDGs). The second set consists of indicators drawn from the recent Public Expenditure and Financial Accountability (PEFA) review of Yemen.

Three MDG health targets were selected as the most important indicators of maternal and child health priorities. These are under-five mortality, maternal mortality and contraceptive prevalence using modern methods. Yemen has set the following MDG targets to be reached by the year 2015:

- Under-five mortality: 40.6 per 1000
- Maternal mortality: 87.8 per 100,000
- Contraceptive prevalence using modern methods: 19.5%

Yemen is not on track to meeting these three MDG health targets. The most recent UNICEF data shows *under-five mortality* to be 102 per 1000 in 2005, while the US Census Bureau put it at 81.9 in 2006. Regardless of which estimate is closer to the actual figure, the country is far from being able to reduce under-five mortality to 40.6 per 1000. *Maternal mortality* estimates from different sources are quite inconsistent. The DHS estimated it to be 351 per 100,000 in 1997, while WHO gave a much higher estimate of 570 per 100,000 in 2000. Reaching the MDG target of 87.8 per 100,000 is highly unlikely, even if one accepts the lower estimate. The DHS estimate of *contraceptive prevalence* using modern methods was 9.8% in 1997, while the Government of Yemen shows a considerably higher figure of 13.4% in 2003. Without considerable effort to increase contraceptive prevalence, the MDG target of 19.5% will not be reached. The wide variability in estimates of the current status between different data sources reduces the reliability of these indicators.

The PEFA indicators were reviewed in detail by the financial sector consultant, Carlos de la Torre. Annex 3 includes two PEFA indicator tables from his assessment. These tables were edited for this report so that they focus on indicators that have relevance for line ministries, such as the MOPHP.

IV. ANALYZING THE MOPHP'S LEVEL OF EFFECTIVENESS

An analysis of the Ministry's effectiveness has to start with understanding its recent history. The Yemeni health authorities are well aware of the failings of the health system. In fact, a decade ago, they stated, "the government's health system is in a state of prolonged crisis that has worsened dramatically in the past decade."⁹ The response was an ambitious health sector reform process, which was launched in 1998. The goals of the reform were universal access and improved equity, allocative and technical efficiency, quality and financial sustainability. The reform strategy outlined twelve key elements:

1. Decentralization,
2. Redefinition of the role of the public sector,
3. District health systems,
4. Community co-management,
5. Cost-sharing,
6. Essential Drugs policy and realignment of the logistics system,
7. Outcome-based management system with integrated focus on gender,
8. Hospital autonomy,
9. Intersectoral cooperation,

⁹ Health Sector Reform in the Republic of Yemen. Strategy for Reform. Ministry of Public Health and Population. October 2000.

10. Encouragement of participation by the private sector and NGOs,
11. Encouragement of innovation and
12. Sector Wide Approach to donor funding and programming

Put plainly, the reform failed. The effort was seen as donor-led and the political consensus on how to implement the reforms never developed. The detailed planning, which would have been required to implement the key reform elements, was never done. Furthermore, the health sector reformers were not prepared for the sweeping *devolution* of public sector responsibilities to *local governments* that Law No. 4 of 2000 brought about. Instead, the national health authorities understood decentralization to mean *deconcentration*, i.e. transferring limited powers to lower level *health authorities*, powers which the Ministry itself could take back if health sector performance deteriorated.

After the first health sector reform strategy “just vanished” - as one donor representative put it - the Policy Unit of the MOPHP decided to redesign it. This time it was to be done in a participatory way and with the responsibility clearly remaining with the Ministry. In December 2005, several donors signed an MOU with the Ministry, pooling funding to support the reform effort. It is reported to have progressed steadily, if somewhat slowly.

The new reform effort has three phases:

1. A joint review of the current status (“status quo”),
2. Benchmarking for the next five years and
3. Development of action lines.

A report of the joint review, which took two years, is available in draft form.¹⁰ Benchmarking is set to start at the end of March 2008. Nine groups are being formed to set benchmarks in different areas, such as finance and human resources. Line ministries are expected to be involved throughout. The action lines are expected to be finalized by the end of 2008. Whether the demands on the already overstretched MOPHP senior staff make it possible to follow this planned schedule remains to be seen. It is also not yet clear whether other key ministries will support the reform’s implementation.

Yemen is still clarifying a common vision on health sector priorities with a clear framework for action, but it has produced three national five-year health plans. There appears, however, to be a considerable gap between preparing plans and implementing them. An informant, who was involved in evaluating the Second Five-year National Health Plan of 2001-2005, observed that “nothing was done according to plan.” A senior MOPHP staff member commented that the current, third plan for 2006-2010 does not seem to function as “any sort of guiding light” to the MOPHP. Instead, the “President’s Plan,” which is reportedly made up of promises made during the presidential election, is said to be given much more attention.

The Third Five-Year National Health Plan was allegedly done as a quick response to the pressure from the Ministry of Planning and International Cooperation (MOPIC). The MOPIC was responsible for preparing the Socio-economic Development Plan for Poverty Reduction, into which the third national health plan was merged. As Table 2 shows, the health sector targets of this Plan are a mixture of numerical targets and statements of wishful intent, and the desired health outcomes are not prioritized.

In contrast to the still emerging priority policies and action lines for health, Yemen’s population policy for 2001–25 is well defined. It is accompanied by a Population Action Program, which takes a comprehensive and integrated approach to reproductive health care and human development. The

¹⁰ *The Joint Health Sector Review Status Quo Report*. October 2007. (Draft – Not for quotation).

Program is, however, highly dependent on donor support and shortage of funds remains a constraint to its implementation.

TABLE 2: HEALTH SECTOR TARGETS IN THE SOCIO-ECONOMIC DEVELOPMENT PLAN FOR POVERTY REDUCTION (2006–2010), REPUBLIC OF YEMEN, MOPIC, OCTOBER 2006

Program	Goals
Reproductive Health	<ul style="list-style-type: none"> - Reduce MMR to below 238 deaths by 2010 - Increase attended births to 45% - Increase usage of family planning methods to 35% - Increase the post partum mother care to 25%
Control of Sexually Transmitted Diseases	<ul style="list-style-type: none"> - Control/limit HIV/AIDS - Reduce STDs incidence rate to 30%
Control of Bilharziasis	<ul style="list-style-type: none"> - Reduce Bilharziasis incidence rate and soil-borne worms - Stop Bilharziasis and intestinal parasites from spreading to new localities
Quarantines	<ul style="list-style-type: none"> - Enhance the infrastructure for quarantines in international ports/outlets - Enhance the activities of quarantines to prevent contagious diseases and their pathogens through international maritime/ navigation movement with the lowest level of intervention
Control of Eye/Ophthalmic Diseases	<ul style="list-style-type: none"> - Reduce ophthalmic diseases incidence by 50% - Enhance the therapeutic capacity to deal with ophthalmic diseases
Control of Rabies	<ul style="list-style-type: none"> - Reduce the number of rabies-caused death incidents by 70% - Reduce rabies incidence rate by an annual 15% in governorates with high incidence rates
Control of Malaria	<ul style="list-style-type: none"> - Reduce yearly Malaria cases by 75% - Protect 60% of women in reproductive age and under-five children in Malaria endemic areas by providing anti-mosquito saturated nets
Nutrition and Nutritional safety	<ul style="list-style-type: none"> - Reduce malnutrition rates among the members of society - Increase the usage percentage of iodized salt
Child Health	<ul style="list-style-type: none"> - Reduce by an annual 10% the incidence rates of diarrhoea, acute respiratory infections, Malaria, Measles and malnutrition - Reduce IMR by 2% per annum
Therapeutic Medicine	<ul style="list-style-type: none"> - Improve first aid and emergency services - Offer safe blood transfusion services - Improve the private sector performance in therapeutic services and primary health care services
Immunization	<ul style="list-style-type: none"> - Increase immunization against polio to a minimum 95% by 2010 - Reduce incidence of Measles by 95% by 2010 - Reduce incidence of Tetanus to less than 1/1000 live births by 2010
School Health	<ul style="list-style-type: none"> - Raise awareness among students through health education programs and help them acquire sound patterns of behavior - Enhance the technical and administrative capacity at the central and local levels
Tuberculosis TB Control	<ul style="list-style-type: none"> - Increase recovery rates for contagious TB cases to 85% - Reach 100% of population coverage through the strategy of treatment under direct daily supervision (in health facilities) - Increase TB and iron-deficiency detection cases to 75% of expected annual incidence
Epidemic /Monitoring	<ul style="list-style-type: none"> - Provide epidemic-related information about contagious diseases to help design plans for timely interventions - Establish an integrated monitoring system - Strengthen technical and epidemic-related skills among staff at the central level
Psychological Health	<ul style="list-style-type: none"> - Enhance psychological health as part of the primary health care services - Reduce incidence of psychiatric diseases by an annual 6%

Program	Goals
Medicinal (pharmaceutical) Policy	<ul style="list-style-type: none"> - Emphasize significance, development and adherence to implement medicinal policy - Ensure that pieces of legislation are compatible and in line with variable changes and to put them in place
Health Insurance	<ul style="list-style-type: none"> - Provide the laws and regulations that govern/regulate health insurance - Train insurance cadres - Rehabilitate the health facilities in the selected governorates to pilot-apply the health insurance system

1. Effectiveness at the Individual level

In the months preceding this assessment, several recent staff changes had taken place at the senior level of the Ministry. These included three of the four Deputy Ministers and at least one Director General. A number of the senior office-holders in the MOPHP are well qualified for their posts, holding post-graduate degrees from overseas universities. It is too early to assess whether the changes will improve the overall effectiveness of the MOPHP.

The human resource challenge is much more severe at the lower level of the Ministry, which appears to be considerably overstaffed. Jobs are said to be largely patronage-based and many lower-level employees are unqualified for the job they hold. One informant in the MOPHP commented that he could rely on only about a quarter of his staff to actually do the work required of them. Such an imbalance between a relatively small number of highly qualified senior officials and a large number of poorly qualified or unqualified lower level employees makes task delegation difficult or impossible. As a result, many of the most capable senior staff are overstretched in coping with their daily work.

The Ministry is said to have no or only some scattered job descriptions. It is thus impossible to know with any clarity which skills are most lacking and in which part of the Ministry's structure they would be most needed. Individuals with computer skills appear to be mainly self-taught and many expressed a desire for more formal training in this area.

2. Effectiveness at the Organizational Level

a. Budget and finance

The availability of sectoral funding is a determinant for any ministry's effectiveness. Health is seriously underfunded in Yemen. The Health Sector Reform strategy emphasized in 2000 that "Without a larger share of government allocations, the MoPH will be seriously crippled in any effort it makes to improve health care, especially for the poor."^{11,12} More recently, the Central Organization for Control and Audit (COCA) commented in its annual report, "Expenditure on health sector is still low as it constitutes only 3.7% of the total expenditures. There is also no change in the financial policies regarding social priorities,

¹¹ The name of the Ministry was later changed from Ministry of Public Health (MOPH) to Ministry of Public Health and Population (MOPHP).

¹² Health Sector Reform in the Republic of Yemen. Strategy for Reform. Republic of Yemen. Ministry of Public Health & Population. October 2000.

as the percentage of expenditure on health sector was 1.4% of local GDP which is the same as the previous year. This percentage is lower than the target percent (2.2%) of GDP.”¹³

The Public Expenditure Review of the health sector adds: “The (Ministry of Finance) has an inordinate degree of influence over how much is budgeted, how much is spent, and when it is spent in the health sector. This has remained the case even after authorities over programming, planning, and project implementation have devolved (since 2002) to local administrations.”¹⁴ The Ministry of Finance (MOF) has several of its own employees working in line ministries, including in MOPHP. The MOPHP has five MOF employees, including the Director General for Budget and Finance, the Treasurer and the Procurement Manager. Perceptions vary widely between the Ministry’s senior health technical staff and its MOF employees regarding the influence of the latter group. Health technical staff we interviewed complained that “Finance people are leading the MOPHP, not the technical health people” and that “MOPHP Finance Department is not public health oriented.” The Budget and Finance Director, in turn, points out that in budgeting, “all MOPHP sectors are contacted to get their priorities” and that the budget committee sets the overall priorities.

The MOPHP budget committee is appointed as soon as the budget circular has been received. The 2008 budget preparation starts in April 2007. The budget committee includes at least the following: Minister of Health or Deputy Minister for Planning and Development, the other Deputy Ministers and Directors General of Planning and Finance. The committee is said to first define the essential commitments and then include additional budget requests for items such as ambulances. Finally, requests or orders from the Minister of Health or the President are included. The MOF and the MOPHP discuss the MOPHP draft budget around the beginning of July, before it is finally approved. The MOF can and does make substantial changes in the budget after these discussions. A senior MOPHP official commented, “After agreeing on theoretical budget figures with the MOF, we are surprised by the low down figures when the budget is declared.”

The Director General for Budget and Finance oversees official and unofficial requests to spend MOPHP funds. He reports receiving, on average, three Ministerial requests every month for expenditure that is not in the budget. He responds, “without arguing,” by asking the Minister for a written order and then informs the MOF of the expenditure. The Minister is said to be reluctant to give such a written order in “90% of the requests.” According to the Director, the reason for the Minister’s reluctance is that “In next year’s budget, I’ll tell the Ministry of Finance to deduct these funds because they were misused.”

The operations budget of the MOPHP is underfunded. Salaries take up about 70% of the resources. Salaries were raised in 2006, but they are still very low. A Deputy Minister’s basic salary (not including bonuses) is \$300 per month, while a Director General earns \$200 per month. The amount of operational funds, which different directorates have in their budgets, appears unbalanced and some directorates are said to have little or no money to do their work.

In executing their budget, the senior health technical officials complain that the Programming Unit of the MOPHP Budget and Finance Directorate is a “cause of real delay.” Accounts for one activity have to be cleared fully with the MOF, before another activity can be started. Getting the final clearance can take up to six months. It is reportedly “not always clear what expenditure has to be approved by the MOF.”

¹³ Annual Audit Report Concerning Final Statements of the Implementation of State General Budget (Both Central and Local), Independent, Annexed Budgets and Special Funds and Budgets of Public and Private Economic Units for the Fiscal Year 2006. Central Organization for Control and Audit, Republic of Yemen. Presented to Parliament on 30 October, 2007.

¹⁴ Fairbank, Alan. Public Expenditure Review, Health Sector, Republic of Yemen, 1999-2003. PHRplus for USAID, April 2006.

b. Human resources

The staff strength of the Ministry of Public Health and Population is approximately 600. This seems a large number, given the devolution of a considerable number of health functions to local authorities. Of the Ministry's staff, 18% are said to have been trained to university level and 52% to certificate level. Administrative staff constitute the remaining 30%.

The human resource function in the MOPHP is split between the Directorate for Human Resources and the Directorate of Staff Affairs. The Human Resources Directorate is responsible for:

- Fellowships,
- Continuing education,
- Health training institutes,
- Planning human resource qualifications and training and
- Monitoring and evaluation.

The Director General of this Directorate has been in his current post for approximately one month and holds a PhD. Of his 21 staff members, two are university-trained, 5 hold diplomas and the remaining 14 are primary or secondary school leavers.

No clear policy on human resources for health appears to exist that could serve as a guide to planning and training staff. The Director General observed about his own department that it "did not have any strategy." He also commented that it had "*no records on any employees at all.*" The responsibility of the Directorate appears to be limited to planning qualifications and training only. It is not clear whether it also holds responsibility for planning numbers and desired distribution of staff and if it does not, who in the Ministry is responsible for these areas.

The lack of rational and data-based human resource planning is evident in the current difficulties to adequately staff existing infrastructure. Shortage of staff has reportedly led to the closure of 59 out of the approximately 400 health centers and two fully equipped hospitals. Lack of clear staffing standards (including minimum qualifications for a post) and the poor enforcement capacity of the Ministry have allowed governors to appoint totally unqualified individuals to health sector positions. The recent experience of the MOPHP illustrates this. The Ministry of Civil Service recently gave the MOPHP for the first time 2000 posts that it could allocate to the governorates to alleviate their staffing shortages. Many governors appointed non-health persons to the allocated positions. In Taiz, for example, 9-10% of the health positions were lost in this manner.

The MOPHP does not have a merit-based selection system, nor has it defined minimum qualifications for each position. Employment is said to be mainly patronage-based. In such a system, political loyalty and personal ties are more important in selecting and posting staff than technical competence. This finding echoes the Yemen Corruption Assessment which states "many, if not most, midlevel employees are thought to be hired and retained only if they share kickbacks and bribes."¹⁵

Staff promotion is not transparent, and it is reportedly very difficult to remove workers who fail to perform. A performance assessment system, which would be appropriate for the Ministry's functions, does not exist. There are few job descriptions, in spite of a recent effort to develop them with support of an EU-funded project. Norms and guidelines for practice either do not exist or they are not enforced.

Health workers are trained in 21 health institutions, which are supervised by two others. A 2003 Presidential Decree made these institutions autonomous, but they are still under the Minister for Public

¹⁵ Robinson, Glenn et al. *Yemen Corruption Assessment*. ARD, Inc., 25 September 2006.

Health and Population. Pre-service training does not seem to be based on strategic objectives or on Yemen's future requirements, as determined by the MOPHP. Coordination in training between the MOPHP and the Ministries of Higher Education, Finance and Civil Service is variably said to be either weak or acceptable. There are 41 private health training institutions. The Ministry currently has no oversight role over these institutions and no legislation is in place to assure quality of training. Reportedly, a draft law to regulate private health training is under consideration in the Cabinet.

Yemen government makes available R12 million annually for training of health workers overseas. This pays for 200 fellowships, the majority of which is currently used for physicians' sub-specialty training. There is little evidence that either the current process of allocating the fellowships or the selection criteria reflect either Yemen's priority human resource requirements or equity considerations. Continuing education is not linked to increase in salary or promotion, nor is it linked to improved performance.

The Human Resources Directorate reports difficulties in coordinating with the Ministry of Foreign Affairs in administering the fellowship program. This is particularly true when the Ministry attempts to follow up trainees during their overseas studies. Yemeni embassies handle fellowship payments to the students. The funds come from the Ministry of Finance, but are included in the MOPHP budget. A few years ago, Yemeni students in the UK reported great difficulties in receiving their fellowship payments. An informant told us that it was discovered that the Yemeni ambassador to the UK had used these funds to finance private property investments in London.

The MOPHP retains in each governorate a staff person with responsibility for continuing education. This person, however, has no operational funds. Donor funding is the only available source for refresher training or continuing education at the local level, which increases the possibility of training being skewed by donor priorities. At the district level, both refresher training and continuing education are said to be practically non-existent. The lack of continuing education opportunities is a major contributor to staff dissatisfaction at all levels.

The Ministry's *Directorate for Staff Affairs* has administrative control over Ministry staff and has the responsibility for:

- Salaries, wages and benefits,
- Recruitment and contracts, and
- Personnel records.

Both the Director General of the Directorate and his Deputy are employees of the Ministry of Civil Service. The Deputy has worked in the MOPHP for only four months. He reports that half of his 45 staff members hold bachelors degrees, 35% are secondary school leavers, and 15% completed grade 9.

The issues that the Staff Affairs Directorate is responsible for appear to be some of the most vexing challenges of the MOPHP. A donor representative called the problems related to employment and staff allocation processes, incentives, staff motivation and capacity constraints a "huge issue," especially at the lower levels.

The MOPHP reports that it previously had many "ghost workers" and "double dippers", but that they were eliminated in 2006. The biometric card, intended to identify civil servants, has reportedly been issued to the majority of health workers. The MOPHP, however, still has no unified database on its employees. There are at least four different staff lists, issued by different departments. Considerable discrepancy exists in the staff numbers on these lists.

Information technology capacity in the Directorate of Staff Affairs is very limited. The seven computers are used mostly for word processing. One computer processes the pay roll; another does the employee

data. There are very few opportunities for staff to undertake computer training and little or no systematic technological backup. Even antivirus protection is said to depend on the initiative of the person using the computer.

Access is the software used to process payroll data. Reportedly, Oracle will be used in the future for this purpose. It was not possible to ascertain the timetable for the transition to Oracle, nor whether its adoption is part of a government-wide effort or only taking place in the MOPHP.

The data on MOPHP employees is processed using Excel. Excel is also used for data on those health workers whom the Ministry recently allocated to governorates, following the exceptional allocation of extra posts. The MOPHP employees' Excel file includes such data items as name of the employee, ID number, date of birth, employment starting data, qualification and civil service grade. The Excel file on the health workers, who were sent to the governorates, contains fewer data items. The design of the Excel format was a personal effort by one of the Directorate employees. The computer on which the employee data are run does not appear to be dedicated to analyzing these data. The employee processing the data exclaimed, "Then they suddenly come and take the computer away and I sit here doing nothing!"

The Directorate of Staff Affairs makes an effort to collect data on the number and category of health workers, who work in the publicly funded health system. An attempt is made to visit each of the 22 governorates annually to collect and validate the data, since local authorities are said to "come with false data." Budget limitations constrain the Directorate's ability to cover all governorates.

The Ministry has little influence over the majority of the workers actually delivering health services. Following decentralization, the MOPHP is only responsible for the Ministry staff. The local governments recruit, hire, transfer and discipline their own health workers. The recruitment levels are set by the Ministry of Civil Service, which also allocates posts and sets remuneration levels. Recruitment and deployment of staff at the local level appear not to be based on actual needs.

Many informants commented that Ministry staff are demoralized and that motivation is low, particularly among the less highly trained staff. Low salaries are a common complaint by respondents at all levels of the bureaucracy. As one informant emphasized, "Good staff are leaving the Ministry of Public Health and Population." There does not appear to be any concerted effort to put in place counter-measures to retain the best staff.

Absenteeism is a major problem. The Ministry currently controls attendance through the use of a punch card. It intends to introduce a finger print scan, which will eventually be linked to payroll records. According to the Director of Staff Affairs, the Prime Minister issued a decree in late February 2008 instructing all ministries to introduce the scanner. Each ministry is expected to finance the scanner from its own budget. The Directorate is currently waiting for the answer of the Minister of Health and Population to their proposal for its purchase.

c. Procurement

The MOPHP procures pharmaceuticals and other supplies, equipment and capital construction of health facilities. It applies the July 2007 procurement law in all procurement. The MOPHP procurement committee is responsible for tenders below the High Tender Board (HTB) threshold of YR125 million (\$625,000). One supplier quote is sufficient for tenders below YR30,000. For tenders between YR30,000 and YR200,000, solicitations for proposals do not need to be publicized, but a minimum of three supplier quotes is required. Tenders over YR200,000 but below YR1 million, are opened and the selection made in the presence of all bidders. Reportedly, no losing bidders have complained thus far, even though the avenue to do so exists.

All tenders above YR125 million are referred to the High Tender Board (HTB). The MOPHP prepares the tender documents and sends them to the HTB for approval. The MOPHP receives all bids, opens them without the HTB being present and makes the selection. The Ministry then sends its report for the HTB's review, together with all bids.

The National Program for Drug Supply prepares tender specifications for *procuring pharmaceuticals*. This office used to be independent, but now comes under the MOPHP. The budget for purchasing drugs is always insufficient in relation to the needs. A senior health manager in the MOPHP complained that it is not clear who actually decides what drugs to buy. The Ministry of Finance, by setting the financial allocations, defines a strong priority for purchasing a larger amount of sophisticated drugs for curative care in tertiary hospitals than those needed for primary care. Another important issue is the classification of some drugs as "vital." The "vital" category includes cancer drugs and insulin, for example. It does not include penicillin for treating pneumonia or oral rehydration solution, which can equally be considered lifesaving. This misleading classification contributes to the imbalance in the fund allocation for different types of pharmaceuticals.

A National Drug Policy and a National Essential Drug List do exist. They are, however, not enforced in practice. A recent example is the intervention of the President to order the purchase of a Roche brand anti-rejection drug for kidney transplant patients. This order reversed the Ministry's decision to import a lower cost equivalent drug from an Indian pharmaceutical company. Standard Treatment Guidelines have been prepared, but reportedly are either not known at the service delivery level or not applied. The MOPHP maintains no drug reserve for emergencies.

The procured pharmaceuticals and supplies are stored in the Ministry's warehouse in Sana'a. The national drug laboratory is said to check the quality of the drugs by analyzing random samples. The MOPHP claims that to date, all drugs have met quality standards. Other sources, however, report that drug quality assurance is rarely done at entry of shipments because of capacity constraints. It is supposedly done as part of pharmaceutical registration. Suppliers have to pay a fee to the national drug laboratory to cover the cost of a chemical analysis before a drug is registered. There is, however, some question whether the laboratory actually does conduct the analyses, after it has collected the fees.

Delivering the drugs to the service level is the responsibility of the governorates. They send a representative to pick up the drugs from the central level. The governorate representative signs for the shipment and is accompanied to the local level by a MOPHP staff member. The Ministry representative obtains a receipt from the local health office or the hospital to certify that the shipment was delivered to the correct location. The Ministry states that 90% of the drugs reach the right place. It was not possible to verify this estimate, but the Yemen Corruption Assessment refers to considerable leakage of drugs at the more peripheral level.

Shortage of drugs at the local level has been a serious constraint in Yemen for some time. In 1998, the Dutch government funded the establishment of a revolving drug fund, which reportedly made drugs more available. The Ministry of Finance canceled this fund in early 2005, allegedly because of corruption in its management.

The revolving drug fund appears to have been abolished without looking at alternatives. Concern is now rising about availability and quality of pharmaceuticals, particularly at the lower levels of the health care system. Some observers have reported that essential drugs are almost completely depleted at the health facility level. At least one Director General of Health of a governorate is said to maintain his own revolving drug fund to improve drug availability.

When the Minister of Health took up his portfolio in 2006, he reportedly attempted to hand over drug procurement to UN agencies, i.e. WHO, UNICEF and UNFPA. These agencies had been procuring

vaccines, contraceptives and a limited number of medications, e.g. for bilharzias and avian flu, for the Ministry. However, they have neither the interest nor the experience to take over a whole country's drug procurement system. UNICEF's experience in interacting with the Ministry over this issue is illustrative of the management problems in the MOPHP. After UNICEF reviewed the first drug order, which it received from the MOPHP (in hard copy and with the Minister's signature), for its appropriateness for primary care, it returned the revised list (in electronic copy) to the Ministry for their comments before proceeding with procurement. The Ministry did not reply for six months. When UNICEF eventually approached the MOPHP, it was told that the Ministry had decided to "go to local tender." WHO has not agreed to take over all procurement either, but it has agreed to provide a consultant to provide advice on establishing a proper drug procurement system.

The Yemen Corruption Assessment identified procurement as one of the main areas of corruption.¹⁶ The Yemen government gives suppliers a monopoly for importing medicines from a particular pharmaceutical company, e.g. Roche or Ciba-Geigy. (This is also true of other Arab countries, with the exception of Lebanon. Lebanon allows a parallel market, where suppliers are free to import drugs from the same companies.) Such a monopoly brings strong incentives to the supplier to ensure a continuing and high demand for the drugs from the pharmaceutical company, which it represents, by bribing high government officials. Some pharmaceutical companies or their representatives reportedly give regular lump sum payments to public sector doctors to refer patients to a particular pharmacy, laboratory or X-ray facility. Private pharmacies are known to give free office space to doctors on the condition that they prescribe only from the pharmacy's list of medicines, coming from certain foreign pharmaceutical companies.

Equipment procurement by the Ministry is poorly planned and skewed toward sophisticated levels of care. Hospitals are reportedly not involved in developing specifications for the type of equipment that the MOPHP purchases. A Manual for Standard Equipment does exist, but the lack of technical review of equipment purchases has brought a number of problems. The equipment purchased is not always appropriate for the type of health facility. For example, expensive X-ray equipment is purchased for facilities lacking a basic laboratory. Purchased equipment is sometimes of low quality or its brand is one for which spare parts are not available in Yemen. As mentioned before, the useful life of purchased equipment is severely shortened by the lack of preventive maintenance. Restorative equipment maintenance is also rare.

The *procurement process for capital construction* is said to follow the recently revised procurement law. The Ministry, however, let out no construction contracts last year due to lack of funding. In 2006, it put out 15 tenders for capital construction. All building contracts over YR125 million have to go through the MOPHP. Governorates can build health clinics and other small structures below that amount. Losing bidders have the possibility of complaining to the Minister's Office, which refers the complaint to a Technical Committee, appointed by the Minister. The Committee reviews the complaint and sends a reply to the bidder. (As noted earlier, we were told that no complaints have been received from losing bidders; this is actually rather surprising that there reportedly *not even a single complaint*. It speaks either of a perception of complete trust in the integrity of the process, or it speaks of a perception of total distrust in the system that it is not worth making a complaint.)

Three engineers from the MOPHP engineering department are said to supervise each construction project. One engineer prepares the technical specifications for the tender. A resident field project manager supervises the construction in the field. The third engineer is responsible for final review and acceptance of the building. The low salary levels leave the engineers, especially the field project manager, especially vulnerable to bribes from the contractor.

¹⁶ Robinson, Glenn et al. *Yemen Corruption Assessment*. ARD, Inc., 25 September 2006.

Planning of capital construction projects does not appear to take into account the need for such a facility and the government's ability to staff and run it. As mentioned earlier, many buildings have been built since 2002, but they remain closed because of inadequate staffing. It was reported that \$5 million was spent on a feasibility study for a 2000 bed President Saleh Charity hospital. This hospital is to be built in Sana'a with funds from the President's foundation. When fully operational, the President's hospital is likely to further strain the availability of staff to the rest of the health system.

The recent COCA Audit Report revealed that 43 projects of MOPH were uncompleted at the end of 2006.¹⁷ This represents an expenditure of approximately 577 million rials. Most of these projects were contracted after 2001. They included rehabilitation of several health centers, and construction of new health units and kidney centers. The COCA reported that a total of 68 projects were not implemented at all. These projects had been allocated approximately 1.3 billion rials in the 2006 budget. In contrast, seven projects of a total value of approximately 2.6 billion rials were implemented, but using non-budgeted funds.

A donor representative reported that the Minister of Health has decided to outsource all civil works to the Public Works project. This project is run out of the MOPIC and applies transparent World Bank procurement rules. The Minister of Planning and International Cooperation is said to have recently sent a letter to inform the relative ministries that civil works in the health and education sectors will in the future be done through either the Public Works project or the Social Development Fund. The officials in charge of procurement in the MOPHP, however, do not appear to be aware either of the Health Minister's decision or the Planning Minister's recent circular.

d. Accountability mechanisms

The COCA Audit Report states, "Health sector is still suffering from a number of tangible organizational, administrative and legal difficulties and problems which restrict the development process of this vital sector."¹⁸ The report gives the following examples of such hindrances:

- Weak planning mechanisms, resulting in poor distribution of health facilities and their low operational efficiency,
- Weak institutional structures, such as legislation governing health sector functions and user fees and other levies on medical services,¹⁹
- Weak regulations and other mechanisms in use to assess health worker performance and monitor and supervise health institutions, and
- Ineffective supervision and planning functions for investment projects.²⁰

A senior MOPHP official asserts, "An accountability system *does not exist*." With the transfer of powers to the Local Authorities, the MOPHP lost much of its ability to hold lower levels of the health care system accountable for health care delivery and appropriate use of financial, human and material resources. The salary budget for local health staff goes directly to the governorates, which have the power

¹⁷ Annual Audit Report Concerning Final Statements of the Implementation of State General Budget (Both Central and Local), Independent, Annexed Budgets and Special Funds and Budgets of Public and Private Economic Units for the Fiscal Year 2006. Central Organization for Control and Audit, Republic of Yemen. Presented to Parliament on 30 October, 2007.

¹⁸ Ibid.

¹⁹ The Local Authorities can set user fees. Fairbank comments in the Public Expenditure Review that "There is transparency and accountability neither for collection of fees nor for distribution of the revenues" and that drug exemption policies are "inconsistent and not well administered."

²⁰ Some donors are now bypassing the Ministry of Public Health and Population and going directly to the district level.

to hire and fire. Money to finance other operating costs of local health service delivery also goes directly from the Ministry of Finance to the local level.

The MOPHP still owns buildings at the local level, as well as the equipment they contain. Local authorities are known to have taken such MOPHP assets (buildings, furniture and land) for purposes other than health, without the MOPHP being able to intervene. One observer commented that there is a “growing divorce between technical needs and the political interests of the local authorities.”

The role of the Ministry as the *steward* of the health sector has not been fully clarified and institutionalized. While five-year health plans have been formulated, the Ministry’s strategic priorities and its targets for health outcomes are yet to be finalized. One knowledgeable MOPHP senior staff member observed, “We make such beautiful plans, but we don’t follow up or monitor.” Holding anyone accountable for the Ministry’s performance in its stewardship role is difficult, when the Ministry’s role is unclear, the priorities have not been defined and follow-up and monitoring is inadequate.

Several laws and Republican and Prime Minister Decrees govern the health sector. They are listed in Annex 4. Knowledgeable respondents comment, however, that the legislative framework is overlapping, suffers from several gaps and is not known to all who are expected to abide by it. Two examples illustrate the challenges. First, no legislation is in place on accreditation of training institutions in spite of Yemen having several public and private training schools for health workers. Second, the law on licensing health professionals (Law 28/2000) assigns the responsibility for the licensure of public and private health providers to the Higher Medical Council. This Council has not been established to date.

Standards exist for medical equipment, staffing and buildings by type of facility. These standards are, however, not generally known and implemented. The Ministry has defined an Essential Service Package, which is supposed to be delivered at the district level. While the package has been defined in theory, its various components have not been integrated and in practice, it is not delivered at the service level.

A uniform and appropriate *health and management information system* (HMIS) is essential for accountability. The current HMIS is said to be weak and unreliable, covering only 20% of health facilities. Some observers, in fact, refer to the “absence of a national health information system,” despite efforts to develop one. Data collection is fragmented or incomplete and data collection has not been unified. Each vertical program maintains its own forms and reporting channels. Governorates have their own approaches to collecting and reporting data. They do not regularly send reports to the MOPHP. Donor agencies also have their own data requirements. These problems are illustrated by the experience of the GAVI Alliance (formally the Global Alliance for Vaccines and Immunization). It suspended its operations in Yemen a year after starting in 2002, because Yemen failed GAVI’s data accuracy test. Yemen was reinstated after a GAVI mission reassessed the accuracy of immunization statistics. There is some question, however, whether the coverage rates in the study sample are indeed an accurate reflection of immunization coverage in the country. They were reportedly higher than equivalent Swedish rates.

Monitoring and evaluation (M & E) is said to be a new concept in Yemen. In the health sector, M & E is not included in the Ministry’s health plans and no funds are budgeted for running costs of M & E activities. Indicators against which to evaluate are rarely defined. The General Directorate of Human Resources in the MOPHP does have a monitoring unit. It is instructive that the Directorate’s recently appointed Director General discovered that the role of the monitoring unit was limited to following up correspondence sent to other departments and ministries!

The lack of monitoring and evaluation is not unique to the MOPHP. The Ministry of Local Authorities admits that they lack a system to monitor whether governorates and districts follow national guidelines. The MOPIC is now said to be pushing all other ministries to improve monitoring and evaluation. It is too early to predict the outcome of this effort.

e. Incentives for performance

The incentives for good performance are few. The Directorate of Staff Affairs states that small financial incentives of approximately \$20 a month do exist for good performance. The supervisors are expected to determine which of their staff members deserve such an incentive, but are given no guidance on how to do it. The Ministry employees consider the financial incentives to be very low in absolute terms. They also believe that the funds for financial incentives are unequally distributed between different MOPHP directorates.

The current salaries of Ministry staff cannot be considered a living wage in many cases. This has led to the workers seeing the small financial incentives as a salary supplement, which they all expect to receive. The amount of money available for incentives in a particular directorate is never sufficient to cover even all the good performers, let alone all members of staff. Given the workers' expectations and the lack of a performance management system, the staff come to consider the supervisor as unfair in the way the incentives are distributed.

Some donor programs have made financial incentives available for certain health activities. A recent experience with UNFPA incentives is instructive regarding the problems that such incentives can create. The Ministry workers came to expect the UNFPA incentives to such an extent that when UNFPA removed them, the staff refused to continue working.

The non-transparent system for hiring and promoting staff and the difficulty of firing poorly performing workers are considerable disincentives for good performance.

f. Organizational structure of the MOPHP

The decentralization of powers to local authorities appears not to have led to a corresponding restructuring of the MOPHP to fit it for its stewardship role. The Ministry's organizational structure was last revised in 2004, but this was done to accommodate its new responsibility over population matters. The Ministry's name changed at the same time to reflect this responsibility. The 2004 reorganization of the Ministry stopped at the level of the Directors General. Additional directorates have since been created, but not yet officially endorsed.

The Ministry of Civil Service is currently reported to be involved in administrative reform of the MOPHP. It was not possible to find out what the reform entails nor whether this reform is to refit the Ministry for its changed role. A MOPHP senior officer complained that the Ministry's senior staff also do not know the current status of the administrative reform. There is a need to reassess the Ministry's organizational structure as soon as its post-decentralization role has been clarified.

The organogram inside the Population Directorate is also not clear, according to the Deputy Minister for Population. She discovered, when she recently took up her position, that many of her staff members did not know whether they worked for the population unit or the reproductive health unit.

There appears to be considerable fragmentation and overlap of functions among the various entities that form parts of the pharmaceutical management system. The Ministry's General Directorate of Medical Supply and Pharmaceutics; the National Programme for Drug Supply, Essential and Vital Drugs; the General Directorate of Financial Affairs and the autonomous Supreme Board for Drugs and Medical Appliances are all involved in pharmaceutical policy. All three of the Ministry offices have a role in forecasting and purchasing of drugs. The Ministry's branches that run vertical programs in the primary care sector, such as the Essential Program for Immunizations, TB and malaria, also obtain vaccines and a limited number of drugs through international partners, while the Population Directorate receives contraceptives.

g. Decision-making

The Ministry's ability to act effectively in defining health sector policy, regulating the sector, improving service delivery and enforcing laws and standards is severely compromised. Many of the reasons are beyond the control of the MOPHP. First, the post-devolution roles of the central Ministry, Local Authorities and governorate and district-level health managers have not been clearly defined. The MOPHP can no longer dictate to local authorities what they are to accomplish in health service delivery. Second, policy decisions of the Ministry are influenced and sometimes reversed by power holders outside the Ministry itself. Third, the Ministries of Finance and Civil Service constrain the ability of the MOPHP to appropriately fund and capably staff its own central-level structure, as well as the health programs and facilities it still looks after. Fourth, accurate information is increasingly difficult to get from the local level, negatively affecting Ministry's efforts to improve service delivery. Fifth, enforcement mechanisms are generally poor in Yemen and the judiciary lacks independence. Both aspects severely hinder the Ministry's ability to enforce regulations, standards and rules.

The MOPHP has been criticized in the past by outside observers for its "lack of a strategic, mid- and long-term leading vision" and for a "silo mentality" in decision-making within the Ministry. It appears that the Ministry is now seriously attempting to develop a strategic vision with clear benchmarks and action lines. The Deputy Ministers also seem to be working closer together. It is, however, too early to assess whether these positive trends can be sustained.

3. Effectiveness at the Macro-Institutional Level

a. Socio-political conditions influencing performance

Health is not currently a priority in the national development framework. As mentioned before, health care is seen as an opportunity for investment and revenue generation, not as government responsibility to its citizens. This has left the Ministry of Public Health and Population in a very disadvantaged position, even when compared to the other social sector ministry, education.

A recent announcement by the President indicates a worrisome lack of appreciation both for the health sector in general and the Ministry's important stewardship function. The World Bank reports that the President introduced a proposal for wide ranging political reforms in September 2007.²¹ They include a reduction of central level ministries to only six. These are Foreign Affairs, Public Security, Finance, National Wealth, and Trade and Planning. The tasks of the remaining ministries, presumably including the Ministry of Public Health and Population, are to be delegated to the Local Authorities, according to this report. The Parliament would have to approve the proposed changes, before they can take effect in 2013.

Frequent mention has been made in this assessment of the various ways in which decentralization has already impacted on the Ministry's ability to efficiently act in its new role. The Health Public Expenditure Review points out that "decentralization has given governorates and districts independent authorities to devote resources to building new health centers and hospitals without prior approval from the MOPHP, and without adhering to MOPHP design and construction standards" and that "Decentralization has aggravated deficiencies in the planning and programming process by devolving spending authority to many more lower levels of government – without adequate oversight, enforcement of standards, and recognition of the future recurrent budget requirements of present investment decisions."²²

²¹ World Bank. *Yemen Economic Update*. Winter 2007.

²² Fairbank, Alan. *Public Expenditure Review, Health Sector, Republic of Yemen, 1999-2003*. April 2006.

One observer has been quoted as saying “We got rid of centralism at the level of nation and fell victim to centralism at the governorate.”²³ The governors are now reported to push for even more powers over the health sector, which the Minister is said to oppose strongly. Transferring additional powers away from the MOPHP without first defining the respective roles of central and local governments regarding the health sector and establishing appropriate check and balance mechanisms will further erode the Ministry’s effectiveness.

Budget allocation and execution decisions, made at the level of the Cabinet and the Ministry of Finance, further constrain the Ministry’s effectiveness. The manner in which these decisions that affect the Ministry are made is not transparent to the MOPHP.

The Yemen Corruption Assessment states, “most private medical supply and drug companies are believed to collude with government health officials on securing procurement bids and then share their future wealth with those same officials.”²⁴ Some drug importers are very powerful and have made a lot of money from pharmaceutical procurement. It was not possible to ascertain whether this perceived collusion between them and high government officials is still common. The intervention of the President in the Ministry’s decision regarding the purchase of the anti-rejection drugs does indicate at the very least that the Ministry’s ability to pursue its policies continues to be limited by powerful outside forces. Access to overseas treatment is another area where Ministry policy is subject to influence by the wealthy and powerful.

Yemen is in process of acquiring full membership in the Gulf Cooperation Council (GCC) in the medium term. The membership will imply the need to adopt common health regulations, which cover areas such as drug registration, disease control and service quality. To what extent Yemen will be able to enforce these regulations remains an open question.

b. Main stakeholder groups

Three main groups in society have a particularly important stake in the performance of the MOPHP. The first group consists of *reformers*, both inside and outside the Ministry. The members of this group are genuinely interested and engaged in seeking ways to improve the Ministry’s performance. This group, regrettably, is small and has limited power to make substantial changes.

The second group is made up of what the Yemen Corruption Assessment report terms as the *parasitic business community*, which profits from drug and equipment procurement and construction contracts, and the corrupt officials they collude with. As mentioned earlier in this report, this group is very powerful and has become very wealthy as a result of its corrupt business practices. Improving the Ministry’s performance by enforcing transparent procurement processes, ensuring that construction of new facilities is based on clear evidence of need and ensuring correct construction standards is not in the interests of this group. There is some question whether the recent demonstrations by kidney patients, demanding the Roche-brand drug, were a spontaneous expression of patients’ concerns or fomented by those who benefited financially from the importation of this medicine.

The third group is comprised of *the poor and the ill*. They currently have very limited access to care of any sort. When they do reach a health facility, they have to pay both officially and under the table for care that is of poor quality. Frequently, they must buy medicines, which are supposed to be free. From a sectoral point of view, the poor and the ill make up the most important group with a stake in the Ministry’s performance. They are, regrettably, also the group with the least power and voice to influence it.

²³ Jennings, Mary. Social Fund for Development: 2006 Impact evaluation study synthesis report. April 07.

²⁴ Robinson, Glenn et al. *Yemen Corruption Assessment*. ARD, Inc., 25 September 2006.

c. External pressures influencing performance

Yemen is a signatory to the UN Millennium Declaration and as a consequence, has defined its Millennium Development Goals. Currently available data show that the country is not on track to meeting these goals. International agencies, such as the World Bank, continue to bring attention to the gap between the MDG targets and current performance in their work with powerful Yemen government ministries, such as the MOF and the MOPIC. It remains to be seen, whether the influence of these outside agencies will bring about an increased allocation of resources for health.

External agencies are also influential in advising the Yemeni government on political and structural reforms. One informant reported that UNDP was responsible for suggesting the reduction of central ministries to only six, which the President announced in his September 2007 speech. If indeed this is true, this UN agency shares the Yemen government's lack of awareness about the essential stewardship role that a central-level health ministry must play in a decentralized country.

The Ministry's performance is also influenced by the sometimes contradictory tug-and-pull of different donor agencies. There is still very little coordination among the donors working in the health sector, in spite of efforts to improve collaboration following the Paris Declaration on Aid Effectiveness.²⁵

Reference has been made in this report to political influence on decision-making in the MOPHP. The President's recent intervention in the Ministry's decision regarding the purchase of anti-rejection drugs for kidney patients is but one such example. The Ministry is also unable to influence decisions about capital construction, which will place future demands on the already critical staffing situation. This is true both of the rapid rise in facility construction by the Local Authorities and of the planned 2000-bed President Saleh Charity Hospital in Sana'a.

V. PRIOR EFFORTS TO ENHANCE THE EFFECTIVENESS OF THE MOPHP

Most of the efforts to improve efficiency in the MOPHP have been part of a larger reform effort, which targeted several ministries. The *Civil Service Modernization Program*, which was launched in 1998, entailed the following:

- Identifying and removing from the civil service "ghost-workers" and "double-dippers" (those who received more than one government salary),
- Implementing a biometric identification card system for civil servants,
- Reforming the payroll system by introducing a uniform pay scale based on qualifications and years of experience, and
- Restructuring seven pilot agencies, including the MOPHP.

The Yemen PEFA Assessment report reveals that cleaning the personnel database, which started at 2001, had to be restarted in 2005.²⁶ This is because "ghost-workers" and "double-dippers" reappeared on the payroll. The MOPHP claims that it has now eliminated all "ghost-workers" and "double-dippers" and that most health workers have been issued the biometric card. The lack of a unified database on Ministry

²⁵ Paris Declaration on Aid Effectiveness. High Level Forum, Paris. February 28 – March 2, 2005.

²⁶ *Report on the PEFA Assessment*. World Bank, Yemen, November 2007.

employees, however, makes it difficult to verify the accuracy of the data, particularly since payroll and employee data are not yet linked.

The restructure of the MOPHP appears not to have taken fully into account the Ministry's changed role following decentralization. In addition, the restructure did not proceed below the Directorate level. The Ministry of Civil Service is currently engaged in another administrative reorganization of the MOPHP and there is an ongoing effort to establish a personnel database. Reportedly, the Civil Service Ministry has also finalized a study of performance indicators for different ministries, but whether the MOPHP is one of them is not clear.

The European Union funded a *Support for Administrative Reform* (SAR) project, which aimed to re-engineer four pilot ministries and introduce new management systems for them. The MOPHP was one of the ministries included in the project. The project cost was \$6 million and it covered the years 2004 to 2007. Many consultant reports were produced under this project for the Ministry. They include:

- Review of human resources management legislation,
- Survey of information technology,
- Accreditation of health qualifications,
- Staff satisfaction assessment and
- Strengthening of M & E and MIS.

It proved very difficult to identify any permanent impact of the SAR project on the performance of the MOPHP. A Ministry employee hinted that the project might have been wound up earlier than planned, because the female expatriate managing the project in the Ministry was threatened. It was not possible to verify whether this indeed was the case. What was clear, however, is that very few of the numerous recommendations have been implemented (See Annex 6).

The 1998 health reform effort by the MOPHP, in which a number of reforms were to be implemented, did not bring lasting results. Informants commented that the reform strategy was done quickly and not in a participatory way. It is thus not surprising that it came to be perceived as donor-led. The World Bank designed its *Health Reform Support project* to bring in needed financial and technical resources to implement the planned reforms (budget of US \$28 million between 2003 and 2007). Three years later, the project was in danger of being cancelled, as it had only disbursed 6% of the funding in that time period. After negotiations between the Yemen government and the World Bank, the project was restructured in 2006. Its new focus was to support well-performing vertical health programs, including Integrated Management of Childhood Illness (IMCI), Expanded Program for Immunization, reproductive health and malaria.

The current Ministry reform effort, in which benchmarks are defined and action lines developed, is in contrast to the earlier one. It has reportedly been truly participatory thus far. The challenge will be in getting the action lines implemented after they have been determined. As Alan Fairbank comments, "One of the persistent difficulties faced by the efforts of the MOPHP to design and implement a reform strategy has been the lack of support from other government agencies, particularly the Ministry of Finance."²⁷

The World Health Organization is expected to fund the development of a *human resource strategy* in May 2008. This is to be done in a workshop with the MOPHP representatives, together with Directors General at the governorate level and heads of training institutions.

²⁷ Fairbank, Alan. Public Expenditure Review, Health Sector, Republic of Yemen, 1999-2003. PHRplus for USAID, April 2006.

VI. RECOMMENDATIONS

The long list of recommendations of previous Health projects, as listed in Annex 6, most of which were unimplemented, gives little encouragement for recommending similar actions to enhance effectiveness. The fundamental problems with the Ministry's effectiveness are not so much the lack of proper systems and structures, but rather the problems are greatly due to a general undervaluing of the importance of health for development. This lack of appreciation of the importance of health to development is compounded by and reflected in the lack of clarity in the role for the Ministry of Public Health and Population and the weak support from other important ministries, which the Ministry has thus far experienced in trying to implement reforms. The following three recommendations target these fundamental causes.

1. Provide Support to the MOPHP to Make Health a High-Priority Development Agenda of the Government

The author recommends providing technical assistance to the MOPHP to assist in making health a high-priority development agenda of the government. Although MOPHP officials are fully aware of how low health is in terms of the government's priorities, they are unclear about how they can elevate its status as a priority issue in the government's agenda.

In this respect, the author recommends providing support to the Ministry in designing and delivering a high-profile symposium on Health in Development as a multi-pronged effort at pushing health up the government's agenda. This symposium would target senior government officials, particularly the Ministries of Finance, Planning and International Development, and the President's and Prime Minister's offices. It will invite internationally recognized and respected presenters to speak in the symposium both from the region and outside it. Ideally, the symposium would be co-sponsored by multilateral organizations such as the World Health Organization and the World Bank and other bilateral aid agencies. Because of broad sponsorship of the conference and its high-profile speakers and resource persons, it will be more likely that the Yemen government will be represented at senior levels across the targeted ministries. A major output of the conference would be a statement by the government and supporting donors that would identify health as a major barrier to development and would commit the signatories to take concrete measures to address the problem.

The symposium will seek to address the fundamental issue that the MOPHP cannot be an effective if its mission is not valued and if health itself is not seen as a national problem. Until senior officials accept and agree to act on the evidence about the importance of health to development and of the prevalence of health problems in the country, the MOPHP will continue to be hobbled by limited resources and constrained authorities.

This proposed symposium is proposed to be delivered over 3 days. A model for this symposium is the sixth global conference on health promotion organized by the World Health Organization held in 2005. This conference was designed to highlight the importance of health to development, understand the determinants of health in a country, and discuss the best practices in policies and partnerships required to address the problem.

In terms of format, the first day of the symposium can focus on multi-media presentations (film, slides, talks) of the impact of health condition on a country's economic development. The second day can be allocated to sessions on findings from recent studies on health problems in Yemen. The third day can be

devoted to workshops and group discussions among different participants on key health issues, including amendments to existing policies or developing new ones.

This proposed activity can be incorporated in one of USAID's existing health projects in Yemen. It can also be conducted in conjunction with Washington, DC-based USAID initiatives. In addition, it can also be co-designed and co-delivered with other international organizations. With broad support, the costs of the activity will be reduced for USAID and other sponsoring organizations.

Technically, this activity will require the short-term technical assistance of an International Health Development Specialist for about 8 person-weeks spread over 4 months (not necessarily consecutive months). Ideally this consultant should be hired out of an existing project so that he or she will have field support from an existing implementer and from the Mission itself.

While 8 person weeks may be seen as more time than necessary, it is arguably reasonable to provide an extended period for the preparation and delivery of such a complex conference and ensure its agenda-setting objective. The first month will entail consultations on the design of the symposium and securing buy-in from the MOPHP and other Yemen ministries as well as from various international organizations. This month will also be spent securing commitments on the nature of contributions from sponsoring organizations, drawing up the list of participants, and the issuance of invitations to speakers and participants. The second month will be focused on finalizing the list of speakers and participants and ensuring delivery of donor and host country commitments. The third month will be devoted to the conduct of the symposium itself. Ideally the symposium should be covered by international and local media, because greater coverage could enhance the prospects of greater importance assigned by participants to the commitments they made at the end of the symposium. Finally, the fourth month will be focused on writing up and disseminating the results and commitments made during the conference.

In addition to labor, this activity will need a budget to cover other direct costs, as follows:

- Cost of the symposium venue (may be provided by government as counterpart funding)
- Payments for international and local presenters
- Air tickets for international speakers
- Lodging for international and local participants outside Sana'a
- Meals and incidentals
- Printing and distribution of symposium documents

2. Provide Technical Assistance to the MOPHP to Conduct a Social Marketing Campaign on Health in Development

Social marketing is a widely recognized tool to effectively reshape public attitudes toward social issues and to encourage them to take individual and collective action.²⁸ The goals of social marketing are generally three-fold. First, it seeks to make the public or target segments aware of the issues involved. Second, building on public awareness, it seeks to make the public or target segments accept that the issues raised constitute problems to be solved. In many cases, there is a dichotomy between what the government considers as problems and what the public views as such (the case of health being a prime example, as noted above). Third, following the building of awareness and acceptance, a social marketing campaign invites the target segments to act on the identified problems by providing accessible alternatives

²⁸ Philip Kotler, Eduardo Roberto and Nancy Lee, *Social Marketing: Improving the Quality of Life*, Sage Publications, 2002.

(such as call-in numbers, citizens response centers, etc.). Examples of effective social marketing include no-smoking programs; family planning and use of contraceptives campaigns; anti-drugs initiatives; recycling of paper and aluminium cans, clean air campaigns, and others.

This proposed Social Marketing campaign would target both public officials and the general public. Its goals would be threefold: first, it will seek to raise governmental and public awareness about the impact of health in development. Second, the campaign would relate the broader issue of health in development to the level of the household and individual, by showcasing, among others, Yemeni examples and experiences in dealing with health issues. Third, the campaign would encourage its target segments to take action, i.e. for public officials to increase resources for health and expand health programs, for citizens to provide feedback to government about their concerns and complaints.

Ideally the delivery of this proposed Social Marketing campaign will be three-way – through print, broadcast and TV media. At the outset, it will entail the engagement of a consulting company with social marketing expertise that will design the campaign and supervise its delivery. This campaign can be conducted at the least over a 6-month period. If resources are limited, a Social Marketing Specialist will need to be engaged for at least 12 person weeks, or 2 weeks per month during the campaign.

In addition to labor costs, the social marketing campaign will entail other direct costs related to the production and dissemination of newspaper ads, radio spots, and TV info-commercials. Specifically, the design and conduct of this campaign would entail the following:

- Survey on perceptions on health issues among government officials and general public – this survey is essential to determining and clarifying the reasons behind public officials’ and the general public’s attitudes towards health; what they consider as critical or priority issues in the health sector; what they would consider as reasonable bases for action.
- Design of social advertising spots in radio, TV, and print media – the design of print, radio, and TV segments will be based on analysis of survey results and feedback from USAID and other partners;
- Cost of newspaper space and radio and TV time to air social advertising spots – this can be the most expensive items in a social marketing campaign; ideally the government should be persuaded to provide newspaper ad space as well as radio and TV time from government-owned or controlled entities as their counterpart funding to the activity.
- Commissions to journalists to write newspaper and magazine “think-pieces” on health and development
- Distribution costs of written social marketing materials (brochures, pamphlets).

3. Provide Technical Assistance to the MOPHP to Re-engineer its Programs and Operations

This proposed activity logically follows from the preceding two recommendations. As articulated in this report, the lack of effectiveness of the MOPHP stems in great part from the fact that its mission is not valued, which consequently has blurred and diffused its role and functions. In the author’s view, at least one of the two preceding recommendations need be satisfied for this proposed technical assistance to

proceed. Without explicit reevaluation of the government about the importance of health in its development priorities, there is no compelling reason to re-engineer the MOPHP.

If the above conditions are met, the author believes that the MOPHP would need immediate technical assistance to redefine its mission, craft a new strategy, reorganize its structure, and develop appropriate activities. It would be particularly crucial to define its role and functions relative to local authorities and their respective health offices. As form should follow function, the technical assistance to the MOPHP should pay close attention to restructuring its organization to reflect its clarified role and relationship with other relevant bodies. In addition, the TA should assist the MOPHP in developing a realistic budget for its strategies and activities. Thus far, as noted earlier, the strategies and activities of the Ministry are not realistic because they are not actually costed.

This proposed TA will require the services of a Health Management Advisor with significant senior-level experience on policy, management and organizational reform of health ministries. It would be critical for this advisor to have regional experience and Arabic language skills to help ensure quick start-up and build rapport with key officials. He or she will take the lead in the design of all activities and supervise closely their delivery and implementation. Among the most important activities that he or she will lead is a Strategic Planning Workshop for the Ministry which will produce a strategic plan with specified results and indicators that Ministry officials and stakeholders can be held accountable to. Building on the strategic plan, the Advisor will work with the MOPHP in developing a more detailed work plan that outlines specific tasks, designate key personnel, specify resources, and assign targets. It is essential that the workshops and meetings for both the strategic plan and the work plan engender a broad sense of ownership, both within the Ministry bureaucracy as well as among key government and non-governmental entities.

We envision this effort to require at least 1 year of technical assistance from the Health Management Advisor on a wide range of areas, i.e. to develop a mission statement for ministry, draft a strategic plan and a work plan with broad ministry and stakeholder ownership, design of priority activities that will have multiplier effects and short-term wins, and assist in the monitoring and evaluation of the Ministry's performance. In addition to the deployment of a Health Management Advisor, short-term local advisors would be needed to assist in the execution of the TA. Associated costs will include expenses for the conduct of meetings and workshops, provision of per diems to consultants and participants as needed, and transportation and communications costs.

In summary, it is the author's finding that the lack of effectiveness of the MOPHP stems in great part on the government's lack of recognition of the consequential impact of health on development (and vice-versa). The persistent neglect of the MOPHP in terms of resources and the haphazard diffusion of its authorities have produced a disorganized and debilitated ministry. Surfacing and reinforcing the importance of health in development is a critical first step to encouraging (if not compelling) the government to increase resources and enhance powers to the ministry. Unless and until there is convergence between the views of Yemen's government and multilateral and bilateral donors on the urgency of the country's health problems, there is little that can be done that will meaningfully have an impact on the quality of life of Yemenis.

ANNEX 1:

ADDITIONAL QUESTIONS DEVELOPED BY HEALTH SECTOR CONSULTANT TO ASSESS THE EFFECTIVENESS OF THE MINISTRY OF PUBLIC HEALTH AND POPULATION²⁹

I. Health policy formulation and health planning

- Are the roles and responsibilities of the Ministry of Public Health and Population (MPHP) vis a vis local councils clearly defined?
- Does the Ministry have a strategic health plan?
- Is the strategic health plan based on sound technical review of performance?
- Does the health plan define the minimum service package for each level or care?
- Does the health plan define types of health facilities and referral links?
- Does the health plan cover all targets of the MDGs (Reduce Child Mortality, Improve Maternal Health, and Combat HIV/AIDS, Malaria and other diseases)?
- Does the health plan set health service targets for lower health system levels?
- Does the Ministry have an annual operational plan, based on the strategic plan?
- Is the execution of the plan regularly monitored and evaluated against targets?

II. Budget and Finance

- Is there a standard list of user fees by facility level and type of service?
- Are there guidelines or instructions on how to account for and use collected user revenue?
- Is there a clear policy to define which patients or health services are exempt from user fees?
- Is the application of the schedules and exemptions enforced? How?

III. Procurement

1. Purchasing pharmaceuticals

- Are there clear policies on pharmaceutical procurement, such as using an Essential Drugs List or procuring generic, rather than branded drugs?
- Are these policies followed in all drug procurements?
- Is there a process of pre- or post-qualification for drug suppliers during tendering?
- Are procured drugs routinely inspected and tested to ensure acceptable safety, efficacy and quality?
- Is the procurement of pharmaceuticals regular and predictable?

²⁹ Adapted from parts of Islam, M., ed. 2007. *Health Systems Assessment Approach: A How-To Manual*. Submitted to the U.S. Agency for International Development in collaboration with Health Systems 20/20, Partners for Health Reformplus, Quality Assurance Project, and Rational Pharmaceutical Management Plus. Arlington, VA: Management Sciences for Health.

2. Purchasing vaccines

- Are there clear policies on vaccine procurement?
- Are these policies followed in all vaccine procurement?
- Is there a process of pre- or post-qualification for vaccine suppliers during tendering?
- Are procured vaccines routinely inspected to ensure acceptable safety, efficacy and quality?
- Is the procurement of pharmaceuticals regular and predictable?

3. Purchasing contraceptives

- Are there clear policies on contraceptive procurement?
- Are these policies followed in all contraceptive procurement?
- Is there a process of pre- or post-qualification for contraceptive suppliers during tendering?
- Are procured contraceptives routinely inspected to ensure acceptable quality?
- Is the procurement of contraceptives regular and predictable?

4. Purchasing medical equipment

- Are there standard specifications for major medical equipment (e.g. X-ray machines)?
- Are these standards followed in procuring medical equipment?

5. Building and maintaining capital infrastructure

- Are there standards for minimum physical infrastructure for different types of health facilities?
- Are there standards for maintenance of physical infrastructure?
- Are these standards followed in procuring construction of new facilities or maintenance of existing ones?

6. Procuring health care services on contract basis (e.g. laboratory services)

- Does the Ministry procure health care services from public or private service providers on contract basis?
- If yes, how are contract completion and compliance monitored and evaluated?

IV. Audit/accountability

1. Health intelligence

- Are there clear standards and guidelines for collection and reporting procedures for data on:
 - a. Health status,
 - b. Health services,
 - c. Health financing, and
 - d. Human resources?
- Are there clear procedures for verifying the data quality (accuracy, completeness, timeliness)?
- Is there a functioning routine surveillance system?
- Does the Ministry have a sufficient number of qualified personnel and infrastructure to compile and analyze health information and provide regular feedback?
- Does the Ministry produce reports on health sector performance regularly and make them available to the general public and civil society?

2. Regulation and standards

- If the Ministry is responsible for licensing health professionals, are the minimum standards of professional competence clearly defined for each health worker category?
- If unlicensed health workers are discovered, what actions does the Ministry take?
- Is there a functioning system for accreditation or certification of public and private health facilities?
- Is this system enforced in practice to ensure minimum acceptable facility standards?
- Is there adequate regulation to ensure the safety, efficacy, and quality of medicines?
- Are these regulations enforced in practice?
- Are clinical standards, standard treatment protocols and procedures clearly defined?
- If yes, are these standards, protocols and procedures followed in practice?
- Are standards for public health laboratories clearly defined?
- If yes, are these standards followed in practice?
- Does the Ministry have the necessary resources (human, technical, financial) to enforce existing legislation and regulations?

ANNEX 2:

LIST OF PERSONS MET

US Embassy and USAID

Mr. Stephen Seche, US Ambassador
Ms. Angie Bryan, Deputy Chief of Mission
Dr. Mike E. Sarhan, USAID Mission Director
Ms. Salwa M. Sarhi, Team Leader/Democracy and Governance
Dr. Iman Ali Awad, Senior Health Advisor/Team leader
Dr. Susan L. Coleman, Chief of Party, Yemen Partners for Health Reform
Ms. Susan Ayari, Senior Education Advisor
Mr. Abdulhamid N. Alajami, Senior Education Advisor
Mr. Raidan Abdulaziz Al-Saqqaf, Program Manager, Yemen Stability Initiative

Office of the President

Mr. Faris Al-Sanabani, Secretary of the President

Ministry of Education

Prof. Dr. Abdusalam M. Al-Joufi, Minister of Education

Ministry of Finance

Mr. Jalal Omar Yaqoub, Deputy Minister for Foreign Financial Relations
Dr. Saif Al-Asali, Former minister of finance

Ministry of Local Administration

Mr. Abdul-Qadir Hilal, Minister of Local Administration
Mr. Mohammed M. Zemam

Ministry of Planning and International Cooperation

Dr. Mutahar A. Al-Abbasi, Deputy Minister for Development Plans

Ministry of Public Health and Population

Dr. Jamal Thabet Nasher, Deputy Minister for Health Planning and Development
Dr. Jamila Saleh Al-Raiby, Deputy Minister for Population
Mr. Faisal M. Al-Gohaly, Manager, Minister's Office
Dr. Nasser Alahkham, DG Human Resources
Mr. A. Al-Junaid, Deputy DG Personnel, and his staff
Mr. Abdul Kareem Al-Wali, DG Budget and Finance
Mr. Mohammad Ghaleb Al-Makrady, Director of Stores and Procurement and his staff
Mr. Ahmad Moslih, Procurement Officer
Mr. Riyadh Mahyrub, Warehouse Auditor

SNACC

Dr. Saadalddine Bin Taleb, Commissioner

Embassy of the Kingdom of the Netherlands

Ms. Marieke Boot, First Secretary

Mr. Laurens Jacobs, First Secretary, Institutional Development

GTZ

Mr. Habib Sheriff, Senior Programme Advisor

Unicef

Dr. Kamel Ben Abdallah, Health and Nutrition Officer

Ms. Samia Al-Haddad, Program Communication Officer

World Bank

Ms. Afrah Alawi Al-Ahmadi, Senior Human Development Specialist

Ms. Samra Shaibani, Senior Communication Officer

Mr. Ali Alabdulrazzaq, Senior Economist

Mr. Arun Arya, Senior Public Sector Management Specialist

World Health Organization

Dr. Muna Al-Midhwahi, Programs and Training

Local support staff

Mr. Mohammed Al-Asaadi, Local organizer

Mr. Yahya Othman, Translator

ANNEX 3:

PEFA INDICATOR TABLES

TABLE A. YEMEN: SUMMARY PEFA INDICATORS

Adapted for MOPHP from Table A in the EGE report of Carlos de la Torre.

A. PFM-OUT-TURNS: Credibility of the budget		
PI-1	Aggregate expenditure out-turn compared to original approved budget	There is significant deviations between actual expenditure and programmed expenditure at the aggregate and line ministry level
PI-2	Composition of expenditure out-turn compared to original approved budget	There is significant deviations between the composition of actual expenditure and programmed expenditure at the aggregate and line ministry level
PI-4	Stock and monitoring of expenditure payment arrears	The basic accounting and internal control procedures in place are not sufficient to maintain an adequate control of government spending and arrears.
B. KEY CROSS-CUTTING ISSUES: Comprehensiveness and Transparency		
PI-7	Extent of unreported government operations	Extrabudgetary funds and donor funded projects are partially covered in budget documents
C. BUDGET CYCLE		
C(i) Policy-Based Budgeting		
PI-11	Orderliness and participation in the annual budget process	The annual budget process is clear but its strict adherence to a calendar varies.
PI-12	Multi-year perspective in fiscal planning, expenditure policy and budgeting	The preparation of the budget focuses on the fiscal year.
C(ii) Predictability and Control in Budget Execution		
PI-16	Predictability in the availability of funds for commitment of expenditures	Predictability of funds limited by extensive use of unprogrammed expenditures.
PI-17	Recording and management of cash balances, debt and guarantees	Cash and debt management is fragmented.
PI-18	Effectiveness of payroll controls	Inadequate controls over the civil service payroll have contributed to over-employment.
PI-19	Competition, value for money and controls in procurement	Procurement is clear but enforcement is limited.
PI-20	Effectiveness of internal controls for non-salary expenditure	The basic accounting and internal control procedures in place are not sufficient to maintain an adequate control of government spending and arrears.
PI-21	Effectiveness of internal audit	Internal audit is not operational
C(iii) Accounting, Recording and Reporting		
PI-22	Timeliness and regularity of accounts reconciliation	The processes of accounts reconciliation are only partly effective
PI-23	Availability of information on resources received by service delivery units	Information on resources received by service delivery units is partial
PI-24	Quality and timeliness of in-year budget reports	Fiscal information is not timely.
PI-25	Quality and timeliness of annual financial statements	Final audited accounts are made available within twelve months of the close of the fiscal year

TABLE B. YEMEN: DETAILED PEFA INDICATORS

Adapted for MOPHP from Table B in the EGE report of Carlos de la Torre.

Statements assessing Yemen government's performance are in *bold italic*.

1.1 Indicator	1.2 Guidance and assessment
1. Aggregate expenditure out-turn compared to original approved budget	The difference between actual primary expenditure and the originally budgeted primary expenditure (i.e. excluding debt service charges, but also excluding externally financed project expenditure). <i>In two or all of the last three years did the actual expenditure deviate from budgeted expenditure by an amount equivalent to more than 15% of budgeted expenditure.</i>
2. Composition of expenditure out-turn compared to original approved budget	Extent to which variance in primary expenditure composition exceeded overall deviation in primary expenditure (as defined in PI-1) during the last three years. <i>Variance in expenditure composition exceeded overall deviation in primary expenditure by 10 percentage points in no more than one of the last three years.</i>
4. Stock and monitoring of expenditure payment arrears	(i) Stock of expenditure payment arrears (as a percentage of actual total expenditure for the corresponding fiscal year) and any recent change in the stock. <i>The stock of arrears exceeds 10% of total expenditure.</i> (ii) Availability of data for monitoring the stock of expenditure payment arrears. <i>There is no reliable data on the stock of arrears from the last two years.</i>
7. Extent of unreported government operations	(i) The level of extra-budgetary expenditure (other than donor funded projects) which is unreported i.e. not included in fiscal reports. <i>The level of unreported extra-budgetary expenditure (other than donor funded projects) constitutes more than 10% of total expenditure.</i> (ii) Income/expenditure information on donor-funded projects which is included in fiscal reports. <i>Information on donor financed projects included in fiscal reports is seriously deficient and does not even cover all loan financed operations.</i>
11. Orderliness and participation in the annual budget process.	(i) Existence of and adherence to a fixed budget calendar <i>A clear annual budget calendar exists, but some delays are often experienced in its implementation. The calendar allows MDAs reasonable time (at least four weeks from receipt of the budget circular) so that most of them are able to meaningfully complete their detailed estimates on time</i> (ii) Guidance on the preparation of budget submissions <i>A budget circular is issued to MDAs. It includes ceilings for individual administrative units, but it is not clear whether Cabinet is involved before or after MDAs have completed their submissions.</i>

1.1 Indicator	1.2 Guidance and assessment
12. Multi-year perspective in fiscal planning, expenditure policy and budgeting	(iii) Existence of costed sector strategies <i>Statements of sector strategies exist for several major sectors but are only substantially costed for sectors representing up to 25% of primary expenditure OR costed strategies cover more sectors but are inconsistent with aggregate fiscal forecasts.</i> (iv) Linkages between investment budgets and forward expenditure estimates <i>Budgeting for investment and recurrent expenditure are separate processes with no recurrent cost estimates being shared.</i>
16. Predictability in the availability of funds for commitment of expenditures	(i) Extent to which cash flows are forecast and monitored. <i>Cash flow planning and monitoring are not undertaken or of very poor quality.</i> (ii) Reliability and horizon of periodic in-year information to MDAs on ceilings for expenditure commitment <i>MDAs are able to plan and commit expenditure for at least six month in advance in accordance with the budgeted appropriations.</i> (iii) Frequency and transparency of adjustments to budget allocations, which are decided above the level of management of MDAs. <i>Significant in-year budget adjustments are frequent and not done in a transparent manner.</i>
17. Recording and management of cash balances, debt and guarantees	(i) Quality of debt data recording and reporting <i>Domestic and foreign debt records are complete, updated and reconciled quarterly. Data considered of fairly high standard, but minor reconciliation problems occur. Comprehensive management and statistical reports (cover debt service, stock and operations) are produced at least annually.</i> (ii) Extent of consolidation of the government's cash balances <i>Most cash balances calculated and consolidated at least weekly, but some extra-budgetary funds remain outside the arrangement.</i> (iii) Systems for contracting loans and issuance of guarantees. <i>Central government's contracting of loans and issuance of guarantees are made within limits for total debt and total guarantees, and always approved by a single responsible government entity.</i>
18. Effectiveness of payroll controls	(i) Degree of integration and reconciliation between personnel records and payroll data. <i>Integrity of the payroll is significantly undermined by lack of complete personnel records and personnel database, or by lacking reconciliation between the three lists.</i> (ii) Timeliness of changes to personnel records and the payroll <i>Delays in processing changes to payroll and nominal roll are often significantly longer than three months and require widespread retroactive adjustments.</i> (iii) Internal controls of changes to personnel records and the payroll. <i>Controls of changes to records are deficient and facilitate payment errors.</i> (iv) Existence of payroll audits to identify control weaknesses and/or ghost workers.

1.1 Indicator	1.2 Guidance and assessment
	<i>Partial payroll audits or staff surveys have been undertaken within the last 3 years.</i>
19. Competition, value for money and controls in procurement	<p>(i) Use of open competition for award of contracts that exceed the nationally established monetary threshold for small purchases <i>Insufficient data exists to assess the method used to award public contracts OR the available data indicates that use of open competition is limited.</i></p> <p>(ii) Justification for use of less competitive procurement methods <i>Other less competitive methods when used are justified in accordance with regulatory requirements.</i></p> <p>(iii) Existence and operation of a procurement complaints mechanism <i>No process is defined to enable submitting and addressing complaints regarding the implementation of the procurement process.</i></p>
20. Effectiveness of internal controls for non-salary expenditure	<p>(i) Effectiveness of expenditure commitment controls. <i>Commitment control systems are generally lacking OR they are routinely violated.</i></p> <p>(ii) Comprehensiveness, relevance and understanding of other internal control rules/ procedures. <i>Other internal control rules and procedures consist of a basic set of rules for processing and recording transactions, which are understood by those directly involved in their application. Some rules and procedures may be excessive, while controls may be deficient in areas of minor importance.</i></p> <p>(iii) Degree of compliance with rules for processing and recording transactions. <i>Rules are complied with in a significant majority of transactions, but use of simplified/emergency procedures in unjustified situations is an important concern.</i></p>
21. Effectiveness of internal audit	<p>(i) Coverage and quality of the internal audit function. <i>There is little or no internal audit focused on systems monitoring.</i></p> <p>(ii) Frequency and distribution of reports. <i>Reports are issued regularly for most government entities, but may not be submitted to the ministry of finance and the SAI.</i></p>
22. Timeliness and regularity of accounts reconciliation	<p>(i) Regularity of bank reconciliations <i>Bank reconciliation for all Treasury managed bank accounts takes place at least monthly, usually within 4 weeks from end of month.</i></p> <p>(ii) Regularity of reconciliation and clearance of suspense accounts and advances <i>Reconciliation and clearance of suspense accounts and advances take place annually in general, within two months of end of year, but a significant number of accounts have uncleared balances brought forward.</i></p>

1.1 Indicator	1.2 Guidance and assessment
23. Availability of information on resources received by service delivery units.	<i>Special surveys undertaken within the last 3 years have demonstrated the level of resources received in cash and in kind by either primary schools or primary health clinics covering a significant part of the country OR by primary service delivery units at local community level in several other sectors.</i>
24. Quality and timeliness of in-year budget reports	<p>(i) Scope of reports in terms of coverage and compatibility with budget estimates <i>Comparison to budget is possible only for main administrative headings. Expenditure is captured either at commitment or at payment stage (not both).</i></p> <p>(ii) Timeliness of the issue of reports <i>Quarterly reports are either not prepared or often issued with more than 8 weeks delay.</i></p> <p>(iii) Quality of information <i>There are some concerns about the accuracy of information, which may not always be highlighted in the reports, but this does not fundamentally undermine their basic usefulness.</i></p>
25. Quality and timeliness of annual financial statements	<p>(i) Completeness of the financial statements <i>A consolidated government statement is prepared annually. Information on revenue, expenditure and bank account balances may not always be complete, but the omissions are not significant.</i></p> <p>(ii) Timeliness of submission of the financial statements <i>The consolidated government statement is submitted for external audit within 10 months of the end of the fiscal year.</i></p> <p>(iii) Accounting standards used <i>Statements are presented in consistent format over time with some disclosure of accounting standards.</i></p>

ANNEX 4:

LEGISLATION GOVERNING THE HEALTH AND POPULATION SECTOR

Laws

- Althawra Hospital 13-85
- Civil Service 04-91
- Government's Tendering and Bidding Procedures 09-93
- Private Health Establishments 60-99
- Financial law 01-99
- Local Authority 04-00
- Medical Council 28-00
- Practice of the Medical and Pharmaceutical Professions 26-02
- Structure of Work, Allowances and Salaries 43-05

Republican Decrees

- High Institution of Drugs and Medical Equipment 231-99
- Yemeni Council of Medical Specialties 20-03
- High Institutes of Health Sciences 324-03
- Regulatory Bylaw of the Ministry of Public Health and Population 76-04
- National Centre for Blood Transfusion and Research 85-05
- National Centre for Public Health Laboratories 246-05

Prime Minister's Decrees

- Bylaw of abroad medical therapy for civil servants 01-98
- Drug Fund 332-00
- Executive bylaw to the Law of Private Health Establishments 132-04
- Modification of Decree "132-04", 269-04
- Industry and Trading of Drugs, Medical Equipments and Others 333-04

ANNEX 5:

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- Yemen's Strategic Vision 2025.*

ANNEX 6:

PREVIOUS RECOMMENDATIONS FOR HEALTH REFORMS

Fairbank Alan. *Public Expenditure Review, Health Sector, Republic of Yemen, 1999-2003*. April 2006.

4.2.1 Level and Composition of Spending on Health

Current operating budgets should be raised considerably, particularly for maintenance, and investment budgets should be reduced. Overall, the level of government spending should be raised as a share of total government spending, but only after the development of a plan to match the increased budgets to identified needs has been developed. The investment budgets should reduce the current focus on buildings and equipment, and, instead, should focus on training of health personnel, particularly non-physicians.

4.2.2 Program and Investment Planning

Program planning processes (at all levels) need to be linked to budgeting decisions, with enhanced accountability for spending. At the same time, budget expenditures need to be linked to sector functions and to progress toward desired program results. New investments in buildings and equipment should be made only if needed staffing and operating budgets are available (MoPHP promises should be documented)—to apply also to Local Councils' building. Any new investment program should be preceded by a *master plan* that includes both a comprehensive examination of current needs versus current capacities (in terms of facilities, equipment, and staff) and also a national plan for infrastructure development that relates human resource and physical plant expansion with needed operating and maintenance budgets that are financed by a commitment of the necessary resources by the MoF, MoPIC, and international donors.

4.2.3 Cost-sharing and Cost-recovery

By-laws and guidelines for collection and allocation of payments for services and drugs need to be made consistent. Policies on exemptions from fees, and locus of responsibility for granting them, need to be clarified. Responsibility for implementing clarified policies, and accountability for doing so, needs adequate enforcement. A study of the level of fees/charges, and of their uses and relationships to other financing sources, is needed. In view of the current lack of clarity in these areas (fees for services, charges for drugs, exemptions, collection and allocation of revenues), large financing reform initiatives, e.g., health insurance, should be approached with extreme caution, and, in any event, should be preceded by exhaustive studies and collection of needed data on the medical and financial risks currently faced by the population due to injuries and sickness.

EU SAR project consultant reports:

Shami, Ahmed. *Review of Human Resources Management Legislation and Current Practices.* November 2005.

1. To review and revise the current HR management system and policy and provide an effective, efficient and high quality HR management system which are necessary to enable public sector entities to perform their function and guarantee effective implementation of the civil service legislation and regulations.
2. Design efficient and effective procedures for selection, promotion, performance, and provide clear standards for job analysis and job description.
3. For human resource management, there is a need for a clear and publicized code of conduct to reinforce and highlight fundamental values and show specifically how to apply them to each ministry and organizational unit of the public service.
4. There is a need to establish a disciplinary system which can guarantee both, a fair hearing and disciplining of public officials, and the development of the civil service which embodies high standards of integrity and conduct.
5. There is a need for a job classification system, and the government should introduce and ensure that recruitment and promotions based on merit and stop the political interference in the civil service.

Rosenow Diana. *Strengthening of M&E and MIS at the Ministry of Public Health and Population, Sana'a, Republic of Yemen.* November 2005.

4.1 HMIS Technology

- The MoPHP suffers overall from a lack of computer equipment, as per SAR survey. All departments should be equipped at least with up-to-date computer technology, which allows for Internet access as well. For further details please request the results of the SAR survey. Since a strong collaboration with the World Bank project is envisioned, the relevant equipment should be purchased as per identified needs under the World Bank project.
- The MoPHP should have a complete LAN system established, so that relevant information can be accessed immediately by every department
- Information from the governorates to the MoPHP should be transferred by email only – WAN is not recommended!
- The database should probably be based on ACCESS or Excel. This needs to be piloted.

4.2 MoPHP

Within the Ministry the division of tasks should be restructured and capacities should be strengthened in order to enhance effectiveness and efficiency of data collection analysis and the use of information. The following entities need to be considered:

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4.2 MoPHP

Within the Ministry the division of tasks should be restructured and capacities should be strengthened in order to enhance effectiveness and efficiency of data collection analysis and the use of information. The following entities need to be considered:

a) Independent IT Department

ToR:

- Establishment and maintenance of full LAN and computer equipment in MoPHP, (in line with structures already existing in Lahj and Taiz)
- Support to various departments in use of applications and data access
- Maintenance of database (regular backup)
- Conducting regular computer application courses for MoPHP staff (in depth courses in Excel and Access – each at least 10 day courses a 2 hours)

b) General Directorate of Information and Research

ToR:

- Emphasis on data quality and follow-up of reports submitted
- Cleaning/verification of data
- Production of monthly/quarterly/annual reports as per defined output (please note that access to reports is ensured through LAN)
- Conduction of research as per organizational bylaw

c) DG Planning

ToR:

- Monthly monitoring of information
- Feedback to respective DGs at MoPHP and Governorates
- Identification of bottlenecks and definition of strategies, initiation of solutions
- Overall stronger managerial responsibility in line with objectives of 5-Y-Health plan
- Further development of strategic 5-Y-Health Plan, with clearly defined indicators.
- Development of annual operational plans for the next 5 years

It is suggested to strengthen this DG to become a driving force in efficient management, through information-led strategy formulation and close monitoring of implementation. Strong collaboration with all other departments required (in line with focus areas of 5 Year Plan).

Suggested staffing: Director General, one person with MBA and experience in strategic planning and development of operational plans, one health economist (Staffing could be supported by World Bank (as per initial discussions with Dr. Adulsalam Akal and the change in ToR for LATH). It is recommended to expand the ToR according to the current recommendations.

4.3 Streamlining Data Collection with MoPHP

To ensure that data collection tools reflect the local information needs a revision of the same in close collaboration with all stakeholders is advised. Generally, information needs have to be streamlined with those of the MoPHP, and **ownership** has to be **created** at the **MoPHP** in order to ensure sustainability of the system after project completion. For this purpose it is recommended to conduct a workshop with the key stakeholders at the MoPHP with the objective to **identify relevant indicators** and to establish a common database. For this purpose a close collaboration between the EC funded Support to Administrative Reforms Programme (SAR) and the HSDS Programme has to be sought. Further it is advisable to **harmonies** the efforts undertaken by various **donors** in the field of HMIS development in order to establish a system, which reflects the information needs of the donor community as well. Special attention should be paid in this regard to WHO, UNICEF, UNFPA, and World Bank. An initial identification of indicators has taken place in workshops conducted with staff at the GHO Lahj and Taiz. Unfortunately is the demand on the rather precious time of key stakeholders due to the various donor requirements quite high, so that it was difficult to work in depth on the identification of relevant indicators. Still the first round of workshops has brought out results.

New data collection tools should be piloted in two districts each in Lahj and Taiz in line with the HSDS. The trial phase should last for six months. Only after completion and evaluation of the trial phase overall implementation of new data collection tools should be done.

4.4 Improving Data Quality

It should be the overall objective to reduce the amount of data collected and rather focus on **improving the quality of data**. For this purpose extensive training should be conducted for the staff responsible for data collection, verification and data entry. The strengthening of the current **monitoring and supervision system** should be at the core of this exercise. A close collaboration with the UNICEF and UNFPA projects should be sought in this respect. It has to be noted, that the commitment of staff filling in the registers and forms can only be gained and maintained if there is a response to the reports submitted, e.g. that drugs are supplied according to the request submitted or that equipment is repaired or replaced accordingly. Without an appropriate reaction to the data submitted staff will lose soon interest in data quality.

4.5 Vital Statistics

The possibility to strengthen the collection of vital statistics through the involvement of community midwives should be discussed between MoPHP and donors. Community midwives may receive a monetary incentive per month for submitted reports covering births and deaths occurring in the community. For further monitoring of data quality the community involvement through sheikhs, etc. might be envisioned. All to be piloted under HSDS with support from UNICEF and UNFPA.

4.6 Main Elements of HMIS and Indicators

The various efforts undertaken by donors to strengthen and develop an HMIS, which is relevant for decision-making, are valuable and should be incorporated into the overall HMIS. Therefore it is recommended to incorporate aspects of the health facility survey into the routine data collection, e.g. drug supply, HR, finances (community financing), maintenance and repair of infrastructure and equipment as mentioned above. This equally holds true for the hospital information system, which is already well developed and relevant components of it should be incorporated into the general

HMIS. Overall it should be tried to support the implementation of the HIS in other district hospitals in Lahj and Taiz, wherever computers, electricity and staff are available. With regard to the monitoring tool developed under the EC project various components of the same should be incorporated into the general HMIS.

4.7 Prerequisites for Meaningful Data Collection and Use of Information

The effectiveness of a HMIS depends on the formulation of clear policies, which need to be approved via a ministerial decree prior to the development of data collection tools. In particular it is required to define HR and equipment keys for all levels, leading to staff development, maintenance, repair- and replacement plans in the broader framework of the 5-Year Health Plan. The 5-Year Health Plan needs to be completed with proper key indicators according to priority areas, and operational plans need to be developed according to identified focus areas

Survey Report on the Situation of Information Technology at the MoPHP, December 2005.

1. Establish an IT department at the MoPHP to be responsible for ICT maintenance and support service as well as promoting ICT culture and policy at the MoPHP

1.1 Determine and endorse the Tasks / functions / structure of the department,

1.2 Train IT professionals – if necessary

1.3 Recruit (additional) staff, provide premises and budget

2. Formulate strategic issues and operational steps to promote ICT Culture

2.1 Develop an institutional ICT Strategy

2.2 Develop an ICT Action Plan based on the Strategies

2.3 Optimize and follow ICT Processes

2.3.1 Develop, consent, endorse and establish a procedure for ICT to enhance distribution and accessibility of Computers amongst Directorates and within Departments

3. Ensure supply of ICT equipment & software (incl. UPS)

3.1 Define the needs

3.2 Secure funding

3.3 Procurement & Installation

4. Enhance ICT Skills

4.1 Define priority staff groups

4.2 Prepare and consent Training activities:

4.3 Identify training supplier / arrange training

5. Establish a MoPHP Computer Network