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Evaluation of the Basic Development Needs Programme in the Republic of Yemen

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Foreword

Health has been widely recognized as a central input into economic development and better lifestyle. Similarly, improved economic prospects help foster other essential life requirements leading to an improvement in the health status of people. This logical association between health and socioeconomic development is clearly defined in the Basic Development Needs (BDN) concept and forms its core strategy for attaining a better quality of life.

The integrated BDN approach has been devised so that its embedded principles, including active community participation and intersectoral collaboration, not only aim at quantifying results of activities, but also build local capacities for sustaining the development process.

With this goal in mind, in 2000, the BDN process in Yemen was embarked upon jointly by WHO and the Ministry of Public Health and Population as a pilot scheme. Since then the programme has experimented with the relationship between health and socioeconomic development, using its various tools and guidelines. It has covered a wide range of social and income-generating activities in 10 governorates of the country.

Evaluation is an important part of project management as it helps to infer valid conclusions and feedback for informed decision-making. During the five-year lifespan of the BDN programme in Yemen, checks and balances, as well as measurement of progress were mostly carried out through the inbuilt monitoring mechanisms of the approach. An in-depth analysis of the programme, including its processes and outcomes, was already envisaged as a means for boosting strengths and correcting errors. The evaluation process also aimed at documenting the BDN experience and generating a pool of relevant data for programme advocacy.

Taking into consideration the objectives of the evaluation process, the current evaluation report has scrutinized various components of the BDN programme in different areas in Yemen, put together all pertinent information and drawn valid conclusions. At the end of the report, the objectives of the evaluation exercise have been spelled out in the form of feasible and pragmatic recommendations.

I hope this evaluation report serves its objectives and plays its role in consolidating the BDN programme at the country level and also, as a Yemeni BDN experience, contributes to the improvement of the process in other countries of the Eastern Mediterranean Region.

Dr Hashim Ali Elzein El-Mousaad
WHO Representative, Yemen

Executive summary

The basic development needs (BDN) approach to sustainable community development has been applied in a number of demonstration areas since 2000 under the umbrella of the World Health Organization (WHO) and with the support of the Ministry of Public Health and Population and the collaboration of other ministries. The programme currently is implemented in 10 governorates of the Republic of Yemen covering a total population of approximately 86 000 people.

To get a better understanding of the status of BDN programmes in countries of the Eastern Mediterranean Region, WHO Regional Office for the Eastern Mediterranean decided to undertake detailed evaluation of the programme. The experiences of the BDN programme evaluation in Djibouti, Jordan, Pakistan and Sudan encouraged the continuation of the process and the evaluation of the BDN programme of Yemen was carried out in order to assess the implementation process and outputs of the programme.

The evaluation took place from 15 March to 5 April 2005. It involved most of the authorities related to the BDN programme at national, intermediate and local levels, including community representatives and beneficiaries. A total of 14 out of 17 well established BDN areas in 9 governorates were visited (82%). Evaluation guidelines and tools developed by the Regional Office were used. Also, different data collection methods were employed including individual and group interviews, a review of records and observations.

Generally, the programme was found to be well organized with the required BDN structures in place in all areas. The national authorities at all levels have been committed in supporting the implementation of the programme. The programme has limited partnerships with other organizations and development agencies although a great many, as yet untapped, potential partners exist and are willing to cooperate.

The programme has had considerable effect in improving health, social and economic indicators resulting in the increase in school enrolment, better literacy rate in women, higher immunization coverage, decrease in infant deaths and low birth weight, besides increase in the income of the direct beneficiary families of the BDN income-generating activities.

A number of improvement measures were recommended, focusing on capacity-building, improved management skills and strengthening intrasectoral coordination, intersectoral collaboration and partnership building.

Introduction

Community-based initiatives

Since the 1980s the WHO Regional Office for the Eastern Mediterranean has been advocating poverty reduction as the most potent strategy to facilitate equitable development for achieving health-related goals. The strategy is consistent with the high priority given to this area of work on the agenda of most international development agencies for achieving the Millennium Development Goals. This is based on the realization that ill health and poverty are mutually reinforcing. In order to have a real impact on the quality of life and achieve substantial and sustainable health gains, it has been considered essential to address all determinants of health and to support individuals, families and communities to attain self-sufficiency and self-reliance through integrated and comprehensive socioeconomic development. In support of this strategy, the Regional Office is actively promoting, among the countries of the Region, community-based initiatives such as the basic development needs (BDN) approach and healthy city, healthy village and women in health and development programmes.

The common goal of these approaches is to create political, physical and economic policies and action plans for all community segments that will produce positive impact on overall environment and quality of life. Since the inception of these initiatives, the majority of the countries of the Region have adopted different schemes and approaches, which are currently at various stages of development.

All community-based initiatives have the common objective of health for all through health and other development interventions. The BDN and healthy village schemes are implemented primarily in rural areas following common objectives, structures and processes. The healthy city programme operates in urban settings, especially in underprivileged suburbs, for improving environmental conditions and bringing health onto the local development agenda. The women in health and development initiative is implemented through existing structures of community-based programmes which have established women's organizations and committees.

Community-based initiatives also try to facilitate integration of health policies and programmes into national development agendas. They aim to improve health and environmental conditions, reduce poverty and achieve better quality of life through active participation of the community, supported by intersectoral cooperation and partnership. The work is focused on promoting equity, especially within the human rights perspectives, gender mainstreaming and enhancing the role of women in health and development.

The research and development approach assists in problem analysis, formulation of appropriate solutions, revising strategies, improving methodologies and developing the future vision of a country programme.

Experiences around the world have shown that, in addition to providing health services to communities, environmental factors and lifestyles are also crucial for health and sustainable development. An increased level of education and awareness in women assists in the reduction of mortality in mothers and children, enhances nutrition and promotes the practice of family planning methods. That is why the Regional Office promotes the concept of community-based initiatives and provides assistance for the implementation of the programmes in different countries of the Region.

The BDN approach

BDN is a strategy that aims at achieving a better quality of life for people and the goal of health for all is its central area. It is a process of integrated socioeconomic development based on active community participation, promoting self-reliance through self-health, self-financing and self-management. It also provides a practical mechanism for intersectoral collaboration.

Health cannot be achieved in isolation, since many of its determinants are outside the domain of the health system. These determinants include education, housing, income, clean water, sanitation, nutritious food and security. Experience around the world has shown that literacy and income are significant factors in reducing morbidity and mortality of mothers and children.

Environmental factors, including housing, water and sanitation, as well as other social and economic factors, are crucial to the improvement of health and hence contribute to sustainable development.

The BDN strategy benefits communities through:

- reducing morbidity and mortality especially among women and children;
- improving health status through increased family income and self-care;
- promoting equity and healthy lifestyles;
- promoting community involvement and ownership;
- encouraging decentralization and self-reliance;
- reducing the financial burden on the government by contributing to the socioeconomic development of the country;
- alleviating poverty and improving the quality of life.

BDN interventions

BDN interventions are in the form of health, social or economic and microcredit interventions. BDN health interventions focus on the following areas:

- strengthening delivery of integrated primary health care programmes;
- integrated management of childhood illness (IMCI);
- support to immunization programmes;
- promotion of healthy lifestyles and healthy settings;
- tuberculosis management through directly observed therapy short-course (DOTS) approach;
- primary eye care;
- promotion of nutrition and breastfeeding practices;
- reproductive health;
- roll back malaria (RBM);
- no smoking campaigns (Quit and Win);
- health education;
- support to curative services including provision of essential drugs;
- fostering school health programmes.

In the social sector, the following are considered as priority social interventions for BDN:

- women's empowerment activities;
- literacy centres and adult education programmes;
- support to basic education and encouraging enrolment in schools (especially for girls);
- promotion of introducing appropriate technologies;
- provision of safe drinking-water and the improvement of sanitary conditions;
- substance abuse rehabilitation;

- ensuring food security through agricultural awarenes and activities;
- vocational training centres and human skills development;
- promotion of cultural activities and encouragement of the establishment of community libraries;
- youth development;
- identification of the handicapped and response to their needs.

The BDN approach considers microcredit interventions as complementary activities to other social and health ones. The following are examples of some of this type of project:

- livestock and dairy development (milking animals, fattening calves, sheep and goat farming, etc.);
- cottage industries (wooden furniture, tool manufacturing, candle making, blacksmiths, mechanics, etc.);
- small trades (grocery shops, animal feed and fertilizer, stationary stores etc.);
- women's industries and home vocations (embroidery, knitting, glass and fabric painting, artificial flowers, handbags, etc.);
- fisheries, family poultry, agriculture (tube wells, water pumps, improved seeds, fertilizers and pesticides, new crops, fruit gardens, kitchengardening, packaging and marketing, etc).

Yemen health profile

The health status of Yemen is poor and the health system performance is weak. There is dissociation between the demographic, epidemiological and health transitions, and the health sector's vision, governance and management. In 2000 Yemen ranked 141st of 191 countries worldwide for the level of health.[1] Furthermore, Yemen lags far behind when compared to other countries of the Eastern Mediterranean Region in terms of development, including health indicators. In 2002 Yemen's human development index was 0.45 in contrast to the regional average of Arab States of 0.64.[2]

Total health expenditure was estimated at 4.5% of the gross domestic product, per capita, which was equivalent to US$ 69. Governmental expenditure accounted for a modest 34% of total expenditure on health, and out-of-pocket expenditure accounted for 89% of private expenditure.

Yemen adopted primary health care in 1978, with the aim of covering the entire population by 2000. Currently, primary health care coverage reaches only about 30% of the population in rural areas and 45% of the population overall. Besides the public health sector there is a significant and largely unregulated private health sector. Official and unofficial fees are charged for health services and the frequent unavailability of drugs in public facilities forces patients to seek the prescribed drugs in the private pharmaceutical sector. Low coverage by public services, combined with user-payments and widespread poverty, poses significant barriers and inequities of access across geographical areas and population groups.

There have been some improvements in the past decade. For example, life expectancy at birth in Yemen is estimated at 60.4 years (2002), an increment of 14 years over the past two decades. However, it is still below the average of 63 years for developing countries. Infant and child mortality has not changed over the past decade with estimates of 2003 comparable to 1997 and 1992 at around 80 for infant mortality and 105 for child mortality. This is expected given the stagnant health and nutritional status of children.

The total fertility rate declined from 7.8 to 6.5,[3] while modern contraceptive use has almost doubled over the same period, although at 13.4% it is still modest.[4] Maternal mortality ratios have not changed over the past decade (351 per 100 000 live births), which might be explained by the fertility rates, especially high-risk pregnancies and low attendance by skilled health workers.

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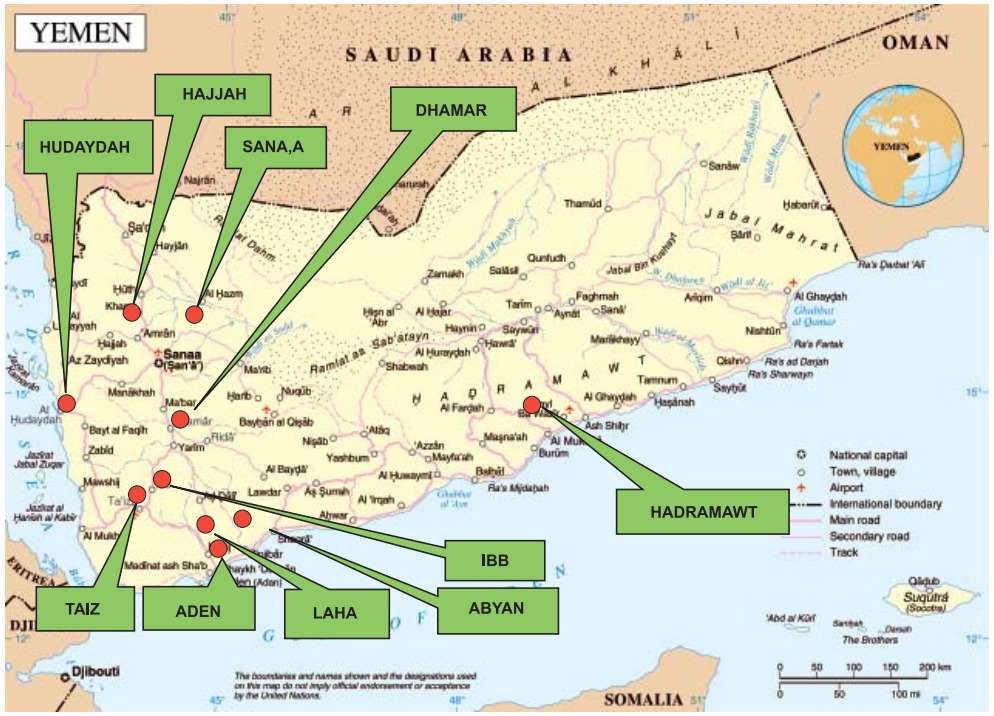
1 World Health Report 2000. World Health Organization, Geneva, 2000.
2 Human Development Report 2002. United Nations Development Programme, New York, 2002
3 Demographic and Health Surveys Pan Arab Project for Child Development. DHS/PAPCHILD, 1992, and Pan Arab Project for Family Health Survey, PAPFAM, 2003
4 Yemen Demographic and Maternal and Child Health Survey. World Bank 2003

Although immunization coverage for target diseases of the expanded programme of immunization has increased modestly in the last few years less than 70% of infants are fully immunized by the age of one year. A coverage survey conducted in July 2004 showed disturbingly low coverage in some districts of less than 50% of the surveyed children. Across all indicators there are large differences between rural and urban areas, between different governorates and districts, and between different income levels, with varying effects.

The BDN programme in Yemen

In Yemen, the BDN approach for sustainable community development has been pursued since 2000, under the umbrella of WHO and with support from the Ministry of Public Health and Population and collaboration of other ministries. A number of demonstration BDN areas were established as the pilot phase. At present, the programme is implemented in 10 governorates of the country, covering a total population of around 86 000 people.



Map 1. Governorates where the BDN programme is implemented

BDN evaluation in Yemen

To obtain a better understanding of the BDN programmes and their progress in the Region, the Regional Office decided to undertake detailed evaluation in countries implementing the programme. During the past few years, the BDN programmes in Pakistan and Sudan, the quality of life programme in Jordan and the BDN programme in Djibouti were evaluated. It has been widely appreciated that the process should be continued and further extended to other countries where the programme has attained a sufficient level of maturity, so that strategic and evidence-based feedback is available for programme expansion.

Evaluation of the BDN programme in Yemen was conducted to examine the following key factors:

- whether the programme can achieve the goals and outcomes it planned at the outset and is being implemented in accordance with the prescribed principles and criteria;
- whether it offers a mechanism for improving the health and well-being of individuals and communities, facilitating the process of overall human development;
- whether it is being used to define and gain a better understanding of principles of the BDN approach;
- whether it can build and provide a resource of common knowledge and experience to other development programmes.

Objectives of the evaluation

The overall objective of the BDN evaluation was to assess the processes and outputs of implementation, and review potential for further programme expansion and institutionalization in the health and development sector. The specific objectives of the evaluation were to:

- appraise the BDN structures, programme management, political commitment and partnership;
- analyse the BDN implementation processes and outputs and monitor progress;
- assess the changes in health and other socioeconomic status in programme areas;
- identify the lessons learned, the major constraints and concluding feasible recommendations and corrective measures for the course and strategic direction of the programme in the future.

Components of the evaluation

The evaluation of the BDN programme assessed the organization, implementation process, project activities and outputs and the sustainability of components of the BDN programme activities as follows.

Organization of BDN

- political commitment, such as the extent and nature of government support, linkages with the national development plans and ownership;
- available structures for BDN in the country (level, composition with gender perspective and responsibilities);
- partners and the nature of their engagement;
- advocacy and promotional strategies and their relevance to programme objectives;
- resource mobilization and allocation.

Implementation processes

- training activities, i.e. the types, resources, materials and target groups, etc.;
- intersectoral collaboration (orientation, composition, roles and responsibilities);
- community mobilization (awareness, organization, role and responsibilities with the perspective of gender equity);
- financial management (operational arrangements, loan disbursement, recovery mechanisms, etc.);
- supervision and monitoring;
- the extent and nature of the documentation.

Project activities and outputs

- total population covered;
- project profiles (types and numbers, beneficiaries, linkages with BDN objectives, the amount invested, the share of WHO, the government, the community and others, and the percentage of loans recovered, as well as direct and indirect beneficiaries);
- ways and means of social and income-generating projects addressing health with special focus on reproductive health, expanded programme on immunization, nutrition, water and sanitation, communicable diseases,especially those related to poverty such as, tuberculosis, malaria, acquired immunodeficiency syndrome (AIDS), and healthy lifestyles;

- outputs and activities of other social sectors including education, both formal and informal, the role of women as partners and addressing their practical and strategic needs, youth development, community empowerment, vocational training, social harmony and solidarity; economic growth and income generating to alleviate poverty.

Sustainability

- the extent at the initiation stage and the present status;
- the appropriate technologies introduced;
- the degree of self-reliance and self-management achieved.

Methodology of the evaluation

The evaluation was conducted by using a framework developed by the Regional Office. This framework ensures that experiences between different countries of the Region can be compared. However, the proposed framework was slightly modified to suit the local situation.

An international consultant was recruited and assisted by a team of two experts (the BDN expert for Yemen WHO country office and the BDN national coordinator). They jointly carried out the evaluation while the Regional Office and WHO country office, together with authorities in the Ministry of Public Health and Population, assisted in coordination and organizational aspects.

The programme sites that had completed 5 years since implementation or had gained a sufficient level of maturity[5] were subjected to evaluation. The required data were collected through questionnaires, direct interviews, focus group discussions and a review of the documents available in the local BDN offices, Ministry of Public Health and Population, and WHO.

[5] **Maturity:** 1. all programme processes are completed i.e. baseline survey done and data analysed; 2. training of community, intersectoral team and other stakeholders took place; 3. community structures such as cluster representatives, village development committees, women's groups, youth groups are in place and actively involved in programme planning and implementation; 4. socioeconomic projects are under implementation and progress is well monitored by the community; 5. community is well aware of the importance of health in development.

Study area and population

The study area covered all the BDN programme authorities at national, intermediate and local levels including the community representatives and some randomly selected beneficiaries of social and income-generating interventions (see Table 1). Only Hadramawt governorate BDN area was excluded from evaluation because of distance and time constraints in addition to the immaturity of the programme. One BDN area in Dhamar Governorate was also excluded for security reasons. Altogether 14 BDN areas in nine governorates were visited (82%).

Table 1. The BDN areas visited by the evaluation team

Governorate	District	BDN area
Aden	Al-Buraiqa	Fuqum
Abyan	Khanfer	Abr Osman
Lahaj	Tuban	Al-Feush
Taiz	Al-Tazia	Sha'abania Ulia
		Janadia Sofla
Ibb	Ibb	Al-Yahari
		Ozlat Al-Raoss
Dhamar	Al-Maifa'a	Kherbat-Afiq
	Dhamar	Mangaza
Hodeidah	Al-Marawa'a	Kashuba'a
	Hodeidah	Mandhar
Hajjah	Mabean	Al-Gazaf/Al-Gaila
Sana'a	Bani-Hushaish	Bait-Al-Sayed
	Bani-Matar	Waqash

Results and findings

Organization

The central office of the BDN programme at national level is run by one full-time national coordinator who is assisted technically by a BDN expert at the WHO Representative's Office, which is situated within the premises of the Ministry of Public Health and Population. The WHO Office in the country provides all the required financial and administrative assistance to the BDN office and coordinator. Table 2 shows the organization of the BDN programme in Yemen.

At the governorate level, the programme has a full-time coordinator and a multisectoral team representing mainly health, education, social affairs and agriculture. Only two governorates that were visited by the evaluation team, Aden and Lahaj, had no Technical Support Team (TST). Also, in a few other places the functions of those teams were found to be minimal.

Table 2. Organizational structure of the BDN programme in Yemen

Level	Management structure
National	National BDN coordinator
Governorate	Governorate level BDN team: BDN coordinator and intersectoral TST in eight governorates
Community	Village development committee and cluster represen-tatives in 23 communities

At the community level, the BDN programme has successfully established village development committees responsible for overall programme planning and supervision. Women's representation in village development committees is absent in many areas, except for Abr Osman in Abyan, Al-Feush in Lahaj, Bait Al-Sayed in Sana'a and Kherbat-Afiq in Dhamar.Most of the village development committees visited were found to be active and organized with clear understanding of their roles and responsibilities. However in a few village development committees (Fuqum in Aden governorate and Kherbat-Afiq in Dhamar governorate) some members were not active and their understanding of the BDN concept and operational procedures was found to be weak. This has had a negative affect on the overall performance of the programme in the respective areas.

At the household level, all BDN areas visited were organized into clusters and each cluster had a cluster representative. The latter were active only during needs assessment surveys and nominating beneficiaries for income-generating activities. Otherwise, they had no other programme-related functions. Most of the cluster representatives were male. Only two women's associations were found in Kherbat-Afiq in Dhamar governorate and Bait Al-Sayed in Sana'a governorate. They were active and had women's skill development centres.

Political and policy commitment

The BDN programme in Yemen enjoys a high degree of political commitment on all levels of programme implementation. The health offices in all governorates have adequate knowledge about BDN programme activities and provide all the required support and facilities. This is either technically, through provision of staff and equipment for support of health facilities, or through provision of trainers for various health activities and programmes.

In many instances the authorities expressed a desire to expand the programme to reach other needy areas within the same district or governorate. This desire shows that they acknowledge the benefits the communities receive through implementing the BDN programme.

In further acknowledging the value of BDN, the Director General of Health in Abyan governorate stated that BDN, besides its health and social interventions, provided them with effective tools for bottom-up planning, intersectoral action and providing information at the village level.

The active participation and collaboration of other government sectors and their valuable contribution through their related activities in BDN areas is another explicit example of commitment. As part of its commitment to the BDN programme, the central Ministry of Public Health and Population regularly supports the running cost of the technical support teams in all governorates.

Partnership

One of the noticeable features of the BDN programme in Yemen is the limited number of partnerships with other organizations and development agencies, except for the governorate of Taiz where the BDN coordinator took the initiative of advocating for the programme in all available forums. As a result of this the Governor requested all organizations and agencies working in the governorate to build partnerships with the BDN programme and to support its activities.

Meetings held with Social Fund for Development and other agencies during the course of the evaluation, reflected the existence of a great many potential partners who expressed their willingness and readiness to cooperate with the programme (see Table 3).

Table 3. Identified BDN partners

Partner	Nature of the contribution
BDN Community	Financial and material
WHO, Ministry of Public Health and Population	Technical and financial
Gesellschaft für Technische Zusammenarbeit (GTZ)	Financial support for education
WHO Regional Centre for Environmental Health Activities (CEHA)	Technical and financial support for sanitation
Netherlands Development Organisation (SNV)	Vocational training
World Bank	Technical and financial support for water supply and sanitation in rural areas

Promotion and advocacy

As part of the promotion and advocacy efforts for the BDN approach, a number of measures were adopted. These included:

- organization of several national and governorate level orientation workshops for the government authorities, United Nations agencies and other potential partners;
- orientation sessions with various officials and development partners;
- field visits to the BDN areas by the government authorities and other concerned parties;
- development of at least two BDN experience documentary films;
- printing and dissemination of pictorial brochures, tools and guidelines (see Table 4).

Table 4. Documents and publications produced by the BDN programme

Type	Subject	Produced and funded by	Year
Book (Arabic and English versions)	BDN tools and guidelines	WHO	2002
Documentary Films (2)	BDN concept and activities	WHO	2003
PowerPoint presentation	BDN concept and implementation methodology	WHO	2000
Web-based database	BDN programme profile	WHO	2002
Brochures (2)	BDN concept and activities	WHO	2003
Consolidated reports (3)	BDN status	WHO	2001 2002 2003
Commission on Macroeconomics and Health report	BDN success stories	WHO Representative office	2003

Community and resource mobilization

It was observed that the community was organized adequately and almost all structures were in place. The organization of the community had positive effects on participation in most of the programme activities, including their planning, implementation and management.

The deficiencies were usually in the part of development and full exploitation of the potential of certain community groups such as women's

and youth associations. However, the tide of public opinion, especially in the BDN programme areas, was in favour of the associations. A number of the BDN communities in the governorates of Ibb, Taiz, and Dhamar, and in Bait Al-Sayed in Sana'a had recently formed women's and/or youth associations and a few other areas were in the process of developing such structures.

Implementation process

Training and orientation activities

Since 2000, various levels of training and orientation sessions have been conducted for the promotion and/or implementation of the BDN programme in Yemen (see Table 5).

As previously mentioned, except for Aden and Lahaj, TSTs exist in all of the areas, however the following findings were observed during the evaluation process.

- One of the noticeable advantages was that all TST offices are located in health offices of the governorates, which makes coordination with health authorities convenient.
- Generally, the composition of the teams was incomplete due to frequent transfer of personnel to other places. The programme did not immediately replace them with new TST members.
- Women's representation was available in TSTs to assist in the development of women and respond to their needs.
- The link and contribution of different sectors to BDN areas was quite evident, especially in health and education. Education was represented in support to schools and adult literacy with special focus on women.
- Meetings of the TSTs in some areas were irregular; hence sharing of information between members was inadequate. This has resulted in an absence of joint plans and less coordinated support to local communities.

Table 5. Summary list of BDN related training and orientation

Name and type of training and orientation	Date	Number of sessions	Number of participants
Community level initial four-day training sessions for village development committees and cluster representatives.	2000, 2001, 2002, 2003, 2004, 2005	17	677
Community level refresher two-day training sessions for village development committees and cluster representatives in Hodeidah, Dhamar, Lahaj and Bait Al-Sayed and Al-Munaqqab in Sana'a.	Four training sessions in September 2003 and one in June 2004	5	175
Governorate level orientation one-day workshops for government authorities and various line departments in Hajjah, Taiz, Ibb, Hadramawt and Abyan governorates.	July 2002, August 2002, August 2002, January 2003, January 2004	5	441
National level orientation one-day workshop for government authorities, United Nations' agencies, nongovernmental organizations, community leaders, and other partners in Sana'a.	March 2000	1	80
National level training four-day workshops for BDN coordinators and TSTs in Sana'a, Taiz, Hodeidah and Aden.	June 2001, September 2002, April 2004, February 2005	4	200

It is also worth mentioning that cooperation was developed with the Faculty of Medicine, University of Taiz in linking medical students to operational research activities and fieldwork in BDN areas.

Intrasectoral health coordination

In all BDN areas visited health interventions were taking place routinely, such as support to the health facility, immunization and reproductive health. Coordinated efforts had been made with Roll Back Malaria in Hodeidah governorate where the cluster representatives of the BDN areas were trained and utilized successfully for this purpose. Other

primary health care programmes, like growth monitoring and nutrition, integrated management of childhood illness, tuberculosis directly observed therapy short-course (TB DOTS), etc. were missing.

Integrated delivery of all primary health care programmes was insufficient, possibly because of inadequate coordination within the health sector itself.

Monitoring and supervision

The BDN programme has successfully established functional monitoring and supervisory systems based on the BDN tools developed by the Regional Office. BDN coordinators at governorate level were trained on the monitoring tools and provided with sufficient copies of the tools.

The first element of the monitoring system was that of reporting on technical progress on a monthly basis while reporting on financial progress every three months. Reporting was found to be regular by all BDN coordinators. At community level, different monitoring tools are being used by village development committees. Among them is the fortnightly meeting, which was suggested by the national BDN programme. Minutes of the meetings are maintained regularly. The village development committees were also found to be using other tools meant for monitoring the status of BDN projects as an inbuilt monitoring mechanism.

The second element of monitoring was the use of baseline surveys. Only in two of the BDN areas visited were the BDN surveys repeated (Kashuba'a and Al-Feush). Results of the original baseline surveys and the surveys made after BDN interventions in those two areas were used to measure progress that took place over a period of time.

The third element of the monitoring system used by the BDN programme was the review meetings which were held every 6 months and have been regular and useful during the past few years. In the workshop of Hodeidah in April 2004, for instance, participants from all BDN areas had the opportunity of taking a field visit and learning from that BDN experience. Although two more review and planning meetings per year, beside other regular monitoring forums, would be costly and cumbersome they are essential to the progression of the programme.

Supervisory visits by the national BDN coordinator to governorates and BDN areas were every 2–3 months, while the governorate BDN coordinator

visited BDN areas twice a month. The quality of the supervisory visits of the latter needed to be improved as a few of the coordinators were found to have no supervisory checklist and the issues that needed to be discussed and followed up in every visit were not clear to them.

Financial management

At Sana'a the BDN programme maintains a main account at the national level for receiving project funds from WHO. The WHO Representative is the authorized signatory for this account. Funds from the main account are transferred to respective governorate level BDN main accounts, which are managed by double signatures of WHO representatives and the governorate BDN coordinators. The first batch of proposed BDN projects is financed directly from this account. The loan is given directly to the beneficiary after fulfilling the required administrative procedures, including signing a social contract as well as other legal guarantees.

Monthly installments for the loan recovery are deposited in a separate revolving fund account in the name of the BDN programme of the respective district. Double signatures of the WHO Representative and the governorate level BDN coordinator manage this account. For the same account in new BDN areas, new financial arrangements were established under which the national BDN coordinator replaced the signature of the WHO Representative.

The financial system of the BDN programme at the community level is managed according to the BDN tools for financial management. A contribution of the beneficiary/ies for each income-generating project is specified to be a minimum 15% of the total cost of the project.

For the return of installments at a governorate level the BDN coordinator deals with the finance person of the village development committee, who manages the finance record of the individual activities in the community. The BDN coordinator makes sure that proper receipts are issued and the record is well maintained.

A service charge is specified in the agreement to range from 3% to 5% of the loan of the project in most of the areas. This amount, which is collected with the monthly installments, is not deposited in the bank with the revolving fund. Instead it is kept by the village development committees for their routine BDN-related expenses including stationery, refreshment

during community meetings, transportation and also minor public projects for the common good, such as repair of the water system, school and mosque, etc. Although so far the amounts have not been significant the income and expenses were properly recorded for making the system transparent and accountable to the public, which is very important for building community trust in the programme.

The loan return rate was generally low in most of the BDN areas visited, except for Al-Yahary in Ibb and Al Kashuba'a in Hodeidah where the loan return rate had reached over 85%

Documentation and reporting

The BDN programme intervention and activities at the national and governorate levels are documented through different means, including regular monthly and annual progress and financial reports, photographs and video-taping, conducting baseline socioeconomic surveys in all BDN areas and also repeated surveys in some areas. In addition, as part of the BDN programme documentation efforts, a web-based database has been prepared and made ready for publishing.

All the available documents are well maintained in both soft and hard copies and are easy to retrieve which is considered as one of the strengths of the programme. At the community level, almost all village development committees keep proper records of their activities, including minutes of the village development committee meetings, registers of all projects and related administrative procedures and copies of the technical and financial progress reports. Also, at the community level an initiative was observed in Taiz governorate where a village development committee member had produced a booklet documenting the whole BDN experience in Sha'abania Ulia area.

Health information system

Development and utilization of health information systems as one of the main objectives of the BDN intervention has been steadily progressing in various BDN areas in Yemen. Some of the areas, Al- Mandhar and Kashuba'a in Hodeidah and Al-Yahary in Ibb governorate for example, have given careful consideration to health data collection, recording, collating and display. Activities concerning health information systems in those areas included reporting on vital events (births and deaths) by the trained traditional birth attendants to their respective health facility, the registration of health services delivery and the immunization and reproductive health.

Programme activities and outputs

Project profiles

The BDN programme in Yemen covers a total population of around 86 000 people in 10 governorates (see Table 6). By the time of evaluation, in the BDN areas listed in Table 6, about 1366 income-generating activities and 89 social and health projects were supported by the BDN programme (see Table 7).

Table 6. Programme areas and population coverage

Governorate	District	BDN area	Initiation date	Population covered	Number of projects		
					Health	Social	Economic
Sana'a	Bani Hushaish	Bait Al-Sayed	2001	1 094	3	3	90
	Bani Matar	Al-Qemma	2001	1 018	1	---	70
	Hamdan	Waqash	2002	1 036	1	1	44
		Al-Munaqqab	2003	1 973	---	---	77
Hodeidah	Hodeidah	Mandhar	1999	2 500	5	2	54
	AlMarawa	Kashuba'a	2001	5 883	5	3	169
	Al-Luhya	Al-Luhya	2002	4 658	4	3	231
Dhamar	Al-Maifa'a	Kherbat-Afiq	2001	4 153	4	2	61
	Ans	Hanud	2001	2 116	4	2	34
	Dhamar	Mangaza	2002	4 562	4	2	81
Aden	Al-Buraiqa	Fuqum	2001	1 993	3	2	92
Lahaj	Tuban	Al-Feush	2002	1 834	4	---	44
Hajjah	Mabean	Al-Gazaf/ Al-Qaila	2002	4 249	5	2	58
Ibb	Ibb	Al-Yahary	2003	2 635	5	2	81
		Ozlat Al-Raoss	2005	9 028	2	1	16
Taiz	Al-Tazia	Sha'abania Ulia	2003	8 292	1	2	96
		Janadia Sofla	2005	12 921	4	2	7
Abyan	Tuban	Obr Othman	2004	2 070	1	3	56
Hadramawt	Ghail Bawazir	Al-Naqa'a	2004	2 300	---	1	5

Table 7. List of the BDN social and health interventions with respect to costing

Type of intervention	Number of projects	Cost (US$)				
		Total	Capital	Operational	WHO grant	Community share
Adult literacy course	18	14 390	4 080	11 570	13 800	120
Health training	39	44 095	9 670	34 425	41 545	100
Health education	9	4 100	1 270	1 321	4 000	----
Skills development training	12	5 980	980	4 700	5 580	400
Water and sanitation	3	13 720	7 520	5 000	2 320	1 400
Miscellaneous*	8	11 720	11 720	-----	5 680	5 000
Total	89	94 005	35 240	57 016	72 925	7 020

* Establishing library, supporting sport activity, maintenance of facility

Basic education enrolment

In some BDN areas the programme has had input in support of basic education, either directly or indirectly, through supporting other activities and facilitating the improvement of students enrolment. The improvement in the enrolment status for girls is more evident, because the government already has a policy of encouraging girls' education and this was further promoted by the BDN programme (see Figure 1).

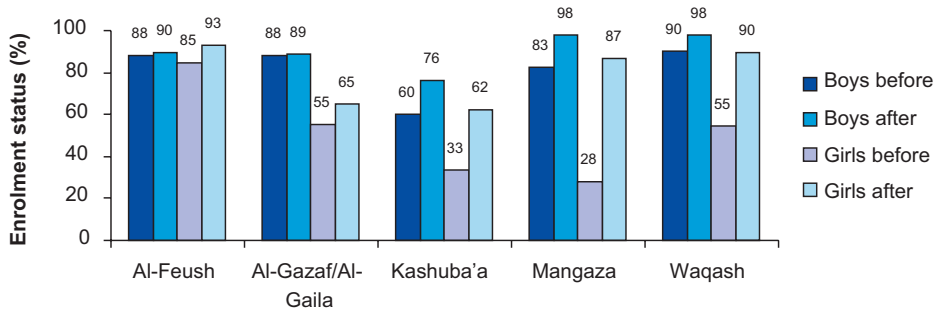


Figure 1. The overall change in enrolment status in BDN areas

Adult women's literacy programme

One of the main strengths of the BDN programme is the focus on improving the literacy rate among adult women in all BDN areas (see Figure 2). In some areas courses were organized several times and consequently there has been a visible improvement in literacy levels

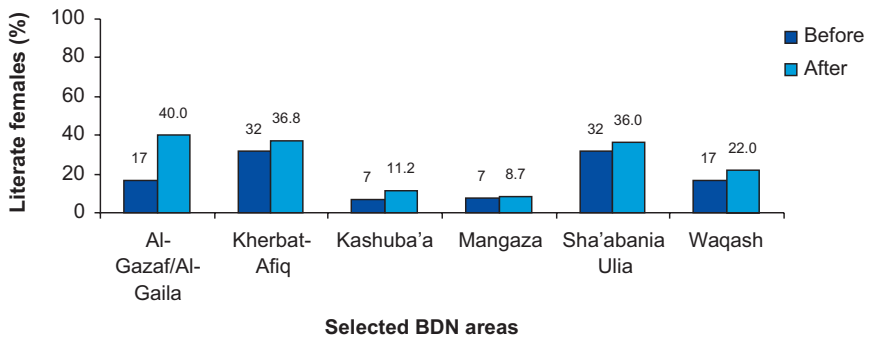


Figure 2. Improvement in female literacy

Low birth weight

Data on this indicator were available only for the two areas where the BDN survey had been carried out twice since the programme inception (see Figure 3). The remarkable reduction in the number of cases of low birth weight in Al-Feush area of Lahaj governorate could be attributed to close coordination between the BDN programme and the governorate health office, which resulted in strong reproductive health services to the community.

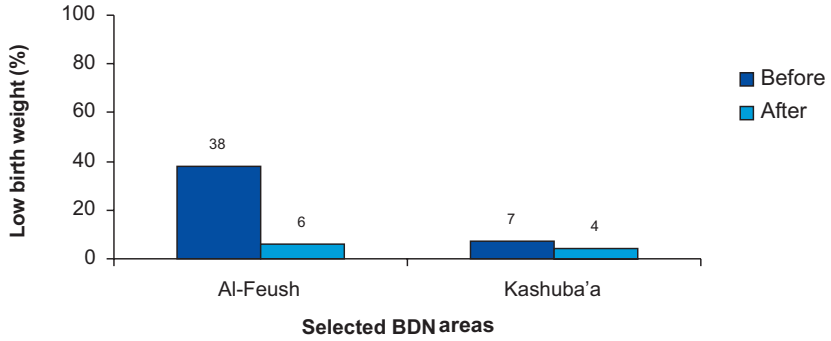


Figure 3. Reduction in low-birth-weight cases in newborn

Infant mortality

It was observed that there has been a slight decrease in the percentage of deaths in infants (see Figure 4). This could be attributed, inter alia, to improved sanitary conditions, better nutrition and, above all, support to child health care through community and facility based interventions.

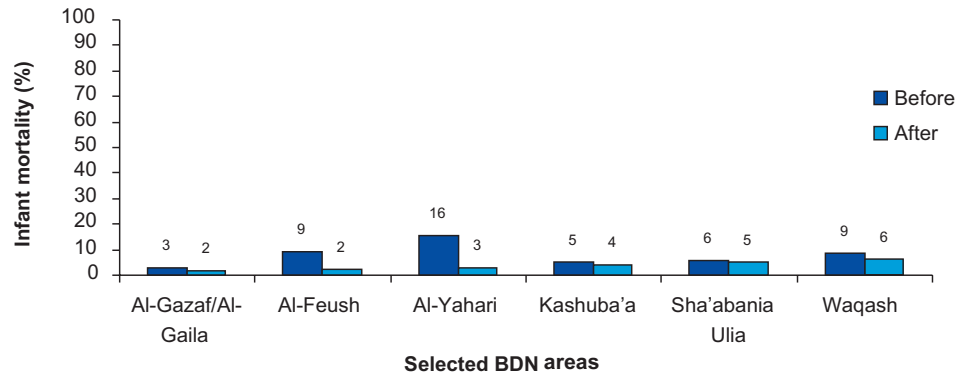


Figure 4. Reduction in the percentage of infant mortality

Immunization of children and pregnant women

An ongoing programme in all BDN areas is immunization of children under the age of 1 year and administration of tetanus toxoid vaccine for pregnant women. Coverage of children under 1 year of age is already high at around 80%, therefore, the slight increase in the status of immunization took place mainly through strengthening the routine immunization programme (see Figures 5 and 6). The coverage could have been better if the cluster representatives had been sufficiently mobilized for this purpose. Since the tetanus toxoid coverage was previously low, the BDN intervention has improved the situation considerably.

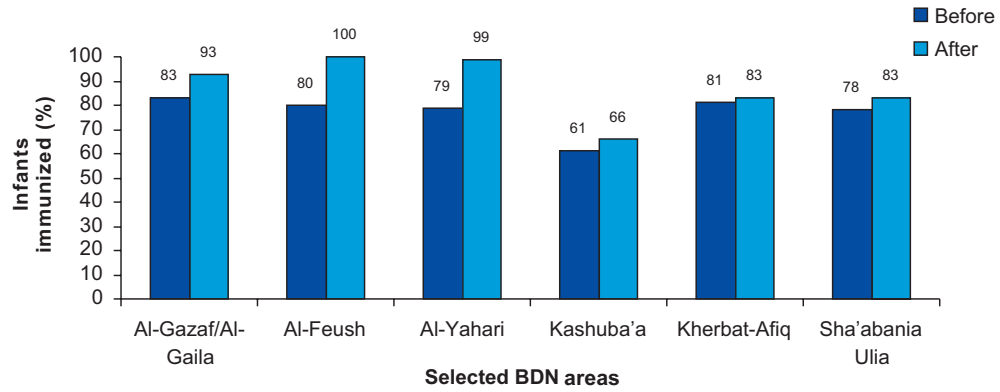


Figure 5. Immunization coverage in infants

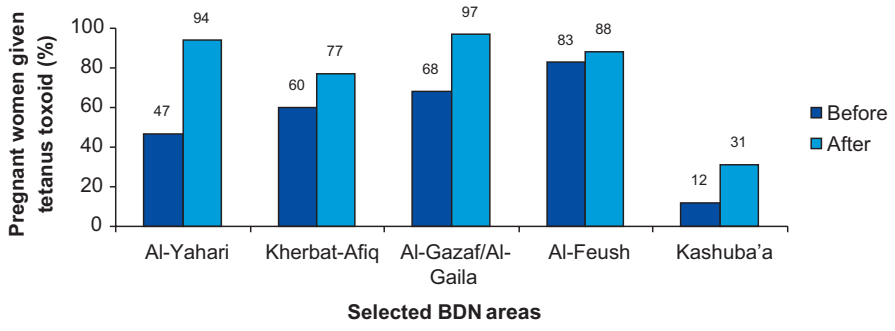


Figure 6. Tetanus toxoid immunization coverage in pregnant women

Cost analysis for BDN interventions

BDN supported activities, whether social and health or income generating, are targeted at health, directly or indirectly (see Figure 7). Although various social and health activities have been supported in the BDN areas, more focus and attention was given to health training and awareness-raising in local communities (see Figure 8).

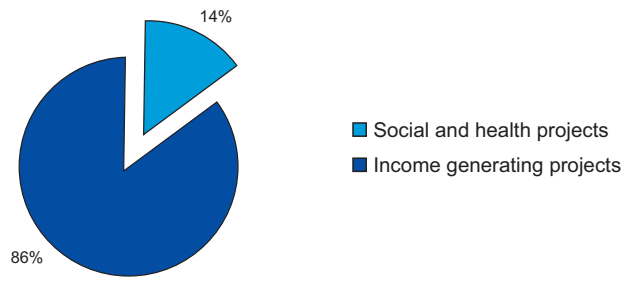


Figure 7. Investment in health through income-generating activities versus health and social projects

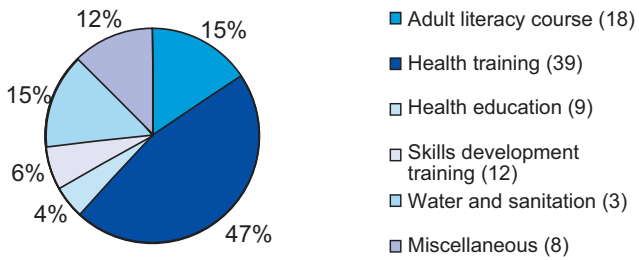


Figure 8. Cost analysis of social and health interventions

Sustainability and ownership

A number of steps and measures were taken by the programme to ensure its ownership by communities and hence contribute to its sustainability and continuity. Those measures included:

- efficient organization of the programme at all levels by creating and establishing the required BDN structures for each level and their training in BDN tools;
- adequate intersectoral action and linkages.

Other factors identified contributed negatively to sustainability and continuity. These included:

- partnership and resource generating which was limited to the Ministry of Public Health and Population, WHO and local communities, so that there were inadequate resources and material support for the programme;
- inadequate efforts for building the capacity of the local communities in using their own initiative or through the support of the TST in generating more resources;
- insufficient understanding of community members, in some areas, of BDN concept and their roles and responsibilities in the development process.

Conclusions and recommendations

Based on the results and findings, conclusions were made for each component, describing weaknesses and strengths. The following is a set of recommendations for the improvement and consolidation of the programme.

1. The national BDN team currently comprises only one person, which makes it difficult to manage all aspects of the programme at the country level. It is, therefore, recommended that a national BDN team is established comprising at least four full-time members including the national coordinator. Tasks and responsibilities are to be divided among the team members as follows: 1) National Coordinator, 2) Technical Officer, 3) Training Officer, and 4) Information, Monitoring and Advocacy Officer.

2. To build the capacity of the BDN programme at the national level, a core team of master trainers should be developed with the support of WHO. The team of master trainers should be composed of, in addition to the national BDN team members, some selected governorate level BDN team members.

3. Refresher courses for TST members at all governorate levels should be organized. The BDN guidelines and tools for training should be utilized for this purpose. The master trainers are expected to perform this task. The training should not be less than 5 days.

4. The BDN structures at community level (village development committees and cluster representatives) require further reorganization and adequate mobilization. In addition, new structures like women's associations, youth clubs and other relevant bodies which seem to be useful and helpful for wider coverage, should be formed. Training of these structures is a prerequisite for their discharging better responsibilities and roles.

5. Field visits should be organized to BDN successful model areas within the country in order to strengthen the capacities of national and local BDN teams and to exchange experiences.

6. Advocacy and promotional activities concerning the BDN programme have so far been mainly directed towards the health sector, which has obviously resulted in high political commitment and resource generating and support. More efforts should be made by the programme to reach other related sectors and agencies for the sake of strengthening and building partnerships and further mobilization of resources for the programme.

7. It is essential that integrated delivery of primary health care services at the health facilities in all BDN areas should be ensured (e.g. integrated management of childhood diseases, TB DOTS, malaria, schistosomiasis, nutrition and growth monitoring, school health, oral health, and hygiene education).

8. It is necessary to develop more partners and hence more resources to ensure programme ownership and sustainability. Intensive and focused training on BDN and on other issues related to skills development should be carried out to build the capacity of the local communities to effectively manage their programme activities.

9. Based on the successful experience of the health information system in some of the BDN areas, the system should be expanded to include all BDN areas and the health information system database developed for planning and monitoring. The cluster representatives, who comprise a potential resource for community-based health information systemresources, should be further organized and mobilized for reporting on vital events, diseases, disabilities and other chronic health problems.

10. While the existing documentation and reporting system functions effectively, further attention should be given to encouraging more community initiatives, such as the display of BDN activities and updates on the bulletin board in all BDN areas for further information sharing and promotional activities among community members.

11. To maximize the utilization of BDN review meetings in the context of effective monitoring every BDN coordinator should be requested to develop a yearly BDN plan of action in close coordination with the village development committees and other community structures and with the active participation of TST members. This plan should be based on the needs assessed through the BDN surveys and the priorities defined by the communities. In the presence of such a plan, the BDN coordinators should report every quarter on technical and financial progress according to the plan. At the yearly review meeting the overall progress of the plan should be monitored. This meeting should also be at tended by village development committee chairmen and members of TSTs and should be the basis for discussion and finalization of the plan of action for the following year. It is also advisable that some of the directors or coordinators of national vertical programmes attend, beside other programme partners if they exist.

12. In order to improve the supervisory skills of BDN coordinators at governorate level, the national BDN programme should organize development training in programme management and supervisory skills. In this regard trainers can utilize the BDN tools.

13. For an improved inbuilt regular monitoring system, it is advised that the baseline survey results are updated annually or the survey repeated at least every two years. This will provide adequate information required for monitoring the progress of the programme.

14. The WHO representative and the national BDN coordinator should continue to be the authorized signatories for the governorate level BDN main bank accounts. For the bank accounts for revolving funds at the governorate level, it is recommended that the governorate level BDN coordinator signs jointly with the head of the concerned village development committee, after technically clearing the proposed BDN project by the national BDN coordinator. This arrangement will ensure the increased participation of communities in financial management that is required for future sustainability of the programme and community self-reliance.

15. At this stage of BDN programme development, more focus should be on implementing less costly income-generating activities. This arrangement will cover a wider range of beneficiaries and ensure faster reutilization of funds. Particular attention should be given to income-generating activities owned by women.

16. Expansion of the programme is taking place at a local level in limited areas. The need for large-scale expansion was expressed on many occasions by national authorities. Large-scale expansion depends on several factors, such as the availability of numerous partners and generating of more financial and human resources. More involvement of the Ministry of Public Health and Population and the Ministry of Planning and International Cooperation in the BDN programme is another required precondition for expansion. However, at this stage it is recommended that the programme continue to expand locally within the model development phase. New initiatives are taken to implement the programme (healthy island approach) in Sucotra Island, as suggested by the WHO Representative and discussed with the Deputy Minister for Planning and Development sector of the Ministry of Public Health and Population. Also, other community-based initiative programmes like the healthy city programme or women in health and development, can be introduced in some sites where the conditions are favourable.

Measuring programme success

As a conclusion of the evaluation of the BDN programme of Yemen (15 March–5 May 2005) a rating scale of 1 to 5 was used in order to determine its success, addressing factors stipulated in Table 8. Based on the results of the rating, the BDN programme in Yemen, according to Table 9 from the Regional Office's evaluation guidelines, falls in category 2 stating that the programme has achieved all planned objectives and WHO should continue technical and financial support for programme expansion.

Table 8. Rating scale for the BDN programme of Yemen

Contributing factor	Score out of 5
Level of government commitment	3
Organization and management of BDN programme	4
Level of intersectoral and partnership development	3
Level of community self-financing	3
Institutionalization of BDN within the government setup	2
Level of human resource development	4
Level of community self-reliance and ownership	3
Improved health and social development indicators	3
Total	**25**

Table 9. Evaluation guidelines for BDN programme evaluation

Categories	Result	Implication
1 (31–40)	Achieved more than was originally planned (sustainable programme)	WHO should limit financial support and continue technical support for programme expansion
2 (21–30) BDN programme of Yemen	Achieved all planned objectives (making satisfactory progress towards sustainability)	WHO should continue technical and financial support for programme expansion
3 (11–20)	Achieved some planned objectives (making progress towards sustainability)	WHO should continue technical and financial support in the same area
4 (1-10)	Achieved nothing/project did not work (no progress towards sustainability)	WHO should cease technical and financial support unless funds for programme support government shows willingness to take the leadership and allocate

Plan of action

Activities have been planned for the Yemen BDN programme for June 2005 until February 2006 (see Table 10).

Table 10. Planned BDN programme activities from June 2005 to February 2006

Activity	By whom	When	Resources (US$)
Selection and designation of three new members for national BDN team	WHO and Ministry of Public Health and Population	June–July 2005	
Conducting a training of master trainers course for 10 participants	BDN expert and national BDN coordinator	July–August 2005	3 000
Conducting 2 training courses for TSTs; each course 20 participants	Core team of master trainers	August–September 2005	2 000
Formation of new community structures e.g. women's associations, youth clubs, etc.	National BDN team	August–September 2005	
Conducting 10 training courses for village development committees and cluster representatives and other new community structures on health and the importance of social projects	Master trainers and TSTs	September–December 2005	15 000
Field visit of TSTs and village development committees to BDN successful areas within the country	WHO Representative office and Community-Based Initiatives /Regional Office	January 2006	10 000
Conducting a one-day BDN advocacy workshop for all potential partners and organizations in the country	WHO Representative office and national BDN team	February 2006	5 000
Conducting a two-day workshop for health programmes for more intra health sector coordination	WHO Representative office and Ministry of Public Health and Population and national BDN team	January 2006	4 000
Organization of field visits to areas of successful health information system experience for training and replication of experience	National BDN team	February 2006	3 000
Conducting a BDN annual review and planning a meeting	WHO Representative office and BDN national team	December 2005	10 000
Conducting BDN surveys in all BDN areas	National BDN team and TSTs and village development committees	October–November 2005	5 000
Introduction of the healthy city programme in selected cities of Yemen	WHO Representative office and Regional Office	January 2006	50 000
Local cost for regular monitoring and supervision	BDN team	May–December 2005	5 000
Development of print and audio-visual advocacy material	WHO Representative office and BDN team	August–December 2005	10 000
Seed money for BDN projects for old and new areas and new initiatives	WHO Representative office and the Regional Office	—	150 000

Evaluation of the basic development needs programme of Yemen

Annex 1
Authorities and potential partners interviewed and met during the evaluation

Level	Authority/structure	Sector/name of BDN area
National	WHO Representative	WHO
	Chief health section	UNICEF
	Deputy country director	WFP
	Deputy Minister for Planning and Development	Ministry of Public Health and Population
	Deputy Minister for Population	Ministry of Public Health and Population
	Director of integrated management of childhood illnesses programme	Ministry of Public Health and Population
	Director of national roll back malaria programme	Ministry of Public Health and Population
	Director of health section	Social Fund for Development (SFD)
	Director of national nutrition programme	Ministry of Public Health and Population
	Director national tuberculosis programme	Ministry of Public Health and Population
Aden Governorate	Deputy Governor	Local government
	Director of the health office	Health
	WHO sub-office coordinator	WHO
	BDN coordinator	Health
	Village development committee members and beneficiaries	Fuqum BDN area
Abyan Governorate	Director of the health office	Health
	Director of the district	Local government
	BDN coordinator and TST	Health and related sectors
	Village development committee members and beneficiaries	Abr Osman BDN area
	Meeting with a group of village women	Abr Osman BDN area
Lahaj Governorate	Director of the health office	Health
	BDN coordinator	Health
	Village development committee members	Al-Feush BDN area
Taiz Governorate	Deputy director of the health office	Health
	BDN coordinator and TST members	Health, education and social welfare
	Village development committee members and beneficiaries	Sha'abania Ulia and Janadia Sofla BDN areas
	Meeting with women participating in embroidery and vocational training	Sha'abania Ulia
Ibb Governorate	BDN coordinator and TST members	Health, agriculture and education
	Village development committee members and beneficiaries	Al-Yahari and Ozlat Al-Raoss BDN areas
	Meeting with graduates of the First Aid course	Al-Yahari and Ozlat Al-Raoss BDN areas
Dhamar Governorate	Director of the health office	Ministry of Public Health and Population
	BDN coordinator and TST members	Health, environmental health, agriculture, reproductive health
	Village development committee members, women association and beneficiaries	Kherbat-Afiq community
	Village development committee members and beneficiaries	Mangaza BDN community
Hodeidah Governorate	Director of the health office	Ministry of Public Health and Population
	BDN coordinator and TST members	Health, local government, agriculture, education
	Village development committee members and beneficiaries	Kashuba'a community
	Village development committee members and beneficiaries	Mandhar community
Hajjah	Director of the health office	Ministry of Public Health and Population
	BDN coordinator and TST members	Agriculture, education and health
	Village development committee members and beneficiaries	Al-Gazaf/Al-Qaila community
Sana'a	Deputy director of the health office	Ministry of Public Health and Population
	Director of health office in Bani Hushaish district	Ministry of Public Health and Population
	BDN coordinator and TST members	Health, social affairs and education
	Village development committee members and beneficiaries	Bait Al-Sayed community in Bani Hushaish district and Waqash in Bani Matar district

Annex 2
Income-generating projects profile

Project title	Beneficiary	Project period and age	Amount invested (US$)	Loan recovery status
Bait Al- Sayed, Sana'a				
Sewing and embroidery machine	39	12 months	3 485	Completed
Cattle and sheep raising	10	15 months	3 370	Completed
Honeybee farm	1	15 months	655	Completed
Water pump for irrigation	6	18 months	7 880	Completed
Small business	3	12 months	2 215	Completed
Small business	20	12 months	13 040	Ongoing
Water pump for irrigation	7	18 months	7 880	Ongoing
Agriculture services	3	18 months	3 930	Ongoing
Agriculture farm	1	12 months	630	Ongoing
Honeybee farm	1	15 months	1 260	Ongoing
Water pump workshop	1	12 months	630	Ongoing
Mechanical workshop	1	15 months	1 000	Ongoing
Lorry for agriculture product distribution	1	18 months	3 360	Delayed
Blacksmith	1	12 months	630	Ongoing
Stone cutter	1	12 months	630	Competed
Gas cylinder distribution transportation	1	18 months	4 200	Completed
Electronic workshop	1	18 months	1 800	Delayed
Al-Qemma, Sana'a				
Sewing and embroidery machine	20	12 months	2 990	Completed
Cattle raising	30	15 months	8 170	Delayed
Sheep raising	20	15 months	3 910	Delayed
Waqash, Sana'a				
Sewing machine	6	12 months	414	Completed
Cattle and sheep raising	15	15 months	5 280	Ongoing
Small business	7	15 months	3 800	Ongoing
Agriculture projects (pipes, seeds)	6	15 months	5 800	Delayed
Al-Munaqqab, Sana'a				
Water pump for irrigation	11	20 months	21 000	Ongoing
Mandhar, Hodeidah				
Sewing machine	10	12 months	600	Completed
Sheep raising	10	15 months	4 000	Completed
Textile weaving	11	20 months	3 500	Delayed
Public transportation	1	18 months	3500	Completed
Small business	22	12 months	14 000	Ongoing
Pharmacy	1	18 months	3 750	Ongoing
Kashuba'a, Hodeidah				
Sewing machine	10	15 months	1 200	Completed
Milking cows raising	67	18 months	24 000	Ongoing
Honeybee farm	3	15 months	2 400	Ongoing
Lorry for agriculture product distribution	1	12 months	1 660	Ongoing
Public transportation	1	15 months	3 600	Ongoing
Health projects (small clinic)	1	18 months	1 380	Ongoing
School buffet and stationery	1	15 months	1 000	Completed
Luhya, Hodeidah				
Boat with engine for fishing	5	20 months	20 120	Ongoing
Bakery	1	18 months	6 000	Delayed
Carpenter	1	15 months	2 000	Ongoing
Electric workshop	1	18 months	2 000	Ongoing
Sheep raising	10	15 months	2 500	Ongoing
Small business	7	15 months	5 500	Ongoing

Evaluation of the basic development needs programme of Yemen

Project title	Beneficiary	Project period and age	Amount invested (US$)	Loan recovery status
Water meter	200	18 months	3 100	Ongoing
Restaurant	1	18 months	1 780	Ongoing
Sanitation projects	5	20 months	2 220	Ongoing
Children's park	1	20 months	2 000	Ongoing
Cement block fabric	1	18 months	1 540	Ongoing
Refrigerator for fish	1	15 months	750	Ongoing
Kherbat-Afiq, Dhamar				
Sewing and embroidery machine	20	15 months	1 600	Completed
Milking cows raising	12	18 months	3 680	Delayed
Stonecutter	1	12 months	500	Ongoing
Cement block	1	18 months	1 900	Ongoing
Sheep raising	15	15 months	2 770	Ongoing
Small business	8	15 months	3 680	Ongoing
Water pump for irrigation	1	20 months	6 380	Delayed
Agriculture tractor	4	22 months	14 000	Delayed
Establishment of pharmacy	1	20 months	3 450	Ongoing
Flourmill (grinder)	1	20 months	3 220	Delayed
Public transportation	1	15 months	1 470	Ongoing
Mangaza, Dhamar				
Sewing and embroidery machine	21	15 months	1 770	Ongoing
Milking cows raising	21	18 months	4 530	Ongoing
Calf raising	13	15 months	3 700	Delayed
Small business	2	18 months	610	Ongoing
Sheep raising	10	15 months	1 850	Ongoing
Agriculture projects (sites, tree, fertilizers, small water pump, etc	14	15 months	3 220	Ongoing
Establishment of pharmacy	1	20 months	3 450	Ongoing

Project title	Beneficiary	Project period and age	Amount invested (US$)	Loan recovery status
Hanud, Dhamar				
Sewing machine	11	12 months	780	Delayed
Raising milking cows	11	18 months	3 370	Ongoing
Establishment of pharmacy	1	20 months	3 450	Ongoing
Small business	5	15 months	1 900	Ongoing
Sheep raising	12	15 months	2 220	Ongoing
Agriculture projects (seeds, trees, fertilizers, etc)	5	15 months	1 430	Ongoing
Fuqum, Aden				
Sewing and embroidery machine	70	15 months	6 000	Completed
Carpentry	1	18 months	800	Ongoing
Engine of fishing boat	7	18 months	18 400	Delayed
Fishing net	10	18 months	10 050	Ongoing
Small business (buffet)	1	12 months	350	Completed
Fishing boat repair	2	15 months	1 360	Ongoing
Fish keeping box	1	18 months	1 600	Ongoing
Al-Feush, Lahaj				
Embroidery machine	5	18 months	680	Completed
Raising milking cows	11	18 months	3 750	Ongoing
Bakery	1	15 months	300	Completed
Small business	7	15 months	2 530	Completed
Sheep raising	7	15 months	1 160	Ongoing
Agriculture projects (sides, tree, fertilizers, etc)	7	15 months	4 800	Ongoing
Carpentry	1	12 months	540	Ongoing
Water pump for irrigation	4	18 months	10 230	Ongoing
Repair pickup for garbage	2	12 months	2 000	Ongoing

Project title	Beneficiary	Project period and age	Amount invested (US$)	Loan recovery status
Al-Gazaf/Al-Qaila, Hajjah				
Sewing and embroidery machine	34	15 months	2 530	Ongoing
Stone cutter	9	18 months	4 770	Ongoing
Flourmill	2	15 months	6 000	Delayed
Small business	8	15 months	3 860	Ongoing
Sheep raising	2	15 months	540	Ongoing
Honeybee farm	1	15 months	500	Ongoing
Establishment of pharmacy	2	20 months	3 450	Ongoing
Gas cylinder shop	2	15 months	1 070	Ongoing
Al-Yahary, Ibb				
Milking cows	55	15 months	17 280	Ongoing
Stonecutter	1	15 months	310	Ongoing
Honeybee farm	12	15 months	3 770	Delayed
Small business	8	15 months	5 000	Ongoing
Sheep raising	5	15 months	1 500	Ongoing
Ozlat Al-Raoss, Ibb				
Milking cows	11	15 months	3 420	Ongoing
Stone cutter	1	15 months	750	Ongoing
Honeybee farm	1	15 months	310	Delayed
Cylinder gas shop	1	12 months	1 240	Ongoing
Sheep raising	1	15 months	310	Ongoing
Flourmill	1	15 months	1 240	Ongoing
Sha'abania Ulia, Taiz				
Poultry farm	4	15 months	8 080	Ongoing
Cows, calf and camel raising	15	18 months	4 680	Ongoing
Honey bee farm	8	15 months	4 170	Ongoing
Water tanker	1	15 months	1 240	Ongoing
Sheep raising	17	15 months	3900	Ongoing
Small business	22	12 months	10 230	Ongoing
Water pump for irrigation	2	18 months	2 200	Ongoing
Agriculture tractor (repair)	1	18 months	5 460	Ongoing
Agriculture projects	1	15 months	500	Ongoing
Tailor shop	3	15 months	1 400	Ongoing

Project title	Beneficiary	Project period and age	Amount invested (US$)	Loan recovery status
Mechanical workshop	1	12 months	620	Ongoing
Public transportation	1	15 months	1 240	Ongoing
Stone cutter	1	12 months	630	Ongoing
Pipe for irrigation	1	15 months	630	Ongoing
Cylinder gas shop	4	15 months	2 660	Ongoing
Janadia Sofla, Taiz				
Support for digging well	1	12 months	560	Ongoing
Stone cutter for digging a water well	1	15 months	3 660	Ongoing
Small business	2	12 months	800	Ongoing
Cylinder gas shop	3	12 months	4 160	Ongoing
Abr Osman, Abyan				
Fishing boat	4	15 months	3 720	Ongoing
Milking cows	3	18 months	1 490	Ongoing
Honeybee farm	9	15 months	3 910	Ongoing
Raising camels	4	15 months	1 730	Ongoing
Sheep raising	17	15 months	5 290	Ongoing
Small business	6	12 months	2 300	Ongoing
Water pump for irrigation	6	18 months	9 320	Ongoing
Digging well	3	15 months	1 550	Ongoing
Repair water pump	1	15 months	310	Ongoing
Embroidery machine	1	12 months	620	Ongoing
Butchery shop	1	12 months	620	Ongoing
Carpentry	1	12 months	620	Ongoing
Grand Total			**561 760**	

Annex 3
Health and other social projects profile

Project title	Project period/age	Project type/kind	Project cost and contribution					
			Total	Capital cost	Operational cost	WHO grant	WHO loan	Community share
Bait Al-Sayed, Sana'a								
TBA training	Health	45 days	2100	600	1400	2000	—	100
Sewing and embroidery training	Skills development	6 months	1540	140	1100	1240	—	300
Adult literacy courses	Women's development	6 months	800	80	720	800	—	—
Public library	Health awareness	September 2004	1100	1100	0	760	—	300
Sanitation project	Health	May 2004	11 200	5000	5000	—	—	1200
Al-Qemma, Sana'a								
TBA training	Health	45 days	755	300	455	455	—	—
Waqash, Sana'a								
TBA training	Health	45 days	800	350	450	450	—	—
Adult literacy course	Women's development	6 months	200	20	180	180	—	20
Kashuba'a, Hodeidah								
TBA training	Health	45 days	2600	350	2250	2600	—	—
Sewing and embroidery training	Skills development	3 months	280	50	230	280	—	—
Adult literacy courses	Women's development	18 months	1720	120	1600	1720	—	—
Environmental health training	Health awareness	7 days	470	70	400	470	—	—
First Aid training	Health	14 days	1100	100	1000	1100	—	—
Health education via literacy course	Health awareness	6 months	2250	800	145	2250	—	—
Support football team		January 2005	450	450	—	450	—	—
Mandhar, Hodeidah								
TBA training	Health	45 days	1800	400	1400	1800	—	—
Sewing and embroidery training	Skills development	3 months	280	50	230	280	—	—
Adult literacy courses	Women's development	6 months	180	180	180	180	—	—
Environmental health training	Health awareness	7 days	320	50	270	320	—	—
First Aid training	Health	14 days	650	80	570	650	—	—
Health education	Health awareness	6 months	300	—	300	300	—	—
Al-Luhya, Hodeidah								
TBA training	Health	45 days	1800	400	1400	1800	—	—
Adult literacy courses	Women's development	6 months	500		500	500	—	—
Environmental health training	Health awareness	7 days	320	50	270	320	—	—
First Aid training	Health	14 days	650	80	570	650	—	—
Kherbat-Afiq, Dhamar								
TBA training	Health	45 days	1800	400	1400	1800	—	—
Sewing and embroidery training	Skills development	3 months	450	50	400	450	—	—

Project title	Project period/age	Project type/kind	Project cost and contribution					
			Total	Capital cost	Operational cost	WHO grant	WHO loan	Community share
Adult literacy courses	Women's development	6 months	1000	—	1000	1000	—	—
Environmental health training	Health	7 days	320	50	270	320	—	—
First Aid training	Health awareness	14 days	650	80	570	650	—	—
Mangaza, Dhamar								
TBA training	Health	45 days	1800	400	1400	1800	—	—
Sewing and embroidery training	Skill development	3 months	700	—	700	700	—	—
Adult literacy courses	Women's development	12 months	1400	—	1400	1400	—	—
Environmental health training	Health	7 days	320	50	270	320	—	—
First Aid training	Health awareness	14 days	650	80	570	650	—	—
Hanud, Dhamar								
TBA training	Health	45 days	1800	400	1400	1800	—	—
Sewing and embroidery training	Skills development	3 months	200	50	150	200	—	—
Adult literacy courses	Women's development	6 months	550	—	550	550	—	—
Environmental health training	Health awareness	7 days	320	50	270	320	—	—
First Aid training	Health	14 days	650	80	570	650	—	—
Fuqum, Aden								
TBA training	Health	45 days	1800	400	1400	1800	—	—
Sewing and embroidery training	Skills development	3 months	200	50	150	200	—	—
Adult literacy courses	Women's development	6 months	130	—	130	130	—	—
Environmental health training	Health awareness	7 days	220	40	180	220	—	—
First Aid training	Health	14 days	950	80	870	950	—	—
Al-Feush, Lahaj								
TBA training	Health	45 days	1800	400	1400	1800	—	—
Environmental health training	Health awareness	7 days	320	50	270	320	—	—
First Aid training	Health	14 days	650	80	570	650	—	—
Al-Gazaf/Qaila, Hajjah								
TBA training	Health	45 days	1800	400	1400	1800	—	—
Sewing and embroidery training	Skills development	3 months	870	170	600	770	—	100
Adult literacy courses	Women's development	18 months	2730	2930	1000	2730	—	—
Environmental health training	Health awareness	7 days	220	40	180	220	—	—
First Aid training	Health	14 days	950	80	870	950	—	—
Maintenance of Qaila health unit	Health	October 2004	6500	6500	—	3000		3500

Project title	Project period/age	Project type/kind	Project cost and contribution					
			Total	Capital cost	Operational cost	WHO grant	WHO loan	Community share
Al-Yahary, Ibb								
TBA training	Health	45 days	1800	550	1350	1800	—	—
Sanitation project	Environmental health	January 2005	650	650	—	450	—	200
Adult literacy courses	Women's development	12 months	1500	100	1400	1400	—	100
Family planning and health education	Health awareness	10 days	380	40	280	380	—	—
First Aid training	Health	15 days	1000	80	920	1000	—	—
Support football team	Youth support	January 2005	670	670	—	670	—	—
Video cassette recorder, television health education tapes	Health	January 2005	350	350	—	250	—	—
Ozlat Al-Raoss, Ibb								
TBA training	Health	45 days	3400	2400	2400	3400	—	—
Family planning and health education	Health	10 days	380	340	340	380	—	—
Adult literacy courses	Women's development	12 months	1280	100	1180	1280	—	—
Sha'abania Ulia, Taiz								
TBA training	Health	45 days	3400	1000	2400	3400	—	—
Adult literacy courses	Women's development	6 months	400	80	200	400	—	200
Sewing and embroidery training	Skills development	3 months	200	20	180	200	—	100
Janadia Sofla, Taiz								
TBA training	Health	45 days	3400	1000	2400	3400	—	—
Adult literacy courses	Women's development	6 months	1820	450	1370	1370	—	—
Health education	Health	6 months	440	40	400	440	—	—
Firts aid training	Health	15 days	710	50	660	710	—	—
Water supply	Health	February 2005	1870	1870	---	1870	—	—
Abr Osman, Abyan								
Embroidery training	Skills development	1 month	510	150	460	510	—	—
Adult literacy courses	Women's development	6 months	180	20	160	160	—	—
Textile weaving training	Skills development	3 months	750	250	500	750	—	—
El-Naka, Hadramawt								
Maintenance of Al-Naqa'a handicrafts centre	Skills development	3 months	3000	3000	—	800	—	—

Annex 4
Profile of programme areas including list of projects

Programme area (Name and district)	Population	House-holds	Type of projects					
			Health		Other social		Income-generating	
			Title/type	Population covered	Title/type	Population covered	Title/type	Population covered
Bait Al-Sayed village, Bani Hushaish district, Sana'a	1094	147	TBA training Sanitation project Equipment for dentist clinic in Health unit	15 1094 1094	Sewing/ embroidery training Adult literacy course Public library	130 60 1094	Sewing and embroidery machine Cows and sheep raising Honey bee farm Water pump Small business Agriculture farm Water pump workshop Mechanical workshop Public transportation Blacksmith Stone cutter Gas cylinder transportation Electrical workshop	39 10 2 7 23 1 1 1 1 1 1 1 1
Al-Qemma, Bani Matar district, Sana'a	1018	152	TBA training	7			Sewing and embroidery machine Cow raising Sheep raising	20 30 20
Waqash village, Bani Matar district, Sana'a	1036	172	TBA training	8	Adult literacy course	20	Sewing machine Cows and sheep raising Small business Agriculture projects	6 15 7 16
Al-Munaqqab, Sana'a	1973	228					Water pump for irrigation	77
Mandhar, Hodeidah	2500	366	TBA training Environmental health training First aid training Health education Pharmacy	8 5 10 60 2500	Sewing/ embroidery training Adult literacy course	10 60	Sewing machine Sheep raising Public transportation Textile weaving Small business	10 10 1 11 22
Kashuba'a area, Al-Marawa'a district, Hodeidah	2500	366	TBA training Environmental health training First aid training	12 8 17	Sewing/embroidery training Adult literacy course Support football team	20 180 22	Sewing machine Sheep raising Milking cows	10 20 67

Programme area (Name and district)	Population	House-holds	Type of projects					
			Health		Other social		Income-generating	
			Title/type	Population covered	Title/type	Population covered	Title/type	Population covered
			Health education	180			Calf raising	47
							Handicraft	4
							Small business	4
							Public transportation	4
							Honeybee farm	3
							School buffet and stationery	1
							Agriculture tractor	1
							Water pump for irrigation	1
							Establishing agriculture farm	6
							Truck for distribution product	1
Al-Luhya area, Al-Luhya district, Hodeidah	4658	801	TBA training	12	Adult literacy course	80	Boat with engine for fishing	5
			Environmental health training	8	Children's park	4658	Bakery	1
			First aid training	17			Sheep raising	10
			Sanitation projects	4658			Electric workshop	1
							Water meter for houses	200
							Small business	10
							Carpentry	1
							Restaurant	1
							Cement block fabric	1
							Refrigerator	1
Kherbat-Afiq area, Al-Maifa'a district, Dhamar governorate	4153	538	TBA training	15	Sewing/ embroidery training	45	Sheep raising	15
			Environmental health training	10			Milking cows	12
			First aid training	20	Adult literacy course	60	Stone cutter	1
			Pharmacy	4153			Cement blocks for building	1
							Small business	8
							Water pump for irrigation	1
							Agriculture tractor	1
							Flourmill (grinder)	1
							Public transportation	1
Mangaza area, Dhamar governorate	4562	598	TBA training	15	Sewing/ embroidery training	45	Sewing/embroidery machine	21
			Environmental health training	10			Sheep raising	10
			First aid training	20	Adult literacy course	80	Milking cows	21
			Pharmacy	4562			Agriculture projects (tree, fertilizer, small water pump	14
							Small business	2
							Calf raising	13

Programme area (Name and district)	Population	House-holds	Type of projects					
			Health		Other social		Income-generating	
			Title/type	Population covered	Title/type	Population covered	Title/type	Population covered
Hanud Ans, Dhamar governorate	2116	340	TBA training	8	Sewing/ embroidery training	45	Sewing/embroidery machine	11
			Environmental health training	5	Adult literacy course	60	Sheep raising	12
			First aid training	20			Milking cows raising	1
			Pharmacy	2116			Agriculture projects (trees, fertilizer, small water pump	5
							Small business	5
Fuqum village, Al-Buraiqa district, Aden	1993	278	TBA training	8	Sewing/ embroidery training	20	Sewing and embroidery machine	70
			Environmental health training	8	Adult literacy course	18	Engine fishing boat	7
			First aid training	15			Carpentry	1
							Fishing net	10
							Small business	1
							Fishing boat repair	2
							Fish keeping boat	1
Al-Feush village, Tuban district, Lahaj governorate	1834	285	TBA training	12			Embroidery machine	5
			Environmental health training	8			Milking cows	11
							Sheep raising	7
			First aid training	16			Bakery	1
			Pharmacy	1834			Small business	7
							Water pump	4
							Agriculture projects	7
							Repair pickup for village garbage	1
							Carpentry	1
Al-Gazaf/ Al-Qaila area, Mabean district, Hajjah governorate	4249	549	TBA training	15	Sewing/ embroidery training	35	Sewing/embroidery machine	34
			Environmental health training	8	Adult literacy course	308	Stone cutter	9
			First aid training	16			Sheep raising	2
			Pharmacy	4249			Flourmill	2
			Maintenance of Qaila health unit	2800			Small business	8
							Honeybee farm	1
							Gas cylinder shop	2
Al-Yahary village, Ibb district, Ibb governorate	2635	364	TBA training	12	Adult literacy course	100	Milking cows	55
			Environmental health and family planning	19	Support football team	22	Stone cutter	1
			First aid training	9			Sheep raising	5
			Television and video cassette recorder for Health unit	4635			Honey bee farm	12
			Sanitation project	2635			Small business	8
Ozlat Al-Raoss area, Ibb district, Ibb governorate	9028	1280	TBA training	20	Adult literacy course	125	Milking cows	11
			First aid training	10			Stone cutter	1
							Sheep raising	1
							Honeybee farm	1
							Cylinder gas shop	1
							Flour mill (grinder)	1

Programme area (Name and district)	Population	House-holds	Type of projects					
			Health		Other social		Income-generating	
			Title/type	Population covered	Title/type	Population covered	Title/type	Population covered
Sha'abania Ulia area, Al-Tazia district, Taiz governorate	8292	1164	TBA training	20	Adult literacy course	35	Poultry farm	4
					Sewing/ embroidery training	16	Cows, calf and camel raising	15
							Sheep raising	17
							Honeybee farm	8
							Cylinder gas shop	4
							Small business	22
							Water pump for irrigation	2
							Repair tractor	1
							Agriculture project	1
							Tailor shop	1
							Mechanical workshop	1
							Public transportation	1
							Stone cutter	1
							Pipe for irrigation	1
							Sheep raising	17
Janadia Sofla area, Al-Tazia district, Taiz governorate	12 921	1994	TBA training	21	Adult literacy course	240	Support to dug well	1
			Health education	240			Stone cutter	1
			First aid	16			Small business	2
			Water supply	3000			Cylinder gas	3
Abr Osman village, Khanfer district, Abyan governorate	2070	316	TBA training	20	Adult literacy course	38	Fishing boat	4
					Embroidery training	9	Milking cows	3
					Weaving training	11	Sheep raising	17
							Honeybee farm	9
							Cylinder gas shop	4
							Small business	6
							Water pump for irrigation	6
							Deepening well	3
							Repair water pump	1
							Embroidery machine	1
							Butcher shop	1
							Carpentry	1
Al-Naqa village, Hadramawt	2300	250			Maintenance of handicrafts centre	2300		