

ASSESSMENT OF CHILD DEVELOPMENT PROJECT, YEMEN

FINAL REPORT

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Preface

This report has been prepared by HLSP contracted by the UNICEF Regional Office Middle East and Northern Africa (MENARO). The contents and opinions expressed herein are those of the consultants and, as such, do not necessarily reflect the opinion of UNICEF MENARO Office.

The team would like to thank all partners who supported us and contributed to this assessment. This includes stakeholders and beneficiaries who have spend their time and shared their experience with the assessment team - at national, governorate, district and village level in Yemen and at UNICEF and World Bank headquarters in New York and Washington.

In addition the evaluators are thanking the UNICEF country office team for their welcome in Yemen, the good working environment provided and the cooperation of UNICEF staff in Sana'a and in the field offices.

The assessment team

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Abbreviations and Acronyms

AAA	Assessment, Analysis and Action
ABP	Area Based Programme
ANC	Antenatal Care
ARI	Acute Respiratory Infections
BEDS	Basic Education Development Strategy
BEEP	Basic Education Expansion Project
CAPA	Cooperation Agreement for Project Assistance
CBN	Community Based Nutrition
CDD	Childhood Diarrhoeal Diseases
CDP	Child Development Programme
CRC	Convention of the Rights of Children
CSO	Central Statistics Office
DAC	Development Assistance Committee
DHMT	District Health Management Team
DPT	Diphtheria Pertussis Tetanus Vaccine
DPT3	Diphtheria Pertussis Tetanus Vaccine, 3 rd dose
DWDC	District Women Development Committee
EC	European Commission
ECD	Early Childhood Development
EFA/FTI	Education for All / Fast Track Initiative
EmOC	Emergency Obstetric Care
EPI	Expanded Programme of Immunization
FGD	Focus Group Discussion
FTI	Fast Track Initiative
GARWP	General Authority for Rural Water Supply Projects
GAVI	Global Alliance for Vaccines and Immunization
GOY	Government of Yemen
G2B	Girls to Boys Ratio
GTZ	Deutsche Gesellschaft fuer Technische Zusammenarbeit
HCMC	Higher Council for Motherhood & Childhood
HIS	Health Information Systems
HRBAP	Human Rights Based Approach
HU	Health Unit
IDA	International Development Cooperation
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
ITN	Insecticide Treated Net
KAP	Knowledge Attitude and Practice
KPI	Key Performance Indicator
LACI	Loan Administration Change Initiative
LDC	Local Development Committee
LM	Logic Model
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MDRP	Multi-country Demobilization and Reintegration Program
MENA	Middle East / Northern Africa
MMR	Maternal Mortality Rate
MoCS	Ministry of Civil Service
MoE	Ministry of Education
MoF	Ministry of Finance
MoPH&P	Ministry of Public Health and Population

MoSAL	Ministry of Social Affairs and Labor
msg	Square Meters
MTR	Mid Term Review
NCHE	National Centre for Health Education
NGO	Non Governmental Organization
O&M	Operations and Maintenance
OPV	Oral Polio Vaccine
OR	Other Resources
ORS	Oral Re-Hydrating Salts
PAD	Project Appraisal Document
PAPFAM	Pan Arab Project for Family Health
PCU	Project Coordination Unit
PHC	Primary Health Care
PMR	Progress Monitoring Report
PRSP	Poverty Reduction Strategy Paper
PSR	Project Supervision Report
PTA	Parent Teacher Association
PWP	Public Works Project
RR	Regular Resources
SC	Steering Committee
STD	Sexually Transmitted Disease
SWAp	Sector Wide Approach
TBA	Traditional Birth Attendant
ToR	Terms of Reference
ToT	Training of Trainers
TT2	Tetanus Toxoid 2 nd dose
U5MR	Under 5 Mortality Rate
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US\$	US Dollar
WB	The World Bank
WES	Water and Environmental Sanitation
WFP	World Food Programme
WHO	World Health Organization
WID	Women in Development
YR	Yemeni Riyal

Executive Summary

Introduction

This report is the result of the assessment of the Child Development Project, Yemen. It was conducted by a team of three evaluators in the period March 05 until July 05.

The Child Development Project (CDP) is a tripartite partnership between the Government of Yemen (GoY), UNICEF and the World Bank (WB). With a total budget of US\$ 45.3 million it is also the largest collaboration between UNICEF and the World Bank to-date. It is also the first time that the Government of Yemen took a loan from WB and delegate a significant part of the project implementation to another agency, UNICEF, which is at the same time a co-funder.

CDP is a five year project which started in 2001 and will come to an end in December 2005. It aimed to improve the basic social services to children and women in 30 districts in nine governorates in Yemen selected on the basis of social deprivation. The project has six key components:

- Project Management
- Community Readiness Programme
- Health Activity
- Nutrition Activity
- Education Activity
- Pilot Early Childhood Development Activity

The overall objective of CDP is “To assist the Government of Yemen in the implementation of a coordinated area-based programme for improving the health and nutritional status of children under five and the educational status of girls in primary schools in districts that are currently under-served in the areas of health and education”¹.

At the end of 2004, the overall expenditure rate was 52.60%, whereas the expenditure rate of UNICEF own funds was 71.13% and the one of IDA funds was 50.45%. The lowest expenditure rate was experienced by the GoY and community funds with 11.05%.²

The purpose of the assessment was to examine the achievements of all project components against the targets for the selected districts and generate findings and recommendations for improving project processes and results. As the project will likely end in December 2005, there will be also lessons learned to be provided.

Assessment Approach

UNICEF Yemen country office team, UNICEF MENARO M&E officer and the evaluators agreed to stay as close as possible to the DAC terminology³ and to use the logic model for the CDP in the project appraisal document (PAD) (see table 1)⁴.

¹ World Bank, CDP Project Appraisal Document, 29 February 2000

² See Annex 8, Final Consolidated Budget Status 2001 – 2004, UNICEF Country Office Yemen.

³ OECD Development Assistance Committee (DAC), Glossary of Key Terms in Evaluation and Result Based Management, 2002

⁴ World Bank, CDP Project Appraisal Document, 29 February 2000

The team allocated the key questions of the ToR to the five evaluation criteria (see annex 2), i.e. relevance, efficiency, effectiveness, potential impact and sustainability. This was done for each of the main components (Health, Water, Nutrition, Education, and Community Readiness) and for project management and cross cutting issues. It applies the DAC terminology (see annex 5).

In preparation for the field interviews, the evaluators developed an assessment matrix for the CDP components (see annex 6) and guidelines for semi-structured beneficiary interviews (see annex 7). These tools were developed to generate as many qualitative information to measure progress and to enrich the sometimes poor quantitative data, in particular on impact.

The assessment was carried out applying a three step approach with a desk phase, a field phase and a reporting phase.

The governorates and districts were chosen in agreement by assessment team and UNICEF Yemen country office. The field visits encompassed three districts in three governorates: Al Hudain (Ibb), Al Milah (Lahej) and Zaidya (Hodeidah). Al Hudain and Zaidya are of the first phase of CDP, one district to be considered relatively easy to work with, and the other as relatively complicated. The third district, Al Milah, is of the second phase of CDP. In addition to the three districts visited, another 8 districts in the same governorates respective indicators have been analyzed, thus the assessment was based on data of 11 CDP districts.

The field phase in Yemen was conducted in two parts. The first part, from 19 March to 10 April, included the desk phase and the field visits to three governorates, including data retrieval. The second part was conducted as planned from 29 April to 11 May 2005 and focused on meetings at central level

Programme Assessment

(1) Project Management

The issues addressed by the CDP are of relevance to Yemen. The objectives are in line with the goal to alleviate poverty by creating an early stream of social benefits in education, health and other social services as set out by the Millennium Development Goals (MDGs). Women and girls as the main group targeted are well chosen, in recognition of the general low level of human development indicators and the significant gender gap in education in Yemen.

Though the issues are correctly addressed, the CDP design has several weaknesses. Several risks were underestimated, e.g. the institutional limitations and the lack of experience in inter-ministerial and inter-organizational cooperation. Taking these into consideration, the scaling and scoping up of UNICEF's previous area based programme (ABP) under CDP was too fast.

The project design also calls for different procedures for procurement, financial management and reporting requirements. There are, for example three types of procurement procedures envisaged: (a) IDA procedures for all IDA financed activities managed by the PCU, (b) procedures described in the CAPA, which are acceptable to IDA for all IDA financed and UNICEF managed activities; (c) UNICEF procedures for all UNICEF financed activities. During project implementation it showed that this is an extremely cumbersome approach, time consuming and sometimes de-motivating for the staff. It has contributed to slowing down of the implementation process

The proposed management structure did not sufficiently take into consideration the institutional limitations, both, of the Government of Yemen (GoY) and of the UNICEF country office as the main implementing agency on behalf GoY.

A monitoring system for CDP, which should have been implemented as a risk minimizing measure, does not exist. The position of a monitoring officer was only introduced in the UNICEF country office at the end of the fourth project year. The assumption of the management in the earlier years of the project – that every international staff member has a good monitoring knowledge and thus an additional international M&E expert is not required - was obviously incorrect.

UNICEF has staffed and equipped seven field offices covering implementation districts in nine governorates. The original idea was to have a counterpart of the HCMC in each of the field offices, to assure cooperation and institutional building. In addition it means a substantial increase of human resources for the field offices. This was not implemented, and the idea has been revitalized only in early 2004. At the time of the assessment four HCMC representatives on governorate level have been nominated and two were observed at work.

The fast growth of implementation districts and governorates, compared to the UNICEF ABP prior to CDP, already meant a management challenge. There is reason to believe that the structure of field offices grew without previous implementation of a clear management structure. This include the provision of training and tools for field monitoring, and putting in place a clear and regular communications mechanism between the field offices and the UNICEF Sana'a country office.

Just recently the M&E officer started efforts to close the information gap between the field offices and the UNICEF country office. This is a step in the right direction; however, this system was primarily developed to monitor the UNICEF country programme progress. The information generated will be of limited use for the CDP monitoring.

The CDP is characterised by overall low expenditure rates. At the end of 2004, the IDA funds had an expenditure rate of 54% of the IDA credit channelled through UNICEF, US\$ 21.4 million, and a rate of 38% of the IDA funds managed by the PCU, 71% of UNICEF funds and 11% of funds of GoY and communities. Overall it does not appear likely that the funds available can be fully spent within the project duration. Regarding UNICEF's own funds there is the chance to spend it during the country programme 2002 – 2006, i.e. one year beyond CDP project end. At the time of the assessment the chances were not high that WB will agree to a rider to the IDA credit contract and/or a no-cost extension.

The project has good local visibility overall. During the field visits, however, the evaluators got the clear and uniform impression in all districts visited that the project is not known as CDP but as "the UNICEF project". For the beneficiaries, the most visible partners of CDP have been UNICEF field officers and staff working directly with local government personnel and the communities.

It is an effectiveness issue that during the first four years of the CDP there was de facto hardly any PCU/HCMC participation in the CDP decision-making and work in the field; this can be considered as the main cause for the ineffectiveness of the PCU in establishing a true partnership with UNICEF at district/governorate level and to establish visibility and presence in the implementation districts.

UNICEF staff interviewed considers it the faster alternative to move forward in the implementation of the CDP working directly with district authorities and communities. This, however, is neglecting the necessity of close cooperation with PCU and other governmental partners. Working in the field without an active involvement of the PCU/HCMC may enhance speed of implementation, but includes the risk that the sustainability of the project is jeopardized.

The prospects for institutional sustainability are weak, in particular on national and governorate level. This has several reasons: The lack of sufficient staffing in quantity and experience; the missed opportunity of early and continuous cooperation (and knowledge transfer) between the UNICEF and the PCU/HCMC at national and field office level; the lack of presence of PCU/HCMC at field level for most of project implementation.

In the recent past, there have been positive attempts of cooperation and increased field presence of the Higher Council for Motherhood and Childhood (HCMC). In order to foster institutional sustainability, this kind of partnership between GoY and UNICEF, as it appears to be working now, should have been launched at the beginning of the project, to make full use of mutual learning.

(2) Health

The project has only achieved its objectives for the health sub-components to a limited extend. Details are as follows:

- a) The immunization rates collected by the Ministry of Health (MOH) are unreliable.
- b) As regards the population's access to health care, exact figures are neither available as a baseline nor for the present. Not all facilities constructed/rehabilitated by the project are yet ready and a couple have been completed, but not yet staffed and habilitated by the MOH.
- c) All 30 districts of the CDP have benefited from the introduction of IMCI. Nevertheless, access of children to quality care for the major childhood diseases has been hampered by long delays in the project coordination unit's (PCU) procurement of IMCI drugs to distribute to all facilities in the 30 districts.
- d) As regards safe deliveries/safe motherhood, the percentage of home deliveries remains high. Eight district obstetric centers were upgraded and the staff retrained. But the community sensitization sub-component of the emergency obstetric care (EmOC) component has been very late in starting, resulting in still very few referrals of high risk obstetric cases from the village to the district EmOC centers.

Some success can be claimed due to the project in the EPI programme. EPI investments have mostly gone to the cold chain. On the other hand, little success can be claimed on EPI record keeping. Moreover, by December 2004, the output of 90% vaccination coverage rates for children in project districts had not yet been reached in the majority of them. The CDP has done relatively well on integrating EPI into district health plans.

Only very partial success can be claimed by the CDP in access to health care. Not due to the fault of the project, many facilities in the 30 districts remain un-staffed and closed. No objective indicator of greater access can be inferred by the evaluators from the existing information.

Success can be claimed by the project for the IMCI outputs - although nothing can be

objectively said about the quality of the training carried out. Only a partial success can be vouched by the evaluators for a streamlined referral of sick patients system in operation. IMCI drugs availability has been a major failure of the project due to severe procurement delays by the PCU.

The project can claim partial success for its work on safe motherhood. Eight EmOC centers were upgraded. ToTs received training on infection prevention control and they trained health staff. The community training is an activity just starting so no judgment can be passed on its efficiency. ANC services have been only utilized by a fraction of beneficiaries - a lack of female health staff being responsible for this.

A yet additional gap to be pointed out is the one in relation to the CDP's intention to center its priority in community participation: community health facility committees; no evidence was found that this had started. A major additional constraining factor overall reported by the UNICEF staff is the low financial and technical capacity of the MOH to accompany the project in the 30 districts.

CDP has fallen short of achieving its expected health outcomes. For now, there are no before-and-after outcome indicators available in the project districts for morbidity and mortality of children and for maternal mortality to measure any project effectiveness.

Assessing the impact of all sub-components in health (namely (1) reduced maternal and child morbidity and mortality and (2) improved health status of young children and of pregnant and lactating mothers) is impossible at the time of this assessment. It will in fact only be partially possible after the re-run of the baseline survey in the form of a short module added to a national household survey being launched by the Central Statistics Office (CSO) in April 2005.

UNICEF ended up collaborating with UNFPA in implementing the delivery kit, but not yet on the community sensitization aspects of EmOC.

Since 2003, WFP has been distributing food to school girls in 1,400 schools for girls in grades 1-9. WFP also distributes food to pregnant and lactating mothers and malnourished children in 85 districts, but only in 15 CDP districts and not always in the same health facilities. There has been an increasing effort by UNICEF to coordinate with WFP to have these activities cover as many as possible of the CDP districts and facilities.

UNICEF has not worked with other institutional partners in the implementation of the CDP health sub-components.

So far, the sustainability of the health sub-components of the project provides a mixed picture.

- a) The EPI will probably remain sustainable due to the importance and verticality of this sub-component and the GoY and donor (importantly UNICEF) efforts to keep it going.
- b) As regards access, the picture for sustainability does not look so good in the near and medium term.
- c) In IMCI, the potential for sustainability definitely exists provided drugs are regularly made available and supervision and retraining activities are funded and kept up.
- d) In safe motherhood, what will be achieved during the remaining months before project end is crucial. All will depend on the efficiency and effectiveness of the upcoming community education activities just now starting now.

(3) Nutrition

Project performance of CDP's nutrition component is assessed as generally good; no comment can be made on the performance of the education of mothers for which the evaluators did not find any information.

Achievements in the area of iron and Vitamin A supplementation have been meager in terms of setting up a lasting system. CDP's efficiency in this area has to be considered minimal. As regards exclusive breastfeeding and complementary feeding, evaluators heard and read plenty anecdotal evidence that this promotion is being carried out and that "the results are good". But no hard data are available on this at this time.

An important gap in the efficiency of this component has to do with the oversight of having trained volunteers to aggregate the data for their catchment area every month so they can judge by themselves the trends in total children weighed and those falling in the red area of the growth chart. This aggregation is also not done at the district level, but only by the CBN coordinator at governorate level who then sends the data to the Nutrition Department of the MOH in Sana'a. As a result, little can be said reliably about the coverage rate of the weighing activity of <3s, i.e., the percentage of all <3s in the community weighed. What can be said is that there is a trend in the nutrition monitoring that shows reductions in the malnutrition rates of those children that attend weighing sessions provided that it is the same children that come back month after month - a fact that is not recorded.

Evaluators can say little about a decrease in the prevalence of low weight for age of <3s and of micronutrients deficiencies for this group and for pregnant women. The same is true for mothers' breastfeeding and using adequate feeding practices: data are not there to assess these key performance indicators set by the PAD.

Before-and-after outcome indicators for malnutrition of children <3 in the project districts are available only since April 2005 and only at the MOH in Sana'a; data for pregnant and lactating mothers are not yet available anywhere (nor is this data being collected). For <3s, rough average underweight rates show that they went from around 42% to around 30% malnutrition in from six to 11 months of operation of the CBN. This is highly unlikely to be representative of the whole cohort of <3s, but rather represents a drop for the CBN users which most likely is a biased sub-group in each community.

Assessing the impact of the nutritional sub-components (namely, improved nutritional status of young children and of pregnant and lactating mothers, as well as an improved micronutrient status of the same groups) is impossible at the time of this assessment. Data are only available for 10 districts and their reliability is not clear for underweight and totally unavailable for Vitamin A and iron status.

Evaluators found no evidence that triple A processes at community level in which the community takes ownership of the project activities were established.

The sustainability of the nutrition activities of CDP is not assured after project end. It is almost sure that the MOH does neither have the resources to continue training/retraining volunteers nor to keep up needed supervisory activities. An expansion of the activity to additional districts is late in starting this year and may not yet establish CBN firmly by the end of December of this year.

(4) Education

Girls' education in Yemen is a highly gender sensitive issue. Cultural factors as gender specific roles, early marriage and segregation between the sexes as well as economic factors related to poverty inhibit in particular girls' access to education. In addition to the gender gap in education, urban-rural differences are significant: 84.8% of urban and 68.9% of rural males in the age group aged 10 and above are literate, compared to only 59.5% of urban and 24% of rural females, respectively.

During the period 2001 to 2003, the number of classrooms constructed surpassed the total number planned (534 as of December 2004, versus 210 classrooms planned). This can be explained by the tendering and construction of the schools at community level, which facilitated the construction. The classrooms were of modest but functional design and did not include a management/storage room, thus involving less construction work. These factors have led to relative low construction cost per classroom while matching functional requirements.

For classroom rehabilitation more than 50% of the target set has been achieved between 2001 and 2004. So far 358 rehabilitated classrooms stand against the targeted number of 600. The year 2004, however, was a year of low implementation of CDP community schools. There has been an intensive discussion between UNICEF and the Ministry of Education (MoE) regarding the required design of the classrooms constructed. MoE argues that each school constructed must have a management room, sanitary facilities and fulfill MoE standards regarding size and materials used. This contributes to increased average construction costs per classroom.

Construction work planned for 2004 was thus seriously delayed and had to be shifted to 2005. By January 2005, according to the UNICEF summary planning sheet, out of 325 classroom constructions due for 2005, 265 are a backlog from previous years. 60 additional classrooms are the planned task for 2005. There is also a backlog in the work on school rehabilitation. Out of 246 classroom rehabilitation works considered due for in the same data source, six were initiated in 2003, 72 were initiated in 2004 and 168 had been due for 2004, but had not been initiated by January 2005. This amounts to a very ambitious workload for construction and rehabilitation for 2005, the last year of the CDP contract implementation.

Two of the three budget lines related to the education component, community schools and women teacher training, show an overall expenditure rate of 37% and 30%, respectively. The likeliness that all available IDA funds for the education component can be spend before December 2005 must be assessed as low. The highest flexibility of funds use is expected to be with UNICEF's own funds, in particular as the UNICEF country programme covers the period 2002 – 2006, i.e. it continues one more year beyond CDP end. IDA funds, in contrast, can only be used before the closing date of the credit, 31 December 2005.

The initial training of newly recruited female teachers is a crucial activity of the CDP education component. The importance of the presence of female teachers for the achievement of the educational project development objective of CDP was already stressed. The project's initial objective was based on the commitment of the MoE to contract 2000 rural female teachers with secondary school degree per year. It was meant to increase the number of female teachers, in particular, in rural areas nationwide, and to provide them with an initial training.

Although meant to have increased, the training figures for this target group show a

sharp decline over time, following the declining figures for newly recruited female rural teachers. In the first CDP project year, 1612 female teachers have been trained, whereas the numbers for the subsequent years are 1403, 967, 647 and for the current academic year 2004/2005 it is 450, respectively. For the academic year 2005/2006, the last recruitment during CDP, a total number of 578 rural female teachers' vacancies were provided; of these, only 138 were allocated to the nine CDP governorates - not necessarily in the 30 CDP districts or for the CDP supported schools.

To solve this chronic problem is beyond the influence of UNICEF as the principal manager of the component. UNICEF continues to address this severe issue by advocacy, together with other major donors in the education sector who share this concern.

The female teachers interviewed, who had been trained during early CDP or already pre-CDP periods had a very positive perception of the training and emphasized its practical approach. They also found the subjects covered as very effective in contributing to improvements in their teaching.

Six of the seven warehouses for textbooks planned were built or rehabilitated between 2001 and 2004, and 18 warehouse staff members were trained in 2004.

Overall, the textbook distribution has been successful. The number of schools provided with textbooks has increased since the start of CDP and earlier problems with storage of books have been detected and solved. The CDP is supporting the transport of the schoolbooks from warehouses to the schools. The issue of sustainability of this activity after project end remains, as the GoY is actually only contributing to transport cost from the printing house to the districts, not to the schools.

CDP school construction is, after changing of the design to be in accordance with MoE requirements, still at the lower end of the models benchmarked (9,423 US\$). Teachers' room and latrines as part of the school construction are justified, and it must be assured that female teachers and female students do equally benefit from this infrastructure.

(5) Early Childhood Development

The component remained dormant until mid 2004. Until that date only a survey on child rearing practices was undertaken. Among the reasons for late take off was the lack of expertise in country and restrictions of financing more international staff. The ECD component was revamped upon the arrival of the expert. The results of the survey provided the basis for several of the component's subsequent interventions.

It appears that the ECD has finally taken off rather well, although it is too early to comment in detail on the quality of results and impact of this CDP component. Relevant questions will be "How are the trained ECD specialists use/share the newly acquired knowledge effectively?" and "How do specialists at governorate level interact with the National Resource Centre?". The overall expenditure rate of ECD at the end of 2004 was 29%. Even anticipating the payment of the final installment of the online course of estimated US\$ 75,000 substantial funds remain to be spent during the short remaining time; in particular the actual expenditure of Government funds remains nil.

(6) Water

Generally, it has been observed that the water management committees function well and keep satisfactory records.

Procurement rules and procedures of both the World Bank and UNICEF are cumbersome. This causes major delays in the case of the former and being too inflexible, in some cases, to shift balances between component items in the case of the latter. With CDP having to face both of them, certain activities have witnessed more delays than had procurement been done through one system. However, this also has highlighted for the assessment team one more issue: UNICEF field and sector staff at the country office has not been given sufficient orientation on UNICEF's own procurement procedures, let alone the World Bank's.

Generally, the design of the water schemes has been undertaken satisfactorily. This kept in view the need of beneficiaries, the capacity of villagers to maintain the schemes, the type of water source available and source depth, the catchment area and the availability of spare parts. In some cases, the last aspect could become problematic especially in the case of solar panels or spare parts for hand pumps which have to be imported.

For the sanitation sub-component, UNICEF developed a set of standard designs for latrines construction. In 2004, this set was sent to GARWP to be reviewed with the local authorities including local councils, water committees and GARWP's branches to agree on potential way through which communities could be convinced to adopt and implement the designs. However, as GARWP lacked and still lacks any expertise in sanitation, no implementation took place. Incidentally, completion of a sanitation package has been in the WES component's workplan since 2003 and is thus overdue.

A study was recently undertaken by an engineer for GARWP examining the relative costs of procurement of supplies for water schemes of GARWP and CDP showed that tenders obtained through GARWP's own system were 27.36% higher as compared to those procured through CDP.

Also due to flexibility in design e.g there is little delay in payment to contractors, the schemes are more efficiently implemented. In traditional schemes undertaken by GARWP, it often takes up to a year for the contractor to be paid. In addition, as noted above the schemes can generate substantial revenues for village communities.

In all cases, interviewed villagers reported that time for fetching water have been substantially reduced, lowering the burden on girls and women. This includes not only travelling time to the water source and back, time spent in drawing water and filling Gerry cans but also time spent in queuing besides wells, etc. Though no quantitative data has been available, villagers also report that incidence of waterborne diseases has significantly decreased. Again, while no substantive data exists, some people have stated that the schemes have freed time for girls to attend school. Despite this, while a sizeable number of households have quicker and cleaner access to water, there is still a large section of population within the 30 districts that is without water.

Involvement of the community in planning, implementation and maintenance of the schemes has led to increasing their capacity and empowering them. Water management committees actively explore mechanisms to adopt to buy new pumps for example, or utilise revenues earned for other village development activities. The

involvement has also fostered linkages with government institutions notably GARWP. However, capacity building of women committee members or users has lagged behind notably because of the social constraints within which they have to work and the lack of female professional staff within government service providing agencies with whom they can comfortably interact.

Where tariffs have been introduced, the revenues in some cases are quite impressive running into several hundreds of thousands of Riyals. However, these sites are the exception and in the majority of cases, a tariff system has yet still to be introduced or the savings so far accumulated are much smaller.

(7) Community Readiness

Participatory Planning

In the project the concepts of training and capacity building have been defined in very loose terms. The participation of government officials, at the district, governorate and central levels and of villagers in annual review and planning meetings have been highlighted by UNICEF as physical achievements of the project, while in actual fact these are just activities, not outputs or outcomes. However, due to expansion of the project and other factors, now they are generally of one day duration split into a morning review and an afternoon planning session.

In the judgement of the assessment team, taking part in a day's proceedings once a year without having had any training previously in social mobilisation, participatory planning methods or, in many cases, being exposed to development projects implemented and managed by the community, cannot be classified as community readiness. Within this component, the project was supposed to equip stakeholders with the requisite skills for participatory planning and implementation on a continuous basis.

Without proper training and sensitization, the participation of government officials in CDP's planning and review exercises are not very effective. Further, the effectiveness of community readiness is undermined in those governorates and districts where the relationship with government is poor. Local councillors, in addition, often lack budgets for field visits, which reduces their interaction with rural communities.

Social Mobilisation Network

As first step a Social Mobilisation Network in partnership with NCHE was established and women village volunteers called community communicators in Lahej, Sana'a and Ibb were trained. In the perception of the assessment team this was an efficient use of resources as NCHE already had the resources and expertise, having engaged in similar activities over the years though lacking outreach at grassroots level.

As a partner, NCHE has had a positive affect on the initiative. It has assisted in developing the various manuals and guidelines and instituted a feedback mechanism. Formats have been created for focal points to record the activities of the community communicators. The feedback obtained from the different liaison persons is analysed by the consultant engaged from NCHE – a step not frequently seen in development projects. Based on the feedback, programming is modified, e.g. the training and message delivery manuals have been updated in the past.

UNICEF describes this arrangement as a social mobilisation network. However, in

the opinion of the assessment team it lacks many features for bodies that are described as networks. Firstly, there are no formal or informal gatherings at which either member belonging to different strata of the 'network' or members within a single stratum interact with one another. Messages on IMCI etc were delivered once at the formal trainings which lasted 3-5 days. After that, there is no methodical way in which the capacity of community communicators is enhanced or the messages reinforced.

None of the community communicators or any of the focal points are remunerated for the services they deliver and neither are the liaison persons, who are supposed to regularly travel to rural villages, to reinforce this 'network', get any travel allowances.

Instead of developing parallel expertise, UNICEF used existing national resources such as NCHE, government officials and other social bodies to execute its work. This was a prudent approach. Additionally, recurrent costs on UNICEF are low. Given that the structure has been weak in both reinforcing and networking, that the impact so far has not been assessed and no tangible results such as the construction of buildings or other schemes were expected, it is difficult to indicate whether the component has been cost-effective or not.

(8) Gender and Human Rights

Women have not enjoyed equal access and representation in the community based committees, as water committees, parents associations (de factor mainly fathers associations, no case of mixed committees have been visited). In the cases identified during the field visits, women were either not proposed or not applying for election or, if finally elected, assumed only a "token women function" than that of an actively participating committee member.

The health component provides a fairly positive picture. The access of children to the services provided has been fully gender balanced (e.g., EPI and IMCI); in the case of adults, the CDP clearly and justifiably emphasized women's reproductive health issues as described in detail above. In the nutrition component, the community-based growth monitoring sub-component has given equal attention to boys and girls; interventions for adults fully centered on pregnant and lactating women.

Women and girls are traditionally assuming the task of water collection in Yemen. They have been clearly benefiting of the water component, if they live in the catchment area of newly installed water systems. Water collection at remote places was reported to have taken up to three hours per day prior to the installation of the CDP water systems. This potentially frees some of the girls' time for other activities, including the possibility to attending school. Some interviewed beneficiaries provided evidence through their statements.

The education component is highly gender sensitive. The gender roles (and expected roles to be assumed) of women and men and of girls and boys have a strong impact on the education component.

The CDP was designed before HRBAP was adopted by UNICEF as the norm for programming. At the time when CDP was designed, *stricto sensu*, the project has not been consistent with the human rights-based approach (HRBAP), although it focuses on some issues of prime human and gender rights importance (e.g. targeting less advantaged areas and population groups and some elements of participation).

Findings

(1) Institutional Structure

The CDP is a rather complex and challenging project. It was the first project of its kind, implemented in a tripartite approach between UNICEF, The World Bank and the Government of Yemen.

The challenges related to different procurement, financial management and reporting systems and requirements of the organizations involved were underestimated in the beginning. The existing institutional capacity was not advanced enough for the approach considered, neither at the GoY nor at the UNICEF level. Interministerial cooperation was widely unknown.

At the same time, the CDP design called for an expansion in scope and scale, compared to UNICEF's earlier area based programme. The implementation area was enlarged from 10 districts in three governorates to 30 districts in nine governorates; from mainly education activities to a multi sector approach.

(2) Monitoring

The PAD was calling for a strong monitoring function as a risk minimizing measure at project start. The importance of the internal monitoring function and system has been widely neglected by the project for almost four years of this five-year project. Only end of 2004 the position of an M&E officer has been staffed in the UNICEF country office. PCU succeeded only sporadically in recruiting an M&E officer, also just towards the end of CDP. The long absence of a stringent monitoring and quality assurance and the late staffing of the M&E position had also a negative impact on the M&E training of field office staff and on counterpart training at district, governorate and central level. Although both organizations, UNICEF and the PCU, are sharing the same problem, the monitoring function of the PCU is not as crucial for the project as the one of UNICEF as the main implementer of CDP. This is felt as a weakness of the project.

The data generated for CDP at field office level is sometimes not comparable, as different data is retrieved by different field offices. In addition, sometimes data from different UNICEF sources is contradicting. The problem of data availability and reliability also applies for data sources of the government counterparts at the various levels. Internal monitoring carried out by the UNICEF field offices is lacking clear guidance of the country office and related standards.

As regular training evaluation was not conducted throughout project implementation, a lot of valuable information to measure the quality, efficiency and sustainability of training and its impact on achieving the objective of CDP has not been gathered systematically.

(3) Coordination

A complex, integrated multi-sectoral project like CDP calls for continuous coordination between the different project components, partners and different levels of implementation involved.

In spite of recent efforts made by UNICEF to intensify coordination between the different sectors responsible for the CDP implementation in the country office and between the country office and the field offices, there is still a lack of coordination

between field offices and the country office and between the components, represented by sectors at country office level.

There are promising attempts of coordination between HCMC and UNICEF at field level. However, these developments are fairly recent and maybe too late to result in a revamping of the project.

The coordination function of CDP appears to be rather centralized, it is thus important to exchange all relevant developments with the field office staff on a regular basis. A crucial role lies with the Area Based sector within the country office. This position was held only temporarily after the previous officer left and has now just recently been filled. De facto each CDP component has been established more as a stand alone project.

The opportunity to share experiences with similar integrated projects and to use synergies, like with SFD's Integrated Community Development Programme, has been missed. However, in components as education, good results have been achieved cooperating with GTZ and the NGO ADRA.

(4) Partnership and Visibility

The CDP has a good local visibility overall. However, during the field visits it became obvious, that the project is not known as CDP, but as "the UNICEF project". Other CDP partners, as the GoY represented by the HCMC/PCU, are not considered by the beneficiaries as major implementing partner.

This relates to the widely missed opportunity of UNICEF and the PCU to work in close cooperation at field level throughout CDP implementation. Only very recently first positive steps have been taken in this direction. Three HCMC representatives are based in UNICEF field offices and a fourth is based in the PCU premises in Sana'a have been recruited and assumed work.

Another observation is that UNICEF country office staff itself hardly distinct between the UNICEF country programme and the CDP. Although there are for sure valuable synergies between the two, CDP is not "an extension of the UNICEF country programme". The fact, that the Government of Yemen borrowed a substantial amount of funds at the WB and has commissioned UNICEF with the implementation of the main part of it, has to be appreciated in this partnership.

(5) Implementing Capacity

At the end of the fourth year of implementation, the overall expenditure rate was 52.60%, whereas, looking at the three sources of budget, the picture is as following: 71.13% of UNICEF' own funds, 50.45% of IDA funds and 11.05% of GoY and Community funds.

UNICEF's own funds might be also used for purposes in line with CDP within the country programme 2002 to 2006, i.e. one year beyond the end of CDP. More critical is the assessment of the unspent IDA funds, i.e. US\$ 14.27 million, which might remain with IDA and will not be accessible by the project beyond its official end date of 31 December 2005. At the time of the CDP assessment, a contract rider with a no cost extension of CDP appeared not likely.

The expenditure rate of the education component at the end of 2004 was as low as 37% for community schools and 30% for women teacher training. Only textbook

distribution achieved 92% expenditure. The Government of Yemen has so far only contributed to the textbook distribution up to the district level.

The low expenditure rate in education, in particular in the women teacher training, has a quantitative and qualitative component. The training cost per person trained remained below those originally estimated. This indicates an increased cost effectiveness of this activity. However, there is big gap between number of people expected to be trained and actual numbers. This calls for an as rapid as possible implementation, as budget reallocation is not likely during the last semester of the contract period. As the funds for construction and rehabilitation in 2005 are only UNICEF's own funds, there may be certain flexibility in using them beyond the CDP contract. After a closer analysis of the funds spent and the remaining budget the SC committee should take decision.

(6) Female Rural Teachers

The target "the proportion of trained female teachers for grade 1-6 at schools in intervention areas increased by at least 15% by the end of the project" is unlikely to be achieved. Instead of increasing by 2000 female teachers nationwide per year, the number of female teachers during CDP implementation has even declined in CDP districts. This will diminish, if not jeopardize, the effects of the CDP education component, and has also consequences on the speed of closing the gender gap in education in Yemen.

The problem of lack of rural teachers, in particular of female teachers, is intrinsic. This is an important missing link to achieve the intended impact of the CDP, and as well as of other education projects.

The definition of quota for female rural teachers involves three ministries, the ministries of education, finance and civil services. Often one Ministry is putting the blame for recruiting too little female rural teacher on another. This problem exists since pre-CDP times and has been repeatedly addressed by members of the Education SWAp. It also relates to lack of inter-ministerial cooperation and coordination.

Female teachers assume several important and highly gender-relevant functions in Yemen's rural areas: (1) as trusted teachers for girls, in particular for girls in pre- and puberty age; (2) as possible links to the females of the community, i.e. mothers and other girls, communicating not only education-related issues; (3) as a role model within their communities and (4) as a possible professional alternative (of only a few) for women.

(7) Sustainability

Based on the financial contributions the GoY has made so far to CDP, the prospects for its overall financial sustainability have to be assessed as low.

Putting finally in place HCMC representatives at governorate level is a good opportunity to enhance institutional knowledge and increase prospects for sustainability before the project ends. So far, institutional sustainability remains weak.

A positive element for financial sustainability has been observed in some villages where the water components implemented water schemes, and where communities have collected substantial amounts of money for maintenance of the system.

The sustainability of the nutrition component of CDP is not assured after project end.

It is almost sure that the MOH does not have the financial resources to continue training and retraining of volunteers. An expansion of the activity to additional districts is late in starting this year and may not yet establish CBN firmly by the end of the project.

The sustainability of the school book distribution up to school level is not secured beyond project end either, as the GoY is contributing under CDP only to the distribution up to district level. An exit strategy was not available at the time of the CDP assessment.

(8) Gender

Women have not enjoyed equal access and representation in the community based committees, as water committees, parents-teachers associations (de factor mainly fathers associations; no cases of mixed committees were seen during field visits). In the cases identified during the field visits, women were either not proposed or not applying for election or, if and when finally elected, assumed rather a “token women function” not really actively participating as committee member. The gender aspect has not sufficiently been built-in the CDP project design.

(9) CDP Component Specific Findings

Health

- A situation that makes little sense was found in which IMCI drugs are given out free and others not. IMCI drugs have been out of stock for months creating serious problems for the staff in the health centers since mothers are then asked to pay for the same drugs from the revolving fund.
- Health Facility Committees do not participate in the management of the drug revolving funds or in the spending of the operational budget of the facilities.
- The drug distribution to rural health facilities is on drug by drug and is cumbersome for the staff to go and get.
- There is no referral sheet for patients in use.
- CDP has an antimalarial component in one governorate which has not been monitored closely.
- During their field visits, the assessment team did not find micronutrients in the stock of the health facilities visited.
- Community communicators in the project are not yet trained on HIV and AIDS.

Nutrition

- The coverage of benefits and services under the nutrition component is still limited, six months before project end.
- UNICEF and WFP both have potential complementary nutrition interventions in different geographical locations.

- CDP currently provides training to volunteer IMCI communicators and nutrition volunteers separately.
- UNICEF runs separate ECD activities with its own funds, alongside with ECD activities under the CDP project.
- No provisions have been taken yet to seek funding to continue the CBN programme. The assessment team found that CBN has neglected the micronutrient aspects of a nutrition intervention.

Education

- During the field visits cases of misallocation and inadequate use of class rooms were observed, e.g. teachers were sitting in a “management room” built as a class room, whereas children were sitting on the stone floor outside.
- CDP school construction is, after changing of the design to be in accordance with MoE requirements still at the lower end of the models benchmarked (9423 US\$). The requirement of the MoE to include teachers’ room and latrines to all school constructions is justified.
- Some of the teachers’ rooms have been occupied by male teachers only, whereas the female teachers were meeting outside.
- Some CDP schools visited were either not equipped with sanitary facilities or the existent facilities were broken and out of use.
- Overall, the textbook distribution has been successfully implemented. The need to equip the textbook warehouses was only discovered during the course of the project. IDA funds were reallocated to purchase pallet racks, stackers and fork lifters. At the time of the assessment, these items were under procurement by PCU.
- Under CDP the Government of Yemen is only contributing to textbook distribution up to the district level. Although not included in the budget, UNICEF and the WB have distributed the books from the districts to the schools. This helps to reduce the direct cost of schooling for children, as the funds for bringing the textbooks from the district to the schools is usually covered by the parents. However, the question of introducing an exit strategy for the time beyond CDP support and the related sustainability issue remain.

Early Childhood Development

- The Early Childhood Development component is attached to the education sector at the UNICEF country office. It only started de facto in mid 2004, after revamping of the workplan. It seems to have finally taken off well, although it is too early to comment in detail on the quality of results. The component started to allocate funds, and the expenditure rate was after six months 29.11%. Taking the short implementation time of 1.5 years for ECD into consideration, it still remains low.

Water

- Overall, the sanitation sub-components have not been adequately addressed

during CDP implementation.

- The sanitation sub-component of WES should have been synchronised to take place together with the implementation of the water schemes. This did not occur for a number of reasons including the unclear roles of UNICEF and GARWP in the area of sanitation, including the type of sanitation that the PAD envisaged and the lack of sanitation expertise to date within GARWP.

Community Readiness

- It appears too late to start participatory planning training in the last six months of the CDP to achieve sustainable results. The participatory planning training should have been provided in the beginning of the project, to use it as a common element needed in all other components.
- The capacity building of local government officers to contribute in the best way possible to the participatory planning exercises was weak. A greater degree of training of local government partners of CDP is needed in social mobilisation, conflict resolution, planning, monitoring and, last but not least, in record-keeping.
- The Social Mobilisation Network, unless reinforced by funds and continued efforts of UNICEF, a third party or the government, will dwindle in its significance and relevance as time goes by.
- Rather than working in a scattered manner, as it is the currently case, resources and attention should have been focussed on particular areas where certain health issues were more pressing e.g. an area where malaria was more prevalent. This would have also increased feedback, backstopping and interaction amongst the different stakeholders involved, thus leading to greater effectiveness and visibility of the network.

Recommendations

(1) Programme Management

To involve the newly assigned HCMC representatives (so far in four governorates) at governorate and district level actively into CDP field work; HCMC to recruit representatives for the remaining CDP governorates; to select potential candidates according to a transparent system and a defined profile. This should be done without further delay, to allow maximum use of the scarce time before project end for knowledge transfer. The activities of the different components should be coordinated as far down as to village level.

For future integrated projects, to share experience and best practice with projects with similar target groups and objectives; to arrange a meeting between CDP, PCU staff and SFD staff to share their experience at field level with CDP-like multi sectoral programmes.

Further foster cooperation between UNICEF field offices staff and the newly appointed HCMC representatives; to involve them actively in the field monitoring and the monitoring training; to proceed with a transparent and professional selection

procedure for eventual further HCMC posts to be filled; GoY to provide more inputs during project preparation and implementation; to enhance the impact of the CDP, exchange experiences and best practices with other implementing agencies; to coordinate the works assumed by various agencies working in the same field and geographical region (SFD, CDP); to intensify without further delay the positive recent trend of joint work between HCMC and UNICEF at field level; to prepare a work and financial plan on how to continue the HCMC presence in the districts beyond project end.

(2) Health

To find a solution to the current situation of free IMCI drugs versus paid other drugs; to measures to assure no interruptions in the supply of IMCI drugs; to allow health facility committees to also participate in the management of the revolving drug fund; to make the new health facility committees accountable for the operational budget of the facilities; to consider distributing pre-packed drug kits for six months for health units and health centers; MoH and UNICEF to design, print, train-on and start using a formal referral sheet for patients send to a higher level; to secure a closer monitoring of the anti-malaria intervention of CDP in 15 districts; to take measure to assure no interruptions in the supply of Vitamin A, iron and folic acid supplies in all health facilities; to add HIV and AIDS training to CDP community communicators' training now starting, using the newly developed manual; to include adult family members in the safe motherhood training, as they are most important in home deliveries.

(3) Nutrition

To expand the nutrition component either to three more districts or, more preferably, with the current ten districts; both organizations – UNICEF and WFP - to focus their existing collaboration to cover the CDP districts; to train the already trained nutrition volunteers also as IMCI communicators: they have initial skills and a high motivation.

The Nutrition Department of the MoH to start soonest the preparation of a proposal for the 2006 onwards funding of the CBN activities; to tackle the micronutrients problem of infants and women more proactively; to link future funding of the CBN component with ECD funding in UNICEF since these two components are intimately linked.

(4) Education

It is recommended to include the correct use of classrooms as an indicator for the field monitoring; to monitor the use of classrooms constructed and clearly instruct the teachers about the attributed use of the classrooms; to consider in new construction the necessity of one or, in case of female and male teachers, two separate teachers' room(s).

To build/remodel facilities with a pit or other latrines both for girls and boys, to assure water supply and to assure its maintenance; to assure that female teachers and students do equally benefit from this infrastructure; to follow up, in course of the monthly school supervision missions, the appropriate use of infrastructure.

To allocate a higher number of female teachers to the CDP supported schools at least for the last school year before project end; to allow their training before project end; to publish the vacancies for rural female teachers with secondary school degree at governorate, district and at school levels; to recruit, with priority, those volunteer teachers, who have gained working experience already; to give a priority to the CDP

schools in the 30 districts; to have an inter-ministerial meeting ASAP to discuss and solve the endemic problem of lack of female rural teachers in Yemen.

As soon as girls reach puberty age, they are, if not withdrawn from school, often segregated in the sitting arrangements in the classroom. To avoid segregating female students in mixed classes, to avoid squeezing girls in the far corner of the classroom; to consider for female teachers to show their faces while conducting the lessons, as interactive communication with the pupils remains otherwise very restricted; to include a profound gender sensitization component into teachers' training - for male and female teachers.

It is recommended to introduce an evaluation system for training activities at the beginning of any project, wherever possible in line with the existing systems involved, e.g. of ministries, governorates and districts; to use standard templates as a tool for quality assurance and to facilitate aggregation of information.

The PCU/UNICEF should complete the procurement process of the equipment for the warehouses ASAP and should provide training on the equipment.

GoY to develop a sustainable strategy beyond project end for delivery of school books along the transport chain from the printing house to village/school level.

(5) Early Childhood Development

The only recommendation for ECD is to speed up the implementation of the ECD component according to the revised work plan before the end of 2005, making good use of the funds available for this component.

(6) Water

It is recommended to define clear roles and divide tasks within sanitation subcomponent; GARWP to enhance their sanitation expertise; to share experience with similar projects with a sanitation component, e.g. SFD.

(7) Community Readiness

As far as possible in the remaining time, to do more training and in-country exposure visits to demonstrate how community participation works. This should enhance the capacity of district and local councils and of governorate officials and thus increase the impact of the project.

The focal points need logistical support which would enable them to interact with liaison persons and community communicators at least once every two months; to provide incentives, financial and/or otherwise, to focal points, liaison persons and community communicators; to introduce regular refresher courses.

Lessons Learned

There are a several valuable lessons learned from the CDP, being the "pioneer" project for this kind of tripartite approach. There are also comparative and complementary advantages between UNICEF and the WB.

(1) Planning

A lot of attention has to be drawn to the early phases of the programme innovation process. The innovation cycle has to be sufficiently progressed, i.e. packaging and institutionalizing have to be completed, before scaling and scoping up. These steps have to be analyzed and decided carefully and, more importantly, jointly by the partners involved.

A risk assessment should include the project size and scope and the scale of money involved. Both should be in proportion to the existing capacities of the UNICEF country office and the institutional capacities at the government level. UNICEF should consider a full-time high profile manager for a contract of the dimension of CDP. Only if these elements are in place, such a project will be in the position to face the challenges related to financial management, procurement and reporting. All partners must be dedicated to and involved in capacity building from the very start of the project.

An important decision has to be taken at planning stage by the organizations involved on HQ and country level: Is the organization prepared, willing and capable to embark on this kind of partnership, and which resources are required.

This includes harmonization of processes (reporting, financial management, procurement). Mid-term reviews should be carried out jointly by GoY, UNICEF and the WB. The transaction costs will likely decrease if harmonized approaches are applied.

Another aspect to be considered while using UNICEF staff in international contracts is their respective contract duration. As UNICEF expatriate contracts are usually for three years, whereas the CDP has a duration of five years, a harmonization of contract durations should be considered to minimize staff turnover during project implementation, as it occurred during CDP implementation.

(2) Monitoring

At the time of the CDP assessment it was almost too late to consider the implementation of a monitoring system for CDP. However, a further important lesson learned from the CDP is the need to set up an internal monitoring system at the very beginning of the project - to follow up project progress and to have an early warning tool. Project managers can retrieve and share data according to defined indicators on a regular basis.

This should be done in close cooperation between UNICEF and the government partner(s) (in the case of CDP PCU/HCMC and ministries). Involvement of the national partner is a crucial element for project sustainability, and has to start at the very first stage of the project cycle, identification, and should continue throughout implementation. This project monitoring system should be related to the monitoring system for the UNICEF country programme, e.g. by interlocking the logic models, but must have its own CDP specific logic model and monitoring.

An important lesson is that the logic model has to be used as a working tool. The original logic model, set up at project appraisal stage, can always be modified at the lower levels of intervention. Should the indicators not be SMART (Specific, Measurable, Achievable, Realistic and Timely) as it was sometimes the case with the CDP, they should have been improved and the logic model adapted accordingly. Weaknesses in the initial logic model, like weak indicators or missing risks, are not an excuse for a lack of monitoring.

Any new area based multisectoral project should stipulate greater flexibility to change design according to changing needs, as long as the development objectives remain untouched.

On organization level, UNICEF headquarters should establish/reinforce the monitoring practice in a monitoring unit. This unit should develop a system and respective training in project/programme monitoring as a core practice for regional and country office staff. A handbook or manual should be compiled for daily use and for training purposes, explaining the monitoring system and providing advice on operational issues as procurement and reporting standards.

(3) Training

A relatively sophisticated, challenging project as CDP should make training in procurement regulations mandatory for each field officer and sector staff in the country office; this applies for both standards - UNICEF's own and the WB procurement regulations. This can be considered as a means to minimize delays in procurement and reporting and thus enhance implementation efficiency.

For future projects, procurement procedures, financial management and reporting should be considered to be harmonized from the very beginning of the project, to facilitate project implementation. There are already promising examples in other WB/UNICEF agreements, as the IDEAL project in Bangladesh or the Multi-country Demobilization and Reintegration Programme (MDRP).

PCU/HCMC members should be in place in the field offices of UNICEF from the very beginning. The field offices must be staffed adequately to the task at stake, in quantity and in professional experience. UNICEF, if assigned with the task of transferring knowledge to the Government counterparts, must assure to be one step ahead of their counterparts to assume their role in a competent fashion.

(4) Female Teachers

A lesson drawn from the existing gender gap is to involve mothers more in the social environment of the rural schools. This includes organizing mothers-female teachers' associations and providing alphabetization courses. Furthermore, the gender dimension should be more pronounced in the project design of future projects. However, without solving the core problems of the recruitment of teachers proactively and the government living up to its promises made at project start, any future education project or component will have to face the same situation as CDP. Thus efforts should be joined to overcome the practices which inhibit fair recruitment and in particular more involvement of female rural teachers.

(5) Other Lessons

For future projects, a Triple A approach should have been used in community mobilization from the very beginning of the project. The baseline study should include project and non-project districts. The supplementation of all micronutrients should be an integral part of the nutrition component.

The HRBAP approach should be considered as well as a pronounced gender approach in the planning stage of similar future projects. The country office can consider involving technical assistance for this approach.

Finally, the CDP has generated a number of important lessons and some good

practices, which could be avoided or replicated in future projects, respectively. A booklet, summarizing the former, to share with UNICEF projects worldwide and other projects within Yemen, would be rather useful. A good example was provided by the UNICEF Bangladesh country office.

1 Introduction

Apart from an internal Mid-Term-Review (MTR) of the Child Development Project (CDP), carried out in late 2003, no formal attempt has been made to assess the achievements (outcome and output), process (including support structures established), and strengths and weaknesses of this project. This assignment was tendered internationally by the UNICEF Regional Office for Middle East and North Africa (MENA), and was awarded to HLSP, an independent consulting firm and its team of evaluators.

The Government of Yemen channelling a significant part of the IDA loan through UNICEF as the main implementing entity. In addition, UNICEF is contributing own funds to the CDP, to complement Government of Yemen's (GoY's) own investment.

The purpose of the assessment is to examine the achievements of all CDP project components against its targets and objectives. Findings and recommendations shall help improving project processes and results. Furthermore conclusions regarding the effectiveness of the special funding mechanism established for the CDP shall be drawn. While at the time the when ToR were issued, it was still an open question if the project would continue beyond 2005. At the time of the CDP assessment, however, it was obvious that the programme will most likely end in December 2005. This calls for adding another purpose of the assessment, to provide lessons learned for similar programmes in future.

The team of evaluators assumed their work after contract signature (17 March 2005). Two evaluators (Monika Zabel, Team Leader, and Claudio Schuftan, 1st Evaluator) started their work in Yemen on 20 March 2005, whereas the third consultant, Ali Dastgeer (2nd Evaluator), arrived on 25 March 2005 in Sana'a.

Assessment Team

Dr. Monika Zabel is the Teamleader and an Evaluation Specialist. She is a development economist and has lead multisector and multicountry evaluations for international and bilateral organisations as EuropeAid, UN agencies, the World Bank and the German Cooperation. In the CDP assessment she led the Education and Project Management components.

Dr. Claudio Schuftan is an Evaluator and Health Consultant. He has worked in M&E assignments in health, social development and emergency responses for international agencies like UNICEF, WHO, EuropeAid and ECHO. He is medical doctor and nutritionist by background and led the assessment of the Health and Nutrition components.

Mr. Ali Dastgeer is an Evaluation Specialist and Development Consultant. Economist by training, he has been working on international M&E assignments mostly in the Near East and South/South East Asia region, and in rural water, social development and micro credit programmes. He led on the Water and Sanitation and the Community Readiness components.

Mr. Mohammed Abbas is Interpreter and Translator. English Teacher by background, he has worked for international organisations like World Bank and UNICEF as well as in Government of Yemen assignments. He accompanied the assessment team during the field visits, in stakeholder interviews and the steering committee debriefing meeting.

2 Background

2.1 Project Description

The Child Development Project (CDP) is a tripartite partnership between the Government of Yemen (GoY), UNICEF and the World Bank (WB). It is a five year project which started in 2001 and will come to an end in December 2005. It aimed at improving the basic social services to children and women in 30 districts in nine governorates in Yemen selected on the basis of social deprivation.

The CDP is the largest collaboration between UNICEF and the World Bank to-date. It is also the first time that the Government of Yemen took a loan from WB and delegate a significant part of the project implementation to another agency, which is at the same time a co-funder.

An important aspect of this project is the decentralised approach to project planning and implementation in close partnership with district councils and communities in line with the UNICEF-supported area-based approach.

The project budget is estimated at US\$ 45.3 million for a five year period with the following contributions:

World Bank – IDA	US\$ 28.86 million
UNICEF	US\$ 12.41 million
Government of Yemen	US\$ 2.40 million
Community	US\$ 1.63 million

The IDA loan is jointly managed; US\$ 22.10 million are channelled through UNICEF and US\$ 6.70 million are managed by the PCU. This makes the CDP an important feature of the current UNICEF Country Programme 2002 to 2006. The country programme recommendation is US\$ 18.85 million regular resources (RR) and US\$ 20.00 million other resources (OR). It could not be clarified if the part of the WB-IDA credit of the GoY, which is implemented by UNICEF, is counted as OR or as a distinct budget. UNICEF is implementing the CDP on behalf of the GoY with a WB IDA credit and is using at the same time contributing its own funds.

The overall objective of CDP is “To assist the Government of Yemen in the implementation of a coordinated area-based programme for improving the health and nutritional status of children under five and the educational status of girls in primary schools in districts that are currently under-served in the areas of health and education”⁵.

The core of the design of this project is an extension of the area-based project of the UNICEF Yemen country programmes 1994 to 1998 and 1998 to 2001.

The project has the following six key components:

1. **Project Management:** management of the project is assumed by the Higher Council for Motherhood and Childhood (HCMC) and by UNICEF.
2. **Community Readiness Programme:** aimed at preparing the community for receiving project inputs through training in assessing local needs and planning through social mobilisation. The expected output of this component is institutional capacity building especially at the local level.

⁵ Project Appraisal Document, page.....

3. **Health Activity:** aimed at improving child health through strengthened district health systems, Integrated Management of Childhood Illnesses (IMCI), immunization, control of diarrhoeal diseases (CDD), safe motherhood and water and sanitation (WES) schemes.
4. **Nutrition Activity:** aimed at improving child nutrition through community nutrition activities such as nutrition education and counseling, growth monitoring and promotion, nutritional rehabilitation, and micronutrient supplementation. It also aims at improving the nutrition of pregnant and lactating women.
5. **Education Activity:** aimed at expanding girls' access to quality primary education through innovative and effective community based schools; women teacher training and textbook/teaching materials distribution.
6. **Pilot Early Childhood Development Activity:** EDC was originally aimed at improving educability of young children through community-based early childhood development (ECD) models.

A Project Coordination Unit (PCU) was established in the Higher Council for Motherhood and Childhood (HCMC) under the Office of the Prime Minister with the overall responsibility of coordination of all implementing partners. The PCU is the Secretariat for the project. At the national level the project is coordinated by a Steering Committee consisting of representatives of various ministries (Deputy Minister Level) chaired by the Minister of Social Affairs and Labour. The sectoral components of the project are implemented jointly by three government ministries: Public Health, Education and Water in close cooperation with UNICEF.

UNICEF has a bilateral agreement with the Government of Yemen outlining the responsibilities of both parties mutually referred to as Cooperation Agreement for Project Assistance (CAPA). The GoY has a separate agreement with the World Bank detailing the funding and project details under WB document No. 19461-RY dated 29th February 2000. UNICEF has no written agreement with the World Bank.

The CDP covers thirty districts in nine governorates. It was introduced in two phases. The first phase covers 12 districts in three governorates (Hudayda, Ibb and Abyan) and started in 2001, including districts, which already been part of the UNICEF area-based programme in YEMEN. The second phase started in 2003 and encompasses 18 districts in six governorates.

The project is currently in its fifth and last year. Considerable time was spent during the first year on internal administrative issues resulting in a slow start. In late 2003, the project had its mid-term review (MTR) conducted by the World Bank as mandated in the agreement between the Government and the World Bank.

At the end of 2004, the overall expenditure rate was 52.60%, whereas the expenditure rate of UNICEF own funds was 71.13% and the one of IDA funds was 50.45%. The lowest expenditure rate was experienced by the GoY and Community funds with 11.05%.⁶

⁶ See Annex 8, Final Consolidated Budget Status 2001 – 2004, UNICEF Country Office Yemen.

2.2 Logic Model

The project appraisal document (PAD) is setting out the logic model for the CDP intervention⁷. The ToR for the CDP assessment did not call for drawing up or revising the Logic Model of the project as a basis for its analysis. This was discussed in the first meeting with the UNICEF Country Team and the UNICEF Middle East and Northern Africa (MENA) Regional Office in Amman. The model remained widely unchanged throughout project implementation. The assessment of project performance indicators, carried out on request of the WB by the UNICEF Country Team early 2005, generally took the indicators set out in the PAD, and modified just a few of them slightly⁸. The CDP assessment team based its analysis on this logic model.

Table 1 Logic Model of CDP: Project Design Summary and Indicators
(See next page)

Republic of Yemen

⁷ Project Appraisal Document on a proposed credit in the amount of SDR 21.2 Million to the Republic of Yemen for a Child Development Project; 29 February 2000.

⁸ CDP Performance Indicators Assessment 2004, February 2005

Child Development Project

Project Design Summary

Sector-related CAS goal: to alleviate poverty by creating an early stream of social benefits in education, health, and other services most valued by Yemenis.

Project development objective: to assist the GOY in the implementation of policies and strategies for improving the health and nutritional status of children and the educational status of girls.

Summary Indicators ⁹	Monitoring and Evaluation	Critical Assumptions
1. Reduction of under-age-five mortality at least 10 percent faster in intervention areas than in comparable, non-intervention areas by 2005.	Direct and indirect calculations of childhood mortality trends from baseline and impact survey data, compared to similar trends for rural Yemen, using data from DHS survey.	No major epidemics or outbreaks occur during project implementation.
2. Reduction of severe malnutrition (wasting) of children under age five in intervention areas by at least 20 percent, between baseline survey and impact survey (2005).	<ul style="list-style-type: none"> ▪ growth monitoring as part of baseline and impact surveys. ▪ continuous monitoring through health facilities records. ▪ general comparison with other areas using data from DHS 1997. 	No major economic or environmental changes affecting food availability and general health status.
3. Decrease in ration of boys to girls enrolled in grade six in intervention areas by at least 15 percent by 2005.	<ul style="list-style-type: none"> ▪ school enrolment data from baseline and impact surveys. ▪ continuous monitoring through school administrations in intervention areas. 	Parents not responsive to social mobilization or severe economic crises.
4. <u>Pilot indicator:</u> improvement of girls' learning achievement scores, and reach at least satisfactory levels, by the fifth year of the project (2005).	<u>In pilot areas:</u> sixth-grade girls' literacy, numeracy and life skills checked against a set of defined basic competencies, in the first year of the project and in its last year.	No major obstacles for children attending schools regularly.

⁹ Summary indicators are discussed in detail in the Technical Note of the Operations Manual.

Intervention-specific Indicators

Key Performance Indicators	Monitoring and Evaluation	Critical Assumptions
Output 1: Communities mobilized		
1. Formation and/or strengthening of Local Development Committees (LDCs) covering all intervention areas		Facilitators are able to convey credibility and feasibility and properly deal with existing authority structures.
1.1 Members, their functions and modalities of LDCs defined .	<ul style="list-style-type: none"> focus-group interviews. back-stopping missions. 	
1.2 LDCs participate in community needs assessment.	LDC reports (minutes of meetings, work-plans, progress reports).	
1.3 LDCs meet regularly and take an active role in various community activities.	<ul style="list-style-type: none"> focus-group interviews. back-stopping missions. 	
Output 2: Children's health status improved		
2. Development of management and operational capacities of District Health Systems		Guaranteed availability of key staff for all health facilities as per MOH's specifications.
2.1 Coverage rates of health services for children under age 1 and children under age 5 increase by 10 percentage points after two years of project interventions.	Health facility records, matched with estimates of target populations using 1994 census data, data from DHS 1997, and base-line survey data.	<ul style="list-style-type: none"> health facility staff keeps reliable daily, weekly, and monthly records of visitors. instructions concerning registration are consistently interpreted and applied.
2.2 District Health Management Teams (DHMTs) established and functioning	<ul style="list-style-type: none"> DHMT reports (minutes of meetings, work-plans, progress reports). backstopping missions 	
2.3 Local Health Committees formed and functioning	<ul style="list-style-type: none"> focus-group interviews. back-stopping missions. LHC reports (minutes of meetings, work-plans, progress reports). 	
2.4 Cost-sharing systems introduced and achieve after 2 years at least 50 percent cost recovery for medicines.	<ul style="list-style-type: none"> back-stopping missions. LHC reports (minutes of meetings, work-plans, progress reports). health facilities' accounts. 	Exemption and other relevant policies formulated and implemented.
2.5 All health facilities function in intervention areas, have required staff and equipment, receive required quantities of essential drugs and supplies, and adhere to agreed-upon opening hours.	<ul style="list-style-type: none"> focus-group interviews. back-stopping missions. LHC reports 	Logistic arrangements with MOH and its branch offices. MOPH to actively support implementation and remove impediments.
2.6 Local communities consider the health services delivery to have improved to satisfactory levels.	Focus group interviews.	

Key Performance Indicators	Monitoring and Evaluation	Critical Assumptions
3. Integrated Management of Childhood Illnesses introduced		
3.1 Case fatality ratio of main diseases (diarrhea, ARI, malaria) reduced by 25 percent after five years of project interventions in health facilities	<ul style="list-style-type: none"> baseline and impact surveys. mid-term evaluation through rapid assessment. continuous monitoring using health facilities records. 	
3.2 ORS provided to all reported diarrhea/dehydration cases in project intervention areas.	Health facilities records.	
3.3 Proportion of mothers using ORS when their children have diarrhea increased by 25 percentage points after five years of project interventions.	<ul style="list-style-type: none"> baseline and impact surveys. mid-term evaluation through rapid assessment. 	
4. Child full immunization rates increased to at least 90 percent in all intervention governorates by year 5 of the project	<ul style="list-style-type: none"> baseline and impact surveys. mid-term evaluation through rapid assessment. continuous monitoring using health facilities and EPI records. 	
4.1 DPT+P (3) vaccinations coverage increased by at least 15 percentage points.	as above.	
4.2 Hepatitis B vaccination coverage increased by at least 25 percentage points.	as above.	
5. Safe Motherhood Program instituted		
5.1 TetanusT (2) vaccination coverage increased by at least 15 percentage points among pregnant women.	as above.	
5.2 ANC first visit coverage increased by at least 10 percentage points.	as above.	

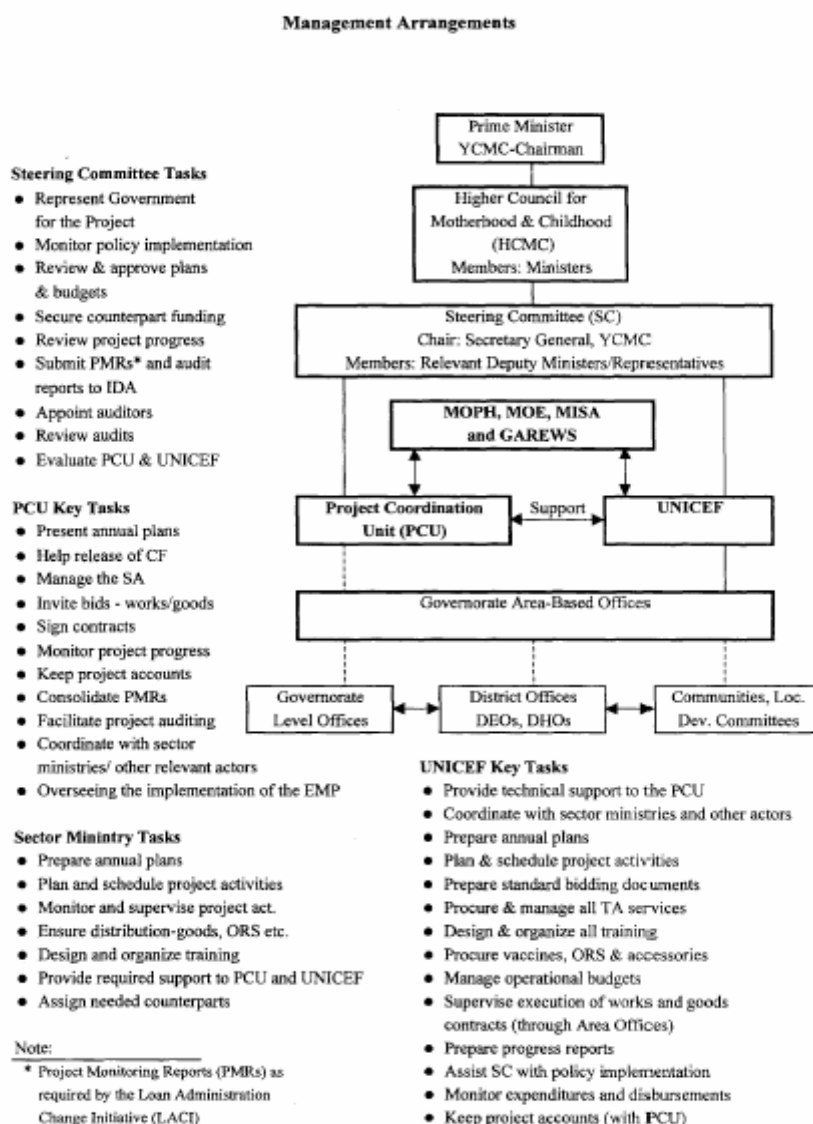
Key Performance Indicators	Monitoring and Evaluation	Critical Assumptions
5.3 Proportion of deliveries at health facilities increased by 10 percentage points over five years.	Health facility records, matched with estimated total numbers of deliveries (based on census data, DHS survey, base-line survey, impact survey).	
5.4 <u>Pilot indicator</u> : Health facilities implement referral system for difficult pregnancies.	<ul style="list-style-type: none"> health facility records matched with records of three pilot hospitals. DHMT reports 	Trained obstetrician, gynaecologist, surgeon available in three pilot hospitals.
6. Sustainable drinking water and sanitation schemes operational		
6.1 LDCs identify community needs for water and/or sanitation schemes.	<ul style="list-style-type: none"> focus group interviews. LDC reports. 	
6.2 LDCs prepare cost-sharing plans for emergency measures, maintenance, and/or new water and sanitation schemes.	<ul style="list-style-type: none"> LDC reports. back-stopping missions. 	
6.3 Access to safe drinking water for households has increased by 25 percentage points in intervention areas.	<ul style="list-style-type: none"> census data, DHS survey data, baseline survey, impact survey. 	
6.4 Water quality attains satisfactory levels in identified key locations.	<ul style="list-style-type: none"> health facilities records. DHMT reports. 	
6.5 Cost sharing systems implemented.	<ul style="list-style-type: none"> LDC reports. back-stopping missions. 	
6.6 Community satisfaction regarding situation of drinking water and sanitation.	<ul style="list-style-type: none"> focus group interviews. 	
Output 3: Children's nutritional status improved		
7. Prevalence of wasting and micronutrient deficiencies decreased and knowledge of food and feeding practices increased in intervention communities	<ul style="list-style-type: none"> triple-A approach. baseline survey, impact survey. continuous monitoring through health facilities records. 	
7.1 Proportion of mothers who implement proper nutrition and feeding practices increased by at least 20 percentage points	as above.	

Key Performance Indicators	Monitoring and Evaluation	Critical Assumptions
in intervention areas.		
7.2 Prevalence of iron, anemia, and vitamin A deficiency reduced by 30% for children in intervention areas by project's end.	<ul style="list-style-type: none"> baseline survey, impact survey. combined haemoglobin and serum retinol surveys. 	
7.3 Prevalence rate of breastfeeding increased by 20% in intervention areas.	<ul style="list-style-type: none"> baseline and impact surveys. focus group interviews. 	
Output 4: Educational status of girls in primary schools (grades 1 to 6) improved.		
8. Girls' enrolment in grades 1 to 6 in intervention areas increased by 20 percentage points by the end of the project	Census data, DHS survey data, base-line survey, impact survey. Continuous monitoring through district education records.	
8.1 Enhanced effectiveness of DEOs in resolving bottlenecks.	<ul style="list-style-type: none"> focus group interviews. backstopping missions. DEO reports. 	
8.2 Regular supervision visits by DEO and cluster meetings.	<ul style="list-style-type: none"> focus group interviews. backstopping missions. DEO reports. 	
8.3 Increased satisfaction of teachers with feedback and management support.	<ul style="list-style-type: none"> focus group interviews. backstopping missions. 	
8.4 Increased willingness of parents to send their daughters to school.	<ul style="list-style-type: none"> Baseline and impact surveys. Focus group interviews. 	
9. Proportion of trained women teachers for grades 1-6 at schools in intervention areas increased by at least 15 percentage points by the end of the project.	District education records.	
10. Storage and distribution of textbooks and educational materials improved in intervention areas.	Amounts of shortages and delays before and after project intervention.	Distribution bottlenecks addressed by MOE.
Output 5: Feasibility of Early Child Development programs explored		
11.1 ECD models piloted and evaluated for impact and sustainability in six districts	Backstopping missions.	
11.2 National ECD policy formulated.	Backstopping missions.	

2.3 Stakeholder Analysis

The PAD was setting out the management structures as following:

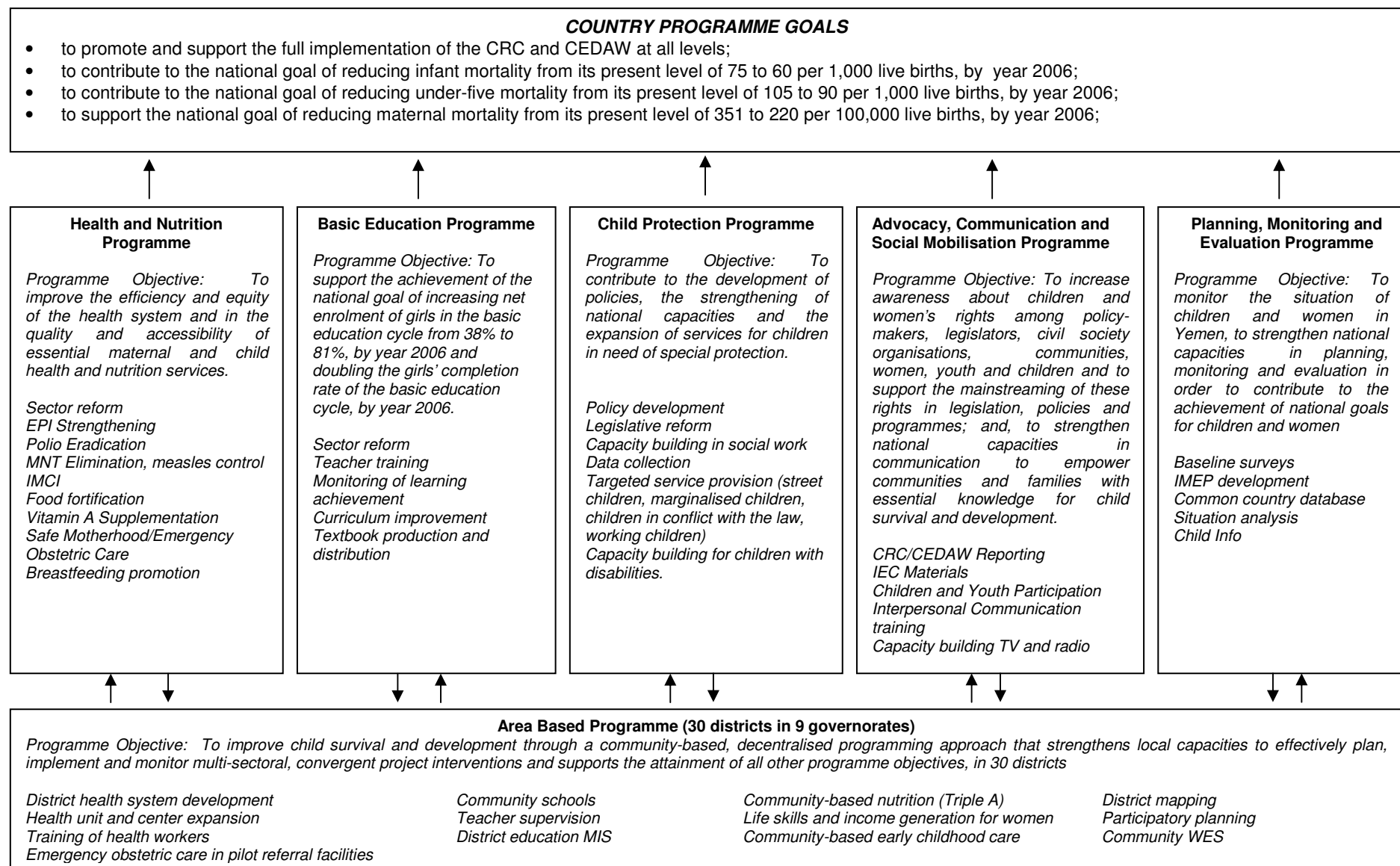
Table 2 Management Arrangements of CDP



UNICEF Country Office Sana'a

UNICEF's Country office Yemen has the following structure: The Representative is heading a programme division and an operations division. Under the programme division there are the subdivisions (sectors) of Health and Nutrition, Education, Area Based Programme (ABP), Child Protection and of Communications. Early Childhood Development, originally planned to be under Area Based Programme, is located in the Education sector.

The ABP subdivision includes community schools construction, water and participatory planning (~ community readiness). The sector called women in development (WID) is currently dormant. The seven field offices covering nine governorates of the CDP are also linked to the ABP subdivision.

Table 3 UNICEF Yemen Country Programme Structure, 2002 to 2006

Looking at the key components of the CDP, there are two to be found under the ABP, i.e. water (WES) as part of the health component of CDP, and community readiness. Community school construction, a part of the education component of CDP, is also located under the ABP, whereas Education as well as Health and Nutrition form distinct sectors. To live up to the integrated approach required to efficiently implementing CDP, it requires close coordination between the different sectors in the country office and between the country office and the teams in the field offices.

UNICEF Field Offices

UNICEF has seven sub-offices with 15 full-time staff designated for project implementation and monitoring in close partnership with local district and area councils. These seven offices are covering the nine governorates of CDP (and the ABP).

Project Coordination Unit

According to the PAD the PCU is responsible for procurement and financial management. The key task of the PCU is procurement. It is responsible for managing for tenders, signing contract with contractors, consultants and suppliers for tasks not managed by UNICEF. These tasks that the PCU is expected to directly manage (using WB guidelines and procurement rules) are for all goods procurement, except vaccines, accessories and ORS, which UNICEF procures directly. It is part of the responsibilities of the PCU to consolidate the reports, including those coming from UNICEF, before submitting them to the SC and to IDA. UNICEF shall provide support to the PCU.

The PCU is supposed to have a director, who is Secretary General of the SC, a finance officer, an accountant, a procurement officer/engineer and an administrative assistant.

At the time of this assessment, the director, the financial officer (former accountant) and a procurement engineer were present.

The World Bank

The WB is the largest contributor to CDP. WB is not involved in the implementation of the project. It carries out monitoring missions, with varying frequency WB has to provide “no objection” in case of proposed budget reallocation (between categories) and for the annual work plan.

Steering Committee

CDP works with three Line Ministries of the GoY in particular: Ministry of Education, Ministry of Health and the General Authority for Rural Water Supply Projects (GARWP). The Ministry of Finance is also represented in the Steering Committee. The mentioned Ministries are represented in the Steering Committee (SC) at Deputy Minister Level. Although not represented officially in the SC, some other Ministries have a direct impact on CDP implementation, e.g. Ministry of Civil Services on the education component.

Higher Council for Motherhood and Childhood

The secretary general of the HCMC is chairing the steering committee.

3 Scope

3.1 Assessment Approach and Methodology

UNICEF Yemen country office team, UNICEF MENARO M&E officer and the evaluators agreed to stay as close as possible to the DAC terminology¹⁰ and to use the logic model for the CDP in the project appraisal document (PAD) (see table 1)¹¹. It was developed in a participatory approach between the Government of Yemen (GoY), The World Bank (WB) and UNICEF. The evaluation team based the assessment on the terminology and contents used in that logic model, however appreciating minor changes and adaptations made since project start. The team applied the DAC terminology (see annex 5) for the five evaluation criteria throughout the assessment.

The team allocated the key questions of the ToR to the five evaluation criteria (see annex 2), i.e. relevance, efficiency, effectiveness, potential impact and sustainability. This was done for each of the main components (Health, Water, Nutrition, Education, and Community Readiness) and for project management and cross cutting issues.

In preparation for the field interviews, the evaluators developed an assessment matrix for the CDP components (see annex 6) and guidelines for semi-structured beneficiary interviews (see annex 7). These tools were developed to generate as many qualitative information to measure progress and to enrich the sometimes poor quantitative data, in particular on impact. Limits in the analysis compared to what was set out in the ToR were flagged in the text when they occurred; whenever it was possible to comment, it was done.

The assessment was carried out applying a three step approach with desk phase, field phase and reporting phase.

Desk Phase

The desk phase was carried out during the first week in Yemen. It included the analysis of the documents made available to the assessment and setting up of the field phase to follow. Main related activities encompassed the selection of governorates and districts to be visited during the field phase, the design of an assessment matrix (based on the logic model and the ToR) leading from outputs to impact and the guidelines for semi-structured beneficiary interviews for each of the main CDP components¹². First interviews with key stakeholder were conducted early on. At the end of the first week an Inception Report has been provided to the contracting party, i.e. the UNICEF MENA Regional Office in Amman, M&E officer. It was approved in April 2005.

¹⁰ OECD Development Assistance Committee (DAC), Glossary of Key Terms in Evaluation and Result Based Management, 2002

¹¹ World Bank, CDP Project Appraisal Document, 29 February 2000

¹² See Annexes XX and YY, respectively.

Table 4 Targeted Districts CDF and Selection of Governorates and Districts for Field Visits

Governorate	District	Relatively easy	Relatively complicated	Remarks
Pre-CDP (ABP) : The districts in Abyan, Ibb (Al-Udain district only) and Al Hudaydah (education only) mentioned for the first CDP phase had been covered already during the UNICEF ABP.				
1st phase , CDP				
Abyan				
Abyan	Lawder	x		
Abyan	Rusud	x		
Abyan	Sarrar	x		
Abyan	Sabbah	x		
AL-Hudaydah				
AL-Hudaydah	Munira	x		
AL-Hudaydah	Qanawis	x		
AL-Hudaydah	Zaydiya	x		
AL-Hudaydah	Al-Mighlaf		x	Low community awareness
AL-Hudaydah	Dhahi	x		
Ibb				
Ibb	Al-Udain		x	Local council not well coordinated
Ibb	Hazm Al-Udayn	x		
Ibb	Fara Al-Udayn	x		Geographically difficult to reach, but local council is active
2nd phase, CDP				
Hajja				
Hajja	Bakil Al-Mir	x		Most remote and poor area, but cooperative
Hajja	Mustaba	x		
Hajja	Aslam		x	Local Council not active, education office not cooperative (Health center very active)
Sana'a				
Sana'a	Hamdan		x	Close to Sana'a, but local council is inactive
Sana'a	Sanhan & Bani Bahloul	x		
Sana'a	Bani Matar	x		
Sana'a	Al-Hayma		x	Difficult to reach, but local council very active
Lahej				
Lahej	Al-Milah	x		
Lahej	Tor Al-Baha	x		
Lahej	Al-Madaraba		x	Geographically dispersed thus difficult to coordinate
Al-Mahra				
Mahra	Al-Ghaydah		x	Ghaydah is a capital of the governorate thus urban and rural areas are mixed which affects the site selection
Mahra	Hasween	x		

Governorate	District	Relatively easy	Relatively complicated	Remarks
Amran				
Amran	Khamer & Bani Sureym		x	Unable to coordinate in the area due to tribal conflict between Khamer and Bani Sureym
Amran	Jabal Iyal Yazid	x		
Amran	IYAL SURAYH	x		
Ad-Dhale				
Ad-Dhale	Qataba	x		
Ad-Dhale	Al-Azareq		x	Geographically dispersed thus difficult to coordinate
Ad-Dhale	Al-Husha		x	Geographically dispersed thus difficult to coordinate

Remark: Districts marked in yellow have been visited during the field visit.
Districts marked in blue have been included in the data analysis.

Field Phase

The governorates and districts were chosen in agreement by assessment team and UNICEF Yemen country office. The field visits encompassed three districts in three governorates: Al Hudain (Ibb), Al Milah (Lahej) and Zaidya (Hodeidah). Al Hudain and Zaidya are of the first phase of CDP, one district to be considered relatively easy to work with, and the other as relatively complicated. The third district, Al Milah, is of the second phase of CDP. In addition to the three districts visited, another 8 districts in the same governorates respective indicators have been analyzed, thus the assessment was based on data of 11 CDP districts.

The field phase in Yemen was conducted in two parts. The first part, from 19 March to 10 April, included the desk phase and the field visits to three governorates, including data retrieval. The second part was conducted as planned from 29 April to 11 May 2005 and focused on meetings at central level.

The field visits were dedicated to semi-structured interviews with beneficiaries on different levels (community, district, governorate), and to field observations (status of construction of buildings, whether the buildings were used according to their destination, how the data is managed etc.). The beneficiary interviews were conducted as individual interviews or in smaller groups (e.g. female teachers, girls, fathers, water committees) applying semi structured interview guidelines. Focus Group discussions, as proposed by UNICEF Yemen country office, did not always provide the results expected. Due to large size of the groups, there was always a small group of opinion makers dominating the discussion.

At the end of the field phase a presentation of the first preliminary findings of the CDP assessment was made in front of members of the CDP Steering Committee, followed by a Questions & Answers session.

Reporting Phase

After collecting the required data and indicators to analyze project progress the assessment team drafted the Assessment Report, along the table of contents agreed with the contracting partner,

The first product was a Draft Assessment Report (DAR). The DAR was forwarded to the representative of the UNICEF MENA Regional Office. The UNICEF Yemen country office, the MENA regional office, UNICEF headquarters and the World Bank in Yemen have provided comments on the DAR.

This is the final product of the CDP assessment, the Final Report. The assessment team has duly considered the comments provided.

3.2 Boundaries of the Assignment

One of the problems and constraints of the assignment was availability, quality and reliability of data.

During the desk study and during the analysis of data in the three of the seven field offices visited, the limited availability of structured data became obvious. The main information sources only provided data for input and output levels, thus only touching upon the lower levels of evaluation.

This, to a certain extent, is contrasting the ToR of the assignment, which also set out questions addressing the outcome and impact level. An end-of-project assessment should indeed cover all five evaluation criteria, and discuss the criteria of sustainability of the project's services as well as benefits beyond project end; the latter is of particular relevance.

An end of project assessment cannot, however, provide data which were not retrieved and updated earlier on a regular basis throughout project implementation; neither can it replace an internal monitoring system nor make good for its previous quasi-non-existence. Comments on project's outcomes and potential impact are thus mainly qualitative and anecdotal, based on field findings – mostly observations. Those statements would need to be verified in a survey- based impact assessment.

At the time of the CDP assessment, UNICEF country office was about to commission the Central Statistics Office (CSO) in Yemen to re-run the baseline survey. This will be in the form of a short module having been added to a national household survey, launched by the CSO in April 2005. This survey will only ask about ten variables of the original 25 that were surveyed by the baseline study, i.e., it will not be able to document progress in the 30 project districts against CDP's own baseline data, but will compare health, education, water and other indicators between CDP and non-CDP districts. Steering Committee members have raised concerns about the usefulness of the upcoming CSO data to comment on the potential impact of CDP.

The other constraint of the assessment was the mismatch between time available and the work at stake. The ToR were foreseeing eight weeks for the completion of the assessment, including the final report and a supplementary note on forms of agreements between UNICEF and the WB. Two weeks were planned for the visits to the governorates, intending to cover about 15 project districts. Given the distances, country topography, village road conditions and the fact the working day in Yemen ends already in the early afternoon, this was not feasible. In order to match the requirements of the ToR in the time available, the assessment team proposed to the contractor to visit three districts in three governorates thoroughly, to enrich the assessment with qualitative information gathered in structured beneficiary interviews and to include data of eight additional districts in the same governorates, resulting in 11 districts covered in the analysis.

Last but not least it was not possible to interview the former UNICEF representative, who was responsible for the first three years of the CDP implementation. He has meanwhile retired and, although the assessment made an attempt, could not be contacted.

4 Programme Assessment

4.1 Project Management

4.1.1 Relevance

Relevance of Issues Addressed

The issues addressed by the CDP are of relevance for Yemen. The objectives are in line with the goal to alleviate poverty by creating an early stream of social benefits in education, health and other social services as set out by the Millennium Development Goals (MDGs). Women and girls as the main group targeted are well chosen, in recognition of the general low level of human development indicators and the significant gender gap in education in Yemen.

Quality of Design

Some of the critical risks, though not all mentioned in the logic model itself, are stated in the PAD. Among those is one that says “Sub-national government offices (are) weak in implementation”. This, as already stated in the PAD, turned out to be a substantial risk. “Data not accurate and political considerations for district selection” and “UNICEF’s (Yemen) current capacity moderate” were considered as modest risks. Other risks, though likely to have been known at that time already, e.g. role and commitment of line Ministries, no history of inter-ministerial cooperation - both crucial elements for successful implementation and institutional sustainability - were underestimated.

In the ex post perspective of this assessment, it must be assessed as a weakness of the project design.

A strong monitoring capacity built into the project was seen in the PAD as a risk minimization measure; for that UNICEF needed to recruit additional staff to carry out implementation tasks, especially for monitoring and evaluation. The assessment team endorses this necessity measure.

Unfortunately, this measure has been taken up by the project only at a too late stage to make an impact on CDP. Monitoring capacity remained underdeveloped with negative implications for project implementation (see efficiency). Only at the end of the third year of project implementation an M&E officer was hired by UNICEF country office, covering the UNICEF country programme and the CDP.

Another felt weakness, taking into consideration the institutional limitations mentioned above, is the fast scaling and scoping up of UNICEF’s previous area based programme. In pre-CDP the area based programme was implemented in 10 districts in three governorates, of which it was in five districts for education only. With the start of CDP this was enlarged to become a multi-sector programme for 30 districts in nine governorates striving for an integrated approach in provision of social services.

The project design also calls for different procedures for procurement, financial management and reporting requirements. There are, for example three types of procurement procedures envisaged: (a) IDA procedures for all IDA financed activities managed by the PCU, (b) procedures described in the CAPA, which are acceptable to IDA for all IDA financed and UNICEF managed activities; (c) UNICEF procedures

for all UNICEF financed activities.

During project implementation it showed that this is an extremely cumbersome approach, which is time consuming and sometimes de-motivating for the staff involved. Thus it contributes to slow down the implementation process.

The proposed management structure (see table 2, chapter 2.3) did not sufficiently take into consideration the institutional limitations, both, of the Government and of the UNICEF country office as the main implementing agency on behalf of the Government of Yemen.

4.1.2 Efficiency

From the management viewpoint, CDP is a complex and very challenging project, both, operationally and administratively. It is a multi-sector project, which covers wide geographic areas and involves a large number of beneficiaries. It also relies on the involvement of a number of stakeholders at community, district, governorate and national level. CDP is characterized by a large number of small project interventions, a challenge to coordination in implementation and supervision. The PAD states as a key task of UNICEF to provide technical support to the PCU.

The CDP organization chart (see table below) indicates a close cooperation between UNICEF and PCU at field offices (area based unit) level.

Table 5 CDP organizational chart



Source: PAD

Management Structures

The nine CDP governorates were selected based on health and education indicators, population size and presence of other donors. However, governance in Yemen is largely centralised and this is especially so for the two most significant ministries for CDP i.e. Health and Education. Because governorate and district level offices have little control over service provision of these ministries in their areas, improvement of performance through supervision is not effective. This hinders an effective assessment of the needs of beneficiaries, as well as their involvement in the sustainability of projects.

This problem is exacerbated, because the ministries are weak at coordinating their activities at the national level and this filters down to governorate and district levels too. In addition, strategy and policy making bodies such as the HCMC have weak technical capacity.

On the other hand, the government has shown a keen interest to decentralise many

functions currently administered through national offices. This can be evidenced by capacity building in health, education and water sectors of sub-national officers and communities. The support to and collaboration with projects such as the CDP and Social Fund for Development (SDF) and other projects which strongly articulate a bottom-up, community-driven development agenda, is also testament to this.

Field Structure

The project has equipped and staffed 7 UNICEF field offices in Ibb, Hodeidah, Hajja, Sana'a (covering Sana'a and Amran), Mahara, Aden (covering Lahej and Abyan) and Dahle. Each field office is staffed with one field officer and one or more staff members. The districts have been selected in two batches, 12 in 2001 and 18 in late 2002.

The fast growth of implementation districts and governorates, compared to the UNICEF ABP prior to CDP, already means a management challenge. Although the assessment team can only analyze retrospectively, there is good reason to believe that the structure of field offices grew without previous implementation of a clear management structure. This includes the provision of training and tools for field monitoring, and putting in place a clear and regular communications mechanism between the field offices and the UNICEF Sana'a country office, in particular with the ABP, Health and Nutrition and Education sections.

Just recently the M&E officer started efforts to close the information gap between the field offices and the UNICEF country office. This is a step in the right direction; however, this system is primarily developed for the UNICEF country office to monitor the country programme progress, and the choice of indicators for each of the field offices will limit its use to follow up the CDP progress and the indicators set out in the PAD. Thus the information that will be generated will be of limited use for the CDP monitoring.

Communication between the ABP sector and other sectors involved has reportedly started late. There appears to be a lack of overall oversight about project progress, sharing of data and progress in each of the components and subcomponents of CDP.

At the time of the assessment, it became obvious that there is no concise mechanism for monitoring and reporting for all field offices. Based on the four offices visited (incl. Sana'a) and data retrieved, evaluators found evidence that several core indicators are not regularly retrieved (for example number of female and male teachers per district). Data provided by field offices to update "Activity Monitoring", an excel spreadsheet summarizing the project progress in the CDP districts, also disclosed contradicting numbers or data not tallying with other data sources. The definition of core indicators is not always clear and uniform throughout the field offices.

Information and Monitoring Systems

The monitoring and evaluation system for CDP in UNICEF country office and field offices were found to be deficient. At the field level, data was not 'readily available' (a term used in the TOR for the assessment to describe the state of existing data) for most activities and consolidated and updated lists showing people trained, schemes implemented or number of female and male teachers in the districts was missing. Mental recollection by Field Offices appears in some cases also weak; in one instance the Field Officer could not recall whether a certain scheme had been implemented through CDP funds or otherwise. Internal monitoring carried out by the

field offices is also lacking clear guidance of the country office. When asked for methods applied for field monitoring, the assessment team was told that there was no procedure in writing but that monitoring was done through mainly observation, e.g. degree of completion of class room building.

Similarly, in health (EPI, IMCI and EmOC) and in nutrition, the evaluators found little or no data (or better: no reliable data) to assess outcomes and impact; only outputs could be somewhat quantified. The MTR had made similar observations. A particular problem arose for the evaluators in that they were given the December 2004 UNICEF CDP Activity Monitoring Matrix of the list of activities carried out and the output indicators 2001/2-2004 that the project follows in the nine governorates for all the components of the CDP. After careful review, evaluators found numerous arithmetic and other inaccuracies in the same for each and every component. This matrix developed on an excel spreadsheet contained contradicting numbers or data not tallying with other data sources.

The lack of accuracy does also refer to data provided by the governmental counterparts at district, governorate and national level. Some of the counterparts were found not to have any records how many people were trained or the participants' evaluation of the training. However, it was part of the CDP to provide knowledge transfer.

Another document, the Performance Indicators Assessment 2004 produced in February 2005 does not provide a comparison of targets versus achievement. Many figures within it are incorrect and the cover page states that 'collecting and aggregating performance indicator through routine monitoring require at least 4-5 months interval'. If this were to be considered as reasonable, and in the opinion of the assessment team it is not, half a year would pass before planning for that year could occur.

The CDP did suffer from the fact that for the first three years the M&E position in UNICEF Country Office remained vacant. According to the current management of the country office, the former Representative did not see the need for a distinct position. Having already several international staff members, the assumption was that a manager per se has good monitoring knowledge and skills. A junior M&E assistant officer was hired. Only in September 2004, a little more than one year before project end, a position for an M&E officer was made available and staffed. This is, from the perspective of efficient and effective project management, far too late. However, the new recruited officer assumes responsibility for the UNICEF country programme as a whole without distinction made for his CDP responsibilities with its own objectives and indicators.

To some extent, the weak monitoring and lack of data can be attributed to weak M&E systems at district, governorate and central levels of those government line departments who are partners of UNICEF in CDP. This issue has been highlighted by UNICEF which states that for many activities, especially in the health and education components, it relies on government records. It should also be mentioned here that UNICEF offices generally house one Field Officer and sometimes one assistant; too small a human resource to be able to maintain independent and up-to-date records of all activities.

Just recently, the M&E officer has started to close the information gap between the field offices and the headquarters. A recently designed reporting format has been developed to provide information about progress of the achievements in different components by field office. This system has been primarily developed for the

UNICEF country office to monitor the country programme progress, and the choice of indicators for each of the field offices will limit its use to follow up the CDP progress and the indicators set out in the PAD. Further, it should be noted that the format is only a reporting document and reporting is only one small element of a viable M&E system which in the case of UNICEF needs to start from the village household level and end at the national level.

Monitoring and evaluation by the PCU has also been weak. The PCU has not had a monitoring system for the first four years of the CDP. Quarterly and monthly reports (PMRs) have been compiled by the UNICEF Sana'a office and provided to the HCMC/PCU. In early 2005 the PCU finally hired an M&E who left some months later. He conducted an outcome assessment in Lahej governorate. Recently, an M&E consultant has been hired instead of a permanent officer as the project is coming to closure. The PCU has thus not been in a position to either examine progress in the field, nor assess or recommend on the M&E system of the project.

Finally, the CDP has brought forth a number of important lessons which should be learnt and some good practices which could be replicated. A synthesis of these in the form of a booklet so that future UNICEF projects worldwide and other projects within Yemen can benefit from the experiences of CDP is recommended. A good example is provided by a publication by the UNICEF Bangladesh Country Office.

It is not always clear where to draw the line between the UNICEF country programme Yemen and the tripartite CDP.

At the time of the CDP assessment it became obvious that there is no concise mechanism for monitoring and reporting for all seven UNICEF field offices. Based on the four offices visited (incl. Sana'a rural) and data retrieved, evaluators found evidence that several core indicators are not regularly followed up (for example number of female and male teachers per district). Data provided by field offices to update the "Activity Monitoring", which is compiled at the country office in an excel spreadsheet summarizing the project progress in the CDP districts, also disclosed contradicting numbers or data not tallying with other data sources. The definition of core indicators is not always clear and uniform throughout the field offices.

Internal monitoring carried out by the field offices also lacks clear guidance of the country office. When asked for the monitoring scheme applied for field monitoring, assessment team was explained that there is not procedure in writing etc. but it's mainly observation, e.g. degree of completion of class room building.

Financial Expenditure

The CDP is characterised by overall low expenditure rates. The IDA credit that is channelled through UNICEF amounting to US\$ 21.4 million for five years is little over UNICEF's regular resources (RR) for the same duration and considerably more than the other resources (OR) that the Yemen country office is able to mobilize.¹³ Handling such a substantial amount of money means a challenge for the UNICEF office.

¹³ See Government of Yemen – UNICEF, Midterm Review 2002 – 2006 Country Programme Cooperation, September 2004.

The expenditure status by end of the household year 2004 shows the following figures:

Table 6 Expenditure Rates by Components and Implementers

REPUBLIC OF YEMEN CHILD DEVELOPMENT PROJECT Final Consolidated Expenditures BUDGET STATUS 2001-2004 Unit: USD'000										
PROJECT COMPONENTS	IDA FUNDS									
	UNICEF			PCU			Total			Diff.
	Actual	Planned	%	Actual	Planned	%	Actual	Planned	%	
Community Readiness	584	1.330	43,91%	-	-	-	584	1.330	43,91%	746
District Health System	2.231	3.605	61,19%	-	-	-	2.231	3.605	61,19%	1.374
IMCI	1.054	3.980	26,48%	319	5.720	5,58%	1.373	9.700	14,15%	8.327
Immunization	3.321	5.710	58,16%	1.638	-	-	4.959	5.710	86,85%	751
Safe Motherhood	283	60	471,67%	138	170	81,19%	421	230	183,05%	(191)
Water & Sanitation	1.866	3.404	54,82%	-	-	-	1.866	3.404	54,82%	1.538
Community Nutrition	163	150	108,66%	-	-	-	163	150	108,66%	(13)
Community Schools	50	1.060	4,72%	-	-	-	50	1.060	4,72%	1.010
Women Teacher Training	436	140	311,43%	-	-	-	436	140	311,43%	(296)
Textbook Distribution	806	859	93,83%	25	-	-	831	859	96,76%	28
ECD	157	260	60,38%	-	-	-	157	260	60,38%	103
Project Management	890	1.543	57,68%	438	807	54,32%	1.328	2.350	56,52%	1.022
Total	11.841	22.101	53,58%	2.558	6.697	38,20%	14.399	28.798	50,00%	14.399

PROJECT COMPONENTS	UNICEF FUNDS			
	Total			Diff.
	Actual	Planned	%	
Community Readiness	284	–		(284)
District Health System	257	1.420	18,12%	1.163
IMCI	277	–		(277)
Immunization	3.747	–		(3.747)
Safe Motherhood	203	310	65,62%	107
Water & Sanitation	594	2.330	25,49%	1.736
Community Nutrition	274	1.260	21,73%	986
Community Schools	2.442	4.874	50,10%	2.432
Women Teacher Training	231	2.020	11,45%	1.789
Textbook Distribution	37			(37)
ECD	9	194	4,61%	185
Project Management	470			(470)
Total	8.826	12.408	71,13%	3.582

PROJECT COMPONENTS	GOVERNMENT & COMM. FUNDS			
	Total			Diff.
	Actual	Planned	%	
Community Readiness		80	0,00%	80
District Health System		735	0,00%	735
IMCI		200	0,00%	200
Immunization	4	190	1,96%	186
Safe Motherhood		60	0,00%	60
Water & Sanitation		1.256	0,00%	1.256
Community Nutrition		310	0,00%	310
Community Schools		736	0,00%	736
Women Teacher Training		30	0,00%	30
Textbook Distribution	224	331	67,78%	107
ECD		116	0,00%	116
Project Management	219			(219)
Total	447	4.044	11,05%	3.597

PROJECT COMPONENTS	TOTAL FUNDS			
	Total			Diff.
	Actual	Planned	%	
Community Readiness	868	1.410	61,55%	542
District Health System	2.488	5.760	43,19%	3.272
IMCI	1.650	9.900	16,67%	8.250
Immunization	8.709	5.900	147,61%	(2.809)
Safe Motherhood	624	600	104,08%	(24)
Water & Sanitation	2.460	6.990	35,19%	4.530
Community Nutrition	429	1.720	24,93%	1.291
Community Schools	2.492	6.670	37,36%	4.178
Women Teacher Training	667	2.190	30,47%	1.523
Textbook Distribution	1.092	1.190	91,77%	98
ECD	166	570	29,11%	404
Project Management	2.017	2.350	85,85%	333
Total	23.662	45.250	52,23%	21.588

The implementation capacity of PCU can be assessed as low. Of all project components the IMCI has the largest budget to be managed by the PCU, 5,720 Mio USD. Of this amount only 0,319 Mio USD was spent, whereas UNICEF is managing 3,980 Mio USD, totaling 9,700 USD. At the end of 2004, only 1,336 Mio USD or 14% of the IDA funds have been spent on IMCI.¹⁴

At the end of 2004, about 11,971 Mio USD or 54% of the IDA funds managed by the UNICEF country office have been spent. The Total Actual and Planned Expenditures¹⁵ of UNICEF funds are not quantifiable. However, the Budget Status indicates an actual expenditure of 8.8 Mio USD or 71%.

4.1.3 Effectiveness

Partnership and Visibility

The CDP is a tripartite approach of the Government of Yemen, The World Bank and UNICEF. The partnership between the GoY and UNICEF aims to provide capacity building of government structures to enable them to carry on with services and social benefits of CDP for the beneficiaries beyond project end.

Evaluators are of the opinion that the CDP has good local visibility overall. During the field visits, however, the evaluators got the clear and uniform impression in all districts visited that CDP is used synonymously with “UNICEF” or “the UNICEF project”.

The assessment team shares the MTR’s concern about the perception of local communities and government officers as the CDP being an “UNICEF project”. This is pointing to the fact that, for the beneficiaries, the most visible partners of CDP have been UNICEF field officers and staff working directly with local government

¹⁴ CDP Budget Status 2001-2004

¹⁵ Total Actual and Planned Expenditures (UNICEF Fund and IDA Fund) 2001 – 2004

personnel. Other partners, as the HCMC/PCU, though conducting 3-4 field visits per year, they are not considered by the intermediate and final beneficiaries as a major implementing partner. On one hand, this provides a positive signal of how recognized UNICEF is as a brand in Yemen; on the other hand, it indicates the wide absence of visibility of the GoY as a partner.

As an effectiveness issue, it has to be said that during the first four years of the CDP, there was de facto hardly any PCU/HCMC participation in the CDP decision-making and work in the field; this can be considered as the main cause for the ineffectiveness of the PCU in establishing a true partnership with UNICEF at district/governorate level (see 4.2.1) and to establish visibility and presence in the implementation districts.¹⁶

From a historical perspective, at project start, it may have been assumed by UNICEF as the faster alternative to move forward in the implementation of the CDP working directly with district authorities and communities, neglecting the close cooperation with PCU and other governmental partners. Working in the field without an active involvement of the PCU/HCMC might enhance speed, but includes the risk that the sustainability of the project may be jeopardized.

The chance to work in close cooperation between UNICEF and PCU has been widely missed during CDP implementation. Only very recently first positive steps have been taken, which could be seen as a starting point for cooperation. HCMC representatives based in three UNICEF field offices and a fourth one for Sana'a governorate based in the PCU premises. Crucial elements of sustainability - knowledge transfer and institutional building - remain so far weak

4.1.4 Impact

Multisectorality and Synergism

There was some evidence of simultaneous implementation/provision of health, nutrition, water and educational services in project districts visited. However, the assessment team has not visited villages where all services have been implemented simultaneously. Coverage of a service is not always in the 30 districts, e.g. nutrition, and not always all uzlas in the same district are covered by CDP. The proportion of villages in project districts in which this simultaneous implementation is fully the case cannot be assessed by the evaluators with the data available. Since, so far, there are no reliable data on outcomes and impact. Whether districts with CDP simultaneous interventions have done better than districts with no CDP presence will only be (partially) possible to assess after the planned CSO survey.

There was no evidence found related to synergies used with other projects or programmes applying a similar, area based approach. People interviewed at The Social Fund for Development (SFD) and UNICEF confirmed that, although covering similar components, SFD and CDP were no exchange of experience and best practice.

The CDP is an area-based project but, regrettably, this assessment mission does not have all the needed elements as of yet to declare this a successful synergistic, convergent, integrated, multi-sectoral approach to local development.

¹⁶ See also CDP Outcomes Assessment, Lahej governorate, Feb 26 – Mar 6, 2005, conducted by the PCU M&E Officer.

To coordinate in a “master plan” the works assumed by various agencies working in the same field and geographical region (SFD and CDP for ex.)

4.1.5 Sustainability

The prospects for institutional sustainability appear to be weak, in particular on national and governorate level. This has several reasons: The lack of sufficient staffing in quantity and experience; the missed opportunity of early and continuous cooperation (and knowledge transfer) between the UNICEF and the PCU/HCM at national and field office level; the lack of presence of PCU/HCMC at field level for most of project implementation.

In the recent past, there have been positive attempts of cooperation and increased field presence of the HCMC. In order to foster institutional sustainability, this kind of partnership between GoY and UNICEF, as it appears to be working now, should have been launched at the beginning of the project, to make full use of mutual learning. The two HCMC representatives in Ibb and Sana'a appear to be high potentials, self driven, keen to learn and sharing the ideas and objectives of the project. Beyond project end, it is foreseen that the HCMC representatives in the governorates should be hosted in governorate office space. Where this cannot be guaranteed, it is anticipated to rent office space in the respective governorate capitals.

Implementation time, however, is short and the future of the seven UNICEF field offices for post CDP was at the time of the CDP assessment not finally decided.

The picture provided for sustainability for the different CDP components varies from component to component and is analyzed in chapters 4.2.1 to 4.2.6.

4.2 CDP Components

4.2.1 Health

4.2.1.1 Relevance

From the point of view of the main health and nutrition components chosen during the design of the Child Development project, the project indeed selected relevant objectives and activities, as well as reasonable expected results. They all responded to real priority beneficiary needs in the 30 districts covered by the project. Activities proposed covered safe motherhood (SM), emergency obstetric care (EmOC), the integrated management of childhood illness (IMCI), the extended program of immunization (EPI) and community-based growth monitoring (CBN), as well as Vitamin A supplementation.

The key performance indicators selected for health and nutrition in the PAD, i.e., reduced child mortality and improved nutritional status of young children, were challenging to begin with: they called for establishing a reliable baseline and then reassessing these two difficult-to-obtain indicators four to five years into the project.

To address the major causes of child mortality, the PAD proposed setting up/strengthening district health management teams (DHMTs) and making available essential packages of preventive and curative services. Key among them was the introduction of IMCI in the 30 districts. In addition, support to the national EPI was proposed including the limited introduction of hepatitis B vaccination. A safe motherhood program with strong outreach capabilities was proposed including safe

birthing, midwifery kits and an enhanced referral system of high risk pregnancy cases. UNFPA linkages were to be sought in this endeavour.

Regarding the PAD's logic model design (not a full logical framework), one summary indicator for health (the reduction in <5 mortality) and one for nutrition (the reduction of severe malnutrition of <5s) were retained. It is noted that the latter has flaws (see table 7). The critical assumptions made for these summary indicators in the model are judged to have been very general and vague. As regards the key performance indicators retained in the logical model for 'Output 2' (children's health status) and covering indicators for district health systems, IMCI, children's immunization and safe motherhood, the same look adequate and relevant. Nevertheless, almost none of these indicators explicit critical assumptions - the boxes were left empty in the PAD's logic model.

Evaluators carefully looked at the targets set by the PAD in terms of them being over-ambitious or not. They conclude that, for health and nutrition, other than the ones listed below, all indicators set reasonable targets.

Table 7 Assessment of nutrition targets

Summary indicator for nutrition	-Formulated wrong altogether (should not be <5s, but <3s; should not be 'wasting', but low weight for age; and should not be severe malnutrition, but moderate plus severe).
Key performance indicators:	
-all health facilities functioning	-an indicator depending on the MOH and not the project;
-case fatality rates for malaria, diarrhoea and ARIs decreasing by 25%	-considered ambitious;
-child immunization rates to be above 90% across the board in all project districts	-considered too ambitious;
-the percentage of mothers properly feeding their children increased by 20%	-considered ambitious;
-the prevalence of iron deficiency and Vitamin A deficiency reduced by 30%, and	-considered too ambitious;
-The prevalence of breastfeeding increasing by 20%	-the wrong indicator; it should be exclusive breastfeeding.

Source: PAD and evaluators' assessment

4.2.1.2 Efficiency

Evidence presented hereunder is importantly based on the field visit of only three districts and on the review of all the documentation made available to and generated by evaluators from raw data when needed information was not available at UNICEF.

Upon request, UNICEF prepared an ad-hoc table for the evaluators that showed achievements in terms of outputs for safe motherhood, IMCI and EPI for the three governorates visited by the team; the table encompassed 11 project districts and covered the time period until the end of 2004 (see Annex 9).

An important number of training activities were carried out by CDP over its lifetime so far. In 2004, UNICEF commissioned an assessment of the quality of this training. The report is overall positive and points out some of the deficiencies to be corrected.

¹⁷

It is fair to say that the project has only to a limited extent achieved its goals for the health sub-components. Details are as follows:

- a) The immunization rates collected by the Ministry of Health (MOH) are unreliable and a 2003 CDP-launched household survey showed a measles vaccination coverage rate of only 38%. This rate roughly agreed with data collected by the Global Alliance for Vaccines and Immunization (GAVI), but not with MOH data that show 2004 coverage for the 30 project districts to be in the 22-101% range for measles and in the 21-97% range for DPT3; for TT2, the range reported is 3-51%. The reliability of data issue aside, these discrepancies arise mainly, but not only, from the MOH using birth rates in the range of 30-35% when UNICEF thinks it is more accurate to use a rate of 40% to estimate the number of <1s. The data presented in this report was gathered from the MoH and directly from the respective districts (see annex 10) and does not match; the evaluators despite asking for specific advice cannot discern which set of data the reader should trust.
- b) As regards the population's access to health care, exact figures are neither available as a baseline nor for the present. Not all facilities constructed/rehabilitated by the project are yet ready and a couple has been completed, but not yet staffed and habilitated by the MOH.¹⁸

As of December 2004, the UNICEF list of indicators for health showed 40 facilities had been constructed and completed, i.e., equal to the total number planned to the end of project; six additional health units (HUs) will be completed in 2005. As for the facilities rehabilitated, 18 of them were planned and all have been completed. Additionally, by the same date, eight obstetric units in referral hospitals had been fully renovated. It is noted that, as per CDP agreement, the Government pays 10% of the construction costs. It did pay its dues up to 2003 but, as per the UNICEF financial officer, still has to pay the corresponding amounts for 2004.¹⁹

- c) All 30 districts of the CDP have benefited from the introduction of IMCI. Nevertheless, access of children to quality care for the major childhood diseases has been hampered by long delays in the project coordination unit's (PCU) procurement of IMCI drugs. Those drugs should have been distributed to all facilities in the 30 districts and be available throughout; in reality this was only the case for oral rehydration salt sachets (ORS),

The production/distribution of ORS paid for by the project is judged to be excessive. The MOH overestimated the needs and the original amount in the

¹⁷ For the executive summary of this report, see Annex 3i of the Midterm Review of the UNICEF Country Program 2002-2006.

¹⁸ See health and nutrition field report in annex.

¹⁹ See the excel spreadsheet in Annex 11 for a detailed analysis of all construction work in health.

budget for ORS was U\$3.5 million. Thousands of sachets risk expiring in MOH warehouses. Moreover, having a dual system with IMCI drugs being given for free and all other drugs being in the revolving fund system is untenable in the opinion of the evaluators.

- d) As regards safe deliveries/safe motherhood, the percentage of home deliveries remains high (82% in rural areas in 2003 according to PAPFAM). Evaluators were told that family members outnumber project-trained traditional birth attendants (TBAs) and community midwives in delivering babies at home. (CDP did train TBAs on clean delivery procedures). As said, eight district obstetric centers were upgraded and the staff retrained. But the community sensitization sub-component of the emergency obstetric care (EmOC) component has been very late in starting (January/February 2005) resulting in still very few referrals of high risk obstetric cases from the village to the district EmOC centers. Antenatal care (ANC) was also to be increased and evaluators found no aggregated statistics for the project districts to objectively measure if visits have indeed increased or not. Moreover, the indicator 'maternal mortality rate' is extremely difficult to estimate with such a high percentage of home deliveries; therefore, little can be said whether this key indicator has decreased through the efficiency of project interventions. It is to be noted that for this safe motherhood sub-component, CDP overspent U\$200,000 as of the end of 2004. When evaluators asked how this could have happened, they were told that, in general, when annual CDP plans (PPAs) were prepared, UNICEF staff did not consult the budget in the PAD to adjust annual expenditures accordingly.

Expanded Programme of Immunization

Key outputs for EPI were:

- health staff trained,
- vaccines, syringes and safety boxes regularly available,
- cold chain functioning, and
- well-kept record books in health facilities.

On the one hand, success can be claimed due to the project for the first three outputs, i.e., 2,300 staff was trained in EPI over 3 years. Furthermore, despite the accounts showing that CDP procured 14.5 million doses of DPT in 2003, project funds are no longer necessary for the procurement of vaccines since the government now covers all these expenses; the project has since shifted its EPI investments mostly to the cold chain. On the other hand, little success can be claimed on record keeping despite the fact that this issue had already been highlighted by the mid-term review (MTR) and by GAVI in its quality assessment of 2003. On a random selection of one health unit (HU) in Lahej, the evaluators found major irregularities in the EPI records.²⁰ As regards the efficiency of EPI micro-planning, according to the CDP's mid-term review, this activity started at district level without involving HU staff and results turned out below expectations. Belatedly starting from 2005, micro-planning is now being done at HU level with the involvement of the staff and importantly tackling the shortcomings described for the recording of key EPI information.

The information on coverage rates for the three districts visited compared with the average for all project districts shows the following:

²⁰ See health and nutrition field report in Annex 9.

Table 8 Vaccination coverage rates in three districts visited:

	DPT3		Measles		TT2	
	2003	2004	2003	2004	2003	2004
Al Udayin	53%	44%	68%	42%	58%	5%*
Zaidiya	65%	60%	55%	65%	70%	16%*
Al Milah	112%**	94%	97%	80%	101%**	46%*
Aver. all project districts	82%	60%	90%	61%	53%	17%*

Source: District EPI data Lahej governorate and UNICEF field offices Ibb and Hodeidah governorates

Note that these are 2003 and 2004 data collected from the 3 districts where they are expected to be more reliable; they do not match with rates found at central level for the same 3 districts from overall EPI surveillance data. Evaluators tried and failed to resolve these discrepancies. See the health and nutrition field report in annex for full details.

*: These drops are impossible since women vaccinated with 2 doses the year before are still covered one year later.

**. These percentages are either inaccuracies in recording or it is revaccinating children because they did not have the vaccination card.

The table above shows that by December 2004, the output of 90% EPI coverage rates for children in project districts, as targeted in the PAD, had not yet been reached for the majority of the vaccines.

Access to Health Care

The key outputs for access to health care were:

- operating old and new facilities (equipped and stocked with medicines),
- health facility committees trained,
- DHMT members trained,
- health workers trained in HIS, and
- a functioning cost-sharing system.

Also here, only very partial success can be claimed by the CDP. Not due to the fault of the project, several facilities in the 30 districts remain un-staffed and closed.²¹ Some HU workers operate out of their homes or in borrowed, inadequate premises; moreover, many health staff members work as 'volunteers', often for years without salary and waiting for a contract. The GoY is the main CDP partner; one would expect that it has the power to ensure staffing and opening. Nevertheless it has so far failed in this. The MoH simply does not have at hand the human resources to deploy. The bottom line is that no objective indicator of greater access can be inferred by the evaluators from the existing information. The project did select members for local health committees. So far, the only health facility committees members trained are 131 people in Lahej. Finally, 260 DHMT members were trained by the end of 2004 and 262 health workers received training in HIS; Moreover, on the same output, CDP did train all DHMTs, but by December 2004 only 58% of them were reportedly active. Evaluators could not find information on how many of these DHMT members were females, however the reproductive health officer in each DHMT is.

Referring back to the health performance output indicators for district health systems retained in the PAD's logic model, evaluators cannot comment on the coverage ratios for health services for <5s had increased by 10% after 2 years of project implementation. The fact that by December 2004 40 health facilities had been completed and equipped and 18 renovated is no guarantee of increased access for under 5s.

²¹ See health and nutrition field report for Lahej in Annex 9.

The cost-sharing system consisting of a drug revolving fund was set up by the MOH and not the CDP. It is functioning, although with problems.²² Finally, evaluators were able to interview too few beneficiaries to pass judgment whether they consider that the delivery of health services has improved in their uzlas (cluster of villages).

Integrated Management of Childhood Illnesses

Key outputs for IMCI were:

- staff trained,
- IMCI materials available in all facilities,
- referral mechanisms working,
- IMCI drugs available in all facilities, and
- a working community volunteers corps positively influencing 14 key relevant health-related household behaviors.

Success (a sizeable at that) can be claimed by the project for the first two outputs, although nothing can be objectively said about the quality of this training. Records show that up to December 2004, this sub-component had trained 32 professors, MOH and other senior medical cadres, 107 physicians from governorates and hospitals, 565 paramedical staff, 54 national facilitators and course directors, 227 community IMCI ToTs and 360 community communicators. For the third output, a streamlined referral of sick patients system being in operation, no success can be vouched by the evaluators. Evaluators did not find records for these referrals in the (few) facilities visited in the field. The forth output, IMCI drugs availability in all facilities, has been a major failure of the project due to severe procurement delays by the PCU, an aspect which was already pointed out by the MTR. Finally, it is found to be too early to assess the efficiency of the volunteer corps since they started to operate only since the end of 2004.

Referring back to the health performance output indicators for IMCI retained in the PAD's logic model, evaluators can say nothing either about the case fatality ratio due to diarrhoea, acute respiratory infections (ARI) and malaria having been reduced by 25% or about the number of children with these diseases being treated every month having decreased; they can say that they found ORS in all facilities visited, but cannot say that all cases of diarrhoea and dehydration are getting ORS; they can also not say, whether 25% more mothers are using ORS for their children. An assessment of ORS use is planned in 2005. No information was found on whether 'diarrhoea corners' have been set up in all facilities. Disagreements with the MOH specifications for the equipment to be used in these corners have delayed action.

Safe Motherhood

Key outputs for safe motherhood were:

- EmOC centers upgraded (physical structure and staff),
- community midwives and TBAs (re-)trained,
- delivery kits distributed, and
- community trained in pregnancy and labor danger signs and the '3 delays' concept (i.e., delay in seeking care, in getting to an EmOC center and in actually being treated in that center).

The project can claim success for the first two outputs. Six EmOC centers were upgraded before the MTR by end of 2003. (two in Ibb, and two in Lahej and Abyan

²² See the health and nutrition field report in Annex 9 for a full description on how it is working.

each) and two more since then, one in Hodeida and one in Al Mahara. Sixty three ToTs received training on infection prevention control and they trained 3,276 health staff. 290 educational sessions on HIV and AIDS are also reported. As regards EmOC training, 688 staff was trained. Evaluators could not find data on the distribution of 20,000 delivery kits for midwives and for TBAs procured by the PCU in 2002 and 2003 and distributed by the Reproductive Health Department of the MOH. The community training is an activity that also just started in January 2005 thus no judgment can be passed on its efficiency yet. ANC services have been only utilized by a fraction of beneficiaries; a lack of female health staff may, in some cases, be responsible for this.²³ In late 2004, the MOH asked CDP for additional funds to train more community midwives; UNICEF forwarded this budget reallocation request to IDA, but the same was turned down. It has to be noted though that there is a past history of newly trained community midwives not having been hired promptly by the MOH. Before CDP, UNICEF was able to give monetary incentives to this staff after training, but that is no longer possible.

Referring back to the health performance output indicators for safe motherhood retained in the PAD's logical model, evaluators cannot comment whether the percentage increases mentioned there were actually attained; quantified information is not available.

Cost Efficiency

The information needed to calculate these efficiency indices, both, financial and on the quantification of the outputs themselves, is simply not available for significant outputs to allow these calculations.

An exception is the cost of HUs constructed. An evaluators' analysis of the information received shows that the average cost of a standard CDP HU in 2002 was US\$ 24,000; in 2003, it was US\$ 28,200 and in 2004, it was US\$ 31,000. Evaluators were told construction materials costs inflation explain these increases.²⁴

Gaps and Constraints

Overall, perhaps the most serious gap has been the failed provision of IMCI medicines. A first tender launched in 2004 failed to materialize due to a number of internal problems of the PCU, i.e., the resignation of the procurement officer on short notice and the MOH sending a request for too small quantities of these drugs compared to what the project really needed. By the time this was sorted out, the supplier could not deliver at the price agreed earlier. A second tender was launched and a contract for an amount of US\$ 293,000 was finally signed in March 2005 for delivery by September/October 2005. Therefore, it is likely that the WB-approved IMCI drugs now being procured by UNICEF for the 2005 requirements, worth US\$900,000, will arrive earlier.

Another important gap is found in the area of HIS with poor record keeping persisting four years after project launching. Another gap could be the failure, so far, to sensitize the population about risk factors during pregnancy and labor so as to enhance the timely referral of complicated cases. A yet additional gap to be pointed out is the one in relation to the CDP's intention to center its priority in community participation: community health facility committees, although selected already before

²³ As per the PAPFAM Yemen Family Health Survey of 2003, in rural areas nationwide, 62% of pregnant women had access to at least one ANC visit.

²⁴ See excel spreadsheet on this in Annex 7

the MTR, have only been trained in one district (Lahej) and no evidence was found that they had started functioning. The Ministry of Health considers these committees to be in the spirit of PHC and thus needed; but it claims it has to look at past and current experiences with them before going ahead and training them. A major additional constraining factor overall reported by the UNICEF staff is the low financial and technical capacity of the MOH to accompany the project in the 30 districts.

Expenditure rate

Another element to measure project efficiency is the disbursement rate for the health component of CDP. The table below summarizes the situation until December 2004: (in US\$000)

Table 9 Expenditure rates of Health Subcomponents, December 2004

	District Health System	IMCI	EPI	Safe Motherhood
IDA FUNDS:				
Planned to be spent by UNICEF	3,605	3,980	5,710	60
Planned to be spent by PCU	-	5,720	-	170
Total	3,605	9,700	5,710	230
Actual Expenditure	<u>2,231</u>	<u>1,373</u>	<u>4,959</u>	<u>421</u>
Difference*	<u>1,374</u>	<u>8,327</u>	<u>751</u>	<u>(191)</u>
UNICEF FUNDS:				
Planned	1,420	-	-	310
Actual Expenditure	<u>257</u>	<u>277</u>	<u>3,747</u>	<u>203</u>
Difference*	<u>1,163</u>	<u>(277)</u>	<u>(3,747)</u>	<u>107</u>
GOVERNMENT AND COMMUNITY FUNDS:				
Planned	735	200	190	60
Actual Expenditure	<u>-</u>	<u>-</u>	<u>4</u>	<u>-</u>
Difference*	<u>735</u>	<u>200</u>	<u>186</u>	<u>60</u>
TOTAL FUNDS:				
Planned	5,760	9,900	5,900	600
Actual expenditure	<u>2,488</u>	<u>1,650</u>	<u>8,709</u>	<u>624</u>
Difference*	<u>3,272</u>	<u>8,250</u>	<u>(2,809)</u>	<u>(24)</u>
Include the RATE in %				

Source: UNICEF Yemen Country Office, Financial Officer, 2005

*: A complicating factor when analyzing the differences between 'planned' and 'actual' above is, as pointed out earlier, that the annual PPAs have most of the time been budgeted without reference to the funds allocated by the PAD budget.

4.2.1.3 Effectiveness

In, general, and based on what was observed and read, the CDP has fallen short of achieving its expected outcomes. For now, there are no before-and-after outcome indicators available in the project districts for morbidity and mortality of children and for maternal mortality to measure any project effectiveness.

At the time of this CDP assessment, no evidence has been found:

- that the incidence of life-threatening pediatric conditions has decreased;
- that the treatment of the conditions above is now qualitatively more adequate,

- and more timely;
- that antibiotics are being used more timely and appropriately in pediatric practice;
- that the situation of deliveries attended by trained personnel has increased;
- that the distribution of clean delivery kits is resulting in fewer post-partum complications;
- that the status of tetanus toxoid (TT) vaccination has improved;
- that more cases of diarrhoea and dehydration are being treated with ORS;
- that DHMT capacities have improved and are more effective than before;
- that women have an active role in DHMTs and in the upcoming health facility committees;
- that exemption mechanisms are working well in the cost-sharing initiative;
- that the health infrastructure set up by the project is increasing access and is being used to the full benefit of patients; and
- that beneficiaries are perceiving any health benefits from the project.

Capacity Building

More so for health workers than for physicians, the skills on the IMCI approach seem to have improved from what evaluators could get from interviews in facilities and from IMCI supervisors. Case management seems to have improved due to the project although no hard data are available on this either. Case management has been severely hampered by the absence of IMCI drugs (mostly in the form of syrups for pediatric use); staff now has to use medicines from the revolving drug fund or drugs provided by the national vertical programs and have to charge for them. As said earlier, nothing can be said yet about IMCI interventions having improved household health, nutrition and hygiene, as well as healthy behaviors of their members.

Procurement and distribution of drugs

The project has poorly contributed to the regular procurement of drugs. Tendering by the PCU for IMCI drugs has experienced severe delays. The procurement and distribution of other medical supplies seems to have been better, especially when those were procured from/through UNIPAC, the UNICEF procurement agency in Copenhagen. This is so much so the case that the PCU has now asked UNICEF to procure the 2005 IMCI drugs from there. This is a US\$ 900,000 order compared with two previous PCU orders of \$293,000 to US\$400,000.

Integration of EPI into district health plans

The CDP has done quite well on integrating EPI into district health plans. Although this is not a direct CDP achievement, but an MOH EPI one, in the three governorates visited, evaluators found evidence of improved decentralized planning in the delivery of immunization services. Record keeping remains a constraining problem though and aggregation of data at district level is only partially used to plan future local coverage activities. The recently completed national census will, in the near future, help overcome differences between UNICEF and the MOH in the calculation of vaccination coverage rates. Differences so far have mostly been centered on the denominator to use, i.e., the number of children <1 that need to be vaccinated. Moreover, the upcoming National Immunization Day will be conducted house to house and will collect information on children <1 so that more accurate denominators will become available from there.

4.3.1.4 Potential Impact

At the time of this CDP assessment it is impossible to comment on all sub-components in health (namely, reduced maternal and child morbidity and mortality and improved health status of young children and of pregnant and lactating mothers). This will actually only be partially possible after the re-run of the baseline survey in the form of a short module having been added to a national household survey being launched by the Central Statistics Office (CSO) in April 2005. This survey will only ask about ten variables of the original 25 that were surveyed by the baseline study, i.e., it will not be able to document progress in the 30 project districts against their own baseline data, but will compare health, education, water and other indicators between CDP and non-CDP districts. Steering Committee members have raised concerns about the usefulness of the upcoming CSO data to comment on the potential impact of CDP.

Evaluators could not find evidence:

- that infant, <5 and maternal mortality rates have fallen;
- that the morbidity and mortality from immunizable diseases has fallen;
- that the mortality from diarrhea, malaria and ARIs has fallen;
- that district health systems are now doing better planning and supervision;
- that the cost-sharing is generating the expected 4% of recurrent project costs; and
- that health facilities committees will be able to change health care services for the better.

Cooperation with WHO, UNFPA and WFP

Working with WHO and the GoY, in 2004, UNICEF selected 15 high risk malaria districts (5 in Hodeidah, 4 in Abyan, 3 in Lahej and 3 in Ibb); not all uzlas are covered. WHO's malaria vector control program sprays insecticides in high risk districts, but has not coordinated this well with CDP. CDP has given impregnated nets to beneficiaries in Al Udayin district in Ibb. As per UNICEF health staff, progress in the malaria intervention has been slow and results not yet evaluated. Finally, WHO has further collaborated with CDP in that it printed the IMCI flipchart now in use and has been doing the polio surveillance including in project districts. In consultation with UNICEF, WHO is planning an assessment of all IMCI activities in the country later this year.

According to the deputy representative of UNFPA, UNICEF UNICEF ended up collaborating with UNFPA in implementing the delivery kit, but not yet on the community sensitization aspects of EmOC. CDP started the latter activity only in early 2005 although this component was jointly planned by UNICEF and UNFPA from late 2002. A joint plan was finalized with parallel funding. An initial KAP study was conducted under the leadership of UNFPA though and the analysis was done together in 2003. Thereafter a communication and training strategy was development with a consultant funded by UNICEF in 2004. The same technical input also contributed to the finalization of the content of a simple clean delivery kit that included a leaflet on danger signs during pregnancy and delivery. The actual implementation of the communication plan was to be done independently in geographic areas covered by UNICEF and UNFPA projects – and this did not happen. However, the two agencies are currently working together on a new proposal for this sub-component with DFID and the Dutch Government funding. The CDP received and used 50,000 clean delivery kits from UNFPA and UNFPA also paid for the costs of the brochures that go with them. Finally, a consultancy was

carried out in 2004 on operations research for community mobilization; this was paid for by UNFPA.

UNICEF has not worked with other institutional partners in the implementation of the CDP. It does work with DFID in other endeavors, e.g., an upcoming maternal and neonatal health project in UNICEF districts including the CDP districts.

Except for EPI, MOH/donors meetings in the health field only happen sparsely and irregularly.

4.2.1.5 Sustainability

So far, the assessment of sustainability of the CDP's health sub-components gives a mixed picture.

The EPI will probably remain sustainable due to the importance and verticality of this sub-component and the GoY and donor (importantly UNICEF) efforts to keep it going. The new census data will hopefully improve statistics and delineate the magnitude of the task still ahead to reach desired coverage rates. A note of interest is that, after having been four years polio-free, from the end of February 2005, the country has experienced a polio outbreak which is now in the process of being controlled.

As regards access, the picture for sustainability does not look so good in the near and medium term. The MOH lacks the resources to expand access (e.g. it has said it can only hire 6,000 health personnel per year, a number that only allegedly replaces staff losses and retirements); evaluators know of no other major donor funding activities in this sub-component that cover a wide geographical area.

In IMCI, the potential for sustainability only exists if drugs are regularly made available and supervision and retraining activities are funded and kept up. It is not clear to evaluators that, with its current resources, the MOH is able to assure this from 2006 on. WHO, ADRA (the Adventist development agency), and the European Commission (EC) support the introduction of IMCI in other districts.

In safe motherhood, what will be achieved from now to the short time to end of project is crucial. The EmOC structure has been prepared by CDP to deal with a greater demand of high risk cases actually consulting. But the referrals are not coming yet. So, what will be achieved depends on the efficiency and effectiveness of the upcoming community education activities that aim to improve utilization and that are starting just now. Solutions to the '3 delays' will also have to be found for any sustainability, especially streamlining transport of women in labour to the EmOC centre. All this has to be done during the community education/sensitization campaign. More female obstetrician/ gynaecologists are also needed to secure sustainability. The overall finding of this assessment is that the safe motherhood sub-component is not sustainable yet. The Dutch Government and DFID might, however, provide some financial resources to expand the EmOC activities.

Institutional and Financial Sustainability

The aspect of institutional and financial sustainability was addressed during the field visits and with the UNICEF Health Section team. They responded that the capacity of the governorate level health offices to support the district health offices has not been greatly increased. The financial and management constraints are still monumental for governorates health offices, including their capacity to keep up basic maintenance activities. It needs to be pointed out that CDP sponsored the preparation of annual

workplans which were discussed and approved at district and governorate level. As per interviews with the UNICEF field officers, these plans, once accepted and often much changed by the line ministries in Sana'a, have only been partially implemented due to budgetary and other constraints thus often frustrating those who participated in the planning.

Some success was also achieved in governorate-level supervision of IMCI and EPI activities, but this was not directly confirmed for the three governorates visited. EPI has traditionally been coordinated from governorate level regardless of CDP. The project did some EPI training though and it included the governorate level. A total of 2,318 health staff were trained from 2002 to 2004.

As regards cost-sharing, the assessment team only had the chance of observing the functioning of the revolving drug funds in one district (Al Milah).²⁵ Waiving charges from the very poor was considered in the design of cost-sharing, but is not working well as per the same UNICEF team above. The whole cost-sharing initiative called for gaining consensus from communities before implementation; this important step was not followed. Health workers are poorly monitored on financial matters.²⁶

Despite some HIS training having been carried out and the HIS registers in use being well designed, not great progress was found on the improvements of the HIS so that there is no sustainability on this issue. Much greater efforts are needed in this area. Districts are not using the information generated by the HIS either. Five pilot districts received computers and computer training from the CDP; evaluators were told by the UNICEF health team that no follow up has been done on this activity. IEC activities in the EPI, IMCI and safe motherhood sub-components were indeed carried out, but since the community sensitization activities are just starting, little can be said about the sustainability of these activities (except, perhaps for EPI extension work which will have some sustainability). Social mobilization activities have been given less attention than called for by the PAD. They are behind schedule for community health facility committees: in almost all districts, they have yet to be trained and to assume their role; whether the latter will result in some sustainability cannot be assessed at this time. At present, sustainability has not been achieved.

4.2.2 Nutrition

The community-based nutrition (CBN) sub-component started in August 2003 in five districts. It expanded to five more districts in June 2004. CBN was preceded by a rapid appraisal on family feeding practices carried out by a consultant in 2001 and by a facilities needs assessment in 2002. With CDP funding, three officers of the Nutrition Department of the MOH were sent to Oman for a study trip to observe a nutrition project using the assessment, analysis and action (AAA) approach.

4.2.1.1 Relevance

From the point of view of the main nutrition sub-components chosen during project design, the project did select relevant activities that responded to real priority beneficiary needs in the ten districts covered in three governorates. The project coverage area is only 24 of 1,526 villages or 16%. Malnutrition is indeed a major problem in Yemen. Having chosen a community-based approach through the training

²⁵ The facilities do exempt some indigent patients so, when the staff goes to replenish their drugs stock, they are short of 10-20% of the cash needed; the drugs depot in the governorate does replenish 100% of the drugs for the upcoming period though, but keeps records of the cash 'debt' each facility is accumulating.

²⁶ An Oxfam Yemen study carried out in 2000/01 (www.oxfam.org) concluded that the cost-sharing system was anti-poor and gender-biased with limited participation of the poorest in it.

of volunteers in the community was also relevant. The MTR in 2003 recommended the nutrition component not be expanded to further districts and instead concentrate in consolidating gains. This is also considered plausible by the evaluators. Nonetheless, this year, prompted by the MOH's insistence, CDP was asked to consider funding permitting to expand to five new districts. Given the lateness in acting upon this request (May-June 2005), evaluators see this as relevant only if UNICEF commits to continue this support after the end of project.

The key performance indicators for nutrition retained in the PAD, i.e. improved nutritional status of young children and increased rates of exclusive breastfeeding and correct introduction of complementary feeding were challenging, in particular as it requires to establish a reliable baseline and then reassessing these difficult-to-obtain indicators (especially the latter two) four to five years into the project.

As regards tackling the malnutrition problem, CDP aimed at setting up community-based nutrition activities with a growth monitoring and a nutrition education component. Volunteers were to be trained in a sub-set of selected districts. In the original design it was 30 districts, but this was then reduced to a more realistic target of ten districts. All this is judged to have been a correct approach to project design for this component. On the other hand, only a very vague mention was made in the PAD about the provision of micronutrients to target populations. This is judged as a design weakness. CDP actually relied on the fact that these activities would be carried out with UNICEF funds outside CDP. Moreover, collaboration with WFP was proposed for the nutrition component.

4.2.1.2 Efficiency

The key outputs for nutrition were defined as:

- the training of health workers in nutrition,
- the selection and training of volunteers in the ten districts chosen,
- the provision of one Salter scale for each two volunteers,
- the sufficient provision of growth charts, educational materials and reporting forms,
- the number of children weighed every month, and
- the number of mothers receiving messages on breast and complementary feeding.

The above outputs, although generally judged adequate, were not quantified.

In general, as per the numbers resented below, achievements at output level are judged by evaluators to have been good; exception has to be made for the education of mothers for which the evaluators did not find any information. 371 volunteers were trained (6% more than planned) and 136 of them were retrained once. They did not cover all uzlas of the selected districts. Volunteers were also trained to check iodine contents of table salt and to prescribe ORS in cases of diarrhea: for this, they were supplied with needed implements. In groups of two, volunteers are expected to cover the growth monitoring of 30-40 children per month (900-1,000/year). In the case of Zaidiya District in Lahej, the district capital was left out in the provision of nutrition services.²⁷ Success of the CBN activity is to be credited, to a large extent, to this group of enthusiastic young women volunteers engaged in this endeavor. Although not observed by evaluators, weighing sessions have become opportunities for overall nutrition education for mothers and children. In 2005, CBN started training imams (religious leaders), teachers, district council members, health staff and scouts for

²⁷ See health and nutrition field report in annex.

them to spread nutrition messages. Moreover, IEC on nutrition topics was also carried out through the mass media in 2002 in districts other than the ten districts that had CBN. In 2003, 165 schools were given nutrition education lectures.

Ad-hoc statistical background information is as follows: 24 TOTs were first trained in 2003 and 25 in 2004, followed by 223 health workers in seven courses and 371 volunteers from 244 villages in 18 courses. Five refresher courses were then held for a total of 136 volunteers retrained. The MOH Nutrition Department reports that only seven of the 371 volunteers have dropped out in the ten districts. Many more Salter scales than one for every two volunteers were procured; the total number is 2,298 scales, so many were given to health facilities and some are still in storage at UNICEF (and some are still reportedly in the port). 50,000 growth charts were printed and distributed.

Despite the project having purchased 15 million doses of iron supplements in 2001 and three million doses of Vitamin A in 2003 (handed over to the MOH's Reproductive Health and EPI programs), actual CDP achievements in the area of iron and Vitamin A supplementation have been meager in terms of setting up a lasting system. CDP's efficiency in this area has to be considered minimal. Vitamin A supplementation was combined with polio vaccination days, in a national campaign that brought the vitamin along. These vaccination days may now be discontinued; the vitamin should, from now on, be given at the time of the two doses of measles vaccination at nine and 18 months of age. Evaluators found no stocks of Vitamin A in any of the health facilities visited in the field; just in one case there was a small stock, but of expired Vitamin A. It must be concluded that this supplementation is not being provided at this moment. Women are also not getting a post-partum Vitamin A dose as per program requirements. As regards iron/folate supplementation of pregnant and lactating women, evaluators did not find these supplements stocked in any of the facilities visited.

As per PAPFAM Yemen Family Health Survey 2003, in rural areas nationwide, only 21% of pregnant women received any iron supplementation during pregnancy. Infants are also not getting iron supplements as per program requirements.

As regards exclusive breastfeeding and complementary feeding, evaluators heard and read plenty anecdotal evidence that this promotion is being carried out and that "the results are good". But no hard data whatsoever are available on this at this time.

Gaps and Constraints

An important gap in the efficiency of this component is related to the volunteers not being trained to aggregate the data for their catchment area every month. This would allow them to judge by themselves the trends in the total number of children weighed and those falling in the red area of the growth chart. This aggregation is not done at the district level either, but is only done by the CBN coordinator at governorate level. S/he then sends the data to the Nutrition Department of the MOH in Sana'a who has neither shared these data with the nutrition officer in UNICEF nor with the districts. As a result, little can be said reliably about the coverage rate of the weighing activity of <3s, i.e., the percentage of all <3s in the community weighed. Despite MOH Sana'a data up to April 2005 having been shown to the evaluators, they cannot definitely say whether this CDP intervention has decreased malnutrition rates in the communities served by CBN. What can be said is that there is a trend in the nutrition monitoring that shows reductions in the malnutrition rates of those children that attend weighing sessions provided that it is the same children that come back month after month; this is information that is not currently recorded, but should be in the future.

The CBN activities in 2005 started with a budget below what had been requested in the PPA for this year, i.e., US\$ 75,000. The funds were not really made available though in the first quarter. It was only during the latter part of this assessment mission (early May) that the full 2005 PPA nutrition budget of US\$ 100,000 was secured from UNICEF funds, i.e., US\$ 25,000 more); whether this amount can be spent in 7.5 months remains to be proven. IDA only contributed US\$ 150,000 to the nutrition component overall and this was overspent by US\$ 13,000 already by December 2004. A request for an additional reallocation of IDA funds to this component was turned down by the Bank in early 2005; they were of the opinion that the absorptive capacity of the nutrition component in 2004 had been low. The evaluators found this latter impression of IDA to be inaccurate after meeting with the financial officer of UNICEF and looking at the 2004 PPA budget and expenditures. It needs to be pointed out though that, from the beginning of CDP, it was UNICEF that contributed the by far larger portion of the funding for the CBN sub-component.

Another gap to be pointed out is the one highlighted above for micronutrients. It should be mentioned that an iron deficiency anemia survey is planned for 2005.

Referring back to the health performance output indicators for nutrition retained in the PAD's logical model, evaluators can say little about a decrease in the prevalence of low weight for age of <3s and of micronutrients deficiencies for this group and for pregnant women. Reasons for this have been given above. The same is true for whether mothers are or are not practicing better exclusive breastfeeding and using more adequate complementary feeding practices: data are not there to assess these key performance indicators set by the PAD.

WFP Contribution

The role of WFP's food distribution of supplementary foods (particularly wheat-soy blend for malnourished children) is potentially important, but generates dependency and is not sustainable. To the best knowledge of the evaluators, the impact of this intervention since 2003 has not been measured by WFP (in terms of nutritional status improvements). The same is true for supplementary feeding of pregnant and lactating mothers.

Expenditure rate

The ultimate element to measure efficiency is to look at the disbursement rate for the nutrition component in the CDP.

Table 10 Expenditure of community nutrition, until December 2004 (in US\$000)

	Community Nutrition
IDA FUNDS:	
Planned UNICEF	150
Planned PCU	-
Total	150
Actual Expenditure	<u>163</u>
Difference	<u>(13)</u>
UNICEF FUNDS:	
Planned	1,260
Actual Expenditure	<u>274</u>
Difference	<u>996</u>
GOVERNMENT AND COMMUNITY FUNDS:	
Planned	310
Actual Expenditure	-
Difference	<u>310</u>
TOTAL FUNDS:	
Planned	1,720
Actual expenditure	<u>437</u>
Difference	<u>1,283</u>

Source: UNICEF Yemen Country Office

4.2.1.2 Effectiveness

Before-and-after outcome indicators for malnutrition of children <3 in the project districts are available only since April 2005 and only at the MOH in Sana'a; data for pregnant and lactating mothers is not collected. For <3s, rough average underweight rates²⁸ show that they went from around 42% to around 30% malnutrition in from six to 11 months of operation of the CBN. This is highly unlikely to be representative of the whole cohort of <3s, but rather represents a drop for the CBN users which most likely is a biased sub-group in each community. The issue here is that it is so far impossible to assess the access of children <3 to weighing sessions in the uzlas with an active nutrition program. Only the numbers of those who attend are recorded with no denominator used as to how many should be coming: this is another lost opportunity to use this information as a means of setting targets for full coverage.

Detailed data are as follows:

Roughly calculated average percentages of children falling in the "red zone" of the growth chart:

²⁸ Calculated by the evaluators from the bar charts in the presentation they got at the Nutrition Department at the MOH. (Printout of the power-point presentation given to evaluators, May 3, 2005)

Table 11 Estimated percentages of malnourished children

For five districts started in:	2003				2004										
	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov
Sep/03(%)	48	42	38	36	31	23	24	28	26	27	33	32	33	30	30
Jul/04(%)											43	40	34	26	28

Source: Nutrition Department, Ministry of Health

Due to the reasons given above, real progress in reducing malnutrition rates of <3s, as opposed to promising trends, remains poorly measured. It is judged that CDP should have taken this function more upon itself.

Moreover, as per the Assessment Matrix the evaluators prepared before starting the assessment of CDP²⁹, no evidence was found:

- that growth charts are always correctly used in CBN;
- that data from CBN are used to increase coverage of children weighed and to improve activities locally;
- that most mothers are convinced of the benefits and are practicing exclusive breastfeeding;
- that most mothers are introducing correct complementary feeding practices;
- that 'EPI Plus' vaccinations did cover all vaccinated children with a Vitamin A dose;
- that measles vaccination is now accompanied by a Vitamin A dose;
- that mothers are receiving a post-partum Vitamin A dose;
- that the percentage of children receiving Vitamin A and iron supplements has increased;
- that pregnant and lactating women and infants are getting iron supplementation;
- that birth weights are showing a trend towards increasing; and
- that CBN is implementing as a genuine participatory process engaging mothers in assessment, analysis, action (AAA or Triple A) cycles based on a conceptual framework of the causes of malnutrition.

4.2.1.4 Potential Impact

As much as this is a very relevant project component, assessing the impact of the nutritional sub-components (namely, improved nutritional status of young children and of pregnant and lactating mothers, as well as an improved micronutrient status of the same groups) is impossible at the time of this assessment. Data are only available for 10 districts and their reliability is not clear for underweight, as commented above, and totally unavailable for Vitamin A and iron status. Evaluators must thus bend to the fact that, at this time, data available are not sufficient and reliable enough to draw conclusions regarding potential impact.

Moreover, as per the evaluators' Assessment Matrix (see footnote 3), no evidence was found:

- that the percentage of <3s with low weight for age are decreasing;
- that the prevalence of Vitamin A deficiency has decreased;
- that the prevalence of iron-deficiency anemia has decreased;

²⁹ Assessment Matrix for Nutrition, see Annex 7

- that exclusive breastfeeding rates have increased;
- that the percentage of mothers with improved habits in introducing complementary feeding has increased;
- that the low birth weight rate has decreased; and
- that beneficiaries perceive the nutritional status of their children has improved and that this is something to strive for.

Community-based triple-A and Social Mobilization

Evaluators found no evidence of the AAA processes at community level in which the community takes ownership of the project activities. Yes, it is community volunteers that carry out the weighing and nutrition education, but that alone does not constitute a AAA/social mobilization model. No efforts have been made to identify and tackle the root causes of malnutrition in the community. Volunteers were not trained in the AAA approach. This is not only true for nutrition, but also for other CDP-trained volunteers as, for instance the IMCI and the EmOC volunteers trained by the project. However, there is explicit use of the AAA language and of the conceptual framework of the causes of malnutrition at the MOH Nutrition Department. MOH officers concede that these concepts have not been taught to volunteers and plan to do so in future refresher courses. So, from the community mobilization point of view, the nutrition component has had no impact.

4.2.1.5 Sustainability

The sustainability of the nutrition activities of CDP are not assured after project end. As per interviews with the Nutrition Department in the MOH, it is almost sure the MOH does neither have the financial resources to continue training/retraining volunteers nor to keep up needed supervisory activities. Funding for the ongoing printing of growth charts and the stationery needed for the reporting on this activity is also not assured. An expansion of the activity to additional districts is late in starting this year and may not yet establish CBN firmly by the end of this year.

4.2.3 Education

CDP aims to address low school enrolment rate³⁰ especially for girls, low completion rate (grade 6) for primary education, inadequate teacher supply especially of female teachers and unsatisfactory quality of education. The education component focuses on expansion of community schools for girls, female teacher training and textbook distribution.

4.2.3.1 Relevance

Relevance of Issues addressed

The current school enrollment, attendance and completion rates in Yemen are rather low. The baseline study³¹ conducted in the 30 CDP districts in 2001 and 2003, respectively, discloses the following results: Across the project areas, 45% of girls and 67. 9% of boys aged 6-11 years are attending school. The highest level of attendance is not reached at the formal school entry age at 6 years, but at the age of 9 years. From the age of 9 years onwards girls' school attendance declines,

³⁰ Net Enrolment Rate: Enrolment of the official age-group for a given level of education expressed as a percentage of the corresponding population.; Gross Enrolment Rate: Total enrolment in a specific level of education, regardless of age, expressed as a percentage of the official school-age population corresponding to the same level of education in given school-year; <http://devdata.worldbank.org/edstats>

³¹ Republic of Yemen, Baseline Study Child Development Project, 2001&2003

indicating a higher drop out rate for girls than for boys.

Girls' education in Yemen is a highly gender sensitive issue. Cultural factors as gender specific roles, early marriage and segregation between the sexes as well as economic factors related to poverty inhibit in particular girls' access to education. This results in gender inequality in education with human development indicators for female literacy and net enrolment ratio for females among the lowest worldwide³². In addition to the gender gap in education, urban-rural differences are significant: 84.8% of urban and 68.9% of rural males in the age group aged 10 and above are literate, compared to only 59.5% of urban and 24% of rural females, respectively.³³

Gender and urban-rural differences are also reflected in the placement of teachers.

Table 12 Gender and urban-rural distribution of teachers working in schools (2003/2004 school year)

	urban schools	%	rural schools	%	Total
Male teachers	27153	49	109394	92	136547
Female teachers	27892	51	9829	8	37721
Total	55045	100	119223	100	174268

Source: MOE Statistical Yearbook 2003/2004

Table 12 shows an almost even gender distribution of teachers in urban schools, whereas only 8% of the teachers in rural schools are female. Whereas about 75% of the Yemeni population lives in rural areas, only 5.6 % of all teachers are rural, female teachers.

The issues addressed by the CDP and its education component are highly relevant for Yemen and are in line with the Government's expressed objective and donors' joint efforts to improve the situation of girls' education in Yemen. The Government's strategy for basic education development (BEDS) and the WB supported Basic Education Expansion Project (BEEP) are examples reflecting the efforts in the education sector. Furthermore Yemen is member of the Fast Track Initiative (FTI) and a Millennium Goal Partner Country³⁴.

Quality of Design

The inputs provided by the project include rehabilitation of existing classrooms and construction of new classrooms, provision of school kits and textbooks, technical assistance in training of trainers for improving teaching methodologies and of female teachers, construction of warehouses for textbook storage, and provision of equipment.

The project document sets out the following key performance indicators for the output 4, "Educational status of girls in primary schools (grades 1 to 6) improved":

- Girls' enrollment in grades 1 to 6 in the intervention areas increased by 20 percentage points by the end of the project.
- Proportion of trained women teachers for grades 1 to 6 at schools in intervention areas increased by at least 15 percentage points by the end of the project.

³² UNDP, Human Development Report, 2004

³³ National Document to Promote Girls Education in Yemen, Draft Version (mimeo), April 2005

³⁴ The "Education for All – Fast Track Initiative" was launched as a global partnership between donor and developing countries to ensure accelerated progress towards the Millennium Development Goal of universal primary education by 2015. All low-income countries which demonstrate serious commitment to achieve universal primary school completion can receive support from the FTI.

- Storage and distribution of textbooks and educational materials improved in intervention areas.”³⁵

In the PAD there are no critical assumptions set out, other than distribution bottlenecks addressed by the Ministry of Education (MoE) for the storage and distribution of textbooks. Potential risks, which should have been well known already at the project start in 2001, are not addressed in the project document. An example is the commitment of the MoE for the provision, allocation and retention of female teachers to rural schools.

The inputs of the education components are likely not sufficient to achieve the anticipated results. Deep rooted cultural factors, which inhibit girls' school attendance and completion, and how to contribute to behavioral change of fathers and mothers, are not sufficiently addressed in the project design. In summary, the design is mainly activity and output (no. of classroom constructed and rehabilitated, number of teachers trained, etc.) oriented, and to a lesser extent results and impact oriented.

4.2.3.2 Efficiency

The key outputs of the education component as described in the PAD are

- Community schools constructed and rehabilitated;
- Trained and retrained teachers, trainers and supervisors, trained district education officers;
- Warehouses for storage of school book constructed and rehabilitated, trained warehouse staff;
- Distributed textbooks and school kits;
- Communities mobilized and ready for CDP implementation.

The last output, communities mobilized and ready for CDP implementation, is crucial for the efficient implementation of all the other outputs of the education component and the other components of CDP. This is at the same time another CDP component that is described in detail in chapter 4.2.6, community readiness.

Community Schools

During the first years of project implementation (2001 to 2003), the number of **classrooms constructed** surpassed the total number planned (534 as of December 2004, versus 210 classrooms planned). This can be explained by the tendering and construction of the schools at community level, which facilitated the construction. The classrooms were of modest but functional design and did not include a management/storage room, thus involving less construction work. These factors have led to relative low construction cost per classroom while matching functional requirements.

According to the information provided by the UNICEF country office, almost all newly built three- room schools recently built were equipped with two latrines. Until 2004, however, UNICEF was not very rigorous in the construction of latrines. It was more demand driven rather than systematic planning and construction of latrines in all schools. During the field visit evaluators witnessed CDP schools without any sanitary installation (e.g. in Al Udain). Interviewed teachers felt this to be a limitation to attract in particular girls to join school, as they need these facilities since some of the children have an up to 45 minutes walk from their homes and cannot go home - like children who live in the village - to use sanitary facilities. The UNICEF country office

³⁵ Project Appraisal Document (PAD), 29 February 2000)

also reported that dry pit latrines, though promoted, were not accepted either by the education offices or by the communities.

For **classroom rehabilitation** more than 50% of the target set has been achieved between 2001 and 2004. So far 358 rehabilitated classrooms stand against the targeted number of 600.

The year 2004, however, was a year of low implementation of CDP community schools. There has been an intensive discussion between UNICEF and the Ministry of Education (MoE) regarding the required design of the classrooms constructed. MoE argues that each school constructed must have a management room, sanitary facilities and fulfill MoE standards regarding size and materials used. This contributes to increased average construction costs per classroom.

Construction work planned for 2004 was thus seriously delayed and had to be shifted to 2005. By January 2005, according to the UNICEF summary planning sheet³⁶, out of 325 classroom constructions due for 2005, 265 are a backlog from previous years (238 were not initiated in 2004, 11 were initiated in 2004 and 16 initiated in 2003). Works were not completed yet. 60 additional classrooms are the planned task for 2005. There is also a backlog in the work on school rehabilitation. Out of 246 classroom rehabilitation works considered due for in the same data source, six were initiated in 2003, 72 were initiated in 2004 and 168 had been due for 2004, but had not been initiated by January 2005.³⁷ This amounts to a very ambitious workload for construction and rehabilitation for 2005, the last year of the CDP contract implementation.

Despite the achievement of number of classrooms constructed in the first years of CDP, the expenditure rate for community schools remains low. This can be partly attributed to the low construction cost in the past. On the other hand it is reflecting the significant backlog in construction work accumulated mainly in 2004. The budget status 2001 to 2004³⁸ shows an overall expenditure for community schools of only 37% of the US\$ 6,67 Mio allocated for this project component. As the table below shows, UNICEF own funds contributed to CDP have an expenditure rate of 50%, whereas IDA funds managed by UNICEF only of 4%. For government and community funds with a planned contribution of US\$ 0,736 Mio, the data provided shows zero expenditure so far. The lack of contribution of the GoY, planned as 10% of the school construction cost, is not only jeopardizing CDP efficiency. It also puts a question mark at the felt ownership of GoY and leads to a negative assessment of the potential financial sustainability of school construction and rehabilitation beyond project end, apart from what donors might be willing to contribute through the National BEDS.

Expenditure Rates

The expenditure rate provides an additional indicator for implementation efficiency. Two of the three budget lines related to the education component, community schools and women teacher training, show an overall expenditure rate of 37% and 30%, respectively. The low expenditure rate can be explained by (1) numbers of female teachers trained is significantly lower than planned and (2) cost for some of the trainings provided have been lower than originally calculated. The likeliness that all available IDA funds for the education component can be spend before December

³⁶ Summary Sheet, Number of classrooms to be completed, by governorate and by district. 26/01/05

³⁷ Quarterly Progress Monitoring Report, IV/2004 of December 2004, in contrast, states: Of the 111 class room rehabilitations committed in 2004, only 72 classrooms have been completed. This provides a more positive picture.

³⁸ CDP Budget Status 2001-2004, provided by UNICEF Yemen Country Office, 05/2005

2005 must be assessed as low. The highest flexibility of funds use is expected to be with UNICEF's own funds, in particular as the UNICEF country programme covers the period 2002 – 2006, i.e. it continues one more year beyond CDP end. IDA funds, in contrast, can only be used before the closing date of the credit, 31 December 2005. Postponing the closing date would require a contract amendment of the Development Credit Agreement³⁹. After interviews conducted at WB this does not appear to be likely to happen. In the other case the unspent funds would flow back to IDA.

Table 13 Total Budget and Expenditure rates 2001 to 2004, Education Components Budget in US\$ 000 and Expenditure (%)

Project component	IDA Funds managed by UNICEF	UNICEF Funds	Government & Community Funds	Total
Community Schools	1,060 (4%)	4,874 (50%)	736 (0%)	6,670 (37%)
Women Teacher Training	140 (309%)	2,020 (11%)	30 (0%)	2,190 (30%)
Textbook Distribution	859 (94%)	none planned*	331 (68%)	1,190 (92%)
Total Expenditure	2,059	6,894	1,097	10,050

* UNICEF contributed additional US\$ 37000 from own funds and PCU from IDA funds to the textbook contribution.

Source: Child Development Project, Budget Status 2001 -2004

The **training activities** consist of initial training of newly recruited female teachers', training of trainers for micro-field training, refresher training and training of supervisors. The assessment team had no chance to witness any of the training activities while working in Yemen, and can thus base their assessment only on observations during the field visits, on documentation made available and on interviews conducted with participants and trainers.

The activity monitoring table provides a mixed picture regarding quantitative results of each of the training activities.

The **initial training** of newly recruited female teachers is a crucial activity of the CDP education component. The importance of the presence of female teachers for the achievement of the educational project development objective of CDP was already stressed. The project's initial objective was based on the commitment of the MoE to contract 2000 rural female teachers with secondary school degree per year. It was meant to increase the number of female teachers, in particular, in rural areas nationwide, and to provide them with an initial training. This quantitative target was not met due to, as expressed in UNICEF progress monitoring report of December 2004, the "inability of the MoE to allocate enough posts for female teachers in rural areas and to efficiently manage the recruitment process".¹⁴⁰

The training figures for this target group show a sharp decline over time, following the declining figures for newly recruited female rural teachers. In the first CDP project year, 1612 female teachers have been trained, whereas the numbers for the subsequent years are 1403, 967, 647 and for the current academic year 2004/2005 it

³⁹ Development Credit Agreement of 3 April 2000, Article II, Section 2.03.

⁴⁰ UNICEF YEMEN – Progress Monitoring Report IV/2004, December 2004

is 450, respectively. For the academic year 2005/2006, starting in September 2005 and thus the last recruitment while CDP is implemented, a total number of 578 rural female teachers' vacancies were provided to the assessment team by the Deputy Minister of Finance. Of these, only 138 were allocated to the nine CDP governorates (but not necessarily in the 30 CDP districts or for the CDP supported schools); Lahej, a governorate where the number of female teachers is declining, has not been allocated with any new female teacher for the coming academic year. However, in 2004/2005, CDP did not provide the training for newly recruited female teachers, but it was done with sources of the catalytic fund, which has trained about 14.000 primary level teachers nationwide and the small number of newly female recruited teachers has been included into this programme.

This phenomenon is beyond the influence of UNICEF as the principal manager of the component. UNICEF continues to address this severe issue by advocacy, together with other major donors in the education sector who share this concern. It can be already safely stated that the impact of CDP will be significantly reduced by this failure of the Government to recruit and retain female rural teachers, compared to what could have been achieved with the recruitment and training of this key target group.

Further constraining factors are the decisions of the MoE to phase out all Teacher Training Institutes which provided pre-service training for teachers in rural areas and the decision to consider candidates with high school degree only in exceptional cases as teachers. Teachers with a University degree are considered the "normal case". This is absurd, given the reality in Yemen. On one hand, the communities trust people (and mainly women) from their village or region most to teach their children, on the other hand there are not too many girls in the rural area who have achieved as much as a high school degree. Urban females with University degree, in contrast, find it generally not attractive to teach in remote rural areas. It is thus not easy to define the "exceptional case": Evaluators are of the opinion that it could be such an exceptional case, if girls in school age otherwise would remain without any primary education.

The responsibility for the achievement of the number of female teachers recruited lies with the three line Ministries in charge, i.e. MoE, MoF and MoCS and with decisions makers at governorate and district level.

In contrast to the scarcity of new placements for female rural teachers, the assessment team encountered during their field visits availability of female teachers - currently without work contract. They are often so-called "female volunteers", i.e. teachers with secondary school diploma working without a salary in the hope to get a long term contract in future. In particular in Hodeidah it was reported by former fellow teachers that female volunteer teachers finally stopped working after having served voluntarily for up to seven years⁴¹. This was also confirmed by field visits of other review teams. In the past, UNICEF has provided transport allowances to these volunteers, but has stopped as it was meant to bridge the time until the volunteers would receive long term jobs as teacher, which did not happen.

There is hardly any analytical information available on the **quality of the training**, for instance evaluation sheets of training participants. The assessment team asked for those data at field offices, country office and at ministry and district education officer

⁴¹ In another school visited, a supervisor disclosed in confidence that he even tried to offer a financial incentive to the DEO to get a job for his wife, who is a teacher and who had volunteered a long time and holds a university degree at a rural village school.

level, without success. The Deputy Minister for Education, responsible for training, confirmed that there is a lack of consequent training evaluation and structured data. A respective proposal for a study on impact of teacher training (grades 1 to 3) has been compiled end of February 2005 and waits to be put in motion.⁴² The UNICEF field offices reported that this kind of evaluation is done after seminars orally on a random basis, to get an impression of the participants' perception of the training.

A lot of valuable information to measure the quality and efficiency of training and its impact on achieving the objective of CDP is not gathered, as regular training evaluation has not been conducted throughout project implementation.

The female teachers interviewed, who had been trained during early CDP or already pre-CDP periods had a very positive perception of the training and emphasized its practical approach. They also found the subjects covered as very effective in contributing to improvements in their teaching.

The female teachers interviewed mentioned the following aspects of the training as of greatest professional importance for them:

- Preparation of lectures/classes
- Child psychology
- Teaching methods and teaching aids
- Trouble shooting
- Linkage with communities

In addition to the positive assessment of the (few) teachers interviewed, the assessment team found in some schools practical evidence of application of the training in the classroom. For example, dialogue oriented communication with the children, gender sensitive distribution of questions and answers to male and female class mates and implementing a sitting order (in columns of equal gender) in the class, which allows both, girls and boys, to sit as well in the first rows.⁴³

In particular for the teachers who have a modest education and no/little previous pedagogical training, the initial training appears to be of great value for improving the quality of teaching.

During the field visits the assessment team observed at least twice wrong utilization of classrooms newly built under CDP; male teachers are using newly constructed classrooms as management rooms, whereas in one of the cases, the first grade was sitting on stone floor outside a nearby mosque. These aspects should have also been detected by the regular supervision missions. The UNICEF field officer for Ibb governorate stated that he complained about this situation at several occasions.

Teacher Training does not only include the initial training, but also in-service **refresher training** for both, female and male teachers. For 2004 3000 teachers were planned to be trained in the CDP governorates (also beyond CDP districts) and a number of 3870 achieved. UNICEF is collaborating with GTZ in this activity, and both work closely with the training sector of the MoE, to coordinate the revision and updating of training modules for teachers, head masters and supervisors, and for training of trainers. MoE has conducted a respective needs assessment of teachers

⁴² Proposal for the evaluation of impact of teacher training (grades 1-3) for the period 4/2005 to 4/2006.

⁴³ In contrast to another school, which coincided to have male teachers only, were female students from grade 5 onwards were squeezed in the far corner of the classroom.

with a pre and post test. This can well contribute to a sustainable development of the training modules.

From July 2004 onwards the CDP training (Teacher training, train the trainer, training of supervisors) covers only 6 CDP governorates (instead of the nine in total). Another project, the BEEP, is covering already the three remaining governorates. The female participation in the training courses amounts to 25% to 30%, according to the PMR IV/2004. The term originally used for the subcomponent, “women teacher training”, is thus misleading for all training courses with the exception of the initial training for female rural teachers.

CDP is providing transportation allowances for eight visits per year per school to the school supervisors. According to the education sector of UNICEF, the supervision reports are not very substantial and describe more problems than solutions. The cadre of supervisors is, however, currently in a phase of revamp which is supposed to conclude with a significant reduction of number of supervisors and an enhancement of quality of supervision. UNICEF and GTZ have collaborated in the compilation of new training manuals for supervisor training; GTZ has provided the technical expertise and CDP has financed the development cost of the manual. The manual is tested and ready to use now, and the training can start.

Six of the seven **warehouses** for textbooks planned were built or rehabilitated between 2001 and 2004, and 18 warehouse staff members were trained in 2004. The training started late, as the “no objection” by the WB for reallocation of budget for equipment for warehouse management was awaited. As that delayed things significantly, the training took place in a warehouse where all equipment was functional, in particular computers for warehouse management training. The expenditure rate of the textbook distribution was of overall 92% at the end of 2004; GoY and community funds show an expenditure rate of 68%. The revised Government contribution for warehouse construction in five governorates has been slightly decreased compared to the 2005 forecast and is US\$ 136.600 ⁴⁴. According to a UNICEF manager, there were some difficulties experienced when applying for a reallocation of IDA funds within the same budget line from construction of warehouses to equipment for warehouses, e.g. forklifts to carry the books inside the warehouse. However, the reallocation has been meanwhile endorsed by the WB and PCU has started the procurement process.

Overall, the **textbook distribution** has been successful. The number of schools provided with textbooks has increased since the start of CDP and earlier problems with storage of books have been detected and solved.

During the field visits, the receipt of the textbooks was confirmed in all schools visited by the assessment team. In most cases, according to the teachers and headmasters interviewed, this was done in due time. Whenever small delays occurred, or quantities were too small to cover all students (which is anyway anticipated by delivering only 70% of the books required for full coverage) the missing textbooks were bridged with textbooks stored of the previous year.

Cost-efficiency

A special aspect of efficiency relates to the question on how prudent CDP has been in introducing innovative, low-cost and locally acceptable school infrastructures in the project districts. The assessment team has benchmarked available information on

⁴⁴ UNICEF PPA 2005 (Annual Work Plan)

different providers of classroom infrastructure.

A comparison done of school construction by SFD, PWP and BEEP in 2003 showed that the average unit cost of schools in rural areas per classroom ranged from US\$7,902 for SFD to US\$14,861 for BEEP and the average cost per msq was between US\$137 to US\$183. The floor area of these classrooms ranged from 29.25 msq to 36.30 msq for 36 and 42 students per classroom respectively. Compared to that, in 2003, CDP was spending a much lower US\$5,142 for the construction of a classroom which measured 24 msq and housed on average 25 students. However, a simple comparison between the four different projects is inappropriate for the reasons given below:

- The facilities being provided by each of the four agencies vary across them and also among their own different construction sites. Sometimes administration rooms, teacher's quarters, stores and latrines are included in the design, while sometimes they are not. The size of SFD, PWP and BEEP schools was 29.25 msq while for CDP it was 24 msq. It should be noted that since 2005, the classroom size of CDP schools has also increased to 29.25 msq.
- The sites chosen for construction have varied widely. Thus the costs of construction have been affected by the site's ease of accessibility and closeness to markets.
- Materials used in construction by the different projects vary as do designs.
- The costs quoted for SFD, PWP and BEEP include, according to the mission which did the comparison, rehabilitation works, which is not the case in CDP. In CDP's case, till 2003 the cost of rehabilitation per classroom was US\$2,500 and from 2005, it has been raised to US\$3,000.

As stated above, till 2003, CDP was applying a figure of US\$5,142 as the average cost of construction for a 24 msq classroom housing 25 students. This included latrines but generally no teachers' room. This seemingly much lower cost compared to other implementing agencies such as the ones quoted above caused consternation in some quarters with some stating that CDP schools were of inferior design. After enquiries by the MoE, UNICEF hired a consultant to assess its design. The consultancy firm came up with standard designs of schools which included three classrooms each of 29.25 msq area, admin and teachers rooms and latrines. The revised costs were estimated at between US\$9,423 and US\$13,806 per classroom. The latter school is made of blocks and is in one of the most difficult locations. That is the costliest design. Where the former is it made of irregular stones and is in central locations the cost is US\$9,423 depending on the material being used.

Thus the debate about whether CDP is cheaper or not, in terms of construction of schools, is difficult to determine. It is important to point out that - according to UNICEF - it's mode of operations differs from other agencies in terms of involvement of the community. While all the agencies mentioned above require community contribution, in addition CDP requires that the Parent Teachers Associations hire the contractors, monitor school construction and be responsible for maintenance work. This has the dual effect of building the capacity of the local community and of reducing the burden on the Ministry of Education to rehabilitate the schools in the future. One could argue that these longer term effects make CDP schools more cost-efficient in the longer run.

CDP school construction is, after changing of the design (to be in accordance with MoE requirements), still at the lower end of the models benchmarked (9,423 US\$).

Teachers' room and latrines are justified, and it must be assured that female teachers and female students do equally benefit from this infrastructure.

Gaps and Constraints

The main constraining factors of the education component are the following:

a) Lack of reliable information

This constraint was already identified by the midterm review of the UNICEF 2002 – 2006 Country Programme of Cooperation for the education sector: "A major challenge for meaningful planning and budgeting to take place at the sub-national level is the lack of information within the education sector itself and among donors regarding the government's budgeting process and lack of transparency in budget allocation and execution at central, governorate and district level. This is critical for the optimum utilization of material, human and financial resources."⁴⁵

b) Community School Construction

The discussion about the required school design between the Ministry of Education and UNICEF can be considered as a constraining factor for the community school construction, as new construction projects in the pipeline were put on hold. On the request of the MoE the standard school design for CDP was redefined in 2004 according to the Ministry's standards. Rooms for teachers and school administration and fence walls are part of the new design. This led to a sharp increase in the classroom unit cost from US\$ 5,142 (2004 estimate) to US\$ 9,000 (2005 estimate, after revision of the standard design previously used under CDP⁴⁶). The discussion led to some delays in the implementation during 2004, but cannot explain the fact that school construction work initiated in previous years (2002 and 2003) have not yet been completed in 2005, as observed during the field visit in Sana'a.

c) Commitment of GoY/MoE

Another, very severe constraint for the achievement of objectives of the education component is the non-fulfillment of GoY of the precondition to recruit 2000 female, rural teachers per year. The actual numbers of newly recruited teachers have decreased and reached a low of 450 in 2004/2005. One of the preconditions to build new schools - the availability and contracting of new female teachers for rural schools – has not been fulfilled by in any of the CDP districts in the three governorates visited⁴⁷. According to the UNICEF field officer in Hodeidah governorate this has led in the district of Zaidia to the decision not to initiate planned construction work unless female teachers are recruited.^{48 49}

d) Monitoring System

A further constraint, encompassing all CDP components, is the absence of a harmonized monitoring system that accompanies the progress of CDP in the respective districts and governorates and feeds results back to the coordination at UNICEF country office. Further comments are made in chapter 4.1.4, information and

⁴⁵ Country programme midterm review

⁴⁶ CDP – Progress Monitoring Report, IV/2004, December 2004

⁴⁷ Table, Number of teachers in 11 districts in 3 governorates

⁴⁸ Interview with UNICEF field officer in Hodeidah

⁴⁹ For the school year 2004/2005 the governorate of Hodeidah has been allocated only 6 new rural female teachers with high school diploma from the national quota; source: Deputy Ministry of Finance – allocation of female rural teachers for the school year 2004/2005

monitoring systems.

4.2.3.3 Effectiveness

Before answering the question how the number of female teachers has developed throughout the CDP implementation, the assessment team would like to stress once again the importance of female teacher in the cultural and gender context of Yemen.

Several studies have already identified the presence of female teachers as one of the key determining factors for girls' enrolment and retaining in higher grades and for access to the female part of the community, i.e. mothers and older girls.⁵⁰ This is tallying with the responses the assessment team has collected during interviews in the field and at central level. It makes it an important indicator for effectiveness, impact and sustainability of the CDP.

The data gathered by the district education offices in the three districts visited (Al Udayn, Zaidia and Al Melah) shows the following results:

Table 14 Male and Female Teachers (1-9 grade) in visited districts

District	Al Udayn			Zaidia			Al Melah (grade 1-6)		
Teachers	2000/2001	2003/2004		2001/2002	2003/2004		2001/2002	2003/2004	
Female	91	95	4	165	140	-25	49	47	-2
Male	693	760	67	607	626	21	132	129	-3

Source: UNICEF Yemen Country Office, data provided by District Education Offices, 05/2005

The development of the number of female teachers in the three CDP visited confirm the lack of female teachers in these districts. Whereas in Al Udayn the number has increased by 4,4% over three years, it has declined in Zaidia by 15% and in Al Melah by 2,3%.

Over the 11 CDP districts in those three governorates visited, the picture appears to be similar; whereas the total number of teachers increased from 4532 to 4574 (42) or 0.9% the number of female teacher declined from 736 to 639 (97) teachers or by 13.2%.

The initial training for teachers is provided throughout the country to all newly recruited teachers. The performance indicator assessment states in this respect that the training, originally foreseen for female teachers only, has also be opened for male teachers.

Based on the findings in the districts visited, underpinned by the numbers provided by the DOEs, it must be stated that the CDP is loosing an important element of its effectiveness. The number of beneficiaries, female teachers, cannot be provided as planned. Replacing vacancies in the seminars by male teachers can be appreciated as a means of trouble shooting, but it is not serving the same purpose. It must be also stated that this problem lies beyond the power of the UNICEF implementing staff of the CDP; they have, however, to cope with the negative consequences.

Overall, the number of female teachers has declined, whereas it should have increased. The target, "the proportion of trained female teachers for grades 1-6 at schools in intervention areas (30 districts in nine governorates) increased by at least

⁵⁰ National Document to Promote Girls Education in Yemen, Draft Version, 19 April 2005; SFD Yemen, The Integrated Community Development Programme, Mid-Term-Review, January 2005

15% by the end of the project”⁵¹ is unlikely to be achieved.

Although the assessment team has not been provided with any quantitative data, there was clear evidence during the field interviews that provision of water and sanitation in schools is an incentive for the parents to send their children to school. In particular for girls who are living outside the village where their school is located (the catchment area of schools visited was up to 45 minutes walking one way) the availability of latrines appears to be a decisive factor for parents to send their girls to school. Again, based on anecdotal evidence during the field visits, water and sanitation is one contributing factor, but not reported as the main or only decisive one. The assessment team has visited schools without sanitation, but with female students, if the other decisive parameters are positive.

The easy access to potable water in a village appears to have a positive effect on time availability of women and girls. Whereas women and girls had to spend several hours to collect water every day, time for water collection was reported to have decreased. As an indirect effect, the girls have potentially more time to attend school. More details are summarized in the following chapter 4.2.5, water.

⁵¹ PAD, Annex 1, page 5

Table 15 **Number of Male and Female Teachers by District**

Governorate	School Year/Grade District	2001/2002			2002/2003			2003/2004			2004/2005		
		Male	Female	Total	Male	Female	total	Male	Female	total	Male	Female	total
IBB	Al-Udayn(1-9)	693	91	784	760	95	855	760	95	855	n.a.	n.a.	0
	Hazm Al-Udayn(1-9)	446	12	458	463	17	480	460	17	477	n.a.	n.a.	0
	Fara Al-Udayn(1-9)	367	22	389	369	24	393	371	26	397	n.a.	n.a.	0
Hodeidah	Munira (1-9)	192	72	264	203	58	261	192	61	253	191	50	241
	Dhahi(1-9)	189	81	270	175	86	261	189	86	275	155	77	232
	Al-Mighlaf(1-9)	204	33	237	208	19	227	169	4	173	184	8	192
	Qanawis(1-9)	362	134	496	373	117	490	378	85	463	487	103	590
	Zaidiya(1-9)	607	165	772	551	151	702	626	140	766	734	141	875
Lahej	Al-Milah (1-6)	132	49	181	152	51	203	129	47	176	147	53	200
	Tor Al-Baha(1-6)	345	72	417	385	73	458	405	74	479	410	74	484
	Al-Madaraba(1-6)	259	5	264	250	4	254	256	4	260	245	2	247
	Total	3796	736	4532	3889	695	4584	3935	639	4574	2553	508	3061

* Number of teachers in Lahej indicates teachers from Grade 1 to 6.

Source: UNICEF Yemen Country Office, as provided by District Education Offices, 05/2005

4.2.3.4 Potential Impact

At the time of the CDP assessment the most recent population data were those of the census 1994. All figures available were based on those data, extrapolated to 2004/2005 figures. The assessment team decided not to work with these unreliable estimates for enrolment⁵² and completion rates, but to built the analysis on the summary indicator “decrease in ratio of boys to girls enrolled in grade six in intervention areas by a least 15% by 2005” to estimate the potential impact CDP interventions had in the education component.

An impact assessment, another piece of work assigned by the UNICEF Yemen, might provide further data, based on the figures for the 2004 census, hopefully published by end of the year.

The assessment team retrieved data on primary education (grade 1 to 6) for the school years 2000/2001 to 2004/2005 (in some cases only until 2003/2004) for the 11 CDP districts in the three governorates visited: Ibb, Lajeh, and Hodeidah. The data has been provided by the District Education Officers (DEOs) and forwarded by the UNICEF field officers.

The summary indicator set out in the PAD is “decrease in ratio of girls to boys enrolled in grade six in the intervention areas by at least 15% by 2005”. This indicator was in course of the project rephrased to “Increase in ratio of girls to boys enrolled in grade six by at least 15% by 2005”.

As examples Al Udayn, Zaidia and Al Melah are chosen:

Table 16 Ratio of Girls to Boys ratio⁵³ in grade one and six in visited districts

District	Al Udayn			Zaidia			Al Melah		
	2000/2001	2003/2004	Diff.	2001/2002	2004/2005	Diff.	2000/2001	2003/2004	Diff.
1 Grade	0,67	0,81	21%	0,66	0,74	12%	0,72	0,91	26%
6 Grade	0,39	0,56	44%	0,55	0,61	11%	0,27	0,39	44%
Total 1-6	0,54	0,70	30%	0,65	0,68	4,6%	0,52	0,69	33%

Source: UNICEF Yemen Country Office, as provided by District Education Offices

The examples chosen provide a mixed picture. The two districts Al Udayn and Al Melah with more modest girls to boys (G2B) ratios in grade 6 in 2000/2001 show both a 44% increase in grade six in 2003/2004; Zaidia (2001/2002 to 2004/2005), in contrast, has the highest absolute girls to boys ratio in grade six, but the lowest increase over the school years, of 11% at grade 6.

Taking the summary indicator of 15% increase, it can be assumed that two of the three districts already surpassed this figure and the third district will likely achieve it by the end of school year 2004/2005, too.

For an analysis of the CDP impact one has to keep in mind that the baseline figures at project start were rather modest. A G2B ratio of 0,25, for example, indicates that in a class of 25 people 20 are boys and 5 are girls (~20%). For education data for the 11 CDP districts in three governorates visited see Annex 8, Education Data.

⁵² The key performance indicator in the PAD is “girls’ enrolment rate in grades 1 to 6 in the intervention areas increased by 20% by the end of the project”.

⁵³ Girls to Boys Ratio: # of girls divided by # of boys; gender equity is achieved at a rate of 1.00

To conclude about the impact of the project interventions on CDP supported schools, data of CDP schools and non CDP schools within one district must be compared. The data for CDP schools was only made available for the schooling year 2003/2004, but not for the schooling year 2000/2001. Furthermore it has to be differentiated by the category of school: (1) Girl's only schools, (2) mixed schools or (3) schools, where girls and boys study in different shifts.

Within a given school year there is a clear decline of G2B ratio from grade 1 to 6 within on school year. This was analyzed in other studies already and can be explained by several factors. Among them is the early marriage, still practiced in Yemen, and preparation of the girls for it.

Taking the developments in grade 6 over three school years, the summary indicator for G2B ratio in grade 6 increased by 15%, has been already clearly surpassed in two of the three districts analyzed.

The summary indicator for **learning achievements** calls for 80% of girls (in school) having acquired minimum levels of learning by the 5th year of the project. Learning achievement has been last measured in 2002 and published in a survey in 2003. The results revealed that only 30,5% of students in grade 4 had achieved the basic competencies in Life Skills, whereas the results for Arabic were 14%, for Science 12,6% and 6,9% for Mathematics, respectively. There was also gender differences stated, in favor of male students in Life Skills and in favor of female students in Arabic. The other analyzed subjects did not show any gender differences. Another survey on learning achievements for grade 4 and 6 is planned for end of 2005. Only with the new data analyzed some statements about learning achievements and the CDP impact can be made.

4.2.3.5 Sustainability

The distribution of the teacher quota for each of the governorates is done on governorate and district level. There have been indications that reallocation (and thus often misallocation) between male and female teachers and rural and urban schools is common practice; furthermore payment of up to one annual salary as recognition for a safe long-term contract was reported.

There have been some steps taken by the Ministry of Education, e.g. to allocate vacancies for teachers to specific schools, not to people. This would, at least theoretically, inhibit the common practice of changes from rural to urban schools after serving for a short time at a rural school.⁵⁴ This practice must be avoided in the future.

The sustainability of the community school component will also depend on the readiness of the GoY to live up to their commitment to contribute 10% of the cost of the community school construction. In course of project implementation UNICEF country office has advanced money to the GoY, e.g. US\$ 136,600 being the government's share of the cost of textbook warehouses in five governorates.

There have been positive examples observed from fathers or teachers committees, which have actively contributed to construction of school facilities and to maintenance of the schools. This is also a positive element of sustainability at village level.

⁵⁴ See Mom with the Minister of Education, March 2005.

The existence of the Sector Wide Approach in Education, which has been recently reinforced, is sharing the main objectives of the CDP education component (increased enrolment and retaining of girls in school etc.), and provides an element of sustainability. However, continuous funding by (current and new) development agencies is not sustainable as understood in assessment terms.

The assessment team thinks that there are serious limits to a sustainable continuation of benefits and services of the education component beyond project end. The lack of contracting and placement of female rural teachers in the project implementation districts (and CDP supported schools) has remained unsolved over the whole period of CDP implementation, which make it a structural, and not just as a temporary problem. It has already been addressed in previous studies, e.g. the WB Midterm Review of October 2003 and remains a shared concern of the major donors involved in the Education Sector in Yemen.⁵⁵

Food Provision to Girls

There has been an increasing effort by UNICEF and WFP to coordinate their activities. However, the WPF school feeding programme (take home rations for girls) is not an integrated part of the CDP education component. In 2003 WFP has been distributing food to school girls in 1,400 schools (which must have working parent-teacher associations) for girls in grades 1-9. The programme operates in 85 districts throughout Yemen, but only 16 of them are also CDP districts. Wheat flour and oil are distributed three times a year at have an estimated cost of 9 U\$ cents per girl per day.

According to a WFP analysis⁵⁶ this has resulted in an up to 40% increase in enrollment rate of girls in grades 1 and 2 and a decrease in drop-out rates. This could potentially reinforce the goals of the CDP education component. There have been also reported cases of negative impact of this programme, for example redirection of girls to schools in areas with take home rations in place, or withdrawal of boys from schools in favor of girls. Where the programme was discontinued, the enrollment rate of girls has decreased again. Though an analysis of the food programme is not subject of this assessment, it can be assumed that such an approach has to be implemented in the long term, so that it could lead to behavioral change, overriding short term decisive factors for girls' enrolment, e.g. economic advantages or disadvantages.

4.2.4 Early Childhood Development

The objective of the Early Childhood Development (ECD) component is "to create awareness among care givers to provide safe, secure, stimulating and enabling environment which promotes the holistic development of the child from conception up to 8 years".

The component remained dormant until mid 2004. Until that date only a survey on child rearing practices was undertaken. Among the reasons for late take off was the lack of expertise in country and restrictions of financing more international staff. The ECD component was revamped upon the arrival of the expert. The results of the survey provided the basis for several of the component's subsequent interventions.

Even for UNICEF this is a relatively new, though important topic. It is also part of

⁵⁵ MoM with Dutch Cooperation, GTZ and UNICEF Education Sector

⁵⁶ WFP, School Feeding Programme Yemen

UNICEF's Midterm Strategic 5-year Plan. When the ECD component started there were only 18 months of the CDP project remaining. The work programme had to be adapted accordingly to the remaining time and budget.

ECD is clubbed with activities in the education and health components, for the age group 1-3 with health, nutrition and IMCI, and for the age group 3-6 mainly with education.

The key activities aiming to build ECD capacity in Yemen are

- Training of ECD students through a one-year ECD online course with presence phases in Sana'a, in cooperation with the University of Victoria, Canada. 16 participants on governorate level from throughout Yemen (4 male, 12 female) have been selected and started the course. Expected completion date is May 2006, but the final installment for the online course should be made in December 2005 prior to project end date; the participants are supposed to be the ECD resource persons and trainers in their respective region.
- An ECD Resource Center was established in Sana'a in the premises of HCMC; resource material has been purchased and the centre is equipped; capacity building of the resource centre staff is ongoing;
- An ECD communication package is developed; sensitization and orientation on ECD has been conducted, in coordination with the NGO SOUL and the ECD national resource centre; training of frontline workers has started in two selected pilot areas, Ibb (Al-Udain) and Hodeidah (Al-Zaidia). About 70 people have been oriented, among them governorate level officials in health and education.
- An applied research with two elements: (1) a study of the situation of kindergarten in Sana'a and Aden, in coordination with Sana'a University, and (2) a study on child rearing practices, is completed and results are in the process of dissemination to six governorates.

It appears that the ECD has finally taken off rather well, although it is too early to comment in detail on the quality of results and impact of this CDP component. Relevant questions will be "How are the trained ECD specialists use/share the newly acquired knowledge effectively?" and "How do specialists at governorate level interact with the National Resource Centre?" The overall expenditure rate of ECD at the end of 2004 was 29%. Even anticipating the payment of the final installment of the online course of estimated US\$ 75,000 substantial funds remain to be spent during the short remaining time; in particular the actual expenditure of Government funds remains nil.

4.2.5 Water

For water and sanitation, the main public sector organisation partnering with CDP is the government's General Authority for Rural Water Supply Projects (GARWP). Headquartered in Sana'a, it has branches at the governorate levels where it houses field engineers and other staff. GARWP has benefited from its partnership with CDP. Training, using CDP resources, has been imparted to 21 members of its staff in how to use computer software to design water schemes. Its field offices have also been supplied water testing kits using CDP resources. GARWP's main responsibility in the partnership is to ensure the completion of capital investment. After completion, schemes are handed over to benefiting communities. Other GARWP responsibilities include training of community water committees in management skills, Operations and Maintenance (O&M) techniques and quality control. GARWP is also responsible

for the environmental sanitation aspect of the sector. This covers raising community awareness to environmental issues; cleanliness, hygiene and conservation of environmental resources. Regular auditing of books or regular supervision or mentoring by GARWP is not stipulated.

4.2.5.1 Relevance

According to the CDP's PAD, waterborne diseases such as diarrhoea are one of the main contributing causes of the high infant and child mortality prevalent in Yemen. The PAD states that in the country only 55% of the rural population has access to safe drinking water and only 17 percent has access to adequate sanitation. In another assessment, i.e. the CDP Baseline Survey, diarrhoea was observed to be a major cause of death of children. The survey noted that overall in the 9 CDP governorates, over 27% of children under 5 years had suffered from diarrhoea in the two weeks prior to the survey. It further stated that in the 30 CDP districts, water and sanitation coverage in rural areas was 63% and 23% respectively.

There are also some observations that the lack of latrines hinders girls' school attendance. As an example, the PAD notes that lack of latrines for girls is one of the main factors leading to poor girls' enrolment and retention rates at the basic education level and that only half as many girls between 6 and 15 years are in school as compared to boys. The PAD also quotes from 'The Situation Analysis of Children and Women (1999)' which shows that access to water is very closely associated with girls' enrolment rates. In some areas, girls spend a substantial part of the day fetching water.

The relevance of the Logic Model as given in the PAD vis-à-vis the project design and objectives, while overall sound, gives no attention to the GARWP, the key public sector partner in the component. A critical assumption which should have been listed in the last column of the Logic Model is the availability of water. As the progress of the project has witnessed, scarcity of water and drought have disrupted the implementation and/or functioning of CDP water schemes in a number of sites. In addition, these mechanisms listed in the Logic Model to measure the key performance indicators do not indicate who is responsible for using the mechanism and with what regularity. Weak capacity to monitor and keep records at district and governorate levels later showed that listing Local Development Committee (LDC) reports as an M&E tool was ambitious.

4.2.5.2 Efficiency

Generally, it has been observed that the water management committees function well and keep satisfactory records. In the case of motorized schemes there are three people in the management committee and another two trained in O&M. All five are paid salaries through revenues earned from charging villagers for access to the scheme. To train these committees, the manuals of IRC and WHO, which explore international experience, were studied by UNICEF and GARWP and then modified to develop the UNICEF Water Supply Schemes Manuals for management and operation and maintenance. The manual was then pilot tested and its language was simplified. Among other issues, it describes how water tariff calculations should be done and different ways of how to cross-subsidize the poor.

During field visits, the average rates per cubic metre consumed for motorized schemes with water metres were stated by villagers to be around 150 Yemeni Riyals (YR) per household. The exact fees are determined through readings of the water metres user households install within or next to their compound. These rates have

been set by the community, not by UNICEF. However, not all schemes have connections to individual households and neither was this an obligation on behalf of the implementing agencies to ensure this. If users of individual water schemes so desire, they can at their own expense install water pipes and meters from the public fountains directly to their households.

In a number of instances, witnessed particularly in Hodeidah governorate, poorer households are supported by the financial contributions of richer households to access water. Often the poorer households have to pay nothing for gaining access or for monthly consumption. In many cases, they may have to fetch water from the public fountains as they do not have the means to get connections to their individual houses.

Especially in the case of handpumps and motorized schemes, achievements are below targets planned. This has been, among other reasons, due to the drying up of sources especially in the case of handpumps, poor performance of contractors (e.g. in Hodeidah), unsuitability of pre-defined water sources and the lengthy procurement procedures, especially of the IDA, which mean that supplies are delivered often more than a year later than the original request. Concerns regarding the lengthy procurement procedures.

According to the WES section in UNICEF, in the original design of the project, the ratio between civil works and supplies was 1,3 to 1 while experience has shown it ideally should be more like 1 to 1,75. Civil works procurement was financed by the World Bank and for supplies by UNICEF. As a consequence of the recommendations of the WB Mid-Term Review, the World Bank accepted that money for civil works could be used for supplies but that in this case procurement should be done by the World Bank or by the PCU. UNICEF then sent specifications to the World Bank in June 2004 for pumps and pipes but delivery of supplies is still awaited.

UNICEF's procurement processes are much shorter; also acknowledged by World Bank. The latter qualifies this by saying that its own rigidity and adherence to quality control ensures better standards of the supplies procured. On the other hand, UNICEF states that when it procures locally, it can demand guarantees from suppliers of up to a year; something which cannot be realistically done when procurement is tendered internationally as is the case with the World Bank.

Procurement rules and procedures of both the World Bank and UNICEF are cumbersome. This causes major delays in the case of the former and being too inflexible, in some cases, to shift balances between component items in the case of the latter. With CDP having to face both of them, certain activities have witnessed more delays than had procurement been done through one system. However, this also has highlighted for the assessment team one more issue: UNICEF field and sector staff at the country office has not been given sufficient orientation on UNICEF's own procurement procedures, let alone the World Bank's.

A relatively sophisticated, challenging project as CDP should have made training in procurement regulations mandatory for each field officer and sector staff in the country office; this applies for both standards - UNICEF's own and the WB procurement regulations. This can be considered as a means to minimize delays in procurement and thus enhance implementation efficiency.

Water quality and quantity testing is done only at the beginning of implementation by GARWP; the cost of this is part of the total financial package. UNICEF has equipped GARWP branches with water testing kits. After the initial testing, no regular testing of

water is mandatory nor is there such a stipulation in the guidelines.

The water management committee, UNICEF and the local council signed an agreement to define the responsibilities of all three parties. The agreement is supposed to oblige the community to construct household latrines. However, while the design of latrines has been completed, no marketing strategy to communities has yet been envisaged. As the consequence, implementation has not taken place.

The guidelines in the training manual for water management committees do not specify how removal of office-bearers or their re-election should occur. Regarding providing access to water to the poorer members of the community, the project only sensitizes the management committee towards these issues and gives certain options of how the needs of the poorer households can be met, e.g. subsidy by the rich or factored as a loss in the accounts or certain number of cubic metres of water to be supplied free. The guidelines in the manual also provide advice on how to set tariffs.

All the schemes so far completed in the Lahej governorate are solar pump schemes. Of the nine, six are operational. Of the three non-operating, wells have dried up in two cases and in the third there is the need for greater drawing of water due to usage of the well by households from surrounding villages (their own wells had dried up). This meant that the village reverted to the traditional method of manually withdrawing water thus abandoning the new scheme. Incidentally, all 3 of these schemes are in the district of Tor Al-Baha which could indicate a problem with the local council. The council has been contacted by UNICEF to assist in resolving the issues including identifying suitable replacement sites.

The maintenance of solar pump schemes is quite easy. All the communities have to do is to clean the panels regularly to prevent them from gathering dust. However, villagers report that in a few cases, solar pumps are performing less well in winters due to less sunlight. One option, they say, is to supply them with solar batteries. The batteries would be very expensive and incur more technical maintenance. UNICEF states that less sunlight is not the major cause of less water availability in the wells. The drought over the last few years has caused drying up of sources and that is one reason why the yield has reduced. In addition, solar pump schemes were supposed to cater to a small number of households. If, as it happens, nomads travelling through the area consume water, then a shortage is bound to occur.

Training on how to maintain the solar pumps was imparted by ITS, the vendor. This simple training included how to clean the panels and other issues. However, there was until now, no requirement of a management committee for these schemes on the part of UNICEF. If the panels get broken or other complex issues arise, there was till April 2005, no management structure in place to solve the issue. During the assessment mission, UNICEF was revisiting this issue and had recruited consultants to assist in instituting village-level water management committees. On a related issue, UNICEF accepts that it is not sure whether automatic disconnection devices, which should accompany solar pumps bought by the project, are indeed present at all installations. This issue was pointed out in the PCU M&E Officer's report during his visit to Lahej governorate earlier this year.⁵⁷

So far, 117 water committees have been trained on WES Management and 146 trained on Operation and Maintenance and a total of 65 schemes have been

⁵⁷ Child Development Project, Outcomes Assessment, Lahej governorate February 26 – March 6, 2005 by PCU (March, 2005)

completed benefiting approximately 124,000 people. A further 29 schemes are in various phases of completion. While the PAD gives a figure for the total amount available within CDP for water schemes and related activities, it does not indicate the number of schemes expected to be implemented nor their type. Some reasons for this are understandable. For example, during the design of the project while the 9 governorates had been identified, the 30 districts for operation had not and neither had the locations within them thus making it impossible to forecast what type of schemes could be implemented, their numbers and individual costs. Additionally, costs of works and services have increased over time with inflation etc.

This has meant that concrete targets, supposed to have been laid down at the beginning of the project, are lacking. One cannot thus ascertain whether the project has performed according to, under or above plans. Rather targets have been set as the project has moved forward. The targets for the number of beneficiaries, as given in the PAD is, stated as between 150,000 to 3,000,000 people. This target is so wide and vague that it borders on the absurd. The project would have been considered having achieved its target had it reached 0.15 million people or 20 times as much, i.e. 3 million.

Another target mentioned in the Logic Model is an increase in easy access to water by 25% in intervention areas. Given that the last census figures available are over 10 years old, it is unclear whether this target will be reached. Based on the figure of a population of 1.75 million based on the CSO projection for 2001 of the 1994 national population census for the 30 CDP districts and according to the CDP Baseline Survey, 63.4% or 1.1 million people had access to water in 2001. An increase of 25% of that number comes to 278,000 people. With an estimated total number of actual beneficiaries of 221,000, the project is falling short of reaching this target by about 50,000 people or 20% as when all the schemes are functioning. The same analysis, based on a less conservative estimate of population growth rate by UNFPA of 3.5⁵⁸, leads to a population of 2.26 million for 2001 in the same 30 districts, whereas 1,43 million people had access to water in 2001. An increase of 25% increase would mean 358,000 planned additional beneficiaries; the shortfall would be almost 40%.

4.2.5.3 Effectiveness

Generally, the design of the water schemes has been undertaken satisfactorily. This keep in view the need of beneficiaries, the capacity of villagers to maintain the schemes, the type of water source available and source depth, the catchment area and the availability of spare parts. In some cases, the last aspect could become problematic especially in the case of solar panels or spare parts for hand pumps which have to be imported.

Water is supplied free to mosques and schools though in some cases, ceilings on the number of units supplied free are imposed. The water projects have enabled communities to accumulate often large reserves of savings from user charges. These savings are kept in banks and are used as contingencies for maintenance and running of the schemes including salaries of committee members and Operations & Maintenance (O&M) personnel who are also from the community. The savings are also used for fuel costs and in some cases, though not witnessed by the mission, it was reported that revenues earned from water supply have been used to pay for the provision of education for children and other social activities.

Women, the prime managers of water in the households, are members in some

⁵⁸ UNFPA, State of World Population 2003 for 2000-2005

water management committees, however generally committees comprise men. During field visits, the sole woman who was a member of the water management committee met in Al-Udain did not know the total savings of the scheme. Neither had she known if any villagers had been trained in O&M. This indicates either actual non-involvement of the female committee member or weak supervision on her part. It also indicates that further capacity building of committee members to fulfil their responsibilities more efficiently may be needed.

In quite a number of cases, not all households have easy access to supply of water from the schemes. Houses, for example, located at a distance from the supply network find it costly to get connected due to the length of pipes needed as do poorer households. The Water Committee in Al-Gabgab in Ibb has suggested to poorer households to pool resources and get group connections thus lowering the installation costs per household. However, the Committee on its part did not indicate that it would take initiatives to tackle this issue even though it has accumulated savings of around 500,000 Yemeni Riyals.

In the case of solar pumps, villagers have stated that during the winter the capacity of the solar pumps to withdraw water is lowered due to less sunlight. To counter this, in some cases, the infrastructure supporting the solar panels has been modified so that the inclination of the panels can be lowered during the winter to capture more sunlight.

For the sanitation sub-component, UNICEF developed a set of standard designs for latrines construction. In 2004, this set was sent to GARWP to be reviewed with the local authorities including local councils, water committees and GARWP's branches to agree on potential way through which communities could be convinced to adopt and implement the designs. However, as GARWP lacked and still lacks any expertise in sanitation, no implementation took place. Incidentally, completion of a sanitation package has been in the WES component's workplan since 2003 and is thus overdue.

As stated above, only motorised water schemes had management committees which are responsible for their supervision, collection of revenues and expenditure on working and capital costs. Only O&M personnel existed for solar schemes and for handpumps though in the case of the former, management committees have recently been instituted for the six schemes which are operational. Agreements in this regard have been signed and their training is expected to commence shortly.

Cost effectiveness of water schemes: A study was recently undertaken by an engineer for GARWP examining the relative costs of procurement of supplies for water schemes of GARWP and CDP. It showed that tenders obtained through GARWP's own system were 27.36% higher as compared to those procured through CDP. The breakdown of this difference is as follows:

- 4% for income tax,
- 10% for procedures such as money spent on opening lines of credit (international agencies such as UNICEF having greater financial capacity do not need to give hidden charges and commission for opening LCs etc) and other procedures and
- 13% was the extra overheads that the contractors charged from GARWP.

The report recommended simplifying GARWP procurement procedures to be more in line with those used by CDP.⁵⁹ However, it is probably unfair to compare UNICEF

⁵⁹ Supplies Cost Comparison Report by Abdul Ghani Amin Al-Ghazali for GARWP (in Arabic) (2005)

procedures with those of the Yemeni Government due to two very different ways of working and different mandates. However, another element in cost-effectiveness should be noted. CDP requires significant contributions from the community during the construction of the water schemes and 100% of the contribution for post-implementation operation and maintenance. The cost to the government is zero once the schemes are operating and there is no cost of water usage to be paid to the GoY. Community contribution required by GARWP schemes includes construction of the pumping house, approach road and transportation costs of getting the pipes from the district to the site. The community also provides unskilled labour for which it pays.

Also due to flexibility in design e.g. there is little delay in payment to contractors, the schemes are more efficiently implemented. In traditional schemes undertaken by GARWP, it often takes up to a year for the contractor to be paid. In addition, as noted above the schemes can generate substantial revenues for village communities.

4.2.5.4 Potential Impact

In all cases, interviewed villagers reported that time for fetching water have been substantially reduced, lowering the burden on girls and women. This includes not only travelling time to the water source and back, and time spent in drawing water and filling Jerry cans but also time spent in queuing besides wells, etc. Though no quantitative data has been available, villagers also report that incidence of waterborne diseases has significantly decreased. Again, while no substantive data exists, some people have stated that the schemes have freed time for girls to attend school. Despite this, while a sizeable number of households have quicker and cleaner access to water, there is still a large section of population within the 30 districts that is without water.

When all 68 schemes are completed, it is expected that a total population of about 221,000 people will be benefiting (see annex 13). While all nine governorates are benefiting, the number of schemes varies from 1 in Hajja to 24 in Abyan. In Abyan, the majority of schemes are rainwater harvesting schemes. In fact, all the rainwater harvesting and handpump schemes are concentrated in Abyan. All the solar pump schemes are in Lahej while motorized schemes exist in all nine governorates.

Despite this, while a sizeable number of households have quicker and cleaner access to water, there is still a large section of population within the 30 districts that is without water. This is because the population without access to water in the target districts is much larger than those who could benefit from the limited resources available under CDP.

Involvement of the community in planning, implementation and maintenance of the schemes has led to increasing their capacity and empowering them. Water management committees actively explore mechanisms to adopt to buy new pumps for example, or utilise revenues earned for other village development activities. The involvement has also fostered linkages with government institutions notably GARWP. However, capacity building of women committee members or users has lagged behind notably because of the social constraints within which they have to work and the lack of female professional staff within government service providing agencies with whom they can comfortably interact.

Where tariffs have been introduced, the revenues in some cases are quite impressive running into several hundreds of thousands of Riyals. However, these sites are the exception and in the majority of cases, a tariff system has yet still to be introduced or the savings so far accumulated are much smaller. It is unclear why for

example in Abyan governorate, according to data given to the mission by the Field Office, projects completed and functioning since 2002 have still not started tariff systems.

Partly because no health and hygiene trainings under the sanitation sub-component (apart from some ToTs) have been undertaken, latrines are either missing or are in need of repair. For raising awareness on health and hygiene issues, a Knowledge, Attitudes and Practice (KAP) study was undertaken in 17 districts of five governorates by UNICEF. Based on this, a manual for hygiene education activities using various communication channels was developed. This will be piloted in Ibb and Hodeidah governorates under CDP as UNICEF has been working in both governorates since 1996 and both are CDP areas where a number of water projects have been implemented.

The sanitation sub-component of WES should have been synchronised to take place with the implementation of the water schemes. This did not occur for a number of reasons including the unclear roles of UNICEF and GARWP within sanitation, the type of sanitation that the PAD envisaged and the lack of sanitation expertise to date within GARWP.

The PAD clearly states, 'The UNICEF ABP pilot (meaning prior to CDP) did not provide sanitation interventions, nor did it ensure sufficient drainage of water around water schemes. As the social assessment points out, this can lead to the major health risks. The CDP's water and sanitation component is designed to ensure that every water scheme has an appropriate sanitation and drainage system.'

During implementation of CDP, the sanitation sub-component has not been adequately addressed. UNICEF's assertion that hardware sanitation inputs were not foreseen in the PAD is not borne out by available evidence. Firstly, nowhere in the PAD it is stated that the CDP will deal only with the software part of sanitation i.e. training and capacity building. Secondly, in at least two places in the PAD, allocations for the hardware component are mentioned. Under 'UNICEF's contribution to the project', the PAD states that UNICEF will finance 'goods for district health systems, water and sanitation schemes'. Further, under 'Project Inputs and Costs by Components' (PAD, Annex 1), an allocation of \$5.3 million is made for 'works and equipment for water systems such as mechanized water schemes, rainwater collectors, and hand pumps, with related sanitation schemes'.

In addition, the water component was not coordinated to be implemented in other sites where CDP activities were taking place in health, nutrition, education and community readiness. This was supposed to have been an innovative feature of the project where synergy would have been created resulting in greater and more sustainable impact. For example, the easier availability of water, resulting in freeing of time for girls was supposed to have resulted in them attending CDP rehabilitated and constructed schools where CDP trained female teachers would be working. These schools supervised and managed by CDP fostered PTAs would have been sensitized by CDP to construct sanitary latrines; both to make it easier for girls to regularly attend school and also for health and hygiene conditions for all students. However, if a water scheme was constructed in one site, schools built in another and health training delivered in a third, it is difficult to see how this synergy would have developed. Unfortunately with CDP this was very much the case.

A lack of coordination between CDP's different components exists.

In terms of impact upon GARWP, it had been, even before CDP, thinking of forming water management committees at the village level. The experience of CDP has

however accelerated implementation of this strategy and has proved to be a learning experience. Formation of water management committees will start from this year; it is expected and is a priority. Secondly, GARWP traditionally implements projects traditionally in 3 phases. First there is the tendering, bidding and contracting for the civil works/tanks in phase 1. In phase 2 is the purchase and fixing of pipes and in phase 3 is the installation of pump sets. Each of the phases, to be complete, requires inspection and certification by GARWP. This causes considerable delays because the next phase is initiated after the preceding phase has been completed. After the experience of CDP, however, GARWP states that it is now starting to implement all 3 phases in parallel, though because of government rules and procedures, there still are 3 separate tenders.

4.2.5.5 Sustainability

A strong indicator of sustainability of water schemes is that water is a major and immediate need of rural communities. The communities themselves are making decisions and managing the projects. Quite a great deal of revenue is invested to maintain the schemes, remunerate the water management and O&M committees and even, in some cases, to invest in other development activities in the village.

The linkages of users of water schemes with GARWP vary. There are no standard instructions for Branch Offices of GARWP to follow up the working of water management committees in terms of auditing their books, supervising their functioning or trouble-shooting in the future. Despite this, in some cases, good linkages of communities with GARWP have been observed indicating future collaboration. However, under the project design, apart from the linkages with GARWP other forms of cooperation were supposed to have been developed with a proposed Water Supply and Sanitation Project, the SDF and PWP. This did not occur. In the case of Rural Water Supply and Sanitation Project, WES UNICEF did attend meetings regarding it but those meetings halted about a year go. In case of the SFD, no contacts have been established between the SFD and the WES sector of CDP.

On the pursuance of GARWP, district councils have appointed government Focal Points as observed in Hodeidah and Lahej. Whether this step will be a hindrance or facilitate smooth running of community-managed water schemes remains to be seen as this development is relatively recent.

4.2.6 Community Readiness

The community readiness component has two main sub-components, participatory planning and social mobilisation network.

4.2.6.1 Relevance

Lack of bottom-up planning and implementation is one reason correctly identified, for the low levels of development of the health and educational status of Yemeni children in many quarters. This means that the children, their parents and the communities in which they live and interact in have traditionally not been involved in the planning or implementation of steps which directly affect their health and educational status in particular and overall well-being in general.

In rural communities and particularly amongst mothers, the level of knowledge about health and hygiene issues relating to their offspring is low. To overcome this, CDP was expected to engage grassroots stakeholders, i.e. rural communities, during

planning and implementation processes by building their capacity. This entailed providing them with necessary skills to conduct their own needs assessments, plan interventions and develop linkages between different sectors, and finally take control of the implementation and management of health and education projects.

The PAD states that the CDP was consistent with the World Bank's strategy of poverty reduction in this sense. This meant that essential health and education services in disadvantaged districts (in terms of poor child health and education indicators) would be provided through innovative community-based interventions. CDP aimed to accomplish this by: (i) engendering community engagement; (ii) building capacity at the sub-district, district, and governorate levels to identify and address child health and education issues; (iii) establishing linkages among communities, NGOs (where available), and Government at the sub-national level; and (iv) supporting health, education, and water supply activities. The first three of the four above listed strategies demonstrate clearly the high importance of community readiness for the success of this project.

The Logic Model in the PAD, though, gives vague Key Performance Indicators (KPI) for achievement of community readiness. As an example, KPIs 1.2 and 1.3 state two achievements as being that "LDCs participate in community needs assessment and play active roles in community activities". 'Participating' and 'active' are vague terms which can range from token attendance in meetings to informed discussion and participatory decision making. The idea behind using logic models as planning and monitoring tools is to have SMART indicators i.e. Specific, Measurable, Achievable, Realistic and Timebound. The mechanisms by which these KPIs will be measured are also vague. One mechanism is 'backstopping missions'. By whom and when is not mentioned in the project's LM and has never been specified in operational tasks.

4.2.6.2 Efficiency

Participatory Planning

It appears that in the project, the concepts of training and capacity building have been defined in very loose terms. The participation of government officials, at the district, governorate and central levels and of villagers in annual review and planning meetings have been highlighted by UNICEF as physical achievements of the project, while in actual fact these are just activities, not outputs or outcomes. According to the statistics made available to the assessment team, till date, several hundred participants have taken part in these review and planning meetings.⁶⁰ Such meetings used to be of two days duration; with one day devoted to review of the previous year and another day devoted to planning for the forthcoming year. However, due to expansion of the project and other factors, now they are generally of one day duration split into a morning review and an afternoon planning session.

This process is initiated at the district level where district level officers and village representatives take part along with UNICEF's field teams. The reviews and plans are consolidated for similar governorate level workshops where officials from planning, health, education, water and social sectors are present along with district management teams and women's representatives. Again, a review and plan development and prioritisation process takes place. Also, underserved groups are identified. Later, plans consolidated by UNICEF's head office in Sana'a are sent to line ministries for their review and acceptance.

⁶⁰ Information as per CDP Activity Monitoring Matrices

In the judgement of the assessment team, taking part in a day's proceedings once a year without having had any training previously in social mobilisation, participatory planning methods or, in many cases, being exposed to development projects implemented and managed by the community, cannot be classified as community readiness. Within this component, the project was supposed to equip stakeholders with the requisite skills for participatory planning and implementation on a continuous basis.

It appears too late to start participatory planning training in the last six months of the CDP to achieve sustainable results. This training should have been provided in the beginning in the project, to use this component as a connecting element for all other components.

Social Mobilisation Network

UNICEF identified a government institution, i.e. National Centre for Health Education (NCHE) to assist in this subcomponent. In the perception of the assessment team this was an efficient use of resources as NCHE already had the resources and expertise, having engaged in similar activities over the years. It does, however, lack outreach at the grassroots level. As first step a Social Mobilisation Network in partnership with NCHE was established and women village volunteers called community communicators in Lahej, Sana'a and Ibb were trained. Subjects of the training are peer communication on issues pertaining to child survival, including breast feeding, basic personal hygiene practices, coping behaviour to take care of children affected by ARI and diarrhoea, use of mosquito bed nets, etc. According to the latest data supplied by UNICEF, 699 community communicators have so far been trained: 193 in Ibb, 240 in Lahej, 79 in Sana'a, 45 in Hodeidah and 142 in Hajja.

The community communicators are not required to undertake special visits for spreading these messages. Rather they are expected to impart them as part of their everyday schedules where they, for example, visit family and friends, attend weddings or other social events.

As a partner, NCHE has had a positive affect on the initiative. It has assisted in developing the various manuals and guidelines and instituted a feedback mechanism. Formats have been created for focal points to record the activities of the community communicators. These are supposed to be handed over to the liaison person (there is one liaison person per district) who compiles all the completed forms in another specially designed format. The feedback obtained from the different liaison persons is analysed by the consultant engaged from NCHE – a step not frequently seen in development projects. Based on the feedback, programming is modified, e.g. the training and message delivery manuals have been updated in the past.

Regular monthly reports are compiled and forwarded to UNICEF by the consultant engaged from NCHE. Copies of these reports have been shared with the assessment team. Generally consisting of two pages in length, they contain useful recommendations and lessons being learnt in the field – such process monitoring is generally not seen in development projects.

4.2.6.3 Effectiveness

Participatory Planning

As stated above, without proper training and sensitization, the participation of government officials in CDP's planning and review exercises are not very effective.

Further, the effectiveness of community readiness is undermined in those governorates and districts where the relationship with government is poor. This could be either because of the official's different agenda, their lack of understanding of the importance of community participation or lack of technical and financial resources. Local councillors, in addition, often lack budgets for field visits, which reduces their interaction with rural communities.

The capacity building of local government to contribute optimally to the participatory planning exercises is weak.

Social Mobilisation Network

UNICEF's information and communication section has been working on the promotion of health and hygiene messages in partnership with the NCHE already dates back to 1999. This work was revitalised under CDP in 2003 with an attempt at deepening the message delivery structure and creating a cadre of communicators at the village level. Based in rural villages, as mentioned above, community communicators are groups of volunteers selected according to certain criteria e.g. they have to be married or mature, have good social skills and be sociable, preferably literate but not currently government civil servants.

Each group of about five female community communicators in a village is overseen by a focal point who in turn reports to a liaison person. There is one liaison person per district and s/he is supposed to keep in regular touch with the focal points acting as a communication bridge between the district and governorate and the field level cadres.

The expansion of the network within a certain governorate is done in three phases. In the first or launching phase, social activists and other stakeholders are introduced to the programme and used to identify lists of trainers and focal points. Launching phases are carried out both at governorate and district levels. To date, 154 people have participated in this phase. In the second or orientation phase, the trainers and focal points are subjected to ToTs and 108 trainers have so far attended this 5-day training. The third phase is the community communicators training, which has been described above and which is performed by those graduating from the orientation phase.

As indicated above, in collaboration with NCHE, a number of guidelines and manuals were prepared. This included trainer's packages on how to train community communicators, technical guidelines and a pictorial manual too for the community communicators. At the end of the training each communicator receives one shoulder bag and a manual which she uses to assist in spreading messages. The manual consists of several dozen pictures with simple Arabic messages on the back. Some of the messages are proverbs, some medical facts and others are sayings quoted from the Quran or Holy Prophet. While overall, the messages are being clear, drawn keeping in mind the local context and simple, some of them could be improved or overhauled even though in the past UNICEF and NCHE have been improving the messages. Additionally, colour pictures would attract more attention from listeners than black and white ones. However, the assessment team was informed by NCHE that cost of producing colour manuals was the main hindrance.

UNICEF describes this arrangement as a social mobilisation network. However, in the opinion of the assessment team it lacks many features for bodies which are described as networks. Firstly, there are no formal or informal gatherings at which either members belonging to different strata of the 'network' or members within a

single strata interact with one another. Messages on IMCI etc were delivered once at the formal trainings which lasted 3-5 days. After that, there is no methodical way in which the capacity of community communicators is enhanced or the messages reinforced.

Village women being trained as focal points and community communicators do get stipends during the length of the 5-day training and their transport costs are paid for. None of the community communicators nor any of the focal points are remunerated for the services they deliver and neither are the liaison persons, who are supposed to regularly travel to rural villages, to reinforce this 'network', get any travel allowances. Thus, it depends upon the enthusiasm of the individual within the network to put efforts into her role. Given that she will neither be paid nor be acknowledged for her efforts, the risk that the network structure is not very effective is high.

These efforts are described under the broad term of community readiness. The literature developed by UNICEF describing these activities states that the network will link up with other service providers. This will reinforce the efforts of district and village-based health, education and other committees and do other activities synonymous with CDP's integrated approach to tackling low educational and nutritional status of Yemeni children. This has not occurred even as far as linking up the activities to other UNICEF components or sectors within the same districts. The so-called network does little more than train community communicators in the delivery of messages largely pertaining to the health and hygiene issues affecting mothers and children with some attention also being given to other critical issues such as girls' education and HIV/AIDS. The network, in reality though, does not 'ready' the community in any substantive way.

Instead of developing parallel expertise, UNICEF used existing national resources such as NCHE, government officials and other social bodies to execute its work. This was a prudent approach. Additionally, recurrent costs on UNICEF are low. Given that the structure has been weak in both reinforcing and networking, that the impact so far has not been assessed and no tangible results such as the construction of buildings or other schemes were expected, it is difficult to indicate whether the component has been cost-effective or not.

4.2.6.4 Potential Impact

Participatory Planning

The impact of this sub-component of community readiness on the whole has been weak. The main achievements have been the conducting of a baseline survey in all nine governorates – some in 2001 and others in 2003 and the participation of government at the district, government and central level in project review and planning meetings. However, hardly any substantial training of villagers in participatory planning has been conducted at the village level.

Social Mobilisation Network

Till 2004, the social mobilisation network efforts were concentrated in three governorates, i.e. Sana'a, Lahej and Ibb. From 2003 to the end of 2004/beginning of 2005, efforts have been expanded to an additional four governorates where activities are still in their infancy. The governorates which have been included in this recent expansion include Hodeidah, Hajjah, Ad-Dhale, Al-Mahra. The sub-component should ideally have been in all nine governorates in which CDP was working as one element of the integrated approach in tandem with other components.

The impact, in a rigorous manner, has to be assessed and UNICEF is in the process of developing an impact assessment mechanism. ToRs have been developed and it is expected that in the coming months, data collection and fieldwork will commence. As part of its own feedback mechanism though, UNICEF encourages reports from liaison persons who in turn should be getting their feedback from focal points. The data asked for and forwarded pertains largely to activities undertaken such as the number of women to whom messages were delivered, the number of gatherings attended, the types of messages delivered.

Although this can be considered as a positive start, seven months prior to project end date no examination has been undertaken. This prevented a check at whether the messages are being acted upon and whether there have been increases in breastfeeding, vaccination, enrolment and retention of girls in schools and other health-seeking practices. The impact assessment to be undertaken based on CSO household survey data may disclose more information about outcomes and impact of this CDP sub-component. Additionally, according to figures provided to the assessment team, the incidence of feedback especially in Sana's and Ibb is poor.

Until a comparative analysis between the baseline study and the status of the indicators to data has been carried out, it remains to be seen which effects this method of spreading health and hygiene messages had. It might also reveal information about synergies with other channels such as the use of mass media, e.g. radio programmes or announcements.

4.2.6.5 Sustainability

Sustainability in both sub-components i.e. Participatory Planning and the Social Mobilisation Network is unlikely. Regarding the former, it is because of the lack of capacity building that has been undertaken. Many government functions are still heavily centralised and resources for planning and follow-up are rather limited at the sub-national levels.

Since the initial training of community communicators, they have received no further mentoring. No allowance or remuneration is paid to them nor are per diems or transport provided to the district based liaison persons who are supposed to periodically visit villages and provide support to the focal points. As such the network's sustainability is very much in doubt.

Salaries or financial rewards would not necessarily be the only solution to ensuring the continuation of this health and hygiene promotion activity. Other incentives such as trainings, recognition or linking up with other bodies/organisations working in the same fields would be alternative or complementary means of invigorating the efforts that have already taken place. UNICEF does state that refresher courses will start soon, however in the context of the CDP that is rather late in the day.

The Social Mobilisation Network, unless reinforced by funds and continued efforts of UNICEF, a third party or the government, will dwindle in its significance and relevance as time goes by.

4.3 Cross Cutting Issues

4.3.1 Gender

Yemen is one of the countries with high gender inequity in access to basic services, e.g. to education. In rural regions these differences in enrolment between girls and

boys become even more pronounced. CDP's objectives clearly aim to reduce the gender gap(s).

The health component provides a fairly positive picture. The access of children to the services provided has been fully gender balanced (e.g., EPI and IMCI); in the case of adults, the CDP clearly and justifiably emphasized women's reproductive health issues as described in detail above. In the nutrition component, the community-based growth monitoring sub-component has given equal attention to boys and girls; interventions for adults fully centered on pregnant and lactating women.

The education component is highly gender sensitive. The gender roles (and expected roles to be assumed) of women and men and of girls and boys have a strong impact on the education component. Until recently there have not been mechanisms in Yemen to monitor the extent to which the implementation of plans and policies ensures equal opportunities between boys and girls, let alone to identify causes where implementation is not succeeding in having the desired impact⁶¹.

The CDP has touched limits in its assumption that a certain number of female teachers would be available for training. The actual number of female teachers available for training is much lower than expected, so the project has concluded to train women and men in the refresher training, as long as they are teaching girls. Otherwise the number of planned participants would not be reached.

Women and girls are traditionally assuming the task of water collection in Yemen. They have been clearly benefiting of the water component, if they live in the catchment area of newly installed water systems. Water collection at remote places was reported to have taken up to 3 hours per day prior to the installation of the CDP water systems. This potentially frees some of the girls' time for other activities, including the possibility to attending school. Although women and girls are

Women have not enjoyed equal access and representation in the community based committees, as water committees, parents associations (de factor mainly fathers associations, no case of mixed committees have been visited). In the cases identified during the field visits, women were either not proposed or not applying for election or, finally elected, assumed rather a "token women function" than that of an actively participating committee member.

Women only groups visited, like groups of female teachers or health workers, provide a different picture. They communicate freely among each other.

The gender aspect has not sufficiently been inbuilt in the project design.

4.3.2 Human Rights Approach to Programming

The CDP was designed before HRBAP was adopted by UNICEF as the norm for programming. At the time when CDP was designed, *stricto sensu*, the project has not been consistent with the human rights-based approach (HRBAP), although it focuses on some issues of human and gender rights importance (e.g. targeting less advantaged areas and population groups and some elements of participation). CDP has not exactly applied the HRBAP in terms of following up the situation analysis (which was done) with a pattern analysis (that looks into the relationships between different layers of claim holders and duty bearers) and with a capacity analysis which looks at the accountability of different individuals and institutions in complying with

⁶¹ National Document to Promote Girls Education in Yemen, April 2005

human rights principles and standards.

5 Findings

5.1 Institutional Structure

The CDP is a rather complex and challenging project. It was the first project of its kind, implemented in a tripartite approach between UNICEF, The World Bank and the Government of Yemen.

The challenges related to different procurement, financial management and reporting systems and requirements of the organizations involved were underestimated in the beginning. The existing institutional capacity was not advanced enough for the approach considered, neither at the GoY nor at the UNICEF level. Interministerial cooperation was widely unknown.

At the same time, the CDP design called for an expansion in scope and scale, compared to UNICEF's earlier area based programme. The implementation area was enlarged from 10 districts in three governorates to 30 districts in nine governorates; from mainly education activities to a multi sector approach.

5.2 Monitoring

The PAD was calling for a strong monitoring function as a risk minimizing measure at project start. The importance of the internal monitoring function and system has been widely neglected by the project for almost four years of this five-year project. Only end of 2004 the position of an M&E officer has been staffed in the UNICEF country office. PCU succeeded only sporadically in recruiting an M&E officer, also just towards the end of CDP. The long absence of a stringent monitoring and quality assurance and the late staffing of the M&E position had also a negative impact on the M&E training of field office staff and on counterpart training at district, governorate and central level. Although both organizations, UNICEF and the PCU, are sharing the same problem, the monitoring function of the PCU is not as crucial for the project as the one of UNICEF as the main implementer of CDP. This is felt as a weakness of the project.

The data generated for CDP at field office level is sometimes not comparable, as different data is retrieved by different field offices. In addition, sometimes data from different UNICEF sources is contradicting. The problem of data availability and reliability also applies for data sources of the government counterparts at the various levels. Internal monitoring carried out by the UNICEF field offices is lacking clear guidance of the country office and related standards.

As regular training evaluation was not conducted throughout project implementation, a lot of valuable information to measure the quality, efficiency and sustainability of training and its impact on achieving the objective of CDP has not been gathered systematically.

5.3 Coordination

A complex, integrated multi-sectoral project like CDP calls for continuous coordination between the different project components, partners and different levels of implementation involved.

In spite of recent efforts made by UNICEF to intensify coordination between the different sectors responsible for the CDP implementation in the country office and

between the country office and the field offices, there is still a lack of coordination between field offices and the country office and between the components, represented by sectors at country office level.

There are promising attempts of coordination between HCMC and UNICEF at field level. However, these developments are fairly recent and maybe too late to result in a revamping of the project.

The coordination function of CDP appears to be rather centralized, it is thus important to exchange all relevant developments with the field office staff on a regular basis. A crucial role lies with the Area Based sector within the country office. This position was held only temporarily after the previous officer left and has now just recently been filled. De facto each CDP component has been established more as a stand alone project.

The opportunity to share experiences with similar integrated projects and to use synergies, like with SFD's Integrated Community Development Programme, has been missed. However, in components as education, good results have been achieved cooperating with GTZ and the NGO ADRA.

5.4 Partnership and Visibility

The CDP has a good local visibility overall. However, during the field visits it became obvious, that the project is not known as CDP, but as "the UNICEF project". Other CDP partners, as the GoY represented by the HCMC/PCU, are not considered by the beneficiaries as major implementing partner.

This relates to the widely missed opportunity of UNICEF and the PCU to work in close cooperation at field level throughout CDP implementation. Only very recently first positive steps have been taken in this direction. Three HCMC representatives are based in UNICEF field offices and a fourth is based in the PCU premises in Sana'a have been recruited and assumed work.

Another observation is that UNICEF country office staff itself hardly distinct between the UNICEF country programme and the CDP. Although there are for sure valuable synergies between the two, CDP is not "an extension of the UNICEF country programme". The fact, that the Government of Yemen borrowed a substantial amount of funds at the WB and has commissioned UNICEF with the implementation of the main part of it, has to be appreciated in this partnership.

5.4 Implementing Capacity

At the end of the fourth year of implementation, the overall expenditure rate was 52.60%, whereas, looking at the three sources of budget, the picture is as following: 71.13% of UNICEF' own funds, 50.45% of IDA funds and 11.05% of GoY and Community funds.

UNICEF's own funds might be also used for purposes in line with CDP within the country programme 2002 to 2006, i.e. one year beyond the end of CDP. More critical is the assessment of the unspent IDA funds, i.e. US\$ 14.27 million, which might remain with IDA and will not be accessible by the project beyond its official end date of 31 December 2005. At the time of the CDP assessment, a contract rider with a no cost extension of CDP appeared not likely.

The expenditure rate of the education component at the end of 2004 was as low as

37% for community schools and 30% for women teacher training. Only textbook distribution achieved 92% expenditure. The Government of Yemen has so far only contributed to the textbook distribution up to the district level.

The low expenditure rate in education, in particular in the women teacher training, has a quantitative and qualitative component. The training cost per person trained remained below those originally estimated. This indicates an increased cost effectiveness of this activity. However, there is big gap between number of people expected to be trained and actual numbers. This calls for an as rapid as possible implementation, as budget reallocation is not likely during the last semester of the contract period. As the funds for construction and rehabilitation in 2005 are only UNICEF's own funds, there may be certain flexibility in using them beyond the CDP contract. After a closer analysis of the funds spent and the remaining budget the SC committee should take decision.

5.6 Female Rural Teachers

The target "the proportion of trained female teachers for grade 1-6 at schools in intervention areas increased by at least 15% by the end of the project" is unlikely to be achieved. Instead of increasing by 2000 female teachers nationwide per year, the number of female teachers during CDP implementation has even declined in CDP districts. This will diminish, if not jeopardize, the effects of the CDP education component, and has also consequences on the speed of closing the gender gap in education in Yemen.

The problem of lack of rural teachers, in particular of female teachers, is intrinsic. This is an important missing link to achieve the intended impact of the CDP, and as well as of other education projects.

The definition of quota for female rural teachers involves three ministries, the ministries of education, finance and civil services. Often one Ministry is putting the blame for recruiting too little female rural teacher on another. This problem exists since pre-CDP times and has been repeatedly addressed by members of the Education SWAp. It also relates to lack of inter-ministerial cooperation and coordination.

Female teachers assume several important and highly gender-relevant functions in Yemen's rural areas: (1) as trusted teachers for girls, in particular for girls in pre- and puberty age; (2) as possible links to the females of the community, i.e. mothers and other girls, communicating not only education-related issues; (3) as a role model within their communities and (4) as a possible professional alternative (of only a few) for women.

5.7 Sustainability

Based on the financial contributions the GoY has made so far to CDP, the prospects for its overall financial sustainability have to be assessed as low.

Putting finally in place HCMC representatives at governorate level is a good opportunity to enhance institutional knowledge and increase prospects for sustainability before the project ends. So far, institutional sustainability remains weak.

A positive element for financial sustainability has been observed in some villages where the water components implemented water schemes, and where communities have collected substantial amounts of money for maintenance of the system.

The sustainability of the nutrition component of CDP is not assured after project end. It is almost sure that the MOH does not have the financial resources to continue training and retraining of volunteers. An expansion of the activity to additional districts is late in starting this year and may not yet establish CBN firmly by the end of the project.

The sustainability of the school book distribution up to school level is not secured beyond project end either, as the GoY is contributing under CDP only to the distribution up to district level. An exit strategy was not available at the time of the CDP assessment.

5.8 Gender

Women have not enjoyed equal access and representation in the community based committees, as water committees, parents-teachers associations (de factor mainly fathers associations; no cases of mixed committees were seen during field visits). In the cases identified during the field visits, women were either not proposed or not applying for election or, if and when finally elected, assumed rather a “token women function” not really actively participating as committee member. The gender aspect has not sufficiently been built-in the CDP project design.

5.9 CDP Component Specific Findings

5.9.1 Health

- A situation that makes little sense was found in which IMCI drugs are given out free and others not. IMCI drugs have been out of stock for months creating serious problems for the staff in the health centers since mothers are then asked to pay for the same drugs from the revolving fund.
- Health Facility Committees do not participate in the management of the drug revolving funds or in the spending of the operational budget of the facilities.
- The drug distribution to rural health facilities is on drug by drug and is cumbersome for the staff to go and get.
- There is no referral sheet for patients in use.
- CDP has an antimalarial component in one governorate which has not been monitored closely.
- During their field visits, the assessment team did not find micronutrients in the stock of the health facilities visited.
- Community communicators in the project are not yet trained on HIV and AIDS.

5.9.2 Nutrition

- The coverage of benefits and services under the nutrition component is still limited, six months before project end.
- UNICEF and WFP both have potential complementary nutrition interventions in different geographical locations.

- CDP currently provides training to volunteer IMCI communicators and nutrition volunteers separately.
- UNICEF runs separate ECD activities with its own funds, alongside with ECD activities under the CDP project.
- No provisions have been taken yet to seek funding to continue the CBN programme. The assessment team found that CBN has neglected the micronutrient aspects of a nutrition intervention.

5.9.3 Education

- During the field visits cases of misallocation and inadequate use of class rooms were observed, e.g. teachers were sitting in a “management room” built as a class room, whereas children were sitting on the stone floor outside.
- CDP school construction is, after changing of the design to be in accordance with MoE requirements still at the lower end of the models benchmarked (9423 US\$). The requirement of the MoE to include teachers’ room and latrines to all school constructions is justified.
- Some of the teachers’ rooms have been occupied by male teachers only, whereas the female teachers were meeting outside.
- Some CDP schools visited were either not equipped with sanitary facilities or the existent facilities were broken and out of use.
- Overall, the textbook distribution has been successfully implemented. The need to equip the textbook warehouses was only discovered during the course of the project. IDA funds were reallocated to purchase pallet racks, stackers and fork lifters. At the time of the assessment, these items were under procurement by PCU.
- Under CDP the Government of Yemen is only contributing to textbook distribution up to the district level. Although not included in the budget, UNICEF and the WB have distributed the books from the districts to the schools. This helps to reduce the direct cost of schooling for children, as the funds for bringing the textbooks from the district to the schools is usually covered by the parents. However, the question of introducing an exit strategy for the time beyond CDP support and the related sustainability issue remain.

5.9.4 Early Childhood Development

- The Early Childhood Development component is attached to the education sector at the UNICEF country office. It only started de facto in mid 2004, after revamping of the workplan. It seems to have finally taken off well, although it is too early to comment in detail on the quality of results. The component started to allocate funds, and the expenditure rate was after six months 29.11%. Taking the short implementation time of 1.5 years for ECD into consideration, it still remains low.

5.9.5 Water

- Overall, the sanitation sub-components have not been adequately addressed during CDP implementation.
- The sanitation sub-component of WES should have been synchronised to take place together with the implementation of the water schemes. This did not occur for a number of reasons including the unclear roles of UNICEF and GARWP in the area of sanitation, including the type of sanitation that the PAD envisaged and the lack of sanitation expertise to date within GARWP.

5.9.6 Community Readiness

- It appears too late to start participatory planning training in the last six months of the CDP to achieve sustainable results. The participatory planning training should have been provided in the beginning of the project, to use it as a common element needed in all other components.
- The capacity building of local government officers to contribute in the best way possible to the participatory planning exercises was weak. A greater degree of training of local government partners of CDP is needed in social mobilisation, conflict resolution, planning, monitoring and, last but not least, in record-keeping.
- The Social Mobilisation Network, unless reinforced by funds and continued efforts of UNICEF, a third party or the government, will dwindle in its significance and relevance as time goes by.
- Rather than working in a scattered manner, as it is the currently case, resources and attention should have been focussed on particular areas where certain health issues were more pressing e.g. an area where malaria was more prevalent. This would have also increased feedback, backstopping and interaction amongst the different stakeholders involved, thus leading to greater effectiveness and visibility of the network.

6 Recommendations

6.1 Programme Management

To involve the newly assigned HCMC representatives (so far in four governorates) at governorate and district level actively into CDP field work; HCMC to recruit representatives for the remaining CDP governorates; to select potential candidates according to a transparent system and a defined profile. This should be done without further delay, to allow maximum use of the scarce time before project end for knowledge transfer. The activities of the different components should be coordinated as far down as to village level.

For future integrated projects, to share experience and best practice with projects with similar target groups and objectives; to arrange a meeting between CDP, PCU staff and SFD staff to share their experience at field level with CDP-like multi sectoral programmes.

Further foster cooperation between UNICEF field offices staff and the newly appointed HCMC representatives; to involve them actively in the field monitoring and the monitoring training; to proceed with a transparent and professional selection procedure for eventual further HCMC posts to be filled; GoY to provide more inputs during project preparation and implementation; to enhance the impact of the CDP, exchange experiences and best practices with other implementing agencies; to coordinate the works assumed by various agencies working in the same field and geographical region (SFD, CDP); to intensify without further delay the positive recent trend of joint work between HCMC and UNICEF at field level; to prepare a work and financial plan on how to continue the HCMC presence in the districts beyond project end.

6.2 Health

To find a solution to the current situation of free IMCI drugs versus paid other drugs; to measures to assure no interruptions in the supply of IMCI drugs; to allow health facility committees to also participate in the management of the revolving drug fund; to make the new health facility committees accountable for the operational budget of the facilities; to consider distributing pre-packed drug kits for six months for health units and health centers; MoH and UNICEF to design, print, train-on and start using a formal referral sheet for patients send to a higher level; to secure a closer monitoring of the anti-malaria intervention of CDP in 15 districts; to take measure to assure no interruptions in the supply of Vitamin A, iron and folic acid supplies in all health facilities; to add HIV and AIDS training to CDP community communicators' training now starting, using the newly developed manual; to include adult family members in the safe motherhood training, as they are most important in home deliveries.

6.3 Nutrition

To expand the nutrition component either to three more districts or, more preferably, with the current ten districts; both organizations – UNICEF and WFP - to focus their existing collaboration to cover the CDP districts; to train the already trained nutrition volunteers also as IMCI communicators: they have initial skills and a high motivation.

The Nutrition Department of the MoH to start soonest the preparation of a proposal for the 2006 onwards funding of the CBN activities; to tackle the micronutrients

problem of infants and women more proactively; to link future funding of the CBN component with ECD funding in UNICEF since these two components are intimately linked.

6.4 Education

It is recommended to include the correct use of classrooms as an indicator for the field monitoring; to monitor the use of classrooms constructed and clearly instruct the teachers about the attributed use of the classrooms; to consider in new construction the necessity of one or, in case of female and male teachers, two separate teachers' room(s).

To build/remodel facilities with a pit or other latrines both for girls and boys, to assure water supply and to assure its maintenance; to assure that female teachers and students do equally benefit from this infrastructure; to follow up, in course of the monthly school supervision missions, the appropriate use of infrastructure.

To allocate a higher number of female teachers to the CDP supported schools at least for the last school year before project end; to allow their training before project end; to publish the vacancies for rural female teachers with secondary school degree at governorate, district and at school levels; to recruit, with priority, those volunteer teachers, who have gained working experience already; to give a priority to the CDP schools in the 30 districts; to have an inter-ministerial meeting ASAP to discuss and solve the endemic problem of lack of female rural teachers in Yemen.

As soon as girls reach puberty age, they are, if not withdrawn from school, often segregated in the sitting arrangements in the classroom. To avoid segregating female students in mixed classes, to avoid squeezing girls in the far corner of the classroom; to consider for female teachers to show their faces while conducting the lessons, as interactive communication with the pupils remains otherwise very restricted; to include a profound gender sensitization component into teachers' training - for male and female teachers.

It is recommended to introduce an evaluation system for training activities at the beginning of any project, wherever possible in line with the existing systems involved, e.g. of ministries, governorates and districts; to use standard templates as a tool for quality assurance and to facilitate aggregation of information.

The PCU/UNICEF should complete the procurement process of the equipment for the warehouses ASAP and should provide training on the equipment.

GoY to develop a sustainable strategy beyond project end for delivery of school books along the transport chain from the printing house to village/school level.

6.5 Early Childhood Development

The only recommendation for ECD is to speed up the implementation of the ECD component according to the revised work plan before the end of 2005, making good use of the funds available for this component.

6.6 Water

It is recommended to define clear roles and divide tasks within sanitation subcomponent; GARWP to enhance their sanitation expertise; to share experience with similar projects with a sanitation component, e.g. SFD.

6.7 Community Readiness

As far as possible in the remaining time, to do more training and in-country exposure visits to demonstrate how community participation works. This should enhance the capacity of district and local councils and of governorate officials and thus increase the impact of the project.

To provide the focal points with logistical support, which would enable them to interact with liaison persons and community communicators at least once every two months; to provide incentives, financial and/or otherwise, to focal points, liaison persons and community communicators; to introduce regular refresher courses?

7 Lessons Learned

There are a several valuable lessons learned from the CDP, being the “pioneer” project for this kind of tripartite approach. There are also comparative and complementary advantages between UNICEF and the WB.

7.1 Planning

A lot of attention has to be drawn to the early phases of the programme innovation process. The innovation cycle has to be sufficiently progressed, i.e. packaging and institutionalizing have to be completed, before scaling and scoping up. These steps have to be analyzed and decided carefully and, more importantly, jointly by the partners involved.

A risk assessment should include the project size and scope and the scale of money involved. Both should be in proportion to the existing capacities of the UNICEF country office and the institutional capacities at the government level. UNICEF should consider a full-time high profile manager for a contract of the dimension of CDP. Only if these elements are in place, such a project will be in the position to face the challenges related to financial management, procurement and reporting. All partners must be dedicated to and involved in capacity building from the very start of the project.

An important decision has to be taken at planning stage by the organizations involved on HQ and country level: Is the organization prepared, willing and capable to embark on this kind of partnership, and which resources are required.

This includes harmonization of processes (reporting, financial management, procurement). Mid-term reviews should be carried out jointly by GoY, UNICEF and the WB. The transaction costs will likely decrease if harmonized approaches are applied.

Another aspect to be considered while using UNICEF staff in international contracts is their respective contract duration. As UNICEF expatriate contracts are usually for three years, whereas the CDP has a duration of five years, a harmonization of contract durations should be considered to minimize staff turnover during project implementation, as it occurred during CDP implementation.

7.2 Monitoring

At the time of the CDP assessment it was almost too late to consider the implementation of a monitoring system for CDP. However, a further important lesson learned from the CDP is the need to set up an internal monitoring system at the very beginning of the project - to follow up project progress and to have an early warning tool. Project managers can retrieve and share data according to defined indicators on a regular basis.

This should be done in close cooperation between UNICEF and the government partner(s) (in the case of CDP PCU/HCMC and ministries). Involvement of the national partner is a crucial element for project sustainability, and has to start at the very first stage of the project cycle, identification, and should continue throughout implementation. This project monitoring system should be related to the monitoring system for the UNICEF country programme, e.g. by interlocking the logic models, but must have its own CDP specific logic model and monitoring.

An important lesson is that the logic model has to be used as a working tool. The original logic model, set up at project appraisal stage, can always be modified at the lower levels of intervention. Should the indicators not be SMART (Specific, Measurable, Achievable, Realistic and Timely) as it was sometimes the case with the CDP, they should have been improved and the logic model adapted accordingly. Weaknesses in the initial logic model, like weak indicators or missing risks, are not an excuse for a lack of monitoring.

Any new area based multisectoral project should stipulate greater flexibility to change design according to changing needs, as long as the development objectives remain untouched.

On organization level, UNICEF headquarters should establish/reinforce the monitoring practice in a monitoring unit. This unit should develop a system and respective training in project/programme monitoring as a core practice for regional and country office staff. A handbook or manual should be compiled for daily use and for training purposes, explaining the monitoring system and providing advice on operational issues as procurement and reporting standards.

7.3 Training

A relatively sophisticated, challenging project as CDP should make training in procurement regulations mandatory for each field officer and sector staff in the country office; this applies for both standards - UNICEF's own and the WB procurement regulations. This can be considered as a means to minimize delays in procurement and reporting and thus enhance implementation efficiency.

For future projects, procurement procedures, financial management and reporting should be considered to be harmonized from the very beginning of the project, to facilitate project implementation. There are already promising examples in other WB/UNICEF agreements, as the IDEAL project in Bangladesh or the Multi-country Demobilization and Reintegration Programme (MDRP).

PCU/HCMC members should be in place in the field offices of UNICEF from the very beginning. The field offices must be staffed adequately to the task at stake, in quantity and in professional experience. UNICEF, if assigned with the task of transferring knowledge to the Government counterparts, must assure to be one step ahead of their counterparts to assume their role in a competent fashion.

7.4 Female Teachers

A lesson drawn from the existing gender gap is to involve mothers more in the social environment of the rural schools. This includes organizing mothers-female teachers' associations and providing alphabetization courses. Furthermore, the gender dimension should be more pronounced in the project design of future projects. However, without solving the core problems of the recruitment of teachers proactively and the government living up to its promises made at project start, any future education project or component will have to face the same situation as CDP. Thus efforts should be joined to overcome the practices which inhibit fair recruitment and in particular more involvement of female rural teachers.

7.5 Other Lessons

For future projects, a Triple A approach should have been used in community

mobilization from the very beginning of the project. The baseline study should include project and non-project districts. The supplementation of all micronutrients should be an integral part of the nutrition component.

The HRBAP approach should be considered as well as a pronounced gender approach in the planning stage of similar future projects. The country office can consider involving technical assistance for this approach.

Finally, the CDP has generated a number of important lessons and some good practices, which could be avoided or replicated in future projects, respectively. A booklet, summarizing the former, to share with UNICEF projects worldwide and other projects within Yemen, would be rather useful. A good example was provided by the UNICEF Bangladesh country office.

Annexes

Annex 1 Terms of Reference

Terms of Reference Assessment of Child Development Project, Yemen

BACKGROUND

Child Development Project (CDP) is a partnership between the Government of Yemen, UNICEF and the World Bank. It is a five year (2001-05) project aimed at improving the access to basic social services to children and women in thirty districts in nine governorates selected based on the level of social deprivation. This project was finalised after a two year negotiation between the parties concerned with the following main objective.

To assist the Government of Yemen in the implementation of a coordinated area-based programme for improving the health and nutritional status of children under five and the educational status of girls in primary schools in districts that are currently under-served in the areas of health and education.

In essence the design of this project is an extension of the area-based project of the UNICEF Yemen country programme, 1994-98 and 1998-2001. The project became effective 30th September 2000 and is expected to end by 31st December 2005. The project has five key components:

Community readiness: aimed at preparing the community for receiving project inputs through training in assessing local needs and planning through social mobilisation. The expected output of this component is institutional capacity building especially at the local level.

Health activity: aimed at improving child health through strengthened district health system, Integrated Management of Childhood Illnesses (IMCI), immunization, control of diarrhoeal diseases (CDD), safe motherhood and water and sanitation schemes.

Nutrition activity: aimed at improving child nutrition through community nutrition activities such as nutrition education and counselling, growth monitoring and promotion, nutritional rehabilitation, and micronutrient supplementation.

Education activity: aimed at expanding girls' access to quality primary education through innovative and effective community based schools; women teacher training and textbook/teaching materials distribution.

Pilot ECD activity: aimed at improving educability of young children through community-based early childhood development (ECD) models.

The CDP is the largest collaboration between UNICEF and World Bank to-date. It is hoped that this project will generate examples of reforms at sub-national level in key social sectors that can be replicated at much larger scale. An important aspect of this project is the decentralised approach to project planning and implementation in close partnership with district councils and communities in line with the UNICEF supported area-based approach. In this respect, this project is an extension of UNICEF's master plan of action in terms of planning, programming, and implementation using decentralised administrative structures of the Government.

Financial outlay: The project budget is estimated at US\$ 45.3 million for a five year period with the following contributions:

World Bank – IDA ⁶²	US\$ 28.86 million
UNICEF	US\$ 12.41 million
Government	US\$ 2.40 million
Community	US\$ 1.63 million

Project expenditure as of mid- July is estimated at US\$ 11.45 million (55%) and it is expected that by the end of 2005 the expenditure levels may reach 75%. The implementation of activities was phased annually so as to cover all the 30 project districts by 2004. By the end of 2004, the project will have achieved significant implementation levels allowing a systematic assessment of achievements, efficiency, and further expansion and sustainability of key project components.

Management arrangement: A Project Coordination Unit (PCU) was established in the Higher Council for Motherhood and Childhood (HCMC) under the Office of the Prime Minister with the overall responsibility of coordination of all implementing partners. The PCU is the Secretariat for the project. At the national level the project is coordinated by a Steering Committee consisting of representatives of various ministries (Deputy Minister level) chaired by the Minister of Social Affairs and Labour. The sectoral components of the project are implemented jointly by three government ministries: Public Health, Education and Water in close cooperation with UNICEF.

UNICEF has a bilateral agreement with the Government of Yemen outlining the responsibilities of both parties mutually referred to as *Cooperation Agreement for Project Assistance*. The Government has a separate agreement with the World Bank detailing the funding and project details under WB document no. 19461-RY dated 29th Feb 2000. UNICEF has no written agreement with the World Bank.

The project is in its fourth year. Considerable time was spent during the first year on internal administrative issues resulting in a reasonably slow start. In late 2003 this project had its mid-term review (MTR) conducted by the Bank as mandated in the agreement between the Government and the Bank. The MTR was a useful exercise based on a rapid but analytical review of all project components and project management issues including supply, financial and human resource management.

The project has mobilised significant amount of IDA-credit to fund activities directly benefiting children and other vulnerable population groups in deprived areas of Yemen complementing the regular funding for similar projects through government and UNICEF. The project has recorded measurable achievements which have been presented to the National Steering Committee as part of the routine project monitoring report (PMR). Apart from the MTR, no formal attempt has been made to assess the achievements (outcome and output), process (including support structures established), and strengths and weaknesses of this project. It is therefore felt timely and useful to systematically assess and document the achievements made and lessons and experiences gained from this tripartite project.

PURPOSE

The purpose of the proposed assessment is to examine the achievements of all project components against the annual targets for all thirty districts and generate findings and recommendations for improving project processes and results and in further negotiations with funding agencies. It is expected that the findings and recommendations from the assessment will be an important basis in planning the extension of the project beyond 2005 and for initiating discussion for possible renewal to a second phase. In addition, the findings and recommendations from the assessment will help draw conclusions regarding the effectiveness of the special funding mechanism established for the CDP (i.e. bilateral funds

⁶² Of this amount only US\$ 21.49 will be channeled through UNICEF while the remaining fund will be managed by Project Coordination Unit located at Higher Council for Motherhood and Childhood (HCMC) for procurement of supplies.

channelled through UNICEF) to complement government's own investment in the social sector for application in Yemen and other countries.

Objectives: The assessment will have the following objectives:

- *Assess the extent to which the project has realised its objectives:*
- *achievements in terms of project development objectives and key outcomes.*
- *achievements in terms of outputs for all project components included during the implementation period from 2001 to 2004.*
- *To the extent possible, assess the efficiency of key project outputs with a view to identifying relation between cost and results (including unit costs).*
- *Assess the adequacy and effectiveness of the structures established and/or strengthened in support of the CDP (including management and coordination mechanism) and identify factors which have contribute to successes and/or weaknesses. In addition, assess the replicability of the structures supported/established by comparing with alternative structures (i.e., Social Fund for Development) for implementing such programmes.*
- *Review the experience gained from the tripartite relationship among the World Bank, UNICEF and Government of Yemen in planning and implementing the project and derive lessons and recommendations for the future.*
- *Review the range of project agreements between UNICEF and the World Bank and make recommendations for the terms of such agreements in future.*

SCOPE AND KEY QUESTIONS

Beyond an assessment of achievements against the key outcome and output targets, cost efficiency, and sustainability, the assessment will include a systematic review of the management and institutional arrangements that have evolved in support of the CDP.

The assessment will focus on project implementation during the period 2001 to 2004. However, the assessment will exclude detailed analysis of the ECD component of the project as the implementation of ECD activities started only in 2004. A brief summary of the key project components and key questions to be answered by the assessment are provided below.

Community readiness

In Yemen, social sector interventions by the Government (health, nutrition, water and sanitation and basic education) tend to be centrally designed and implemented with minimal community consultation raising the issue of sustainability and local ownership. The CDP has tried to address this issue by engaging beneficiaries during the planning and implementation processes by providing necessary skills to the communities to conduct their own needs assessments, plan interventions and develop linkages between different sectors and take control of the implementation and management of the project.

Project activities under this component include training of district and area council members on planning and managing local level activities. The project has trained local and district council members in all 30 districts. In addition community level training includes those to parent-teacher associations responsible for school renovation and construction and to health committees and water committees. Many water supply schemes have become self sustaining with the introduction of cost recovery schemes managed by water committees.

Key questions for the community readiness component will include:

- To what extent has the project been successful in engaging the beneficiaries in the planning process and how? What have been the major facilitating and/or constraining factors?
- How effective has this component been in transferring skills to communities to assess needs and capacities, plan interventions (in health, education, water and education) and develop linkages with the district level offices?

- How well have the communities performed in assessing and fulfilling their financial contributions (cost-sharing) to the project and for improving demand for (and use of) services through community/social mobilisation efforts?
- What has been the overall experience in strengthening local capacity for planning and implementation and what lessons can be drawn for the future?
- Whether local development committee (LDC) member's functions have been clearly defined in the target communities? To what extent such arrangements have been clearly defined in the target communities? And to what extent the arrangements have been made operational and sustained in target districts and communities?
- If any, what are the positive and less favourable impacts of the 2002 Decentralisation Policy on the local-level arrangements agreed/established for the project?

Health

The health component has five sub-components: district health system development, IMCI, immunization, safe motherhood and water schemes. The health infrastructure in Yemen has generally a weak management and disease monitoring system. This is compounded by weak public awareness on health and disease issues. The project is aimed at improving referral infrastructure in selected districts by constructing new health units and renovating old ones, training health staff on management and improving health information system.

Project support in IMCI and immunization is expected to improve child health services by training peripheral health staff and improving health supplies required in the clinics such as vaccines and other immunization related supplies, oral re-hydration solution (ORS), supplies and drugs. The support to safe motherhood includes renovation of maternity homes, training of health workers for outreach activities, supply of delivery kits, improving referral services and provision of operating costs in selected health facilities. Interventions in clean drinking water and sanitation are provided as part of controlling diarrhoea and water born disease in children. Inputs in water and sanitation include installation of water supply schemes, training of water management committees and institutionalisation of cost recovery systems in all water schemes with provision of free water supply in schools, health facilities and poor families where applicable.

Key questions to be addressed for the health component will include:

- To what extent has the project achieved the objectives and targets (immunization coverage, access to health care, safe delivery, access to safe water and sanitation, etc.) set for each sub-component?
- What are the key outputs of the project and what factors have contributed to success?
- How efficient are the key project interventions in terms of cost per unit of the output produced?
- What are the key gaps and what have been the constraining factors?
- What conclusions can be drawn with respect to measurable outcomes/impact with the respect to improved health status (including reduction of morbidity, malnutrition and mortality) of children in the project districts?
- How successful has the project been in improving the capacity of the governorate-level health offices to support the district health offices and operationalise cost-sharing and maintenance schemes?
- How successful is the project in improving the capacity of the physicians and health workers on the IMCI approach and what are the impacts in terms of improved case management and improving household health, nutrition and hygiene behaviours?
- How well has the project contributed to regular procurement and distribution of drugs and other medical supplies? What have been the key success and/or constraining factors?
- How successful has the project been in integrating the Expanded Programme in Immunization (EPI) into the district health plans (to improve decentralised planning and delivery)? What are the key facilitating and/or constraining factors?

- How successful has the project been in implementing safe motherhood related interventions and conclusions can be drawn with respect to the measurable impact/outcome from this sub-component?
- How innovative has the project been in introducing innovative, low-cost and locally acceptable structures especially in the area of water and sanitation schemes?
- How adequately has the project contributed to the strengthening of the information, education communication (IEC) and social mobilisation activities in support of the health components?
- What has been the experience in working with WHO, UNFPA, WFP and other partners on the health component?

Nutrition

The main aim is to reduce the prevalence of child malnutrition and stop growth faltering in children. Key interventions include micronutrient supplementation and establishment of growth monitoring and nutrition surveillance system in selected districts. The collaboration with WFP which is involved in food supplementation to pregnant, lactating women and girls in schools are expected to improve the nutritional outcome.

Key questions for the assessment of the nutrition component will include:

- To what extent has the project achieved the objectives and targets (micronutrient supplementation, breastfeeding, growth monitoring and promotion coverage etc.) set for the project component?
- What are the key outputs of the project and what factors have contributed to project success?
- What are the key gaps in performance and what have been the constraining factors?
- What conclusions can be drawn with respect to measurable outcomes from this project component with respect to reduction of malnutrition in the project districts?
- How successful has the project been in establishing community-based triple-A and social mobilisation approaches for improving nutrition status of children? What have been the key success and/or constraining factors?

Education

The project aims to address low enrolment especially for girls (40%), low completion rate (grade 6) for primary education, inadequate teacher supply especially female teachers and unsatisfactory quality of education. The education component focuses on expansion of community schools for girls, female teacher training and textbook distribution. Inputs from the project include rehabilitation of existing classrooms and construction of new classrooms, provision of school kits and textbooks, technical assistance in training of trainers for improving teaching methodologies, construction of warehouses for textbooks, provision of equipments including computers and provision of operational costs in selected districts.

Key questions for the education component will include:

- To what extent has the project achieved the objectives and targets (community schools established, teachers recruited and trained) set for the project component?
- What are the key outputs of the project and what factors have contributed to project success?
- How efficient are the key project interventions in terms of cost per unit of output produced?
- What are the key gaps in performance and what have been the constraining factors?
- What conclusions can be drawn with respect to measurable outcomes/impact (improvement in enrolment, retention and completion rates for girls and boys, learning achievements) from this project component with the respect to reduction of malnutrition in the project districts?
- How innovative has the project been in introducing innovative, low-cost and locally acceptable school infrastructures (classrooms, furniture) in the project districts?
- How have the provision of textbooks and furniture helped increase and retain girls in schools? Is there an increase in female teachers? What are the influences of water and sanitation provisions in schools?

Early child development (pilot project)

This project was designed in response to poor ability of the parents to provide adequate care and learning at home for their children, especially in rural and remote areas. During the pilot phase, the project is expected to generate relevant information for supporting the Government in its efforts to develop community-based financially sustainable policies and strategies for developing programmes for children in their early years. Since the implementation of this project started only in 2004, there is no need for it to undergo in-depth assessment. The assessment will review the experience gained so far and suggest recommendations for strengthening this component during the remaining duration of the project.

Key questions for the ECD component will include:

- What factors caused the delayed implementation of this project component?
- To what extent were the targets set for 2004 realised and what were the key success and/or constraining factors?
- How can the ECD component benefit from the local institutional structures and processes established by the CPD project?
- What lessons from the rest of the project can be applied for strengthening and accelerating the implementation of the ECD component?

Cross-cutting themes/issues

In addition to the above questions, the assessment will assess the following supportive themes and strategies related to the project.

Gender: The assessment will review the extent to which the CDP has affected male and females in different ways, including whether males and females have enjoyed equal access to services and benefits, and the underlying reasons for any differences.

Human Rights Based Approach to Programming: The CDP was designed before HRBAP was adopted by UNICEF as the norm for programming. However, in the light of a possible project extension or renewal, the assessment will review the extent to which the project has been consistent with HRBAP.

Management structures: How successful are the relationships between UNICEF, World Bank and the Government represented by HCMC and PCU? What has been the role of the Steering Committee in facilitating project implementation? How facilitative and/or constraining have the management procedures (including finance-related) been within the Government, the Bank and UNICEF with respect to contracting, intra-sector reallocation of funds and overall financial management?

Field structure in support of the project: UNICEF has seven sub-offices with 15 full-time staff designated for project implementation and monitoring in close partnership with local district and area councils. The assessment will review the relationship between the sub offices and the local councils, district/Governorates offices; explore the adequacy of the support-structures established and make recommendations for further strengthening and/or alternatives for these arrangements.

Information and monitoring systems: The assessment will review the information and monitoring systems introduced at all levels with respect to their adequacy, efficiency and flow/use of information in planning and decision-making.

Partnership and visibility: UNICEF Yemen considers this project to be a good example of partnership with joint funding and shared implementation responsibility. However there have been a number of concerns with regards to the perception of local communities and the government on the visibility and ownership of the project. This concern was also raised during the mid-term review conducted by the World Bank in October 2003. An important issue which needs to be examined is how the project can maintain joint partnership and visibility without losing the momentum already achieved. In addition, the assessment will derive lessons that learned from the tripartite partnership (managing, funding and related aspects) that can be useful for the future.

Multisectorality and synergism: The assessment will explore the extent to which simultaneous provision of health, education, and water services have taken place in targeted areas, (i. e., the proportion of villages that have seen the implementation of all/multiple interventions/components under CDP). How well do the villages with multiple component interventions perform in terms of key outcomes as compared with other villages in the same project district (other villages may include one supported by CDP and the other not supported by CDP but by government or other project)? What conclusions can be drawn with respect to the success of integrated multi-sectoral approaches?

ASSESSMENT METHODOLOGY

The assessment will rely on the following methods:

Comprehensive desk review of documents related to planning and implementation, reporting, monitoring, reviews (including reports from the field-visits) of the project. The project prepares detailed annual work plans, which includes targets (including infrastructure development), provision of supplies and human resource capacity building in the form of training in all sectors. The routine quarterly and annual reports show progress achieved and delays experienced across all sectors. These reports include input and output indicators such as number of class rooms (schools) and health units rehabilitated or constructed, number of maternity homes renovated, number of water schemes completed, number of personnel trained on specific issues in education, health and nutrition and water and sanitation. A tentative list of documents to be used for the desk review is attached.

The assessment will compare the targets achieved against the annual work plans. Source data is readily available in UNICEF field offices and at the technical departments in all 30 project districts. Additional documents include project progress reports submitted to the Steering Committee and the annual audit reports.

Interviews with key informants at the central, district and local levels and focus group discussion with selected groups of local and district councils in target districts. A key group of key informants will be the Steering Committee members including the Chairman (Minister of Social Affairs) and Head of PCU (Secretary General of HCMC responsible for day to day monitoring of the project). The focus of these interviews and discussions would be to assess the management (administrative and financial) arrangement of the project and their impressions on implementation and achievements of the project. The assessment will include interviews with key officials from education, health and water departments at the central and sub-national/local levels. In addition, meetings will be held with other relevant agencies such as SFD for gathering information for comparing some aspects (supportive structures established) of CDP against similar other structures.

Cost-benefit analysis will be an important part of the assessment. The project has multiple clients and stakeholders, the communities to whom the project interventions are intended, the Government which is responsible for managing the IDA credit to fund the proposed project interventions and the World Bank, the agency which entrusted the IDA credit to the Steering Committee going beyond the conventional criteria of managing such credit. It is therefore important to look at the cost aspect of this project as part of project accountability to all clients and stakeholders.

The assessment will undertake cost-benefit analysis in key project components (where possible by data availability) such as improvements in girls' enrolment as a result of additional classrooms, increased access to safe water through new water distribution networks. The data available include cost of classroom construction, cost of water supply schemes, cost of furniture supplies to schools, cost of textbook (supplied by the government) distribution, school enrolment data, population covered with new water schemes, etc. Using the data available, the assessment will derive and compare unit costs such as cost per child for primary education, per capita cost of providing safe water supply using appropriate depreciation rates over the life span of the hardware provided.

The project has accumulated data on construction and renovation of health units, maternities, immunization, human resource training, etc. Linking these costs to the health outcome is a

complex task but the assessment will as far as possible assessing the cost-benefit of immunization coverage, health facility usage and IMCI components.

Field visits for observation of the local situation, project accomplishments and interaction with the local population will also be an important part of the assessment. Since all the work is done in the rural districts this assessment should be based on information available from the Government and UNICEF field offices and the clients in the thirty target districts. The team is expected to visit about half (15) of the project districts to meet with the local communities, leaders and staff of various project offices.

As part of the **Beneficiary Consultation** the assessment team will make field visits to selected communities to draw out from the communities their views of project outcomes and their impact on the lives of communities.

ASSESSMENT REPORTS

The final CDP assessment report will present findings and conclusions vis-à-vis the assessment questions detailed above, proposing specific and achievable recommendations for the remaining period and for the future of the CDP.

In addition to the main report on the CDP, a supplementary report will be completed by the team leader after leaving Yemen, comparing the World Bank/UNICEF agreement for the Yemen CDP agreements with other agreements and Memoranda of Understanding between the two agencies in relation to projects on other countries. Following consultations with UNICEF and the World Bank HQs, this second report will make recommendations on the terms of future agreements.

The assessment team leader will be responsible for the completion of the draft and final reports and for presentations of findings to UNICEF. All reports will be in English.

The reports must conform to the UNICEF Evaluation Report Standards and UNICEF Style Guide. The UNICEF Evaluation Office will specify the report format. The final reports should be provided in hard-copy (1 copy) and electronic version in Microsoft Word. Any survey data will be provided in Microsoft Office compatible format. All electronic files will be submitted on a CD-ROM.

ORGANISATION AND MANAGEMENT

Assessment team: The comprehensive nature of the assessment (i. e. examination of the technical, management, financial, institutional aspects of project performance) will require the assessment team to have an appropriate balance of experts. Since education, health and water are the key project components with heaviest investment, these areas should receive the priority in identifying the assessment team. A three-member team is proposed as follows:

- The team leader who will manage the team assigning tasks as necessary and drawing together the drafts and final report as per the TOR. The team leader will require previous experience of leading/managing international teams in assessing/evaluating development interventions. Key skills include project management, consensus building, cross-cultural awareness, report writing and presentation.
- Evaluator with expertise in social sector studies and assessments and a specialist in either education, health or water
- Evaluator with expertise in social sector studies and assessments including experience in conducting cost-benefit analysis, and a specialist in either education, health or water

The assessment team will be supported by a research assistant/database manager and an admin assistant who will be recruited locally.

The assessment team must offer the following experience and demonstrated competencies:

- Significant knowledge and experience in the evaluation of community development projects in developing countries, (experience in the Middle East an advantage)
- Significant knowledge and experience in stakeholder consultation exercises and Rural Rapid Appraisal methodologies
- Familiarity with child-centred programming and human rights based approaches to programming
- Prior consultancy experience with major international agencies, preferably with one or more UN agency, (prior experience with UNICEF or the World Bank an advantage)
- Facilitation skills
- Gender analysis skills
- Strong quantitative and qualitative data collection and analysis skills
- Excellent written and verbal communication skills, in English

Reference group:

A reference group led by UNICEF Representative in Amman will be established with the following members:

- A World Bank official from Washington
- A World Bank official from Yemen
- A UNICEF official from NYHQ
- UNICEF MENA Regional M&E Advisor
- Two government officials (Ministry of Planning, Ministry of Social Affairs, PVU)

The reference group will have the responsibility of guiding and supporting the assessment by:

- Reviewing and finalising the draft TOR
- Ensuring that UNICEF establishes a balanced and qualified assessment team
- Responding to the methodological and other substantive issues arising during the course of the assessment
- Providing comments on draft and final reports
- Organising a debriefing meeting involving key stakeholders in Yemen

TIMING AND IMPLEMENTATION SCHEDULE

The assessment is to be conducted from mid February 2005 for a period of approximately eight weeks, with approximately 5 weeks in Yemen. A tentative plan for the assessment is suggested below:

Key activities	Weeks							
	1	2	3	4	5	6	7	8
Arrival of the assessment team in Yemen and briefing in UNICEF, Sana'a								
Desk review of selected documents								
Discussion on arrangements for meetings & field visits and design of field survey questionnaires								
Meeting with the Steering Committee								
Interviews in Sana'a (government officials, UNICEF, others)								
Meeting with local & district councils in selected districts and field surveys								
Meeting with project communities/beneficiaries								
Analysis of available data/records								
Clarification on issues from interviews, data, field visits								
Drafting of assessment report								
Presentation of draft report to Steering Committee					X			
Finalisation of CDP report after receiving comments								
Supplementary report on UNICEF/World Bank MOU's inc New York visit								

SUBMISSION OF PROPOSALS

UNICEF invites proposals from suitably qualified assessment teams (team leader plus two evaluators). The proposal should include:

- Company profile, where relevant
- Proposed methodology, including key assumptions, and proposals for document analysis, qualitative and quantitative data collection and analysis, stakeholder participation, feedback and reporting.
- CV/Résumés of all assessment team members, highlighting experience relevant to this assessment. Individual CVs should not exceed 4 pages.
- Assessment work plan, showing tasks, timelines and allocation of work to team members, using the schedule above as an approximate guide
- Contact details of two referees from recent clients for each team member
- A sample report from a prior consultancy assignment with content directly relevant to this assessment and completed by one or more of the proposed team members
- Financial proposal (do not include travel and subsistence costs, which will be determined in line with UNICEF travel procedures).

PAYMENT TERMS

Payment is by results. Payment will be made in stages with allotments corresponding to the completion of key intermediate phases and products. Dates and sums will be negotiated with the consultants. No advance payment can be made under UNICEF contractual regulations.

DEADLINE FOR SUBMISSIONS

Proposals should be submitted by email to yemencdp@unicef.org by **January 28 2005**

23/12/2004

Annex 2 Key Questions by Evaluation Criteria

1. Key questions project management

Efficiency:

- How successful are the relationships between UNICEF, World Bank and the Government represented by HCMC and PCU?
- What has been the role of the Steering Committee in facilitating project implementation?
- How facilitative and/or constraining have the management procedures (including finance-related) been within the Government, the Bank and UNICEF with respect to contracting, intra-sector reallocation of funds and overall financial management?
- Which have been the relations between the seven UNICEF sub-offices, designated for project implementation and monitoring in close partnership with local district and area councils, and local councils and district/governorates' offices?
- Are the support-structures established at field level adequate?
- What is the quality of the information and monitoring systems introduced at all levels with respect to their adequacy, efficiency and flow/use of information in planning and decision-making?

Effectiveness:

- How the project can maintain joint partnership and visibility without losing the momentum already achieved?

Impact:

- To which extent has simultaneous provision of health, education, and water services have taken place in targeted areas, (i. e., the proportion of villages that have seen the implementation of all/multiple interventions/components under CDP).
- How well do the villages with multiple component interventions perform in terms of key outcomes as compared with other villages in the same project district?
- What conclusions can be drawn with respect to the success of integrated multi-sectoral approaches?

2. Key questions health

Efficiency:

- To what extent has the project achieved the objectives and targets (immunization coverage, access to health care, safe delivery, access to safe water and sanitation, etc.) set for each sub-component?
- What are the key outputs of the project and what factors have contributed to success?
- How efficient are the key project interventions in terms of cost per unit of the output produced?
- What are the key gaps and what have been the constraining factors? (also ad effectiveness)

Effectiveness:

- What conclusions can be drawn with respect to measurable outcomes/impact with the respect to improved health status (including reduction of morbidity, malnutrition and mortality) of children in the project districts?
- How successful is the project in improving the capacity of the physicians and health workers on the IMCI approach and what are the impacts in terms of improved case management and improving household health, nutrition and hygiene behaviors? (and impact)
- How well has the project contributed to regular procurement and distribution of drugs and other medical supplies? What have been the key success and/or constraining factors? (and efficiency)
- How successful has the project been in integrating the Expanded Programme in Immunization (EPI) into the district health plans (to improve decentralized planning and delivery)? What are the key facilitating and/or constraining factors? (also ad effectiveness)?
- How innovative has the project been in introducing innovative, low-cost and locally acceptable structures especially in the area of water and sanitation schemes?

Impact:

- What has been the experience in working with WHO, UNFPA, WFP and other partners on the health component? (and ad partnership)
- How successful has the project been in implementing safe motherhood related interventions and conclusions can be drawn with respect to the measurable impact/outcome from this sub-component?

Sustainability:

- How successful has the project been in improving the capacity of the governorate level health offices to support the district health offices and operationalise cost sharing and maintenance schemes?
- How adequately has the project contributed to the strengthening of the information, education communication (IEC) and social mobilization activities in support of the health components?

3. Key questions nutrition

Efficiency:

- What are the key outputs of the project and what factors have contributed to project success?
- To what extent has the project achieved the objectives and targets (micronutrient supplementation, breastfeeding, growth monitoring and promotion coverage etc.) set for the project component?
- What are the key gaps in performance and what have been the constraining factors?

Impact:

- What conclusions can be drawn with respect to measurable outcomes from this project component with respect to reduction of malnutrition in the project districts?

- How successful has the project been in establishing community-based triple-A and social mobilization approaches for improving nutrition status of children? What have been the key success and/or constraining factors? (also under and effectiveness)

4. Key questions education

Efficiency:

- To what extent has the project achieved the objectives and targets (community schools established, teachers recruited and trained) set for the project component?
- What are the key outputs of the project and what factors have contributed to project success?
- How efficient are the key project interventions in terms of cost per unit of output produced?
- What are the key gaps in performance and what have been the constraining factors?
- How innovative has the project been in introducing innovative, low-cost and locally acceptable school infrastructures (classrooms, furniture) in the project districts?

Effectiveness

- *Have the textbooks and furniture been provided?*
- *Has the number of female teachers increased?*
- *Have water and sanitation been provided in schools?*

Impact

- How have the provision of textbooks and furniture helped increase and retain girls in schools?
- Is there an increase in female teachers? (also ad effectiveness)
- What are the influences of water and sanitation provisions in schools? (also ad effectiveness)
- What conclusions can be drawn with respect to measurable outcomes/impact (improvement in enrolment, retention and completion rates for girls and boys, learning achievements) from this project component with the respect to reduction of malnutrition in the project districts?

Sustainability

- *Are the institutions on local district, (governorate) and central level prepared and capable to continue with the flow of benefits beyond project end?*
- *Are the local communities (PTA, mothers and fathers) prepared and capable to continue with the flow of benefits beyond project end?*

5. Key questions ECD

Efficiency

- What factors caused the delayed implementation of this project component?

- To what extent were the *targets* set for 2004 realized and what were the key success and/or constraining factors?

Effectiveness

- How can the ECD component benefit from the local institutional structures and processes established by the CDP project? (also ad sustainability)
- What lessons from the rest of the project can be applied for strengthening and accelerating the implementation of the ECD component?

6. Key questions community readiness

Efficiency

- Have the functions of the local development committee (LDC) member's functions have been clearly defined in the target communities? To what extent such arrangements have been clearly defined in the target communities?

Effectiveness

- To what extent has the project been successful in engaging the beneficiaries in the planning process and how? What have been the major facilitating and/or constraining factors?
- How effective has this component been in transferring skills to communities to assess needs and capacities, plan interventions (in health, education, water and education) and develop linkages with the district level offices?

Impact

- What are the positive and less favorable impacts of the 2002 Decentralization Policy on the local-level arrangements agreed/established for the project, if any?

Sustainability

- How well have the communities performed in assessing and fulfilling their financial contributions (cost-sharing) to the project and for improving demand for (and use of) services through community/social mobilization efforts?
- What has been the overall experience in strengthening local capacity for planning and implementation and what lessons can be drawn for the future? (also ad effectiveness)
- To what extent the local level arrangements have been made operational and sustained in target districts and communities?

7. Key questions cross-cutting issues

Gender

- How has CDP affected males and females in a different ways, including whether males and females have enjoyed equal access to services and benefits and which are the underlying reasons for any differences?

Human Rights Based Approach

- To which extent the CDP has been consistent with the Human Rights Based Approach (HBRP), as adopted by UNICEF as the norm for programming? (in the light of a possible project extension or renewal)

Annex 3 Literature and Documents consulted

- A Report on Assessment of Decentralized Level Training Activities, September 2004
- Activity Monitoring Matrix as of December 2004
- Analysis of the School Construction 1996-2003 by World Bank (Sep, 2003)
- Annual Programme Review Governorate Meeting Guideline 2003 (Sep, 2003)
- Annual Review, Guidelines for the Preparation of District Presentations by UNICEF (Sep, 2002)
- Beneficiary Level Evaluation of WES sector interventions, 2004
- CDP 2004 Annual Workplan
- Child Development Project Baseline Survey 2001 & 2003 by UNICEF (Oct, 2004)
- Child Development Project Performance Indicators Assessment 2004
- Child Development Project, Outcomes Assessment, Lahej Governorate February 26 – March 6, 2005 by PCU M&E officer, March 2005
- Children and Women in Yemen: A Situation Analysis 2004, September 2004
- Cooperation Agreement for Project Assistance (CAPA) between Government of Yemen and UNICEF
- Government of Yemen – UNICEF; 2002 – 2006 Country Programme of Cooperation
- Guideline for Annual Planning Exercise 2004 (Oct, 2003)
- Guidelines for Annual Programme Pre-Review at District Level (Aug, 2003)
- Guidelines for Planning for 2003 by UNICEF (Oct, 2002)
- Integrated Management of Childhood Illnesses (IMCI) assignment, report to UNICEF, August 2004
- Knowledge, attitudes and practices on hygiene and sanitation in the governorates of Ibb, Abyan, Hodeidah, Lahej and Mahra, December 2003
- Level of Mastering Basic Competence in Primary Education: Grades Four and Six. 2004
- Midterm Review, 2002-2006 Country Programme of Cooperation, GoY-UNICEF (Sep, 2004)
- Mid-Term Review, Child Development Project, 4-13 October, 2003
- Minutes of the Steering Committee Meetings
- Monitoring Report by Dr M Al-Fageeh, M&E Officer, CDP, PCU of Gabal Eyal Yazid District, Amran Governorate (January 2005)
- Monthly Reports submitted by Consultant from NCHE regarding Social Mobilisation Network activities (Feb, 2004 to Apr, 2005)

- Progress Monitoring Report CDP
- Republic of Yemen, CDP, IDA, WB; World Bank Mid Term Review Mission, Aide Memoire, 4-14 October 2003
- Review and Assessment of Basic School Design in Rural Areas, Interaction in Development, (Oct, 2004)
- Review and Assessment of Basic School Design in Rural Areas, October 2004
- Supplies Cost Comparison Report by Abdul Ghani Amin Al-Ghazali for GARWP (in Arabic) (2005)
- Terms of Reference for Assessment of Community-based Communications Interventions, Yemen
- Terms of Reference for the Mid-Term Review of the Water and Sanitation Sector
- UNICEF Yemen 2002 Annual Report (undated)
- UNICEF Yemen 2003 Annual Report (undated)
- UNICEF Yemen 2004 Annual Report (Dec, 2004)
- Vaccination Coverage Survey and EPI Evaluation for the UNICEF Community Development Project Area, July 2004
- World Bank; Project Appraisal Document (PAD), February 2000

Annex 4 People and Organizations consulted

NAME(S)	POSITION
UNICEF:	
Abdul Alim	M&E Officer
Abdulhalim Ayyash	National Health Officer
Abdulkudos Al-Marwani	Social Policies and Planning Officer
Abdulsalam Al Sunhigi	Finance Officer
Adnan Abdulfattah	Field Officer Hodeida
Dhekra Annuzaili	Assistant Nutrition Officer
Eiko Sato	M&E Junior Officer
Hayaam, Ms	Assistant Education Officer
Kamal Ben Abdallah	Health Officer
Krishna Belbase, Dr	Regional Programme Officer M&E
Marc Lucet	Former Project Officer Area Based Programme
Mohammed Al Ebbi	Field Officer Aden
Nada Abdulwahab	Supply Officer
Ramesh Shresta	UNICEF Representative Yemen
Sami Saeed	Assistant Project Officer WES
Samia Al-Haddad	Assistant Communications Officer
Solofo Ramaroson	Program Officer
Suad Nabhan	Area-based Officer
Vijaya Singh	UN Volunteer, Early Childhood Development
Waleed Norman	Field Officer Ibb
Zaid Jurgi	Water and Sanitation Officer
World Bank:	
Mustapha Rouis	Country Representative
Ousmane Diagana	Former Task Manager
Takako Yuki	Task Manager
Robert Hindle	Former Country Representative
Regine Bendukat	
UN Agencies:	
Hashim A. Elzein Elmousaad, Dr	WHO Representative in Yemen
Naguia Bahubeishi	UNFPA Assistant Representative
Naila Sabra	WFP Representative
Omar Ertur	UNFPA Interim Representative
Salman Omer	WFP Deputy Country Director
Government of Yemen:	
Abdul-Gabbar A. Al-Waeli, Dr	Director General Training and Orientation, Ministry of Education
Abdulkareem E Al Arhabi, Dr	Minister of Social Affairs; Head of Social Fund of Development
Abdul Wahab Al-Mujahad	Head of Water and Environment Unit, Social Fund for Development
Galal Ibrahim Fakirah, Dr	Deputy Minister of Education for Training and Qualification, Ministry of Education
Husnia Al-Kadri, Dr	Director of Women Study and Development Center, University of Sana'a
Hashim	Deputy Minister of Planning
Majid Al Jormaid	Deputy of Minister of Health for Public Health Care

NAME(S)	POSITION
Nafisah Al Jaifi, Dr	Director of HCMC and Head of PCU
Tahir Jumai	Head of Education, Social Fund for Development
GARWP:	
Abdul Nasser Al-Mekhlafi	G.D. of Studies, Supervision and Follow-up Engineer
Abdulhamid H. Al-Bashiri	Vice Chairman GARWP
Ali Al-Raboie	G.D. of Planning
Ali M. Al-Suremi	Chairman
Ali M. Taher	Deputy G.D. of Laboratory
Fawzi Al Khirbash	Director General of International Cooperation
Kaid Al Darwish.	
Water Committee Members:	
Al-Gabgab (Ibb)	
Bait Ata (Hodeidah)	
Bani Zuhair (Ibb)	
Jabal Bahri (Ibb)	
Mahar Khalil (Hodeidah)	
District Council Focal Points for Water Schemes:	
Al-Milah (Lahaj)	
Ziyadah (Hodeidah)	
Governorate and District Officials:	
Ahmed Mohammed Salih	District Health Education Officer, Bani Matar
Ahmed Moussa	Health Worker, Zaidiya
Ali Azman	Director Education, Bani Matar
Ali Mohammed Jebeli	i/c of EPI, Zaidiya
Altaf Taj, Ms	Trainer and Health Education Officer, Bani Matar
Baha Tabit	Staff Doctor, Zaidiya
Colonel Amin Ali AlWarafi	Deputy Mayor Ibb
Elima Abdalasalah	i/c of Safe Motherhood, Al Milah
Fureija Aish	i/c of Reproductive Health, Zaidiya
Idris, Dr	Incharge Health Centre, Misyab, Bani Matar
Maysoon Norman	HCMC Officer, Ibb
	HCMC Officer, Sana'a
Mohamed Hassan	Director of Health, Zaidiya
Mohamed Saleh Shamlan	Governor Hodeidah
Mohammed Al Jafari	Trainer Education Complex Wadi Adur, Al Hudain, Ibb
Mohsin Ali Ahmed	Deputy Director of Health Hodeidah - Al Milah Distr.
Mujahid, M	District Health Officer Bani Matar
	District Supervisor for Vaccination
Social Mobilisation Network:	
District Council	
District Education Officers	
EmOC Staff	
Gubain Village	

NAME(S)	POSITION
Nutritionists at Al Udayn Hospital	
Other Organisations:	
Afkar Ali Al-Shami	Senior Programme Officer Education, Royal Netherlands Embassy
Dominic O'Neill	DFID, Country Representative
Ralf Dreyer, Dr	Charge d'Affaires a.l., Delegation of the European Commission
Rebekka van Roemburg	First Secretary for Education, Royal Netherlands Embassy
Manal Subhi	Consultant
Al-Ainsi Abdul Karim Ali	Consultant from National Centre for Health Education
Steering Committee Meeting:	
Abdulhameed H. Al Bashiri	Vice Chairman, GARWP
Abdulkareem E Al Arhabi, Dr	Minister of Social Affairs and Labour
Abdullah Ali Esmail	General Director of Inspection, Ministry of Education
Afreen Haq	Education Officer, UNICEF
Ali Dastgeer	Evaluator, CDP Assessment Team
Bin Abduallah Mehmam	Health Project Officer, UNICEF
Claudio Schuftan, Dr	Evaluator, CDP Assessment Team
Krishna Belbase, Dr	Regional M&E Officer, UNICEF
Majid Al Gunaid	Deputy Minister of Health (Public Health Care)
Mohammed Abbas	Freelance Translator
Mohammed S. Hussein	Deputy Minister of Information
Mohammed Y. Al Nemi	Minister of Public Health
Monika Zabel, Dr	Team Leader, CDP Assessment Team
Nafisah Al Jaifi, Dr	Director of HCMC and Head of PCU
Ramesh Shresta	Country Representative, UNICEF
Safiah M. El Eryani	Task Manager Health, World Bank
Solofo Ramaroson	Program Officer, UNICEF
Suad Nabhan	Area-Based Project Officer, UNICEF

Annex 5 Assessment Criteria and Definitions (DAC)

Relevance

The extent to which the objectives of a development intervention are consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors' policies. Note: Retrospectively, the question of relevance often becomes a question as to whether the objectives of an intervention or its design are still appropriate given changed circumstances.

Efficiency

A measure of how economically resources/inputs (funds, expertise, time, etc.) are converted to results.

Effectiveness

The extent to which the development intervention's objectives were achieved, or are expected to be achieved, taking into account their relative importance. Note: Also used as an aggregate measure of (or judgment about) the merit or worth of an activity, i.e. the extent to which an intervention has attained, or is expected to attain, its major relevant objectives efficiently in a sustainable fashion and with a positive institutional development impact. Related term: efficacy.

Impacts

Positive and negative, primary and secondary long-term effects produced by a development intervention, directly or indirectly, intended or unintended.

Sustainability

The continuation of benefits from a development intervention after major development assistance has been completed. The probability of continued long-term benefits. The resilience to risk of the net benefit flows over time.

Inputs

The financial, human, and material resources used for the development intervention.

Activity

Actions taken or work performed through which inputs, such as funds, technical assistance and other types of resources are mobilized to produce specific outputs. Related term: development intervention.

Outputs

The products, capital goods and services which result from a development intervention; may also include changes resulting from the intervention which are relevant to the achievement of outcomes.

Outcome

The likely or achieved short-term and medium-term effects of an intervention's outputs. Related terms: result, outputs, impacts, effect.

Purpose

The publicly stated objectives of the development program or project.

Project or program objective

The intended physical, financial, institutional, social, environmental, or other development results to which a project or program is expected to contribute.

Goal

The higher-order objective to which a development intervention is intended to contribute. Related term: development objective.

Formative evaluation

Evaluation intended to improve performance, most often conducted during the implementation phase of projects or programs. Note: Formative evaluations may also be conducted for other reasons such as compliance, legal requirements or as part of a larger evaluation initiative. Related term: process evaluation.

Summative evaluation

A study conducted at the end of an intervention (or a phase of that intervention) to determine the extent to which anticipated outcomes were produced. Summative evaluation is intended to provide information about the worth of the program. Related term: impact evaluation.

Logical framework (Logframe)

Management tool used to improve the design of interventions, most often at the project level. It involves identifying strategic elements (inputs, outputs, outcomes, impact) and their causal relationships, indicators, and the assumptions or risks that may influence success and failure. It thus facilitates planning, execution and evaluation of a development intervention. Related term: results based management.

Annex 6 Assessment Matrix for each of the Key Components**ASSESSMENT MATRIX
HEALTH**

Outputs to be assessed (quantity, quality)	Processes set in motion	Outcomes to be observed	Impact indicators to be checked or assessed
Record books operational. Outpatient consultations of greater quality. Obstetric and pediatric personnel trained and equipped.	Changes to increase No. of outpatient consultations. Changes to increase deliveries attended by qualified person. Set up of district HIS and ad-hoc training.	Incidence of life-threatening pediatric conditions decreased; treatment of the same adequate and timely. Situation of institutional and home deliveries Improved.	Decreased IMR and <5MR Quantifiable?
Safe motherhood program instituted. ANC visits records kept and visits increased. Visit/referrals to EOC centers increased. Clean delivery kits distributed	Changes effected to increase ANC. EOC activities implemented. Actions to minimize 3 delays.	Analysis of 3 delays achievements. Success of referrals of high risk pregnancies. Midwifery/clean delivery kits resulting in fewer complications. Increase in deliveries assisted by trained person.	Decrease MMR Quantifiable?
Cold chain operational. Vaccines available. Outreach activities working well. IEC and social mobilization for EPI functional. Good records on EPI.	Cold chain maintenance operations. Vaccines procurement system. Outreach activities reorganization and changes. Introduction process of Hep B vaccine. Changes to improve TT vaccination.	Status of Hep B and TT vaccination. Vaccination coverage rates increased	Decrease morbid/mortality from immunizable diseases. Quantifiable?
ORT corners fully functional. Record books operational. Diarrhea incorporated in the IMCI approach.	ORT corners set up process. ORS procurement system. ORS distribution and IEC program (to mothers).	ORS universally available. ORS usage by mothers widespread. Cases of dehydration decreased. Home interventions of IMCI having an impact.	Decrease mortality from diarrhea. Quantifiable?
Antibiotics available. Staff retrained. Record books functional. ARIs incorporated in the IMCI approach.	Antibiotics procurement system. Training in diagnostic skills.	Antibiotics used more timely and appropriately. Patient management quality increased. Home interventions of IMCI having an impact.	Decrease incidence of/mortality from ARI. Quantifiable?

Antimalarials and impregnated nets available. Staff skills improved. Record books operational. Malaria incorporated in the IMCI approach.	ITN procurement system. Training in diagnostic skills. Antimalarials procurement system.	Higher treatment rates with antimalarials. ITNs used properly? Home interventions of IMCI having an effect on disease prevalence.	Decr. incidence of/mortality from malaria. Quantifiable?
DHS members trained. Equipment provided.	DHS members training. DHS offices equipping.	DHS capacities (planning, supervision) improved.	DH System improved. Measurable?
Recording system of cash receipts and expenditures of cost-sharing funds operational. Drugs in stock.	Cost-sharing system amendment and full implementation. Drug revolving fund optimization.	People paying for services and drugs received. Exemption mechanisms working.	Cost-sharing functional (% contribution +/- 4%). Measurable?
Construction work completed. Supplies procured.	Construction/rehabilitation contracts process set up. Supplies procurement and distribution system.	Visit of selected facilities at random, with no previous notice. Adequacy of health services provided in those facilities.	Better health indicators in the catchment area of the contracted health facilities.
Members of DHMTs trained.	Support and training of DHMT members.	Functional DHMTs. Frequency and perceived usefulness of meetings. Decisions being made locally. Improved planning mechanism.	Improved decentralized management of health services
Groups (both genders?) formed. Members trained. Meetings ongoing.	Mobilization to create health facilities committees. Training of members.	Female participation in female groups. Decisions being made and implemented.	Functional health committees in rural health facilities.
Needs assessment carried out Planned construction work and clinics equipping/furnishing carried out.	Construction /rehabilitation/ furnishing of the health infrastructure as planned.	Infrastructure being used to the benefit of patients. (Interviews). Increased utilization of health facilities	Health infrastructure strengthened.

ASSESSMENT MATRIX WES

Outputs to be assessed (quantity, quality)	Processes set in motion	Outcomes to be observed	Impact indicators to be checked or assessed
Civil works carried out. Water committees formed.	Needs assessments. Social mobilization for WES. Hygiene education. Contracting of civil works. Procurement of pumps and other inputs.	Record books in health facilities recording water-borne diseases? Water points and water committees functioning. Hygiene in the HHs improved.	Decreased incidence of water-borne diseases. Girls' time to carry water saved.

Water committees keeping records. Water fees being collected. Repair/maintenance work being done as needed. Training done for maintenance.	Water fees collection system set up and guidelines set for the use of proceeds from it. System of maintenance set up.	Water committees fully functional. Inspection of records of repair/ maintenance work And water quality checks. Sustainable access to clean water	Decreased incidence of water borne diseases. Girls' time to carry water saved.
Participatory needs assessment and social mobilization carried out. Cost-sharing arrangements agreed-upon. Construction work carried out. Latrines built in public facilities and homes. Records kept. Hygiene education done.	Needs assessment and social mobilization for WES processes set up. Hygiene education. System for the procurement of slabs and other inputs.	Latrines in use in public facilities and homes? Hand washing being practiced.	Feces disposal systems improved and expanded.

ASSESSMENT MATRIX NUTRITION

Outputs to be assessed (quantity, quality)	Assessment of processes set in motion by the project	Outcomes to be assessed by looking at the following	Main outcome and impact indicators to be checked or assessed
Weighing sessions ongoing. Growth charts in use to record weights. Scales available.	CBGM set up and training of volunteers in weighing and recording. Volunteers training to give nutritional advice and refer failure to thrive cases.	Weighing sessions being used to educate mothers. (Observation) Growth charts correctly used. Nutrition volunteers and mothers interviews (applying new knowledge?)	% children <3 with low weight /age decreased.
Vaccinations and Vitamin doses recorded in growth charts. Training done.	EPI plus set up and ad-hoc training.	Review of EPI plus records and growth charts. Decrease in prevalence of Bitot spots.	% children receiving Vit. A supplementation increased. Part of CDP??
Education on exclusive BF done. Records kept.	Exclusive BF campaign.	Mothers convinced of the advantage of excl BF. Interview with staff and lactating mothers.	Exclusive BF rate increased.
Education on complementary feeding done. Records kept.	Complementary feeding education campaign.	Mothers convinced of introduction of complementary feeding at age 6 m. Correct introduction of complementary foods mastered by mothers. Interview with staff and lactating mothers.	% mothers with improved habits in introducing complementary foods.

Recording of birth weights done in growth charts. Summaries prepared.	Mechanisms set up to monitor birth weight.	Review of BW records (if found).	Decreased low BW rates. Measurable??
Iron supplementation of pregnant mothers and infants ongoing.	Activities set up to tackle the IDA problem.	Review of any records kept on this. Interview staff.	Decrease in Iron deficiency anemia prevalence.
Meetings held with community to discuss improvements in the nutrition situation of mothers and children.	Establishment of open communication with and participation mechanisms for beneficiaries.	Degree of participation and perceived benefits. (Focus groups and individual interviews).	Beneficiaries perceive the improvements

ASSESSMENT MATRIX EDUCATION

Outputs to be assessed (quantity, quality)	Processes set in motion	Outcomes to be observed	Impact indicators to be checked or assessed
Increased No of women teachers trained in the intervention areas.	Staff retraining and educational set in motion. Concerted actions set in motion to increase girls' enrollment and retention.	Increased No. of women teachers working in rural areas. Interview of female teachers and their trainers. Random unannounced visit of schools. Interview of girl students.	Girls enrolment increased (%). Girls retention increased. Girls school completion (grades 1-6) increased. Correlation between increased number of female teachers and increased enrolment of girls.
Textbooks produced and distributed to the targeted schools.	Materials production and distribution system set up.	Teachers retrained? Supervision activities regularly carried out? Textbooks available and gainfully used? Planned construction work and school equipping/furnishing carried out? Education committees formed and active?	Quality of primary education has increased. (Interviews with headmasters/headmistresses teachers (male, female) and children, with parents (fathers, mothers) where possible).
Teacher training carried out considering intended gender balance goal.		Proportion of trained women teachers for grades 1-6 at schools in intervention areas has increased. Analysis of district education records. Interviews with trained teachers (re quality of training, incentives to work in rural areas. Staff turnover after training)	Improved proportion of women teachers has led to increased enrolment and attendance of girls in grade 1 to 6.

Production, storage and distribution of textbooks according to schedule or completed.		School books and kits delivered in sufficient quantities and in use by teachers and children.	Improved quality of learning. Books and kits have contributed as incentives to an increased willingness of parents to send their girls to school. (Evaluation tool: Interviews with mothers and fathers of girls; Is this an incentive to send girls or a general one to send children to school?)
Construction and rehabilitation of schools (infrastructure) according to schedule or completed.		Evaluation tool: Unannounced visits to schools Newly built and rehabilitated schools are fully operational and used by girls (and boys)	Improved quality of learning Improved enrolment and attendance rate of girls
School feeding (dry ration) for girls provided by WFP delivered to schools in the implementation areas.		Evaluation tool: Benchmarking various incentives by interviewing headmasters/headmistresses , children, teachers and parents (ranking of incentives).	Food incentives for girls actually increase enrolment and retention.

ASSESSMENT MATRIX COMMUNITY READINESS

Outputs to be assessed (quantity, quality)	Processes set in motion	Outcomes to be observed	Impact indicators to be checked or assessed
Assessments done. LDCs strengthened. Ad-hoc committees/ groups formed. Needed equipment, training and TA given to the new groups.	Organizational activities set in motion. Training of LDCs and new committees.	LDCs meeting regularly and actively participating in decision making. Gender balance in groups. Groups having a true decision-making role? Interview of community group members.	Community mobilized and participating in decision making in health, nutrition, education and WES.

Annex 7 Guidelines semi-structured Beneficiary Interviews during Field Visits

Education

- When did CDP interventions begin in this school?
- When was the school built/rehabilitated/enlarged? By CDP?
- How many classrooms are new, how many classrooms are there in total?
- Did schoolbooks arrive? In time? For the First and Second Term?
- How many teachers has this school? Male and Female?
- Have there been female teachers prior to CDP working in this school already?
- What is the education background of the female and male teachers?
- Have the teachers been trained? When? For how long? Male and Female?
- How many of the trained teachers are still teaching in this school? Male and Female?
- How do the trained teachers perceive the quality of the training? How does it help them in their teaching (planning, didactics, and curriculum)? Are there changes in the behaviour of the children?
- How has the number of female and male teachers developed since CDP intervention started?
- How long to the teachers have to walk/drive to come to the school? Do you walk alone or with friends, brothers etc.?
- Where do the female teachers come from? Same village?
- How many children are in this school? By grade 1-6 and by gender (see standard list)
- Is there a visible drop out after grade 5 or 6? If so why?
- Has the number of children (girls, boys) changes since the CDP (or other) interventions?
- How long is the way for the children to come to school every day (km or minutes)?
- Do the children have household duties or other duties as well (work etc.)? Which is the effect on enrolment, retainment and completion of basic education?
- Which are the major obstacles for higher enrolment of girls? (to check if its just the same as prior to project start.....)
- Have there been water pumps installation close to the villages (by CDP or others)?
- When? Which is the effect on enrolment, retaining and completion of basic education?
- Have the children perceived changes in the provision of classes by the (trained) teachers?

- Do the parents and teachers perceive an improved quality of learning (e.g. grade 4 can read and write)?
- Does a Parents-Teachers Association exist? Are mothers and fathers represented? In case no mothers are represented, why so (perception of male and female interviewees)? What can be done to involve mothers more actively, if this is currently not the case?
- Have literacy courses provided by the project? Who conducts/conducted the classes? Is this a possible first entry point to attract mothers?
- Is this school subject to school feeding for girls? If yes, since when? What is the assumed effect?

Annex 8 Financial Consolidated Budget Status, 2001 – 2004

REPUBLIC OF YEMEN																			
CHILD DEVELOPMENT PROJECT																			
Final Consolidated Expenditures																			
BUDGET STATUS																			
2001-2004																			
Unit: USD'000																			
	IDA FUNDS							UNICEF FUNDS			GOVERNMENT & COMM. FUNDS			TOTAL FUNDS					
	Planned			Actual Exp.			Diff.	Planned	Actual Exp.	Diff.	Planned	Actual Exp.	Diff.	Planned Budget	Actual Exp.				
PROJECT COMPONENTS	UNICEF	PCU	Total	UNICEF	PCU	Total													
Community Readiness	1,330		1,330	584	-	584	746	-	284	(284)	80		80	1410	868			61.55%	
District Health System	3,605		3,605	2,100	-	2,100	1,505	1,420	257	1,163	735		735	5760	2357			40.92%	
IMCI	3,980	5,720	9,700	1,017	319	1,336	8,364	-	277	(277)	200		200	9900	1613			16.30%	
Immunization	5,710		5,710	3,627	1,638	5,265	445	-	3,747	(3,747)	190	4	186	5900	9015			152.80%	
Safe Motherhood	60	170	230	283	138	421	(191)	310	203	107	60		60	600	624			104.08%	
Water & Sanitation	3,404		3,404	1,866	-	1,866	1,538	2,330	594	1,736	1,256		1256	6,990	2460			35.19%	
Community Nutrition	150		150	155	-	155	(5)	1,260	274	986	310		310	1720	429			24.93%	
Community Schools	1,060		1,060	50	-	50	1,010	4,874	2,442	2,432	736		736	6670	2492			37.36%	
Women Teacher Training	140		140	436	-	436	(296)	2,020	231	1,789	30		30	2190	667			30.47%	
Textbook Distribution	859		859	806	25	831	28		37	(37)	331	224	107	1190	1092			91.77%	
ECD	260		260	157	-	157	103	194	9	185	116		116	570	166			29.11%	
Project Management	1,543	807	2,350	890	438	1,328	1,022		470	(470)		219	-219	2350	2017			85.85%	
Total	22,101	6,697	28,798	11,971	2,558	14,529	14,269	12,408	8,826	3,582	4,044	447	3,597	45,250	23802			52.60%	

Source: UNICEF Yemen Country Office

Annex 9 Educational Data of 11 CDP Districts in 3 Governorates

Total Number of students in Primary Education 1-6 2000 - 2004									
School Year	Ibb								
	Al-Udayn		G/B Ratio	Hazm Al-Udayn		G/B Ratio	Fara'a Al-Udayn		G/B Ratio
	Boys	Girls		Boys	Girls		Boys	Girls	
1999/2000	11599	6233	0.537374	4755	2397	0.504101	7246	3228	0.445487
2000/2001	12714	12714	1	12714	12714	1	12714	12714	1
Difference	1115	6481	5.812556	7959	10317	1.296268	5468	9486	1.734821
2000/2001	12714	7396	0.581721	5754	3197	0.555613	7816	3656	0.467758
2001/2002	15010	9591	0.638974	7537	4771	0.63301	8754	4781	0.54615
Difference	2296	2195	0.95601	1783	1574	0.882782	938	1125	1.19936
2001/2002	15010	9591	0.638974	7537	4771	0.63301	8754	4781	0.54615
2002/2003	13964	9454	0.677027	7677	5272	0.686727	9076	5405	0.595527
Difference	-1046	-137	0.130975	140	501	3.578571	322	624	1.937888
2002/2003	13964	9454	0.677027	7677	5272	0.686727	9076	5405	0.595527
2003/2004	15140	10623	0.701651	8053	5881	0.730287	9248	7629	0.824935
Difference	1176	1169	0.994048	376	609	1.619681	172	2224	12.93023
2004/2005	N/A		N/A			N/A			N/A

Total Number of students in Primary Education 1-6 2000 - 2004															
Hodeidah															
School Year	Munira		G/B Ratio	Dhahi		G/B Ratio	Al-Mighlaf		G/B Ratio	Qanawis		G/B Ratio	Zaidiya		G/B Ratio
	Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls	
1999/2000	N/A		N/A			N/A			N/A			N/A			N/A
2000/2001			N/A			N/A			N/A			N/A			N/A
Difference			N/A			N/A			N/A			N/A			N/A
2000/2001	2431	3161	1.300288	1762	2795	1.586266	1662	1986	1.194946	5284	5073	0.960068	4946	4843	0.979175
2001/2002	2334	3587	1.536847	3087	2505	0.811467	2230	2066	0.926457	5937	5186	0.873505	7630	4950	0.648755
Difference	-97	426	4.391753	1325	-290	0.218868	568	80	0.140845	653	113	0.173047	2684	107	0.039866
2001/2002	2334	3587	1.536847	3087	2505	0.811467	2230	2066	0.926457	5937	5186	0.873505	7630	4950	0.648755
2002/2003	2650	2983	1.12566	3060	2490	0.813725	2650	2983	1.12566	6329	4027	0.636277	6000	4618	0.769667
Difference	316	-604	1.911392	-27	-15	0.555556	420	917	2.183333	392	-1159	2.956633	-1630	-332	0.203681
2002/2003	2650	2983	1.12566	3060	2490	0.813725	2650	2983	1.12566	6329	4027	0.636277	6000	4618	0.769667
2003/2004	2709	3157	1.165375	3096	3279	1.059109	1905	1447	0.75958	6585	4264	0.647532	6834	5036	0.736904
Difference	59	174	2.949153	36	789	21.91667	-745	-1536	2.061745	256	237	0.925781	834	418	0.501199
2004/2005	2763	3839	1.389432	2763	3839	1.389432	1997	1312	0.656985	6575	4374	0.665247	7545	5127	0.679523

Total Number of students in Primary Education 1-6 2000 - 2004									
School Year	Lahej								
	Al-Milah		G/B Ratio	Tor Al-Baha		G/B Ratio	Al-Madaraba		G/B Ratio
	Boys	Girls		Boys	Girls		Boys	Girls	
1999/2000	1808	1095	0.605642	4013	2787	0.694493	2893	1013	0.350156
2000/2001	2286	1188	0.519685	4386	3316	0.756042	2659	1227	0.461452
Difference	478	93	0.194561	373	529	1.418231	-234	214	-0.91453
2000/2001	2286	1188	0.519685	4386	3316	0.756042	2659	1227	0.461452
2001/2002	2364	1337	0.565567	4466	3637	0.814375	3203	1439	0.449266
Difference	78	149	1.910256	80	321	4.0125	544	212	0.389706
2001/2002	2364	1337	0.565567	4466	3637	0.814375	3203	1439	0.449266
2002/2003	1808	1095	0.605642	4574	3859	0.843682	3193	2193	0.686815
Difference	-556	-242	0.435252	108	222	2.055556	-10	754	-75.4
2002/2003	1808	1095	0.605642	4574	3859	0.843682	3193	2193	0.686815
2003/2004	2932	2030	0.69236	5849	4979	0.851257	4242	2497	0.588637
Difference	1124	935	0.831851	1275	1120	0.878431	1049	304	0.2898
2004/2005	2225	2219	0.997303	5983	4443	0.742604	3193	2193	0.686815

By district																
Al-Udayn																
School Year/Grade	1999/200		G/B Ratio	2000/2001		G/B Ratio	2001/2002		G/B Ratio	2002/2003		G/B Ratio	2003/2004		G/B Ratio	
	Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls					
1st Grade	2401	1604	0.668055	2689	1800	0.669394	3044	2289	0.751971	2643	2114	0.799849	2974	2423	0.814728	
2nd Grade	2110	1355	0.64218	2365	1538	0.650317	2760	2053	0.743841	2511	1937	0.771406	2693	2068	0.767917	
3rd Grade	2037	1112	0.545901	2190	1300	0.593607	2743	1724	0.628509	2466	1758	0.712895	2644	1878	0.710287	
4th Grade	1828	880	0.4814	2031	1254	0.61743	2502	1449	0.579137	2420	1514	0.62562	2578	1757	0.681536	
5th Grade	1780	709	0.398315	1828	826	0.45186	2115	1168	0.552246	2120	1160	0.54717	2263	1384	0.611578	
6th Grade	1443	573	0.397089	1611	678	0.420857	1846	908	0.491874	1804	971	0.538248	1988	1113	0.559859	
Total	11599	6233	0.537374	12714	7396	0.581721	15010	9591	0.638974	13964	9454		15140	10623	0.701651	
Hazm Al-Udayn																
School Year/Grade	1999/200		G/B Ratio	2000/2001		G/B Ratio	2001/2002		G/B Ratio	2002/2003		G/B Ratio	2003/2004		G/B Ratio	
	Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls					
1st Grade	956	669	0.699791	1310	865	0.660305	1450	1097	0.756552	1483	1276	0.860418	1620	1318	0.81358	
2nd Grade	855	514	0.60117	1090	695	0.637615	1420	1007	0.709155	1368	1042	0.761696	1438	1141	0.793463	
3rd Grade	899	476	0.529477	941	602	0.639745	1360	893	0.656618	1406	941	0.669275	1414	1124	0.794908	
4th Grade	777	348	0.447876	978	520	0.531697	1147	743	0.647777	1255	813	0.647809	1407	935	0.664534	
5th Grade	672	230	0.342262	791	314	0.396966	1187	621	0.523168	1113	671	0.602875	1175	781	0.664681	
6th Grade	596	160	0.268456	644	201	0.312112	973	410	0.421377	1052	529	0.502852	999	582	0.582583	
Total	4755	2397	0.504101	5754	3197	0.555613	7537	4771	0.63301	7677	5272	0.686727	8053	5881	0.730287	
Fara'a Al-Udayn																
School Year/Grade	1999/200		G/B Ratio	2000/2001		G/B Ratio	2001/2002		G/B Ratio	2002/2003		G/B Ratio	2003/2004		G/B Ratio	
	Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls					
1st Grade	1440	954	0.6625	1670	940	0.562874	1843	1278	0.693435	1842	1338	0.726384	2063	2791	1.352884	
2nd Grade	1329	843	0.634312	1429	844	0.590623	1669	1007	0.603355	1759	1163	0.661171	1741	1346	0.773119	
3rd Grade	1409	548	0.388928	1355	777	0.573432	1496	869	0.580882	1626	962	0.591636	1392	1182	0.849138	
4th Grade	1126	389	0.345471	1341	531	0.395973	1383	762	0.550976	1457	859	0.589568	1536	924	0.601563	
5th Grade	1073	262	0.244175	1098	349	0.317851	1330	516	0.38797	1230	624	0.507317	1383	777	0.561822	
6th Grade	869	232	0.266974	923	215	0.232936	1033	349	0.337851	1162	459	0.395009	1133	609	0.537511	
Total	7246	3228	0.445487	7816	3656	0.467758	8754	4781	0.54615	9076	5405	0.595527	9248	7629	0.824935	

Munira															
School Year/Grade	2000/2001		G/B Ratio	2001/2002		G/B Ratio	2002/2003		G/B Ratio	2003/2004		G/B Ratio	2004/2005		G/B Ratio
	Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls	
1st Grade	N/A			499	761	1.52505	600	504	0.84	657	732	1.114155	658	1004	1.525836
2nd Grade				487	765	1.570842	526	618	1.174905	503	459	0.912525	559	883	1.579606
3rd Grade				410	788	1.921951	510	606	1.188235	501	577	1.151697	533	478	0.896811
4th Grade				378	629	1.664021	399	551	1.380952	444	627	1.412162	390	550	1.410256
5th Grade				338	472	1.39645	351	407	1.159544	322	466	1.447205	341	542	1.589443
6th Grade				222	172	0.774775	264	297	1.125	282	296	1.049645	282	382	1.35461
Total	0	0		2334	3587	1.536847	2650	2983	1.12566	2709	3157	1.165375	2763	3839	1.389432
Dahi															
School Year/Grade	2000/2001		G/B Ratio	2001/2002		G/B Ratio	2002/2003		G/B Ratio	2003/2004		G/B Ratio	2004/2005		G/B Ratio
	Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls	
1st Grade	N/A			661	483	0.730711	741	537	0.724696	729	1161	1.592593	788	1080	1.370558
2nd Grade				604	497	0.822848	557	421	0.755835	611	602	0.98527	620	808	1.303226
3rd Grade				607	488	0.803954	571	440	0.770578	594	461	0.776094	609	544	0.893268
4th Grade				491	452	0.92057	472	432	0.915254	507	396	0.781065	518	394	0.760618
				454	411	0.905286	404	367	0.908416	374	365	0.975936	349	329	0.942693
5th Grade 6th Grade				270	174	0.644444	315	293	0.930159	281	294	1.046263	346	306	0.884393
Total	0	0		3087	2505	0.811467	3060	2490	0.813725	3096	3279	1.059109	3230	3461	1.071517
Al-Mighlaf															
School Year/Grade	2000/2001		G/B Ratio	2001/2002		G/B Ratio	2002/2003		G/B Ratio	2003/2004		G/B Ratio	2004/2005		G/B Ratio
	Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls	
1st Grade	N/A			585	574	0.981197	600	504	0.84	483	473	0.979296	658	365	0.554711
2nd Grade				452	498	1.10177	526	618	1.174905	349	282	0.808023	364	298	0.818681
3rd Grade				432	441	1.020833	510	606	1.188235	338	214	0.633136	329	259	0.787234
4th Grade				384	295	0.768229	399	551	1.380952	297	227	0.76431	293	152	0.518771
5th Grade				218	203	0.931193	351	407	1.159544	245	134	0.546939	191	175	0.91623
6th Grade				159	55	0.345912	264	297	1.125	193	117	0.606218	162	63	0.388889
Total	0	0		2230	2066	0.926457	2650	2983	1.12566	1905	1447	0.75958	1997	1312	0.656985

Qanawis																			
School Year/Grade	2000/2001		G/B Ratio	2001/2002		G/B Ratio	2002/2003		G/B Ratio	2003/2004		G/B Ratio	2004/2005		G/B Ratio				
	Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls		
1st Grade	N/A			1574	1527	0.97014	1516	1095	0.722296	1598	1284	0.803504	1633	1336	0.818126				
2nd Grade				1168	1131	0.968322	1356	903	0.665929	1271	881	0.693155	1272	950	0.746855				
3rd Grade				991	904	0.91221	1059	832	0.785647	1216	784	0.644737	1129	723	0.64039				
4th Grade				913	701	0.767798	913	604	0.661555	1060	693	0.653774	1110	570	0.513514				
5th Grade				750	489	0.652	888	290	0.326577	818	350	0.427873	819	499	0.60928				
6th Grade				541	434	0.802218	597	303	0.507538	622	272	0.437299	612	296	0.48366				
Total	0	0		5937	5186	0.873505	6329	4027	0.636277	6585	4264	0.647532	6575	4374	0.665247				
Zaidia																			
School Year/Grade	2000/2001		G/B Ratio	2001/2002		G/B Ratio	2002/2003		G/B Ratio	2003/2004		G/B Ratio	2004/2005		G/B Ratio				
	Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls		
1st Grade	N/A			1805	1199	0.664266	1458	1149	0.788066	1676	1215	0.72494	1794	1334	0.74359				
2nd Grade				1413	955	0.675867	1334	857	0.642429	1355	1149	0.84797	1389	1017	0.732181				
3rd Grade				1291	993	0.769171	1177	823	0.699235	1423	854	0.600141	1337	901	0.673897				
4th Grade				1230	681	0.553659	982	790	0.804481	1112	750	0.67446	1249	792	0.634107				
5th Grade				1038	650	0.626204	371	499	1.345013	487	607	1.246407	980	596	0.608163				
6th Grade				853	472	0.553341	678	500	0.737463	781	461	0.590269	796	487	0.611809				
Total	0	0		7630	4950	0.648755	6000	4618	0.769667	6834	5036	0.736904	7545	5127	0.679523				
Al-Milah																			
School Year/Grade	1999/2000		G/B Ratio	2000/2001		G/B Ratio	2001/2002		G/B Ratio	2002/2003		G/B Ratio	2003/2004		G/B Ratio	2004/2005		G/B Ratio	
	Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls		Boys
1st Grade	462	333	0.720779	498	361	0.7249	509	399	0.78389	462	333	0.720779	708	643	0.908192	511	607	1.187867	
2nd Grade	409	266	0.650367	494	306	0.619433	466	290	0.622318	409	266	0.650367	484	415	0.857438	456	664	1.45614	
3rd Grade	157	200	1.273885	391	191	0.488491	519	294	0.566474	157	200	1.273885	502	309	0.615538	402	392	0.975124	
4th Grade	407	164	0.402948	490	170	0.346939	404	185	0.457921	407	164	0.402948	438	263	0.600457	460	315	0.684783	
5th Grade	373	132	0.353887	413	160	0.387409	466	169	0.362661	373	132	0.353887	427	253	0.592506	396	241	0.608586	
6th Grade	353	110	0.311615	356	97	0.272472	373	168	0.450402	353	110	0.311615	373	147	0.394102	396	223	0.563131	
Total	1808	1095	0.605642	2286	1188	0.519685	2364	1337	0.565567	1808	1095	0.605642	2932	2030	0.69236	2225	2219	0.997303	

Tor Al-Baha																		
School Year/Grade	1999/2000		G/B Ratio	2000/2001		G/B Ratio	2001/2002		G/B Ratio	2002/2003		G/B Ratio	2003/2004		G/B Ratio	2004/2005		G/B Ratio
	Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls	
1st Grade	920	903	0.981522	1000	1056	1.056	983	954	0.970498	1105	1008	0.912217	1196	1258	1.051839	1290	667	0.517054
2nd Grade	847	629	0.742621	864	727	0.841435	917	894	0.974918	876	830	0.947489	1094	988	0.903108	1214	1083	0.892092
3rd Grade	912	655	0.718202	831	644	0.77497	819	697	0.851038	905	821	0.907182	939	845	0.899894	882	682	0.773243
4th Grade	696	340	0.488506	875	554	0.633143	878	579	0.659453	821	604	0.735688	927	757	0.816613	858	725	0.844988
5th Grade	638	260	0.407524	816	335	0.410539	869	513	0.590334	867	596	0.687428	849	598	0.704358	877	652	0.743444
6th Grade	625	258	0.4128	601	247	0.410982	707	338	0.478076	798	519	0.650376	844	533	0.631517	798	522	0.654135
Total	4013	2787	0.694493	4386	3316	0.756042	4466	3637	0.814375	4574	3859	0.843682	5849	4979	0.851257	5983	4443	0.517054
Al-Madarabah																		
School Year/Grade	1999/2000		G/B Ratio	2000/2001		G/B Ratio	2001/2002		G/B Ratio	2002/2003		G/B Ratio	2003/2004		G/B Ratio	2004/2005		G/B Ratio
	Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls		Boys	Girls	
1st Grade	657	401	0.61035	242	444	1.834711	890	507	0.569663	657	401	0.61035	1030	1002	0.972816	31	37	1.193548
2nd Grade	649	228	0.35131	654	307	0.469419	693	315	0.454545	649	228	0.35131	754	523	0.693634	782	833	1.065217
3rd Grade	584	209	0.357877	632	215	0.34019	565	282	0.499115	584	209	0.357877	773	327	0.423027	637	479	0.751962
4th Grade	531	96	0.180791	595	165	0.277311	569	200	0.351494	531	96	0.180791	601	244	0.40599	679	335	0.493373
5th Grade	472	79	0.167373	536	96	0.179104	486	135	0.277778	472	79	0.167373	614	242	0.394137	622	286	0.459807
6th Grade	433	52	0.120092	409	63	0.154034	468	67	0.143162	433	52	0.120092	470	159	0.338298	442	223	0.504525
Total	2893	1013	0.350156	2659	1227	0.461452	3203	1439	0.449266	2893	1013	0.350156	3772	2338	0.61983	3193	2193	0.686815

Source: UNICEF Yemen Country Office

Annex 10 Health Data of 11 CDP Districts in 3 Governorates

Project	Ibb	Lahej	Hodeidah
Safe motherhood /EmOC			
• No of districts covered	3	1	3
• No of CMWs trained	25	25	60
• No. of TBAs trained (training on clean delivery)	50	0	0
• No of delivery kits distributed	ND	0	0
• No. of volunteers trained	0	0	0
• No. of EmOC centers rehabilitated and equipped and staff trained	3	2	1
• No. of ante-natal visits (new visits plus revisits)	6,864** (see table below)	407 new + 835 revisits (Jul-Dec 2004)	ND
IMCI			
• Proportion of HFs with IMCI trained staff and materials	44 of 49 facilities + 21% of governorate staff	95% of facilities +19% of governorate staff	85 of facilities + 36% of governorate staff
• Regularity of supplies of IMCI drugs (planned)	Every 6 months *	Every 6 months *	Every 6 mths*
• No. of diarrhea corners set up***	Total 92 in 19 (not 3!) districts (39 of them in HUs)	I all HCs of 3 districts + 1 hospital	ND
• No. of patients seen per month	See table below	10,551**	ND
• No. of volunteers trained	56	58	118
• No. of volunteers currently still active	26	58	71
• No. of supervisory rounds carried out since training was completed.	1 by central team and 2 by governorate/district team	ND	ND

Project	Ibb	Lahej	Hodeidah
Construction			
<ul style="list-style-type: none"> No. of new facilities planned 	Al-Udayn: 1 Faraa Fal-Udayn: 1 Hazm Al-Udayn: 1	Al-Melah: 2 Tor Al-Baha: 2 Al-Madaraba: 2	Munira: 1 Mighlaf: 1 Qanawis: 2 Zaidiya: 1
<ul style="list-style-type: none"> No. of facilities built and operational 	Al-Udayn: 1 Faraa Fal-Udayn: 1 Hazm Al-Udayn: 1	Al-Melah: 1 Tor Al-Baha: 1 Al-Madaraba: 2	Munira: 1 Mighlaf: 1 Qanawis: 2 Zaidiya: 1
<ul style="list-style-type: none"> No. of them built and still not operational 	0	2	0
<ul style="list-style-type: none"> No. with work in progress 	0	Al-Melah: 1	0
<ul style="list-style-type: none"> Upgrading of facilities 	Al-Udayn: 3 Faraa Fal-Udayn: 1 Hazm Al-Udayn: 1	6 (2 in each district)	Munira: 1 Mighlaf: 1 Qanawis: 1 Zaidiya: 1
<ul style="list-style-type: none"> No. of facilities with upgrading completed 	Al-Udayn: 3 Faraa Fal-Udayn: 1 Hazm Al-Udayn: 1	6	Munira: 1 Mighlaf: 1 Qanawis: 1 Zaidiya: 1
EPI 2004	DPT3 %	Measles %	TT2+ %
Ibb			
<ul style="list-style-type: none"> Al dayn 	44	42	5
<ul style="list-style-type: none"> Fara-Al Udayn 	51	71	17
<ul style="list-style-type: none"> Hazm-Al Udayn 	59	80	17
Lahej	83 (average 3 distr)	74 (av 3 distr)	16 (av 3 dist)
Hodeidah			
<ul style="list-style-type: none"> Al-Munirah 	77	56	5
<ul style="list-style-type: none"> Al-Zaidiah 	57	67	19
<ul style="list-style-type: none"> Al-Kanawes 	48	72	8
<ul style="list-style-type: none"> Al-Dhahi 	47	42	17

Project	Ibb	Lahej	Hodeidah
• Al-Meghlaf	55	47	21
Nutrition		(not CBN)	
• % uzlas covered in each district	See table below	Al Madarabah 60% Al Milah 45%	ND
• No of scales + growth charts distributed from the central level	ND	ND	ND
• No of children weighed	6,599 (July-Dec 2004)	ND	5,052 (Jan-Nov 2004)
• % children falling in the red area	40% (see tables below)	ND	37%
Health facilities committees			
• No of committees formed****	49 (in 3 districts)		67

Notes:

ND: No Data available

* IMCI drugs are supposed to be delivered to governorates bi-annually, but delays in the PCU procurement have resulted in only the first and second deliveries having been completed and, now, a six to nine months hiatus in the availability of these drugs has seriously hampered implementing the IMCI sub-component. (exception is made for ORS which have been available throughout).

** Monthly numbers fluctuate quite widely.

*** These corners have not always been set up formally with new chairs for the mothers and new utensils to prepare ORT. But mothers do stay at the facility to start rehydrating their infants under observation until they are well enough to leave.

**** None yet trained, none yet active.

ADDITIONAL DATA FOR GOVERNORATE OF IBB (BY DISTRICT) (Al-Udayn, Fara'a Al-Udayn and Hazm Al-Udayn)

Safe Motherhood/EmOC:

No. of EmOC centers rehabilitated, equipped and staff trained: 3 EmOC Centers were rehabilitated: 2 referral Hospital at the Governorate level (Al-Thawra and Nasir hospitals) and 1 District hospital (Al-Udayn hospital).
Total No. of antenatal care visits July-December 2004: 6,864 Al-Udayn: 2512 Fara'a Al-Udayn: 958 Hazm Al-Udayn: 1502 Ibb District (Al-Thawra): 553 Ibb District (Nasir): 1339

IMCI:

Proportion of facilities that now have IMCI trained staff and materials: 44 of 49 (90%) Al-Udayn: 15 out of 15 = 100% Fara'a Al-Udayn: 15 out of 18 = 83% Hazm Al-Udayn: 14 out of 16 = 88%
Regularity of supplies of IMCI drugs since training was completed (or number of months each districts have been with less than full supply): Drugs have been replenished twice only since distribution took place in 2003. Now 6 months with no stocks. ORS have been available at all times.
No. of diarrhea corners set up: (see *** above) 53 centers and hospitals set up ORT corners 39 Health Units also set up ORT corners Total 92 corners set up were distributed to 19 districts across Ibb Governorate.
No. of IMCI patients seen per month: <u>monthly average</u> during 3 previous months Jan-March 2005 (over a total of 2012 visits for the 3 districts: 900 girls and 1112 boys). Al-Udayn: 138 Fara'a Al-Udayn: 261 Hazm Al-Udayn: 270 * Please note that many reports are still to come after the compilation of this report.
No of volunteers trained to do the home visits: Total 56 Al-Udayn: 17

Fara'a Al-Udayn: 20 Hazm Al-Udayn: 19
Percentage of trained volunteers currently active: Average is 2/3. Al-Udayn: 11 out of 17 = 64% Fara'a Al-Udayn: 13 out of 20 = 65% Hazm Al-Udayn: 12 out of 19 = 63%

Nutrition:

Percentage of uzlas covered in each district: Al-Udayn: 2 uzlas out of 22 uzlas = 10% Fara'a Al-Udayn: 10 uzlas out of 10 uzlas = 100% (only certain village in uzla) Hazm Al-Udayn: 1 uzla out of 21 uzlas = 5%
No. of children being weighed: July to December 2004: Total 3 districts: 6,599 Al-Udayn: 1635 Fara'a Al-Udayn: 3855 Hazm Al-Udayn: 1109 See table below for monthly data including those falling in the red area (40%)
Iron supplements and Vitamin A capsules supplied?: Yes and distributed centrally

Data being aggregated by district for No. of children in the Red area July-Dec 2004								
District/month	July	August	September	October	November	December		Total
Al-Udayn	?	?	?	?	?	?		367
Fara'a Al-Udayn	177	360	368	376	441	97		1819
Hazm Al-Udayn	170	121	66	56	27	49		489
Total								2,675 (40%)

Data being aggregated by district for No. of weighted children in Green area July to December 2004								
District/month	July	August	September	October	November	December		Total
Al-Udayn	93	249	229	176	254	267		1268
Fara'a Al-Udayn	274	411	449	327	408	167		2036
Hazm Al-Udayn	164	147	108	86	52	63		620
Total (green area)								3,924
Total weighed								6,599

EmOC	Data being aggregated by district for No. of antenatal care visits July-Dec 2004							
District		New	repeated visit					Total
Al-Udayn		1013	1499					2512
Fara'a Al-Udayn		496	462					958
Hazm Al-Udayn		563	939					1502
Ibb District (Al-Thawra)		308	245					553
Ibb district (Nasir)		723	616					1339
Total								6,864

Source: UNICEF Yemen Country Office

Annex 11 Construction & Rehabilitation of Schools Summary Sheet**Community Schools** Plan for 2005**Number of Classrooms to be Completed, by Governorate and by District**

Governor.	District	CONSTRUCTION					REHABILITATION				Class to be Furnished		
		2003, initiated	2004 initiated	2004 not initiated	2005 additional	Total	2003, initiated	2004 initiated	2004 not initiated	Total	Constr. 2004, 2005	Rehab 2004 (Lahej only)	Total
IBB	Hazm Al-Udayn			6	3	9			6	6	9		9
	Fara Al-Udayn			6	3	9			6	6	9		9
	Al-Udayn			4		4			6	6	4		4
Sub-Total Ibb		0	0	16	6	22	0	0	18	18	22		22
ABYAN	Lawdar			3		3		12	0	12	3		3
	Rusud			3		3		12	0	12	3		3
	Sabah			5		5			6	6	5		5
	Sarar			5		5			6	6	5		5
Sub-Total Abyan		0	0	16	0	16	0	24	12	36	16		16

Community Schools

Plan for 2005

Number of Classrooms to be Completed, by Governorate and by District

		CONSTRUCTION					REHABILITATION				Class to be Furnished		
HODEIDAH	Munira			5		5			12	12	5		5
	Dhahi			10		10			24	24	10		10
	Al-Mighlaf			10		10			12	12	10		10
	Qanawis			6		6			6	6	6		6
	Zaydiya			4		4			12	12	4		4
Sub-Total Hodeidah		0	0	35	0	35	0	0	66	66	35		35
HAJJA	Bakil Al-Mir			12		12			0	0	12		12
	Mustaba			12	3	15			0	0	15		15
	Aslam			12	3	15			0	0	15		15
Sub-Total Hajja		0	0	36	6	42	0	0	0	0	42		42
SANA'A	Hamdan	3		12	3	18	0		6	6	15		15
	Sanhan & Bani Bahlul			12	6	18			12	12	18		18
	Bani Matar			10	3	13			6	6	13		13
	Hayma Al-Dakhiliya	13		10	3	26	6		6	12	13		13
Sub-Total Sana'a		16	0	44	15	75	6	0	30	36	59		59
LAHEJ	Al-Milah			8	3	11			6	6	11	6	17
	Tor Al-Baha			10	3	13			6	6	13	6	19
	Al-Madaraba			6	3	9			6	6	9	6	15
Sub-Total Lahej		0	0	24	9	33	0	0	18	18	33	18	51

Community Schools

Plan for 2005

Number of Classrooms to be Completed, by Governorate and by District

		CONSTRUCTION					REHABILITATION				Class to be Furnished		
MAHRA	Al-Ghaydah		3	3	3	9		0	0	0	9		9
	Hasween		8	2	3	13		0	0	0	13		13
Sub-Total Mahra		0	11	5	6	22	0	0	0	0	22		22
AMRAN	Jabal Iyal Yazid			10	3	13			6	6	13		13
	Iyal Surayh			10	3	13			6	6	13		13
	Khamer & Bani Sureym			12	6	18			12	12	18		18
Sub-Total Amran		0	0	32	12	44	0	0	24	24	44		44
DHALE	Qataba			10	2	12		15	0	15	12		12
	Al-Azareq			10	2	12		17	0	17	12		12
	Al-Husha			10	2	12		16	0	16	12		12
Sub-Total Dhale		0	0	30	6	36	0	48	0	48	36		36
GRAND TOTAL		16	11	238	60	325	6	72	168	246	309	18	327

Source: UNICEF Yemen Country Office

Annex 12 Construction Health Units

Requisition Reference	Issue Dt	Amount	Obligation Reference	Description	Health Unit Name	Progress of work	Comments	Gov.	No R	No.C
PGM/YEMA/2002/00000010-0	12-Feb-02	48,170.07		Rehabilitation of 2HUs & 2 HCs in Hodidah	ImSORAH- Lawdar (HC)	100% complete	warranty period finished	Abian	1	
					Al-Rakb Hutat Serar (HC)	100% complete	warranty period finished	Abian	2	
					Hamoma Serar	100% complete	warranty period finished	Abian	3	
					Al-Gafria Lawdar	100% complete	warranty period finished	Abian	4	
					Dhaba Rusud	100% complete	warranty period finished	Abian	5	
PGM/YEMA/2002/00000027-1	15-Apr-02	66,717.03	POX/YEMA/2002/00000042-1	Rehabilitation of 3 HUs & 2 HCs in Abyan	ImSORAH- Lawdar (HC)	100% complete	warranty period is over	Abian	6	
					Al-Rakb Hutat Serar (HC)	95% complete	Still some finishing work to be done	Abian	7	
					Hamoma Serar	100% complete	warranty period is over	Abian	8	
					Al-Gafria Lawdar	100% complete	warranty period is over	Abian	9	
					Dhaba Rusud	100% complete	warranty period is over	Abian	10	
PGM/YEMA/2002/00000028-0	15-Apr-02	70,591.57	POX/YEMA/2002/00000043-0	Rehabilitation of 2 HUs and 3 HCs in lbb	Bani Abdllah- Al-Udain	100% complete	warranty period is over	lbb	11	
					Al-Jobjob -Hazm Al-Udain	100% complete	warranty period is over	lbb	12	
					Bani Awad -Al-Udain (HC)	100% complete	warranty period is over	lbb	13	
					Al-Amarnah - Al-Udain (HC)	100% complete	warranty period is over	lbb	14	
					Bani Yousef Fara'a Al-Udian (HC)	100% complete	warranty period is over	lbb	15	
PGM/YEMA/2002/00000063-1	23-Jul-02	33,695.34	POX/YEMA/2002/00000073-0	Rehabilitation of three EmOC referral hospitals, lbb	Al-Udain EMOC	100% complete	warranty period is over	lbb		
	23-Jul-02		POX/YEMA/2002/00000074-1	Rehabilitation of three EmOC referral hospitals, lbb	Nasser EMOC	100% complete	warranty period is over	lbb		
	23-Jul-02		POX/YEMA/2002/00000075-0	Rehabilitation of three EmOC referral hospitals, lbb	Al-Thawra EMOC	100% complete	warranty period is over	lbb		

Requisition Reference	Issue Dt	Amount	Obligation Reference	Description	Health Unit Name	Progress of work	Comments	Gov.	No R	No.C
PGM/YEMA/2002/00000077-0	06-Aug-02	111,878.70	POX/YEMA/2002/00000089-0	Construction of 5 health units in Hodeidah	Khofan- Al-Muneerah	100% complete	warranty period is over	Hodidah		1
					Bait Atta -Al-Zaidyah	100% complete	warranty period is over	Hodidah		2
					Dir Kazaba - Al-Qanawes	100% complete	warranty period is over	Hodidah		3
					Dir Assadr - Al-Qanawes	100% complete	warranty period is over	Hodidah		4
					Al-Shaqba -Al-Mighlaf	100% complete	warranty period is over	Hodidah		5
PGM/YEMA/2002/00000078-0	06-Aug-02	74,919.66	POX/YEMA/2002/00000091-0	Construction of 3 health units in lbb	Bani Zuhair - Odain	100% complete	warranty period is over	lbb		6
					Al-Ahmoul - Fara'a	100% complete	warranty period is over	lbb		7
					Al-Odain	100% complete	warranty period is over	lbb		8
PGM/YEMA/2002/00000079-0	06-Aug-02	25,120.00	POX/YEMA/2002/00000090-0	Construction of health unit in Abyan	Amsha'a - Lawdar	100% complete	warranty period is over	Abian		9
PGM/YEMA/2003/00000137-1	29-Jul-03	131,001.00	POX/YEMA/2003/00000243-0	CDP-06-A Renov of EmOC referral hospitals in Lahj & Abyan	Toor Al-Baha	100% complete	warranty period is over	Lahj		
	29-Jul-03		POX/YEMA/2003/00000240-1	CDP-06-A Renov of EmOC referral hospitals in Lahj & Abyan	Al-Razi -Zongobar	100% complete	warranty period is over	Abian		
	29-Jul-03		POX/YEMA/2003/00000241-0	CDP-06-A Renov of EmOC referral hospitals in Lahj & Abyan	Ebn Khaldoun- Al-Hwta	95% complete	Still some finishing work to be done	Lahj		
	29-Jul-03		POX/YEMA/2003/00000244-0	CDP-06-A Renov of EmOC referral hospitals in Lahj & Abyan	Mahnaf - Lawdar	100% complete	warranty period is over	Abian		
PGM/YEMA/2003/00000214-0	16-Dec-03	310,533.00	POX/YEMA/2003/00000310-0	Construction of HUs in the new CDP districts (2003)(CDP-03-A	Al-Aros	100% complete	warranty period is over	Sana'a		10
					Bait Ghalea'a	100% complete	warranty period is over	Sana'a		11
			POX/YEMA/2003/00000308-0	Construction of HUs in the new CDP districts (2003)(CDP-03-A	Al-Farawat	100% complete	warranty period is over	Sana'a		12
					Bani Basheer	100% complete		Sana'a		13
					Sarfa & Daga	100% complete	warranty period is over	Sana'a		14
					Bait Noum	100% complete	warranty period is over	Sana'a		15

Requisition Reference	Issue Dt	Amount	Obligation Reference	Description	Health Unit Name	Progress of work	Comments	Gov.	No R	No.C
			POX/YEMA/2003/00000312-0	Construction of HUs in the new CDP districts (2003)(CDP-03-A	Al-Makhad	100% complete	warranty period is over	Amran		16
			POX/YEMA/2003/00000309-0	Construction of HUs in the new CDP districts (2003)(CDP-03-A	Al-Haet	100% complete	warranty period is over	Amran		17
					AL-Dhamari	100% complete	warranty period is over	Amran		18
					Khiran	100% complete	Still some finishing work to be done	Sana'a		19
					Bani Abd	95% complete	Still some finishing work to be done	Amran		20
PGM/YEMA/2003/00000215-0	16-Dec-03	8,088.00	POX/YEMA/2003/00000313-0	Additional work to Al-Razi Hospital (EmOC) (CDP-06-A)	Al-Razi -Zongobar	100% complete	warranty period is over	Abian		
PGM/YEMA/2004/00000020&22	02-Mar-04	30,253.00	PO/YEMA/2004/00000074-0	Constuction of Health Unit in Al-Sabeel, AIMudaharebah, Lahj	Al-Sabeel, AIMudaharebah	100% complete	under warranty period	Lahaj		21
PGM/YEMA/2004/00000021&23	02-Mar-04	30,253.00	PO/YEMA/2004/00000072-0	Constuction of Health Unit in Al-Qadhi, Tour Albaha, Lahj Go	Al-Qadhi, Tour Albaha	100% complete	under warranty period	Lahaj		22
			PO/YEMA/2004/00000073-0	Constuction of Health Unit in AlQadhi, Tour Albaha, Lahj Go						
PGM/YEMA/2004/00000024&25	02-Mar-04	29,334.00	PO/YEMA/2004/00000068-0	Constuction of HF AIMegazaa,AIMelah,Lahaj	AIMegazaa,AIMelah	100% complete	under warranty period	Lahaj		23
			PO/YEMA/2004/00000069-0	Constuction of HF AIMegazaa,AIMelah,Lahaj						
PGM/YEMA/2004/00000026&27	02-Mar-04	33,388.00	PO/YEMA/2004/00000164-0	Constuction of HF AISoreisera, AlAzariq, Dhale	AlSoreisera, AlAzariq	95% complete	Still some finishing work to be done	Dhale'e		24
			PO/YEMA/2004/00000165-0	Constuction of HF AISoreisera,AlAzariq,Dhale10%Gov						
PGM/YEMA/2004/00000028&29	02-Mar-04	36,926.00	PO/YEMA/2004/00000172-0	Constuction of HF AlRabba,Qa'tabba, Dhale90%IDA	AlRabba,Qa'tabba	100% complete	under warranty period	Dhale'e		25
			PO/YEMA/2004/00000173-0	Constuction of HF AlRabba,Qa'tabba,Dhale10%Gov.con						
PGM/YEMA/2004/00000030&31	02-Mar-04	36,906.00	PO/YEMA/2004/00000170-0	Constuction of HF Almeswala,AlHasha,Dhale90%IDA	Almeswala,AlHasha	100% complete	under warranty period	Dhale'e		26
			PO/YEMA/2004/00000171-0	Constuction of HF Almeswala,AlHasha,Dhale10%Gov						
PGM/YEMA/2004/00000034&35	08-Mar-04	29,561.00	PO/YEMA/2004/00000038-2	Constuction of HF in Dar Al-Dawla in Almelah Muderiate in La	Dar Al-Dawla in Almelah	100% complete	under warranty period	Lahij		27
			PO/YEMA/2004/00000039-0	Constuction of HF Dar Al-Dawla in Almelah Muderiate in Lahej						
PGM/YEMA/2004/00000036&37	08-Mar-04	33,000.00	PO/YEMA/2004/00000016-0	Construction of HF Al-Said/Bait Al-Khataby 90% IDA	Al-Said/Bait Al-Khataby	95% complete	Still some finishing work to be done	Sana'a		28
			PO/YEMA/2004/00000015-0	Construction of HF Al-Said/Bait Al-Khataby 10%Gov						

Requisition Reference	Issue Dt	Amount	Obligation Reference	Description	Health Unit Name	Progress of work	Comments	Gov.	No R	No.C
PGM/YEMA/2004/00000038&39	08-Mar-04	30,000.00	PO/YEMA/2004/00000018-0 PO/YEMA/2004/00000019-0	Construction of HF Belad Al-Kabail 90% IDA Construction of HF Belad Al-Kabail 10%Gov	Belad Al-Kabail	50% complete	Roof is under construction-work in progress	Sana'a		29
PGM/YEMA/2004/00000048&39	12-Apr-04	34,635.00	PO/YEMA/2004/00000091-0 PO/YEMA/2004/00000092-0	Construction of HU Madrik in Al-Mahra Governorate - 90% IDA Constuction of HU Madrik in Al-Al-Mahra Governorate - 10% go	Madrik	95% complete	Still some finishing work to be done	Mahra		30
PGM/YEMA/2004/00000050&51	12-Apr-04	13,183.00	PO/YEMA/2004/00000089-0 PO/YEMA/2004/00000090-0	Rehabilitation of HU Yaroub in Al-Mahra Govdernorate - 90% Rehabilitation of HU Yaroub in al-Mahra Governorate - 10%gov	Yaroub	100% complete	under warranty period	Mahra	16	
PGM/YEMA/2004/00000052&53	12-Apr-04	8,063.00	PO/YEMA/2004/00000093-0 PO/YEMA/2004/00000094-0	Rehabilitation of HU Mohaifeef in Al-Mahra Governorate - 90% Rehabilitation of HU Mohaifeef in Al-Mahra Governorate - 10%	Mohaifeef	100% complete	under warranty period	Mahra	17	
PGM/YEMA/2004/00000012&17	25-Feb-04	27,200.00	PO/YEMA/2004/00000071-0 PO/YEMA/2004/00000070-0	Constuction of Health Unit in Nakhlain, AIMelah, Lahaj Gover Constuction of Health Unit in Nakhlain, AIMelah, Lahaj Gover	Nakhlain, AIMelah	95% complete	Still some finishing work to be done	Lahaj		31
PGM/YEMA/2004/00000118&119	09-Jun-04	29,879.00	PO/YEMA/2004/00000132-0 PO/YEMA/2004/00000133-0	Construction of HF Yashee 90% IDA (CDP-03-A) Construction of HF Yashee 10% gov. contribution	Yashee	100% complete	under warranty period	Amran		32
PGM/YEMA/2004/00000120&121	09-Jun-04	30,929.00	PO/YEMA/2004/00000126-0 PO/YEMA/2004/00000122-0	Construction of HF Al-Miqa'a-AMRAN Construction of HF Al-Miqa'a10%gov.contribution	Al-Miqa'a	100% complete	under warranty period	Amran		33
PGM/YEMA/2004/00000122&123	09-Jun-04	26,700.00	PO/YEMA/2004/00000123-0 PO/YEMA/2004/00000124-1	Construction HF at Dhula/Allao 90% IDA Construction of HF at Dhula'a/Allao-Sana'a 10% gov	Dhula/Allao	100% complete	under warranty period	Sana'a		34
PGM/YEMA/2004/00000124&125	09-Jun-04	30,240.00	PO/YEMA/2004/00000130-0 PO/YEMA/2004/00000131-0	Construction of HF at Wda'a-Amran 90% IDA Construction of HF at Wda'a-Amran 10% gov	Wda'a	100% complete	under warranty period	Amran		35
PGM/YEMA/2004/00000138&139	03-Jul-04	35,871.00	PO/YEMA/2004/00000179-0 PO/YEMA/2004/00000180-0	Construction of Al Khadira HF in Abian 10% Gov. Constr. of HF Al Khadira in Abian 90% IDA contr. CDP-03-A	Al Khadira	100% complete	under warranty period	Abian		36
PGM/YEMA/2004/00000140&141	03-Jul-04	12,924.00	PO/YEMA/2004/00000156-0 PO/YEMA/2004/00000157-0	Construction of HF Al-Safa in Abian 10%gov. contr. CDP-03-A Construction of HF Al-Safa in Abian 90%IDA. contr. CDP-03-A	Al-Safa	0% complete	Problems with local communities	Abain		
PGM/YEMA/2004/00000142&143	03-Jul-04	18,151.00	PO/YEMA/2004/00000158-0 PO/YEMA/2004/00000159-0	Construction of HF Moquaifa in Abian 10% gov. contr. CDP-03- Construction of HF Moquaifa in Abian 90% IDA contr. CDP-03-	Moquaifa	100% complete	under warranty period	Abain		37

Requisition Reference	Issue Dt	Amount	Obligation Reference	Description	Health Unit Name	Progress of work	Comments	Gov.	No R	No.C
PGM/YEMA/2004/00000144&145	03-Jul-04	32,482.00	PO/YEMA/2004/00000176-0 PO/YEMA/2004/00000177-0	Construction of HF Sarar-Amsedrah in Abian 10% gov.contr. Construction of HF Sarar-Amsedrah in Abian 90% IDA contr.	Sarar-Amsedrah	80% complete	Still some finishing work to be done	Abain		38
PGM/YEMA/2004/00000146&147	03-Jul-04	25,692.00	PO/YEMA/2004/00000160-0 PO/YEMA/2004/00000161-0	Construction of HF Hadaq 10% gov. contribution Construction of HF Hadaq Abian 90% IDA contribution	Hadaq - Sabah	0% complete	Problems with local communities	Abain		
PGM/YEMA/2004/00000174&175	07-Jul-04	29,486.00	PO/YEMA/2004/00000202-0 PO/YEMA/2004/00000203-0	Construction HF Bani Amer Construction HF Bani Amar in Hajja 10%Gov.	Bani Amer	100% complete	under warranty period	Hajja		39
PGM/YEMA/2004/00000176&177	10-Jul-04	34,445.00	PO/YEMA/2004/00000204-0 PO/YEMA/2004/00000205-0	Constr. of HF Sabran in Hajja 90% IDA Constr. of HF Sabranin Hajja 10% gov.	Sabran	100% complete	under warranty period	Hajja		40
PGM/YEMA/2004/00000178&179	07-Jul-04	30,663.00	PO/YEMA/2004/00000209-0 PO/YEMA/2004/00000210-0	Constr. HF Al-Shafal Hajja 90% IDA Constr. HF Al-Shafal 10% gov.	Al-Shafal	100% complete	under warranty period	Hajja		41
PGM/YEMA/2004/00000180&181	01-Aug-04	28,120.00	PO/YEMA/2004/00000208-0 PO/YEMA/2004/00000199-0	Constr. HF Bakeel Al-Meer in Hajja 90% IDA Constr. HF Bakeel Al-Meer in Hajja 10% gov.	Bakeel Al-Meer	100% complete	under warranty period	Hajja		42
PGM/YEMA/2004/00000182&183	07-Jul-04	12,667.00	PO/YEMA/2004/00000200-0 PO/YEMA/2004/00000201-0	Reh. HF aslam 90% IDA Reh. HF aslamin Hajja 10% gov	aslam	100% complete	under warranty period	Hajja	18	
PGM/YEMA/2004/00000254&255	06-Oct-04	36,135.00	PO/YEMA/2004/00000298-0 PO/YEMA/2004/00000299-0	Construction of HF in Hasween 90% IDA(CDP-03-A) in Al-Mahara Construction of HF Hasween 10% (CDP-03-A) in Al-Mahara Gov.	Hasween	45% complete	Roof is under construction-work in progress	Mahra		43
PGM/YEMA/2004/00000256&257	06-Oct-04	31,603.00	PO/YEMA/2004/00000295-0 PO/YEMA/2004/00000297-0	Construction of HF Al-Fatk 90%(CDP-03-A) in Al-Mahra Gov. Construction of HF Al-Fatk 10%(CDP-03-A) in Al-Mahra Gov.	Al-Fatk	45% complete	Roof is under construction-work in progress	Mahra		44

Source: UNICEF Yemen Country Office, Supplies Officer

Annex 13 CDP Water and Sanitation Implementation 2001 to 2005

CDP WES - Updated on 7 May 2005																
Governorate	District	Sub-district	Site	Population	Type of Project	Starting Year	Overall Progress	Progress of Activities								
								Preliminary Assessment	Social Mobilization	Technical Assessment / Designs and B/Qs.	Supplies and Installation of Electro-mechanical Units	Civil Works	Capacity Building to Management Committee	Capacity Building to Operators	Sanitation Component (Hardware).	Sanitation Component (Software).
Ibb	Al-Udain	Bani Abdulla	Bani Abdulla	9,235	Motorized Gen. Set	2001	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
Ibb	Al-Hazem	Al-Gabgab	Al-Gabgab	4,664	Motorized Gen. Set	2001	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
Ibb	Al-Fari'	Bani Ahmed	Bani Ahmed	23,625	Motorized Gen. Set	2002	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
Ibb	Al-Fari'	Aquba Sullia	Qabas, halja & Dabwan	2,100	Water source protection	2004	76.57%	100.00%	100.00%	100.00%	N/A	42.56%	N/A	N/A	N/A	N/A
Hodieda	Al-Zaidia	Al-Zaidia	Bait Alta	6,717	Motorized Diesel	2001	94.44%	100.00%	100.00%	100.00%	100.00%	75.92%	100.00%	100.00%	N/A	N/A
Hodieda	Al-Zaidia	Al-Zaidia	Mahal Khalil	1,602	Motorized Diesel	2001	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
Hodieda	Al-Munira	Al-Munira	Mahal Al-Emad	2,599	Motorized Diesel	2001	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
Hodieda	Al-Qanawis	Al-Qanawis	Der Tubash	4,308	Motorized Diesel	2001	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
Hodieda	Al-Meghlaf	Al-Meghlaf	Al-Mahgam	2,310	Motorized Diesel	2001	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
Hodieda	Al-Dhahi	Al-Dhahi	Der Shwall	3,638	Motorized Diesel	2001	98.29%	100.00%	100.00%	100.00%	100.00%	92.61%	100.00%	100.00%	N/A	N/A
Hodieda	Al-Qanawis	Al-Qanawis	Al-Huzar & Al-Habel	3,119	Motorized Diesel	2001	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
Hodieda	Al-Mighlaf	Bani Mohammad	al-Muqana' wal Saqaf	7,700	Motorized Diesel	2002	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
Hodieda	Al-Munira	Rubu' al-Qaham	al-Doam wal Qushria	3,248	Motorized Diesel	2002	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
Hodieda	Al-Dhahi	Kadan	Mahal al-Sheikh	3,638	Motorized Diesel	2002	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
Hodieda	Al-Zaidia	Al-Zaidia	Al-Jareb & surrounding villages	6,398	Motorized Diesel	2004	63.25%	100.00%	100.00%	100.00%	15.43%	17.28%	100.00%	100.00%	N/A	N/A
Hodieda	Al-Munira	Al-Munira	al-Jareb, al-Jutamia & al-Msharefa villages	3,960	Motorized Diesel	2004	63.25%	100.00%	100.00%	100.00%	15.43%	17.28%	100.00%	100.00%	N/A	N/A
Lahej	Malah	Al-Lujaen	Al-Salaba	800	Motorized solar	2002	100.00%	100.00%	N/A	100.00%	100.00%	100.00%	N/A	100.00%	N/A	N/A
Lahej	Malah	Al-Lujaen	Al-Lujaen	1,328	Motorized solar	2002	100.00%	100.00%	N/A	100.00%	100.00%	100.00%	N/A	100.00%	N/A	N/A
Lahej	Malah	Al-Souk	Der Al-Ashraf	1,328	Motorized solar	2002	100.00%	100.00%	N/A	100.00%	100.00%	100.00%	N/A	100.00%	N/A	N/A
Lahej	Tor Al-Baha	Al-Sha'ab	Al-Sumalta	1,980	Motorized solar	2002	100.00%	100.00%	N/A	100.00%	100.00%	100.00%	N/A	100.00%	N/A	N/A
Lahej	Tor Al-Baha	Al-Mashareg	Al-Mashareg	822	Motorized solar	2002	100.00%	100.00%	N/A	100.00%	100.00%	100.00%	N/A	100.00%	N/A	N/A
Lahej	Tor Al-Baha	Al-Khatabia	Al-Khatabia	1,147	Motorized solar	2002	100.00%	100.00%	N/A	100.00%	100.00%	100.00%	N/A	100.00%	N/A	N/A
Lahej	Al-Mudharaba	Al-Mudharaba	Al-Masdyah	1,210	Motorized solar	2002	100.00%	100.00%	N/A	100.00%	100.00%	100.00%	N/A	100.00%	N/A	N/A
Lahej	Al-Mudharaba	Al-Mudharaba	Al-Sabeel	980	Motorized solar	2002	100.00%	100.00%	N/A	100.00%	100.00%	100.00%	N/A	100.00%	N/A	N/A
Lahej	Al-Mudharaba	Al-Mudharaba	Uzafa	1,250	Motorized solar	2002	100.00%	100.00%	N/A	100.00%	100.00%	100.00%	N/A	100.00%	N/A	N/A
Lahej	Tor Al-Baha	Al-Farsha	Thugar	3,750	Motorized Diesel	2004	61.54%	100.00%	100.00%	100.00%	7.25%	17.28%	100.00%	100.00%	N/A	N/A
Lahej	Malah	Al-Gasha'	Al-Gasha'	4,000	Motorized Diesel	2004	61.54%	100.00%	100.00%	100.00%	7.25%	17.28%	100.00%	100.00%	N/A	N/A
Mahra	Hasween	Hasween	Al-Wadi	4,000	Motorized Diesel	2002	100.00%	100.00%	N/A	100.00%	100.00%	N/A	100.00%	100.00%	N/A	N/A
Mahra	Hasween	Hasween	Wadi (network)	4,000	Motorized Diesel	2003	100.00%	100.00%	N/A	100.00%	N/A	100.00%	N/A	N/A	N/A	N/A

CDP WES - Updated on 7 May 2005																
Governorate	District	Sub-district	Site	Population	Type of Project	Starting Year	Overall Progress	Progress of Activities								Sanitation Component (Software).
								Preliminary Assessment	Social Mobilization	Technical Assessment / Designs and B/Qs.	Supplies and Installation of Electro-mechanical Units	Civil Works	Capacity Building to Management Committee	Capacity Building to Operators	Sanitation Component (Hardware).	
Abyan	Sabah		8 locations	2,000	Handpumps	2002	100.00%	100.00%	N/A	100.00%	100.00%	100.00%	N/A	N/A	N/A	N/A
Abyan	Rusud		11 locations	2,750	Handpumps	2002	100.00%	100.00%	N/A	100.00%	100.00%	100.00%	N/A	N/A	N/A	N/A
Abyan	Lawder	Al-Saila Al-Baidha	9 locations	2,250	Handpumps	2002	100.00%	100.00%	N/A	100.00%	100.00%	100.00%	N/A	100.00%	N/A	N/A
Abyan	Rusud	Al-Saila'a	Al-Saila'a	6,000	Motorized Gen. Set	2002	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
Abyan	Lodar	Al-Gouf	Al-Gouf	3,500	Motorized Diesel	2001	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
Abyan	Lodar	Al-Mesghala	Al-Kayal	1,335	Motorized Diesel	2001	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
Abyan	Lodar	Al-Saila	Khalha	3,121	Motorized Diesel	2001	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
Abyan	Lodar	Al-Mesghala	Al-Mesghala	5,210	Motorized Diesel	2001	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
Abyan	Sarar	Sarar	Hama	1,500	Rainwater Harvesting	2002	100.00%	100.00%	N/A	100.00%	N/A	100.00%	N/A	N/A	N/A	N/A
Abyan	Sarar	Amran	Amran	1,500	Rainwater Harvesting	2002	100.00%	100.00%	N/A	100.00%	N/A	100.00%	N/A	N/A	N/A	N/A
Abyan	Rusud	Al-Rubat	Al-Raha	1,500	Rainwater Harvesting	2002	100.00%	100.00%	N/A	100.00%	N/A	100.00%	N/A	N/A	N/A	N/A
Abyan	Rusud	Al-Omar	Al-Hajib Al-Omar	1,500	Rainwater Harvesting	2002	100.00%	100.00%	N/A	100.00%	N/A	100.00%	N/A	N/A	N/A	N/A
Abyan	Rusud	Al-Sa'adi	Al-Mustaf Al-Sa'adi	1,500	Rainwater Harvesting	2002	100.00%	100.00%	N/A	100.00%	N/A	100.00%	N/A	N/A	N/A	N/A
Abyan	Sarar	Um Udhaiba	Juhaili Mu'haba Falaha	1,500	Rainwater Harvesting	2002	100.00%	100.00%	N/A	100.00%	N/A	100.00%	N/A	N/A	N/A	N/A
Abyan	Sabah	Qardh	Qardh	1,500	Rainwater Harvesting	2002	100.00%	100.00%	N/A	100.00%	N/A	100.00%	N/A	N/A	N/A	N/A
Abyan	Sabah	Sabeeh	Sabeeh bin Auda	1,500	Rainwater Harvesting	2002	100.00%	100.00%	N/A	100.00%	N/A	100.00%	N/A	N/A	N/A	N/A
Abyan	Rusud		Sakha'a	1,400	Rainwater Harvesting	2005	49.99%	100.00%	N/A	100.00%	N/A	0.00%	N/A	N/A	N/A	N/A
Abyan	Rusud		Al-Wateh	1,500	Rainwater Harvesting	2005	49.99%	100.00%	N/A	100.00%	N/A	0.00%	N/A	N/A	N/A	N/A
Abyan	Rusud		Qara	3,200	Rainwater Harvesting	2005	49.99%	100.00%	N/A	100.00%	N/A	0.00%	N/A	N/A	N/A	N/A
Abyan	Sabah		Marsa'	1,000	Rainwater Harvesting	2005	49.99%	100.00%	N/A	100.00%	N/A	0.00%	N/A	N/A	N/A	N/A
Abyan	Sabah		Hadaq	1,000	Rainwater Harvesting	2005	49.99%	100.00%	N/A	100.00%	N/A	0.00%	N/A	N/A	N/A	N/A
Abyan	Sarar		Kilsam	800	Rainwater Harvesting	2005	49.99%	100.00%	N/A	100.00%	N/A	0.00%	N/A	N/A	N/A	N/A
Abyan	Sarar		Jaradat Amran	750	Rainwater Harvesting	2005	49.99%	100.00%	N/A	100.00%	N/A	0.00%	N/A	N/A	N/A	N/A
Abyan	Sarar		Al-Qili Amran	950	Rainwater Harvesting	2005	49.99%	100.00%	N/A	100.00%	N/A	0.00%	N/A	N/A	N/A	N/A
Sana'a	Bani Mattar	Al-Jabal	Al-Qalees	4,450	Motorized Gen. Set	2003	96.57%	100.00%	100.00%	100.00%	83.57%	100.00%	100.00%	100.00%	N/A	N/A
Sana'a	Hamdan	Rabou'	Rukba-Wadi Thahar	6,600	Motorized Gen. Set	2004	61.54%	100.00%	100.00%	100.00%	7.25%	17.28%	100.00%	100.00%	N/A	N/A
Sana'a	Haima Dakhlila	Hadaq	Ra'an	7,790	Motorized Gen. Set	2004	59.26%	100.00%	100.00%	100.00%	15.43%	0.00%	100.00%	100.00%	N/A	N/A
Sana'a	Sanhan	Bani Bahlool	Ghaiman	5,747	Motorized Gen. Set	2004	61.54%	100.00%	100.00%	100.00%	7.25%	17.28%	100.00%	100.00%	N/A	N/A
Dhale'	Qataba		Dar Al-Sayed	950	Motorized Gen. Set	2003	96.12%	100.00%	100.00%	100.00%	89.58%	92.61%	100.00%	100.00%	N/A	N/A
Dhale'	Al-Hasha		Al-Zukma	1,000	Motorized Gen. Set	2003	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A
Dhale'	Al-Azareg		Shan	950	Motorized Diesel	2003	98.29%	100.00%	100.00%	100.00%	100.00%	92.61%	100.00%	100.00%	N/A	N/A
Dhale'	Qataba	Qataba	Bait Asa'ad	3,275	Motorized Diesel	2004	59.04%	76.00%	100.00%	100.00%	7.25%	17.28%	100.00%	100.00%	N/A	N/A
Dhale'	Qataba	Qataba	Shagran	3,366	Motorized Diesel	2004	59.04%	76.00%	100.00%	100.00%	7.25%	17.28%	100.00%	100.00%	N/A	N/A
Dhale'	Al-Hasha		Khazja	3,745	Motorized Diesel	2004	59.04%	76.00%	100.00%	100.00%	7.25%	17.28%	100.00%	100.00%	N/A	N/A
Amran	Jabal Yazid	Jabal Yazid	Al-Dhumairi	3,055	Motorized Gen. Set	2003	94.86%	100.00%	100.00%	100.00%	83.57%	92.61%	100.00%	100.00%	N/A	N/A
Amran	Bani Suraim		Homi	2,442	Motorized Gen. Set	2004	61.54%	100.00%	100.00%	100.00%	7.25%	17.28%	100.00%	100.00%	N/A	N/A
Amran	Khamer	Khamer	Al-Jiraf Al-Astal	2,590	Motorized Gen. Set	2004	61.54%	100.00%	100.00%	100.00%	7.25%	17.28%	100.00%	100.00%	N/A	N/A
Amran	Ayal Suraih		Kahal	10,390	Motorized Gen. Set	2004	56.75%	76.00%	100.00%	100.00%	15.43%	0.00%	100.00%	100.00%	N/A	N/A
Haja	Mastaba	Khamis	Khamis	2,300	Motorized Gen. Set	2003	63.25%	100.00%	100.00%	100.00%	15.43%	17.28%	100.00%	100.00%	N/A	N/A
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