Evaluation of Community-Based Primary Health Care Project in Hadhramout, Yemen

Full Report

Oxfam GB Programme Evaluation

December 2008

Commissioned by: Oxfam GB MEECIS

Evaluators: Khalid Yasin Dubai

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Chapter 1: List of Acronyms

CBHF	Community-Based Health Financing
CBO	Community-Based Organisation
CHC	Community Health Committee
CMW	Community Midwife
DHC	District Health Council
DHMT	District Health Management Team
DHO	District Health Office
DHS	District Health System
EC	European Commission
EPI	Expanded programme of Immunization
FGD	Focus Group Discussion
FP	Family Planning
HC	Health Centre
HF	Health Facility
HIS	Health Information System
HO	Health Office
HU	Health Unit
IMCI	Integrated Management of Childhood Illnesses
KAP	Knowledge, Attitudes and Practices
LC	Local Council
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MoE	Ministry of Education
MoLA	Ministry of Local Authority
MoPH & P	Ministry of Public Health & Population
MoPIC	Ministry of Planning and International Cooperation
MOSAL	Ministry of Social Affairs and Labour
NGO	Non-governmental Organisation
PHC	Primary Health Care
PHCW	Primary Health Care Worker
PRSP	Poverty Reduction Strategy Paper
RH	Reproductive Health
RHO	Regional Health Office
SOUL	Society for the Development of Women and Children
TBAs	Traditional Birth Attendants

Chapter 2: Executive Summary

This is an end of project evaluation of the Oxfam **Community-Based Primary Health Care Project in Hadhramout, Yemen** funded by the EC. The overall objective of the project is to improve the health status of poor women, men, and children in 24 remote villages in Sah and Sayoun districts of Hadhramout

The purpose of the evaluation is to provide decision makers of the project management, Oxfam and the EC with sufficient information about the performance of the project in terms of its efficiency, effectiveness and impact. The primary purpose is to help Oxfam GB Office in Yemen to assess lessons learned for the future work of Oxfam in its attempt to build on the experience of this project in supporting health care in the area and Yemen in general, and community based health financing in particular.

The methodology utilized in this evaluation comprised of a desk study and visits to the project areas in which key informants interviews and group discussions were conducted with the project team and with various stakeholders including end-beneficiaries.

The findings of the evaluation revealed the followings:

- The project overall objective is in line with the National Development Plan for Poverty Reduction and relevant to national health policies. The specific objectives are linked with the pursuit of sectoral goals and contribute to the achievements of MDG goals and targets. Of particular relevance to national health policy is the decentralized district health system in which the project supported the district health structures (DHMTs and the DHCs) in the two targeted districts and built their capacity. The project interventions were technically adequate in reducing the main causes of problems that have persistently faced the health system in delivering quality health care in the remote areas of the two districts. The interventions included innovations that have gained acceptance and popularity at local level and has caught the eyes of the MOPHP leadership at national level and raise its interest in the scheme for possible replication in similar settings in Yemen.

- The project has improved the allocative efficiency by investing in district health system and PHC facilities. The project has increased the technical efficiency which can be seen in the increase in utilization of services at health unit level. The services are produced at lower cost in health facilities which were underutilized. The project has also been efficient in the sense that the CBHF generated additional funding from families contribution and from philanthropic organizations and wealthy individuals as well as from oil companies. Cost effectiveness of the project is high in terms of creating synergies with other programs and projects financed by the EC and by other donors, which means that the project has provided *"value for money"* for the EC and for Oxfam. The flexibility adapted by the project to respond to changing circumstances and the way in which the project was designed has increased the project cost effectiveness to make up for the project low efficiency due to delay in implementation and the relatively high turnover of staff faced by the project at the start

- The project has improved access to and utilisation of good quality health services at peripheral health facilities, which, before the start of the project, received little investment and insufficient operational budget, and many, if not most, were challenged by a crumbling physical infrastructure, shortage of skilled personnel, biased staffing pattern (exclusively male and often

lacked a midwife), serious gaps in basic equipment for obstetric care and lack of essential drugs and supplies, a result, they are often bypassed in preference for hospital level care in Sayoun. This health seeking behaviour of bypassing lower level health facilities to hospital level care where people have no choice results in paying higher costs from their out-of-pocket money for hospitalisation and transport at the expense of their other basic needs. The improved access of women and children to quality health care have resulted in greater equity in access to health care between deprived rural and areas who are relatively better off in terms of access to services. Greater equity has also been realized by reducing the gender gap in access to services between women and men in rural areas due to the increase in female cadre in health facilities which were previously almost exclusively staffed by male cadre.

- There are significant changes to project indicators at the output and outcome level which are attributable to the project not to any other external factors. These observed changes would have been impossible to occur without the intervention. The evaluation mission reviewed the project assumptions and tested whether they still hold true in the light of the information collected during fieldwork, and found that most assumptions have held true. Therefore, there is no reason why the overall objective would not be realised. The increase coverage of reproductive health services (for instance ANC) is considered a proxy or indirect indicator for improved health because a high coverage of ANC relates positively to maternal health. Likewise high coverage of child care relates to improved child health.

- The project has improved perceptions, shaped attitudes and changed practices at local level. The attitude towards girls' employment in health facilities have changed favorably. Men who are the decision makers at household level are now more likely to accept that their daughters join the CMWs training course and work in health facilities after graduation. Another project impact relates to the advocacy efforts which materialized in an increase in resource allocation for health facilities.

- The project planned and implemented activities that addressed *practical gender needs* which are concerned with meeting people's basic needs by improving the quality of health care while accepting the existing division of labor and without challenging existing gender roles. The "*bias in staffing pattern*" was addressed by the project from the perspective of improving access to health care through the training of female CMWs. During implementation, the project found itself dealing with *strategic gender needs* when parents did not allow their daughters to join the CMWs training course. The project respected this and worked in the most sensible way to change the statuesque by addressing the social barriers that prevented girls from joining the CMWs training course. For a conservative society to allow their girls to train as community midwives outside their areas and to stay nights away from home might have been a killer assumption at the start of the project. The dedication and persistence of the project team and their accumulative knowledge of local culture together with the keen interest of girls to become midwives have turned this into a success story.

- The project was not involved in service delivery, but rather strengthened local institutions to assume responsibilities according to their mandates - a process which empowered local actors and fostered a sense of ownership, and increased the chances of sustainability of these services. The project supported activities, which are in line with national health policies and are key elements of the Health Sector Reform. Most of these activities are already institutionalized within the health care system and have their own operational costs although not sufficient to effectively maintain the improved quality of care. Few other activities such as the CBHF and the regular visits of the mobile medical team were initiated by Oxfam to improve access to and utilisation of health services in peripheral health facilities. The regular visits of the mobile

medical team were initiated by the project based on the recommendations of the Midterm Review. The mobile medical team is demand driven by the community and should stand a higher chance of sustainability, but the community can not currently afford to bear the full cost of *the "the mobile clinic"*. Oxfam supported the mobile clinic by paying for the vehicle hire and remuneration for the team knowing that the initiative will raise the interest of the health office and in a way create pressure through community demand on the health office to takes responsibility by allocating the necessary resources for it. The regularity and frequency of the mobile clinic has reduced to a minimum since the project stopped its support. Hadhramout Regional Health Office has expressed commitment to allocate resources for the mobile clinic from next year onwards. In the mean time Oxfam is looking into how to resume such activities giving the high demand for it from various stakeholders including end-beneficiaries.

- The project has been able to link micro level initiatives to macro and policy level and served as a breeding ground for the development of national policy in CBHF. The development on the micro and policy level should serve as a supportive environment for the sustainability of CBHF. The CBOs have accumulated a modest review in their accounts which can be used to sustain the quality of services. The CBOs currently cover first line health facilities and should expand to cover referrals to (say) comprehensive obstetric emergency care and possibly share the operational cost of the mobile clinic.

The project achievements to-date should be seen as the basis to further consolidate and institutionalise the CBHF within the district health system, and to expand the experience in the project area and to inform national policy for scaling up the experience to other areas in Yemen. Aware of this, Oxfam has secured funding from a British Based Trust Fund and is seeking to raise funds to cover the remaining 20% of the estimated budget to sustain and consolidate the current innovations and to further strengthen the DHMT and DHC to assume responsibility under a decentralised setting where major devolution of authority to local level is expected by the MOPHP under the forthcoming local governance. For the remaining 20%, it makes sense to approach the EC first for possible contribution who may like to continue to be part of this success story in the making and eventually cultivate further achievements when they are fully realized and sustained.
Along the same line and to capitalise on current achievements, it is recommended to focus the forthcoming support on further consolidating the CBHF and promoting rights based approach to support women and men to gain a better understanding of their rights as an important first step to promote their active engagement to influence policy.

Chapter 3: Introduction and Background

The Health status of the Yemeni people is of particular concern. Approximately 50% of the population do not have access to basic health care, the worst affected are women living in rural areas. The Ministry of Public Health and Population (MoPHP) has been involved in a comprehensive health sector reform (HSR) programme since 1998 which has potential to improve the overall performance of the health sector to ensure that health services are provided to the majority of the population in rural areas at an affordable, effective and efficient health care system. At the core of the reform lies the operationalisation of the District Health System model as a way of bringing basic services closer to the (rural) population, which has not yet been fully realised. Reviewing the current status suggests that the MoPHP is required to disengage from everyday service delivery and taking a stronger and more effective policy and regulatory role in order to improve the quality and efficiency of the entire health sector, public and private and to move toward more effective decentralisation of the public sector.

Oxfam has worked in remote villages in Hadhramout districts, where less than 25% of people have access to basic health services and where many women cannot access, or afford maternal and reproductive health care. Communities were helped to work together with the health authorities and other stakeholders to run and finance primary health care schemes and the most vulnerable people can access quality and affordable health services. Oxfam has helped to improve primary health care services in peripheral health facilities through community based approaches since 2003.

Chapter 4: The Purpose of Evaluation

The purpose of the evaluation is to provide decision makers of the project management, Oxfam and the European Commission with sufficient information about the performance of the project (its efficiency, effectiveness and impact). The primary purpose is to help Oxfam GB Office in Yemen to assess lessons learned for the future work of Oxfam in its attempt to build on the experience of this project in supporting health care in the area and Yemen in general and Community based health financing in specific.

The evaluation focussed on the following priorities:

1. The progress and impact made by the project towards its objectives and overall goal.
2. Assessment of the methodologies used by the project and its partners and the sustainability and quality issues linked to it such as, institutionalization, participation, equity, technical quality, coverage, gender mainstreaming, ownership, pro-poor orientation, cost-effectiveness, linkages with other Oxfam programmes, etc.
3. Contribution of learning into national policy

Chapter 5: Programme Goals and Objectives

The overall objective of the project is to improve the health status of poor women, men, and children in 24 remote villages in Sah and Sayoun districts of Hadhramout Governorate in the Republic of Yemen through promoting health awareness, improving the quality of promotive, and preventive and curative basic health services, ensuring equitable and affordable pro-poor access

through the establishment of sustainable community based co-financing models in selected villages, ensuring effective district health management structures with active community participation and co-management, advocating the learning from the model at policy level and the implementation of community based health insurance schemes at the national level by the government and donors.

Specific Objectives:

1. Improving quality and effectiveness of preventive, promotive and curative basic health and reproductive services in 12 rural communities in Hadhramout by strengthening and reinforcing the sustainability of the district health management structure, conducting health awareness campaigns, through active community participation and community co-management.
2. Increasing access to basic health services through establishing innovative community based co-financing models, building on indigenous experiences with exemptions for the poorest women and men and poorest households and for some essential health services.
3. Contribute to national health policy debate by using the learning from Hadhramout project to demonstrate challenges, resources and policies needed to set up pro-poor health systems.

Main Expected Results:

- District Health Management structures are strengthened with representation from the local communities.
- Increased utilisation and access to basic health services as a result of the improvement in the quality of basic health services in 12 health facilities.
- Increased capacity of the target communities to independently manage, sustain and consolidate the Primary Health Care Services
- Increased awareness and understanding of public health issues.
- The community based models of financing and co-management influenced health policies on Health Sector Reform and on Health Insurance.

Main Activities:

1. Strengthening of the district health management.
2. Improving the quality of health services
3. Enhancing the community and women's participation in the management and finance of health services
4. Promoting community health awareness and education.
5. Policy and advocacy activities.
6. Project management activities.

Chapter 6: Evaluation Methodology

This end of project evaluation which is *a summative evaluation* is carried out after completion of the project in order to "sum up" the achievements, impact and lessons learned. Such type of evaluation is useful for planning follow-up activities or related future project. The evaluation is carried out by an independent expert not directly associated with the project to avoid any bias.

The evaluation utilized various methods of data collection that included the followings:

1. Review of available documentation (terms of reference, project proposal, logical framework annual work plans and project reports, Midterm Evaluation Report)

2. Interview key informants of project management and staff, intermediary organizations and relevant local institutions
3. Group discussions with the project team and with members of the CHCs and CBOs
4. Exit interviews with end-beneficiaries particularly female clients at health facilities
5. Spot check observation at health facilities to assess the physical conditions of the facilities and to observe the quality of service delivery.

The resources allocated for this evaluation (time and personnel) were underestimated for fieldwork and for report writing, which has influenced the time for completion.

Chapter 7: Findings

Findings answer the evaluation questions and flow from the data gathered and are backed up by the evidence collected. They describe the situation, compare it to what was expected, and explain the reasons for the situation and its consequences for achieving project objectives.

7.1 Assessment of Project's Achievements

Assessment of progress and constraints towards the achievements of the three specific project objectives is discussed in this part of the report. The mission looked at the indicators for each specific objective and measured progress in reaching targets and compared the results with the baseline data.

Specific objectives	Indicators
Improving quality and effectiveness of preventive, promotive and curative basic health and reproductive services in 12 rural communities in Hadhramout	- 8 health units in the target area are rehabilitated and provided with basic equipment - 12 health facilities in project districts meet quality of health service provision assured by promotion of WHO standards, treatment protocols and guidelines in all targeted HU by the end of the project. - 12 health facilities offer the basic package of maternal and child health services.
Increasing access to basic health services through establishing innovative community based co-financing models	- 6 health facilities implement exemption criteria for the poorest. - 20% increase in utilisation rate for 12 HU, especially for women frequentation - 12 health facilities are managed by community health committees and their plans are reflected in the district health plans and in the local council's plans.
Contribute to national health policy debate through effective advocacy	- Co-financing schemes acknowledged by the Ministry and main donors by the end of the project - Participation of women in the Health Committee - DHMT structures are strengthened with representation from the local communities.

Objective 1: Improving the quality and effectiveness of preventive, promotive and curative basic health and reproductive services in 12 rural communities in Hadhramout

indicator: 1 (input-output)	8 health units and 2 health centres in the target area are rehabilitated and provided with basic equipment

By the end of 2007, all the planned rehabilitation of health facilities (8 health units and 2 health centres) were completed. The rehabilitation work consisted of upgrading the building, provision of basic furniture and medical equipment. The health facilities that were rehabilitated are listed below:

	Village name	District name	Type of facility	Planned date	Completion date
1	Kutna,	Sah	HU		
2	Sakdan	Sah	HU		
3	Al-Dhubaiha	Sah	HU		
4			HU		
5			HU		
6			HU		
7			HU		
8			HU		
9			HC		
10			HC		

Tam health unit in Sah district after rehabilitation

[Figure Removed]

indicator: 2 (output)	12 health facilities in project districts meet quality of health service provision using WHO treatment protocols and guidelines in all targeted Health Unit by the end of the project

The WHO treatment protocols and guidelines refer to the Management of Childhood Illnesses (IMCI), which is a broad strategy adapted in Yemen to reduce child mortality and morbidity. IMCI has a significant impact on improving child health and is cost-effective. It encompasses interventions to prevent illness and reduce deaths from the most common child health problems and promote child health and development.

Project records and the interviews with the DHMT and health workers and project staff revealed that the project supported the organisation of two IMCI training workshops of 11 days each. The workshops targeted 48 health workers to assume responsibility for child care in the twelve health facilities in Sayoun and Sah districts. The training was conducted by national trainers from the MOPHP, aimed at improving skills and practices of health workers in the diagnosis and treatment of child illnesses and the rationale prescription of essential drugs. The training curriculum followed the World Health Organisation (WHO) standards and approach for quality assurance of health services. The involvement of the IMCI unit at central level aimed at establishing linkages with the IMCI unit and creating a supportive environment for the future sustainability of project intervention.

Of the twelve targeted health facilities, the evaluation mission visited four randomly selected facilities (two from Sayoun and two from Sah). The visit revealed that the buildings seemed to have been upgraded and still looked in good shape. The health facilities have essential equipment, materials, drugs and supplies for IMCI. During these visits the skills of health workers were observed to check their compliance with the IMCI guidelines and protocols. The observation of the health worker (one in each health facility) revealed that each child was checked for the four general danger signs and for the presence of cough, diarrhea and fever. The weight of child was checked against a growth chart, and child vaccination status was also checked. These observations indicate that the health workers are complying with the IMCI guidelines and protocols. However, the fact that the health workers were aware of being observed may have resulted in an observation bias (the health workers may have complied with the guidelines during observation only. To eliminate such bias, the perceived quality of care was assessed using exist interviews with mothers on their departure from the health facility. During the exit interviews women expressed their satisfaction with the quality of the services provided and appreciated the attitudes of health workers.

The supervision and monitoring of health facilities by the DHMTs and the regular visits by the mobile medical team provided opportunities for immediate skills reinforcement and problem solving, and ensured that the skills gained are institutionalised into standardised procedures by the health workers in their day to day work at the 12 health facilities. The standardised procedures were reinforced by the availability of essential drugs from Oxfam resulting in an improved quality of care in the health facilities which were supported by the project.

The interview with the project team and the review of statistics revealed that the health facilities that are now providing IMCI has reached 31, although the project has trained health workers in 12 health facilities only. The increased in the number of health facilities providing IMCI could have resulted from cross fertilisation and the project influence on the DHMTs.

indicator: 3 (output)	12 health facilities offer the basic package of maternal and child health services

The project has implemented a number of activities and accomplished a number of outputs that led to the achievement of the target in this indicator. The implemented activities and accomplished outputs are detailed below:

- The project supported a Community Midwives Training Course (CMWs) in Sayoun District for 21 girls from the target areas of Sayoun District. Of the 20 CMWs who graduated from the course 15 of them were recruited by the health facilities close to where they live, and were integrated within the civil service payroll. The new midwives are providing the basic package of maternal and child health services, and have improved the quality of care. There has been some delay in proceeding with the training of community midwives as planned due to socio-cultural barriers which the project team dealt with in the most sensible way being sensitive to the local culture. Besides CMWs, there are also 24 new female nurses who has been trained by the project to work in Sayoun District
- The project has supported the DHMTs in conducting supervision and on-the-job training for health providers.

[Figure Removed]

Looking back at the baseline data for the year 2003 showed that most health facilities in Sah and Sayoun districts were primarily providing curative services by male health workers. Reproductive health (RH) services and IMCI were not available in most of the health facilities (HFs). Project records and the Statistics Yearbook for 2007 show that at least 19 health facilities now provide RH compared with 7 health facilities at the baseline. None of the HFs provided IMCI at the base year. Now there are 31 health facilities providing IMCI. The number of health facilities providing immunisation (EPI) increased from 14 at the baseline to 29 after the project intervention. In addition, data on attended deliveries and antenatal care services in Sah and Sayoun shows significant improvement (what are the figures). At the start of the project tetanus vaccination for pregnant women increased from 0% in Sah to 28% after the project intervention. These figures are expected to increase when the recently graduated female CMWs from Sah District start working in the health units in their areas.

- The project in collaboration with the Regional Health Office conducted a refresher course on diarrhoeal and respiratory tract infectious for health workers and members of the DHMTs in each of the two targeted districts. According to the baseline study carried out in 2004, diarrheal and respiratory tract infections were considered the most common health problems among children in

the project area. These workshops are instrumental in refreshing the staff knowledge and upgrading their skills, but they should continue to be provided every six months and should include communication skills and other emerging issues from supervision.

Objective 2: Increasing access to basic health services through establishing innovative community based co-financing models, building on indigenous experiences with exemptions for the poorest women and men and poorest households and for some essential health services

The following three indicators were set to measure progress of activities towards reaching this objective

Establishing innovative community based co-financing model is not explicitly stated in the abovementioned indicators, but one could argue that it is implicitly stated in indicator 1, which refers to CHCs and in indicator 2, which refers to the exemption criteria.

indicator: 1 (outcome)	12 health facilities are managed by community health committees (CHCs) and their plans are reflected in the district health plans and the plans of the local councils

The number of community health committees (CHCs) that have been setup around health facilities exceeded the project target of 12 CHCs to reach 24. Seven of these CHCs qualified to become CBOs and were registered by the Ministry of Social Affairs with the support of the project. The registration gives these CBOs the legitimacy under the Yemeni Law, and registration has a number of perceived advantage, which include: (i) ensuring the sustainability of the CBOs; (ii) enabling the CBOs to have their own bank account, (iii) raising additional funds for their activities, (iv) offsetting the financial constraints facing the health facilities due to the shortage in government allocations for the operational costs of the health facilities; (v) hopefully enabling the CBOs to tackle health problems from a broader prospective not only through the health sector.

Steps in outlining the CBHF Scheme in the two Districts of Sayoun and Sah

Communication with Health Facility Committees that were established by the project in 24 communities.

1. Where prerequisite to start CBHF schemes are present, re-organizing committee into a local CBO to protect them through having their separate entity
2. Starting collection of monthly premiums in five communities
3. Providing seed essential drugs to three health facilities after completing the preparatory phase i.e. rehabilitation and equipping. Three health facilities got drugs from an oil company, thus project postponed the process of giving them essential drugs to explore the situation with the regional health office and MoPH&P.
4. Holding consultative workshops with communities and different stakeholders at the community level, to agree on the design of the CBHF scheme.

The transfer of CHCs into CBOs has made them more accountable towards their local communities.

> *"As members of the Management Board of this CBO we are now accountable to the citizens in this constituency who are members of the General Assembly of the CBO. They are the ones who elected us and they are the ones who can change us. Our work is monitored by inspection committee"*

The interviews with members of the management board of the CBOs, revealed that Oxfam provided capacity building to CBOs in the form of training in various relevant areas such as planning and management, follow up, bookkeeping, CBO principles, requirements and internal

regulations. Member of the CBOs' management boards attended a number of awareness raising sessions and were exposed to messages on the importance of disease prevention and the importance of promoting the utilisation of health services, particularly by women and children in order to improve their health and wellbeing.

> *"All the support we got was a result of working with Oxfam. There was no committee before and no CBO as it is now. The health facility was ruined. Even Yaser - the medical assistant and head of the health unit who is now the general secretary of the CBO - was always absent from the facility".*

As part of the institutional strengthening, Oxfam furnished and equipped the CBO office room with filing cabinet, desk, table and few chairs. Although each CBO has its own bank account, however, most of these CBOs are located in relatively remote areas from where the bank is located, so they need safes to temporarily deposit the revenue. Other priority needs expressed by the CBOs are relevant to their context and include the need for a computer and training in its use to enable them to write their reports and letters. They also need a fax machine to enable them to communicate in writing with the DHMTs, the district and regional health office and the relevant local authorities as well as institutions at central level and donor agencies.

The awareness raising and capacity building and institutional strengthening have undoubtedly empowered the communities to demand for further improvement of the quality of and access to health care in their areas. For instance, the mobile clinic which was initiated by the Health Office in each district with the support of Oxfam came as a result of the CBOs' persistence requests - reflecting their community needs - for the availability of a physician, a midwife, and laboratory in their remote health facilities that are limited to medical assistants. These mobile clinics stopped when the project ended, but the Regional Health Office for the Wadi and Desert and the District Health Offices in Sayoun and Sah feels they are under pressure from communities through the CBOs and feel obliged as duty holders to resume services through the mobile clinic. However, this feeling has not yet materialised due to lack of government financial allocations for the mobile clinic. The Regional Health Office has included this service in its next year budget for 2009. Despite such evidence of the CBOs' influence, there was no evidence to show that the CBOs/CHCs plans are explicitly incorporated within the district health plans and the plans and the local councils as indicated in indicator 2.

The exemption policy for the poor was built around the community based health financing (CBHF), which was initiated by Oxfam in February 2006 as an innovative scheme in the two districts of Sayoun and Sah. The scheme is attached to the local community around each health facility and managed by community representatives (CHCs or CBOs). The CBHF Scheme is based on the concept of solidarity that prevails among the people in Hadhramout. The steps followed in initiating the CBHF are outlined in the opposite box:

indicator: 2 (output)	6 health facilities implement exemption criteria for the poorest

The project has achieved its planned target of setting up the CBHF with an exemption policy for the poor in 6 health facilities. This target was exceeded by expanding the experience to another 18 health facilities through communities' own initiatives with the support of the project bringing the total number of health facilities that apply the policy to 24. Of these 24 health facilities there are 7 health facilities that effectively apply the CBHF and exemption policy. The project focused its support on the planned target (6 CBHF schemes) in order to consolidate the experience while providing minimum support to the other CBHF schemes in the two districts. Members enrolled in

each CBHF are families not individuals. The total number of families who are registered as members in the 6 CBHF schemes reached 1,524 of which 82% are paying their monthly subscription fee while 18% are exempted. The relatively high percentage of exempted families reflects the socioeconomic status among people in these remote areas. The following graph shows the paying and exempted families at each scheme.

[Figure Removed]

Each CBHF scheme has set the level of prepayment fee to be levied from families enrolled in the Scheme. The exercise was initiated by Oxfam through a wider consultation for all NGOs / CHCs with the participation of all stakeholders in which they discussed and reached consensus on a framework for CBHF and the exemption policy. This was followed by a closer consultation carried out by each NGO with its community taking into account the socioeconomic situation of families and their ability to pay. The exercise resulted in a prepayment fee that slightly varies from scheme to scheme. Some schemes have set the fee at YER 100 (equivalent to USD 0.50), while others have set it at YER 150 (equivalent to USD 0.75). Examination of the process of consultation that was carried out to arrive at these fees shows that the fees are affordable by the majority of families, and those who could not afford them are obviously exempted. Members of each CBHF Scheme are eligible for health services and essential drugs in health facilities without paying any additional charges. The amount does not include referral to hospital or hospitalisation.

[Figure Removed]

The existing prepayment fee levied from each family generates modest additional resources for these remote health facilities intended to improve the quality of care, besides making health services responsive to the needs of the local population. The fee is too small to cover all the needs and to sustain services or for CBHF to become self sufficient. Nevertheless, the CBHFs schemes do not necessarily have to exclusively rely on fees from families, and this is evidently the case in Sayoun and Sah where the CBHF seemed to have attracted other source of funding from philanthropic individuals and organizations, oil companies working in the area, and from Oxfam. Few CBOs/CHCs received donations from philanthropic individuals and organisations to implement community projects ranging from a water project to the expansion of school building or in kind donations to health facilities, etc. However, these extra funds are not included in the revenues shown in the graph

It was not possible for the mission to calculate **the ratio of prepaid contributions to healthcare costs** due to lack of available data for the costs of health care at health facility level. It is expected, however, that the government budget still covers the larger part of the cost of health services, followed by donations from philanthropic organizations and individuals, and Oxfam. Oxfam financial contribution to the CBHF was in the form of donation of drugs which was sold and the money was retained by CBHF as seeds money.

Since enrolment in CBHF is organized on a **voluntary basis**, it is important to assess its **effective coverage** (the number of enrolled and exempted families as a percentage of the total families in the community). This will be an indicator of effective coverage, but can also be a proxy indicator on how **attractive** the scheme is and as well as it measures the extent to which the scheme is **feasible and equitable**. Unfortunately, assessment was not possible due to lack of precise information on the denominator. Approximate figures for the denominator from the project team and from members of the NGOs' Management Boards point out to an effective

coverage of over 90%. In Dubayah village the interview with a member of the NGO's Management Board who is responsible for financial affairs revealed that very few families withdrew from the Scheme. This might happen due to lack of interest and they feel the scheme is not attractive or not being followed up to pay their contribution, which might be due to the fact that the person in charge of collecting the fee is a volunteer. It is important that each NGO makes use of this indicator in its regular reports to prove that it has a high coverage. **The timing of payment** of contributions is said to be done on a monthly basis, but the schemes should also make it flexible for people to pay on a quarterly, semi-annual, annual or on a seasonal basis (i.e. during the harvesting of dates of other cash crops). This will probably increase the number of households enrolled. Aware of the **factors that usually influence enrollment in CBHF schemes,** the project worked on:

- improving the perceived and technical quality of care by upgrading, furnishing and equipping the health facilities, increasing the number of cadre and providing intensive training and refresher courses to all staff, etc
- sensitizing the communities, the local authorities and health workers of the importance for the CBHF schemes to be handled and managed by people who have the trust of the community
- raising awareness of various stakeholders of the need to ensure that the health services are responsive to people's preferences to the extent possible to increase community satisfaction

indicator: 3 (outcome)	20% increase in utilisation rate for 12 HUs, especially by women

The review of the annual statistics yearbooks for the period of 2003 (the baseline) up to and including the year 2007 shows a progressive increase in the utilisation of services by women and men in the 12 health facilities supported by the project. The average increase in utilisation rate for women and men at the end of the project period (2007) compared to the base year (2003) is 76% and 83% for Sayoun and Sah respectively (see the graphs below). The observed utilisation rate of health services by women at the end of the project is 94% and 93% in Sayoun and Sah respectively..

[Figures Removed]

Disaggregating utilisation by type of service provided also shows an increase in the utilisation rates in each district as a result of project intervention. For antenatal care in Sayoun, the utilisation by women has increased from 994 visits in 2003 (the base year) to 3,152 in 2007 (the end of the project). This means that the utilisation rate for antenatal care has increased by just by 68% from the original baseline data. For antenatal care in Sah, the utilisation has increased from 495 visits in 2003 (the base year) to 709 in 2007 (the end of the project). This means that the utilisation rate for antenatal care has increased by just 30% from the original baseline data.

[Figures Removed}

The assisted deliveries through CMWs have increased by the end of the project by 103% compared with the baseline. This increase comes at the expense of home deliveries assisted by trained TBAs which decreased by 15% from the baseline. The results disaggregated by district shows an increase in trend of assisted deliveries by CMWs in Sayoun shows a progressive increase which in the last year of the project reached 101%. This dramatic increase in the percentage of deliveries comes as the expense of TBAs whose assistance was reduced by 25% compared to the baseline. Sah district has also witnessed an increase in assisted deliveries through CMWs and TBAs by 65% and 23% respectively.

[Figures Removed]

The increase in utilisation of health services by women particularly of antenatal and postnatal was largely due to among other factors the recruitment of the recently graduated CMWs to work in the health facilities of Sayoun district besides the training of TBAs and their linkage to the public health system in both districts. The number of female cadre in health facilities has increased remarkably by 89% from a handful of seven in 2003 to 69 female staff. This 89% increase exceeded the 30% project target.

[Figure Removed]

With regards to child care, an increase in immunisation coverage of children against measles in Sah district by 13%. The reported figure by the end of 2007 was 74% while the figure reported in 2004 was 61%.

[Figure Removed]

The CBHF initiated by the project in the two districts has improved equity in access to health care and contributed to the increased utilization and coverage of health services, particularly for the poorest, because families contribute according to their ability to pay the YER 100 or YER 150 as the case maybe rather than to the costs of health services that are utilized, and those who cannot pay are exempted. In the past, cost sharing for health services in the form of user fee was established in Yemen, and is still in place in a number of health facilities as a response to severe constraints in government allocations for operational cost. User fee policies were thought to be a possible form of community participation and contribution. However, recent studies have raised concerns of the negative effects of user fees on the demands for health care, especially for the very poor. Therefore, the poor and marginalized communities living in remote areas now have greater access to health care and essential drugs, which will lead to the health area particularly of women and children.

While it is better to have a member of the management board of the NGO responsible for collecting the fee, however there is a limitation when this is done on a voluntary basis and may result in low enrollment or members' withdrawal.

The project should further explore the feasibility of creating CBHF Coordination Council in which funds are pooled. The project should in the coming period start encouraging NGOs to utilize some of the revenue on improving health care. With the assistance of the project NGO should negotiate with service providers (the health facility at community level and the district hospital in Sayoun) and the district health office to purchase health care which are not currently accessible to the community, but are considered a local priority, socially acceptable, technically appropriate and in line with the national health policy of MOPHP such as the mobile clinic and the early referral of complicated deliveries which require obstetric care, etc. This will increase the credibility of both health services and CBHF and will ensure that the services are demand driven. These organisations still require the support of the project if they are to be strong enough to assume responsibility as agents of change in their communities. It is therefore important to continue building their capacity and to strengthen their organisations in order to be self sustained. The capacity building could focus on planning, management teamwork, leadership, and proposal writing skills, etc geared towards improving and health status of women, children and men in their communities.

The interviews with officials from various structures of the MoPH&P at district and regional level (Regional Health Office, District Health Offices and DHMTs) they all praised the CBOs' role and expressed their appreciation for the efforts in community organisation and resource mobilisation.

The interaction with the local councils varies among CBOs with each have a different experience. During the group meeting with the Board of Directors of Kasdan CBO, the members pointed out that the community received a donation for the water supply project from philanthropic businessman through the CBO. This has made the head of the local council unease about the CBO.

The meetings with the Director of the Regional Health Office, members of the DHMTs, health workers as well as the local health committees and local CBOs who represent the communities all confirm that the CBHF is socially appropriate and culturally acceptable by the local communities. The CBHF is initiated by community representatives the setup at each health facility built around the CHC

One of the risks is that if there are new members in the local council who are not aware of this initiative may start accusing the CBOs of not paying the percentage of the fee as an income for the Local council according to the law. It all depends on relations and contacts. It is therefore important that the project influences the MOPH&P.

The pilot experience still needs to be supported for some time to sustain and learn from its lesson for replication nationwide.

Objective 3: Contribute to national health policy debate using the learning from Hadhramout project to demonstrate challenges, resources and policies needed to set up pro-poor health systems

The following indicator was set to assess achievement towards this objective.

indicator: (output to outcome level)	Co-financing schemes acknowledged by the Ministry and main donors by the end of the project

The project has implemented a number of key activities and organized a number of events to advocate on pro-poor health financing schemes with particularly reference to its CBHF pilot models. The advocacy was in the form of meetings, briefings and updates, exposure visits to keep the MOPH&P informed of and to attract its attention to the innovative CBHF experience in Sayoun and Sah districts. This process together with development on the ground have initiated a national debate on the challenges, resources and requirements for setting up a pro-poor health financing system in Yemen learning from Oxfam's CBHF experience in Sayoun and Sah. The CBHF has indeed caught the eyes of the MOPHP and a number of development partners. Recently, the Health Sector and Demographic Support (HSDS) EC funded program with the blessing of the MOPHP has sent a fact finding mission to Sayoun and Sah to learn from the experience at a close range. The mission recommended the replication of the experience with some adaptation to hospital level to be piloted in the HSDS's targeted areas of Taiz and Lahej Governorates. In another development the project work with TBAs by linking them to the public health system has also inspired other donors to apply similar approaches. For instance, Improved Maternal and Newborn through Community Mobilization implemented by Vision Hope has used this approach in Hajja Governorate. Hence, the results of the project have influenced national health policy, and means that the project has been able to link micro level initiatives to macro and policy level.

Advocacy activities that were carried out by the project to inform policy at national level include:

- From the outset, the project has organised various meetings with the Health Sector Reform Unit and the Deputy Minister of Health for Planning and other implementing partners.
- A number of key ministry officials from the MOPHP and representatives of development partners conducted exposure visits to the project areas to learn from the experience
- The project also involved relevant national staff of MOPHP and HIHS in training local level staff
  In the community midwives training courses, diploma courses, etc, and this has established linkages between national strategies and what the project is doing at local level, and maintained better relationship between the project and the MOPH&P at national level, and fostered a sense of being involved and acceptance of the project results
  The project has contributed to policy debate at national level on CBHF. The project was represented by the team leader Mr. Thabet Baggash who worked as a member of a national taskforce formed by the MOPHP to develop a concept note on community based health financing, and Oxfam's experience on CBHF is available on the MOPHP website
- Oxfam was involved in a research on CBHF in partnership between the MoPH&P, WHO, and ILO

7.2 Assessment of relevance, efficiency, effectiveness, impact and sustainability

Relevance - of objectives to in-country needs

The overall project objective of improving the health status of poor women, men and children is relevant to the National Development Plan for Poverty Reduction and other national health policies. The specific objectives are linked with the pursuit of sectoral goals of National Health Sector Reform Strategy and contribute to the achievements of MDG goals and targets, particularly MDG four of reducing child mortality and MDG five of improving maternal health. Project

Relevance - of the approach to in-country context

- Knowing that a pre-packaged blue print project will not work in such setting, the project used a **process approach** in the implementation of its activities in close consultation with local and national stakeholders and learning from lessons as they move ahead. This has empowered local actors and enabled them to be on the driving seat thus promoting the sense of ownership.

- The project approach was well in tune with the Yemeni development policies and administrative systems of district and regional level in Yemen, and it is consistent with the EC policy of supporting Yemen's ownership. The project interventions were technically adequate in reducing the main causes of the problems which persistently faced the health system in the two districts in delivering quality health care in remote areas. The interventions included innovations which have potentials for replication.

- Of particular relevance to the national policy and to local level is the decentralized district health system. As an approach to strengthen the district health system, the project has supported setting up and strengthening the DHMT and the DHC in each of the two targeted districts. Both structures are within the National Health Policy, and are key elements of the Health Sector Reform Strategy. The government of Yemen is in the process of transferring the current local administration into local governance whereby the local authority will have more power "devolution", and the District Heath Office will be integrated within the local government. It is expected that the MoPHP at central level will be responsible for policy development, regulation and oversight.

- Along the same line, the project has been **gender sensitive** in its approach with gender dimensions being an integral part of every activity: women joined the DHMTs and were included in all the capacity building activities that were supported by the project. Where the norms *"rules of the game"* were unfair and unjust as in the case of girls not being allowed to join the community midwives training course due to cultural reasons the project respected this and worked in the most sensible way to change the statuesque by addressing the social barriers that prevented girls from joining the community midwives training course. For a conservative society to allow their girls to go and train as community midwives outside their areas and stay nights away from home might have been a killer assumption at the start of the project. The dedication and persistence of the project team and their accumulative knowledge of the local culture together with the keen interest of girls to become midwives have all contributed to this success. The first batch of CMWs has joined work at health facilities in Sayoun District. But, why is gender so important to national and local levels? The review of baseline data for Sayoun and Sah shows that the *"biased staffing pattern - exclusively male and often lacked a midwife"* was one of the main barriers for women to access health care in remote areas. Therefore addressing gender inequity has improved women's access to health care. At national level, the National Reproductive Health Strategy (2007-2011) of

the MoPH&P acknowledges that the low status of women in Yemen has a significant negative impact on women as clients of the health system and as health care providers. The Strategy considers women empowerment as an important pre-requisite to enhancing their status and health. The MoPHP has in recent years established a Directorate for Women Affairs within the Population Sector with the aim enhancing women's status and improving their health throughout their life cycle. The Directorate is supposed to be responsible for supporting and securing women's employment in the health sector. The Strategy calls for policies, programs and interventions to promote gender equality as a must, and to give priority to poor and underserved populations.

- The focus of project interventions in rehabilitating and equipping rural health facilities at the peripheries is quite relevant, because well equipped and appropriately staffed peripheral health facilities are the most accessible, especially for the rural poor and particularly for women who need the consents of their husbands to be able to seek care beyond the village boundary. The Regional Director of the Health Office for Sayoun and Sah confirmed the importance of the midwife in the health facility by saying:

  > *"The training of midwives is one of the priorities for the Health Office because it increased women's utilization of health services. We noticed that the health facility, which is equipped and has a midwife, seems to exhibits an increase in utilization rate, because the presence of a midwife facilitates women to come for checkups".*

- The project has initiated an innovative CBHF scheme, which is relevant and appropriate to the local context, and in line with the national health policy, which the MOPHP is eager to put into effect. The scheme, which in Arabic is called "*Takaful"* meaning *"Solidarity*", which is currently being tested shows promising signs of success, and has gained popularity and acceptance as oppose to the insurance scheme that might have otherwise been rejected for socio-cultural reasons. The CBHF experience to-date has raised the MOPHP's interest in the scheme for possible replication in similar settings in Yemen.

- In the context of Yemen where most women prefer delivering at home assisted by a female family member or through a TBA, and giving the realities facing the country in terms of shortages in manpower the project has trained TBAs in the two districts to assist in childbirth and to refer complications when necessary. The project has also been successful in linking TBAs to the public health system in terms of reporting.

- The IMCI strategy introduced by the project was until recently part of the national health policy. It is still used in a number of districts, but the MOPH&P has shifted focus towards HSS which is also an integrated approach.

Effectiveness - in achieving planned results and the project

A project is considered effective if the outputs delivered or planned results have attained or are expected to attain its relevant objectives. Effectiveness is measured at the level of outputs and here we looked at the extent to which the targets for the delivery of outputs have all been achieved, and the extent to which these targets.

The project was quite effective in realizing the results which was confirmed by the Regional Health Office and the District Health Office and stated that effectiveness has substantially exceeded what was planned.

"All planned outputs have been realized, and there were outputs that were delivered although they were not planned"

- **The district health management structures (DHMTs and DHCs) at district level** were institutionalised and strengthened and are now functional. They include the following structures:
  - At district level:
    - The DHMT for Sayoun District and the DHMT for Sah District
    - Two District Health Councils have been setup and is functional in the two district, and includes community representatives
  - At health facility level / community level:
    - The intended target was to setup 12 CHCs around each health facility, but the project was able to setup 24 CHCs of which 12 were unintended (unplanned). Of the total 24 CHCs 7 had the potentials to become CBOs and were supported by the project to register formally at the MOSA&L as an NGO

  The abovementioned structures was the subject of institutional strengthening and capacity building by the project

- **Community needs are reflected in the district health management and the plans of local councils**
  The project assisted the District Health Management Teams to develop their health plans based on community needs.

- **At least 10% of district health council members are women by the end of the project**
  There is at least one female in the District Health Management Team.

- **Health information system established in two districts that disaggregates data by sex and age by the end of the project**
  The management information system (MIS) has been very effective in improving the quality of monitoring of health services and in making monitoring systematic and regular. Records at the district health office in each district indicate that health facilities collect routine data on the utilisation of health services and report monthly to their district health office. The person in charge of statistics in each District Health Office then carries out the data entry and data analysis using the MIS. The DHMTs are involved in the interpretation of the data and in making decision if needed, then give feedback on the findings to health facilities, and reports to other stakeholders

- **Increase by 30% of the number of female staff in the targeted Health Units by the end of the project**
  The project has remarkably increased the number of female cadre in health facilities by 89% from a handful of 7 in 2003 to 69 female staff have eliminated the social barrier of lack of female cadre. This 89% increase exceeded the 30% target of the project. On the other hand the 30% planned target means 2 CMWS which is not a realistic figure and may have been under estimated, because one does not expect the project to organize a CMWs training course for less than 10 to 15 students.

- **Increased utilisation and access to basic health services as a result of the improvement in the quality of basic health services in 12 health facilities**

- **20% increase in the use of health facilities in the target area**

  The quantitative evidence of achievement of project result on utilization of men and women is observed in the increase which has significantly exceeded the project target of 20% to reach 76% for Sayoun and 83% for Sah by the end of the project compared to the base year. The observed utilisation rate of health services by women at the end of the project is 94% and 93% in Sayoun and Sah respectively. This increase in utilisation was a result of the combination of the availability of basic package of maternal and child health services due to the presence of community midwives, the regular visits of the mobile medical team together with the improved quality of care at the health facilities as a result of rehabilitation of buildings, training of staff, and availability of essential drugs. All these project interventions in combination with the awareness raising activities at community level have alleviated the factors, which influenced poor health. Disaggregating utilisation by type of service provided also shows an increase in the utilisation rates in each district as a result of project intervention. For antenatal care in Sayoun, the utilisation by women has increased from 994 visits in 2003 (the base year) to 3,152 in 2007 (the end of the project). This means that the utilisation rate for antenatal care has increased by just over two folds (2 1/6) or (217%) from the original baseline data. For antenatal care in Sah, the utilisation has increased from 495 visits in 2003 (the base year) to 709 in 2007 (the end of the project). This means that the utilisation rate for antenatal care has increased by just 43% from the original baseline data. There has not been any factor that could have led to the improvement in the utilisation rate of services by women in the two districts during the project period other than the project activities that aimed at removing the barriers in women's access to and utilisation of health care. The barriers identified during the baseline data included: (i) the poor quality of health services and shortage of essential drugs, (ii) lack of female cadre particularly midwives, (iii) health workers lack the skills and the motivation (iv) absence of the health workers. Most project activities were directly and indirectly geared towards the removal of these barriers.

- **Cost of obtaining drugs reduced by 20% for participants of the Revolving Drug Fund**

  The project has improved accessibility to all basic health services including essential drugs for all, particularly the poor through the setup of CBHF with its pro-poor exemption policy managed by CHCs / CBOs. The project target aimed at reducing the cost of drugs by 20%, for by participants in the Revolving Drug Fund (RDF), however, subscribers to the CBHF obtained drugs free of charge.

- **The most vulnerable 10% of families within the population of health units piloting RDF exempted from user fees and have access to first-line treatment and essential drugs**

[Figure Removed]

To improve accessibility to quality health services by vulnerable and marginalized families, the project initiated a CBHF scheme with its pro-poor exemption policy attached to each health facility and fully managed by CHCs / CBOs. Records of CHCs/CBOs show that the percentage of families exempted from payment has reached 18% which is 8% higher than planned target. Therefore, the poor and marginalized communities living in remote areas now have greater access to health care and essential drugs.

- **20% increase in the attendance rate of pregnant women for regular medical checks during pregnancy due to trained CMWs, mobile reproductive health team/ clinic, or encouragement by TBAs by the end of the project**
  There is an increased utilisation rate for antenatal care by women in the districts as a result of project intervention. For antenatal care in Sayoun, the utilisation by women has increased from 994 visits in 2003 (the base year) to 3,152 in 2007 (the end of the project). This means that the utilisation rate for antenatal care has increased by just over two folds (2 1/6) or (217%) from the original baseline data. For antenatal care in Sah, the utilisation has increased from 495 visits in 2003 (the base year) to 709 in 2007 (the end of the project). This means that the utilisation rate for antenatal care has increased by 43% compared to the baseline.

- **20% increase in the number of deliveries assisted by trained CMWs and TBAs**
  The project has been effective in increasing deliveries by skilled attendants by 103% compared to the baseline. This dramatic increase comes at the expense of deliveries assisted which were reduced by 15% compared to the baseline. The mission considers this shift from TBAs assistance to skilled attendants an outstanding achievement by the project, because TBAs assistance in deliveries is not longer acknowledged as skilled attendants. The results disaggregated by district shows an increase in trend of assisted deliveries by CMWs in Sayoun shows a progressive increase which in the last year of the project reached 101%. This dramatic increase in the percentage of deliveries comes at the expense of TBAs whose assistance was reduced by 25% compared to the baseline. Sah district has also witnessed an increase in assisted deliveries through CMWs and TBAs by 65% and 23% respectively.

- **Increased capacity of the target communities to independently manage, sustain and consolidate the Primary Health Care Services**

- **12 community health committees are operational by the end of the third year**
  The project planned to target 12 CHCs, but the figure was doubled to reach 24 by the end of the project. Of these 24 CHCs the project assisted 7 potential committees to become CBOs and to register as formal NGOs at MOSAL. The registration gave these NGOs the legitimacy under the Yemeni Law to operate as autonomous entities and to raise funds and to independently open their own bank accounts. This in turn will enable these CBOs to offset the financial constraints facing health facilities due to the limited government allocations. Moreover, in becoming formal NGOs the CBOs are not only narrowly focussing on health services alone to improve health, but have begun to look at solutions to their community health problems from a broader perspective. The CBOs require further institutional strengthening and capacity building in order independently, sustain and consolidate the primary health care services.

- **12 community health committees have improved capacity to plan, finance and execute community health related activities**
  The CBHF which the project planned to start in 2006 faced delay when realising that the committees were not mandated by law to independently collect fees and retain revenues and for public services, or open bank account and autonomously manage funds without the control of the local authority or the Ministry of Finance. Further delay was inevitable when MOSAL halted the registration of new NGOs until a national review of existing ones is carried out. Extensive negotiation with MOSA was concluded by an agreement from MOSA Branch in Sayoun to license 7 CBOs in communities that have already advanced in the process of establishing CBHF schemes. In 2006 the project conducted wider consultations with all

stakeholders, and based on the results and recommendations of these consultations organised several training sessions to build the institutional capacity of CHCs / CBOs and to strengthen the management capacity of the heads / chairs of the CHCs/CBOs. The areas covered by the training included accounting, report writing, fund raising, managing funds, and proposal writing.

"I was trained in bookkeeping, I never knew about bookkeeping before. The training was for five days and was very useful and I can now manage my books, but I need more training, because I have not absorbed everything. We need Oxfam to build our capacity and to monitor our work"

- **Increased awareness and understanding of public health issues**

- The project through SOUL has focussed on reproductive health, respiratory tract infection and diarrhoeas as the three key priorities for awareness-raising in the two districts.

Topics	Male	Female	School Students	Total
reproductive health	51%	25%	24%	**58,162**
respiratory tract infection	48%	30%	22%	**57,760**
Diarrhoeas	47%	29%	24%	**67,916**
Total	**32,085**	**19,770**	**16,061**	**183.838**

- Measuring an increase in the level of awareness of those who participated in training workshops required baseline data before training to be compared with data after completion of training. Similarly the increase in the level of knowledge among men and women at community level who were exposed to messages (except for mass media) required baseline data before the intervention to be compared with the level of awareness after the intervention. The difference between before and after would be the increase in the level of awareness. Unfortunately, such information is not available at the project. The mission have tested the knowledge and skills of very few staff and observed their work practices, but this cannot be generalized was not sufficient to assess the gained in knowledge and skills by those who were exposed to awareness-raising because there was no pre-test and post-test to compare results. The mission was constrained by time and money to carry test a credible sample size or to do a case control. Moreover the case control are generally known for their weaknesses in that they require the control group to be of similar characteristics to the exposed group. Moreover, awareness raising have particular difficulties in that we will not be able to not know if the gain in knowledge and skills was directly due to the project efforts or to other sources of information.

- **The community based models of financing and co-management will influence health policies on Health Sector Reform and on Health Insurance.**

- **Community Based Health Financing Framework developed by the MoPH&P.**
  Oxfam has worked with MOPHP and other donors to develop CBHF framework. This is now ready.

- **Main donors refer to community Health Financing in their programming documents.**
  The project has been a breeding ground for the national health policy in CBHF. The scheme has caught the eyes of the MOPHP. In a study on proposed models for health financing in Yemen, a team from Oxford Management Consultants identified the CBHF scheme as the

most suggested models for health financing in Yemen. This study was done for the MoPH&P in collaboration with WHO and ILO, and a dissemination workshop was organizes to share the study results with key development partners. The CBHF scheme initiative is in the process of being adapted for replication at hospital level by the EC HSDS in Taiz and Lahj Governorates to be adapted at the level of district hospital.

- **10% more civil society representatives engage in advocacy activities in the districts.**
  Members of the Management Board of the CBOs continue to raise community awareness of the benefits of the schemes in order to maintain success The mission was however, not able to find out whether representatives of civil societies do actually advocate at higher level.

- **10% of poorest people in each community exempted from payments**
  The target indicator refers to people, which means individual units, while the subscribers to the CBHF schemes are families. The number of poor families which have been exempted by CBHF schemes has reached 18% of the total families who are subscribed to the system.

- **MoPH&P recognises and advocates for pro-poor health policies**
  The leadership of the MOPHP has shown keen interest in applying the CBHF in similar setting. This interest was translated into action by stimulating the the EC HSDS in Taiz and Lahj Governorates to be replicate the CBHF at the level of district hospital. Moreover, the MOPHP has commissioned the abovementioned study on proposed health financing models for Yemen in collaboration with WHO and ILO.

Efficiency - in providing inputs promptly and at least cost
A project or a service is considered efficient or cost-effective if effectiveness is achieved at the lowest possible cost.

- The project did not implement activities but built the capacity of existing institutions to assume their responsibilities. The staff of these institutions are on the government payroll

- The qualitative evidence of project results can be seen in its focus on existing low level rural health facilities, which, before the start of the project, received little investment and insufficient operational budget, and many, if not most, were challenged by a crumbling physical infrastructure, shortage of skilled personnel, biased staffing pattern (exclusively male and often lacked a midwife), serious gaps in basic equipment for obstetric care and lack of essential drugs and supplies, and limited referral capacity, a result, they are often bypassed in preference for hospital - level care in Sayoun Hospital. This care-seeking behaviour of bypassing lower level health facilities to hospital level care results in higher costs to women and households, as well as to the health system as a whole. Costs of care - both to women and to the health system - are lowest at the peripheries. Therefore the project has utilised its inputs efficiently by creating more demand for health services, and delivered its outputs at the least cost.

- The efficiency of the project in delivering its outputs was tested through the verification of project expenditure for the cost of activities or outputs. In the case of building rehabilitation the unit rate per square meter of rehabilitation, and the cost of training per participant per day for short term and also for long term, and the cost of a one day trip for the mobile team per day. The unit rates evidently show that the project has been efficient in the delivery of its outputs. The result of the verification reinforces the above hypothesis that says that focusing on existing low level health facilities can result in an efficient and cost effective health care to improve access to health care while narrowing the equity gap.

- The project has been efficient in the sense that the CBHF attracted additional funding from families and also from philanthropic organizations and individuals. The project has also been cost effective in the sense that it created synergies with other programs and projects financed by other donor funded projects. Several project initiatives have potentials for replications. For instance the CBHF initiative is in the process of being replicated by the EC HSDS in Taiz and Lahj Governorates to be adapted at the level of district hospital. This means that CBPHCP in Hadhramout have provided *"value for money"* for the EC. Another initiative which has been echoed by another donor funded project is the project work with TBAs and their link to the the public health system which was replicated by Vision Hope in the Improved Maternal and Newborn in Hajja Governorate. Again these are evidence that the project have been able to link micro level initiatives to macro and policy level, which dhows its cost effectiveness.

- The flexibility adapted by the project team and the way in which the project was designed is considered paramount in maintaining cost effectiveness. The project was quite effective when it comes to realizing the planned outputs. This was also confirmed by the Regional Health Office and the District Health Office and stated that effectiveness has substantially exceeded what was planned.

  "All planned outputs have been realized, and there were outputs that were delivered although they were not planned"

- The project planned to organize joint training workshops in Sayoun for both districts, but this was not possible in practice leading to the organization of separate workshops in each district which resulted in more inputs for less the same outputs.

Impact - on overall objectives to which the project results contribute to

Impact refers to what happened as a result of project interventions in terms of direct and long term effects influenced by the project.

The evaluation mission examined the intermediate outcomes and direct effects or observable results in terms of **access and utilisation of good quality health care**, which are indirect or **proxy indicators that relate positively to the health status and contribute to the overall objective**. The mission further looked at the results of the project and posed a challenging question (so what?) on the extent to which these results have contributed to the overall objective of the project. The evaluation mission did not assess Assessment of impact will not attempt to measure long-term effects or sustainable changes on the people and their surroundings such as the decrease in morbidities and mortalities, because the increase in reported morbidities does not necessarily mean that the health facility has poor quality or lacks the skilled cadre or is short of essential drugs. To the contrary, the increase in reported morbidity might be due to other positive factors such as the improved management information system, which was within the control of the project. The increase in morbidity and mortality rates might be attributable to other external factors in the wider environment - beyond the project control - such as the prevailing socioeconomic and cultural factors at household level that can only be validated through a household survey, which is relatively expensive to conduct and beyond the scope of this evaluation. Besides the difficulty to measure maternal mortality in terms of cost and time it is also impractical if not impossible to measure maternal mortality in small districts like Sayoun and Sah of a population size less than 100,000, because maternal mortality 365/100,000 although neonatal mortality 37,2 per 1000 and infant mortality 74,8 per 1000 because the denominator is 1,000.

- Quantitative evidence of project impact on the target population is assessed by looking at project effects on the utilisation and access to basic package of maternal and child health services. The average increase in utilisation rate for women and men at the end of the project (the year 2007) compared to the baseline (the year 2003) is 76% and 83% for Sayoun and Sah respectively. The observed utilisation rate of health services by women at the end of the project is 94% and 93% in Sayoun and Sah respectively. This increase in utilisation resulted from a combination of the availability of maternal services due to the presence of CMWs together with the improved quality of care at the health facilities as a result of rehabilitation of building, the regular visits of the mobile clinic, the training of staff, availability of essential drugs, the awareness raising activities at community level. The mission reviewed the problems that pertained in the two districts prior to the start of the project and looked at the project logical framework and analysed the cause-effect relationship of the results and how they logically contribute to the impact taking into account the assumption and the influence of other external factors. The exercise revealed that project interventions have alleviated the factors that influenced poor health. The improved access of women and children to quality health care have resulted in greater equity in access to health care between deprived rural and urban areas who are relatively better off in terms of access to services. Greater equity has also been realized between women and men in rural areas with regards to access to health care due to the increase in female cadre in the health facilities which were previously almost exclusively staffed by male cadre. This equity in access to health care has resulted in the reduction of cost and time to seek care, and will a good coverage of health services (for instance ANC) can be a proxy or indirect indicator for improved health because a

high coverage of ANC it relates positively to maternal health. Likewise high under-five coverage and immunisation coverage relates positively to child health.

- The project was not involved in direct implementation of activities, but strengthened existing institutions to assume responsibilities as stipulated in their mandates, and empowered individuals who are benefiting from the project. This approach has impacted positively on all those who have been involved in the implementation: It has increased the ability of the two DHMTs to plan for and monitor the implementation of health services in their districts.
    - ✓ The project has developed a sound institutional capacity at the district level with a special focus on leadership, planning, and supervision
    - ✓ The DHO was supported and appropriately involved at all stages.
    - ✓ The development of an appropriate, especially female, cadre to deliver reproductive health services to the entire population
    - ✓ Training of health care providers to improve their skills that have decayed over time
    - ✓ Setup the CHCs / CBOs to co-manage the health services and to be in charge of CBHF

- The project has supported the DHMTs to conduct supportive supervision that aimed to bring about change and impact service delivery as it provided interactive opportunity between supervisors and health workers in terms of joint identification of problems and solutions. Supportive supervision should be based on relevant tools and checklists, which is not the case now.

- The project has been the breeding ground for the development of national policy on CBHF. The pilot experience in Sayoun and Sah has paved the way for the replication of the experience in Taiz and Lahej with the EC support.

- The project has changed perceptions, attitudes and practices at local level. Men who are the decision makers at household level are now more likely to accept that their daughters join the CMWs training course and work in health facilities after graduation. In fact they now feel proud that their daughters are helping other women and have their own income. The attitude towards girls' employment in health facilities have changed favorably. The Director of the District Health Office confirmed that the Health Office has in the past announced the organization of CMWs course, but no one applied. A snapshot of the situation before the start of the project of women not being able to access health care because the health facilities lacked female cadre, and of parents not allowing their daughters to join the CMWs training course and to work in health facilities after graduation, because it is not socially acceptable or not conforming to the norms. Two key factors which the project used in breaking this deadlock and can be one of the lessons learnt: The first one was the rigorous dialogue and negotiation between the local council and the parents stimulated by Oxfam. The second was the small financial incentives paid by Oxfam for girls attending the course, which created demand for girls to join the future community midwives training course

> *"In the past we used to announce about midwives training courses through the local radio and in health facilities but no one applied, and that was it. In Sah, even if the girls would like to join the course they could not do so, because their parents would refuse. With the help of Oxfam we were able to convince parents by directly communicating with them. We asked the local council to gather parents to discuss with them, but people did not agree at the start, and later agreed provided that the training takes place in Sah. We agreed on this, and then we went back to the community to inform them that there is no hospital in Sah where girls could do their practical training during the course. Then people agreed for their daughters to go to*

Sayoun for training provided that they return daily by bus. We found this difficult due to road accidents and would be tiring for the girls. The negotiation went on for two years. Finally parents agreed for their girls to stay in a female guest house provided that two of the parents stay with them as Sheppard. Then after two months shepardon went back to their community and convinced community members that the place is safe for the girls to stay in"

- The project advocacy efforts at local level have materialized in influencing the Regional Heath Office to increase the resources allocated for health facilities, particularly for operational costs.

> *"We have learnt a lot from Oxfam's experience. For instance, they started with upgrading, furnishing and equipping the health facilities, and then they advised on the importance of increasing the budget for the operation cost. We followed that up with the local authority and we secured the operational costs for these facilities from the government budget. Of course the success on the ground has helped us to put our case strongly. We did not have a budget for operational costs for each health facility in the past. We used to have YER[1] 50,000 for all the HCs and HUs in the district. Now, each HC has a budget of YER 50,000, and each HU YER 9,000. Now, we do not need equipment and furniture and if we need we can provide the budget for that from our office. We still need Oxfam to help strengthen supervision and to train more midwives. A batch of midwives graduated in Sayoun and has been deployed to work in health facilities. There is currently an ongoing course for new midwives for Sah. They will soon graduate and we will get them on the government payroll"*

- The project has trained TBAs and developed and tested means of forging appropriate links between TBAs and health facilities, and institutionalized a simplified reporting system for TBA to communicate with the health facility. This approach is now being replicated by another development partner in Hajja governorate.

- The project refers to the deliveries assisted by TBAs as skilled attendants, and there is a debate of who should assist women during delivery that has been going on for decades at the international level, and policies regarding safe delivery have evolved over time. In the 1960s, WHO emphasised on training traditional birth attendants (TBAs) as the appropriate approach for developing countries, then later recommended that TBAs should work with the health-care system, and then later recommended the integration of TBAs within the health care system through training, supervision and technical support. Nowadays WHO is promoting skilled attendance during all deliveries, a position which WHO adopted in 1997. The question is how can this policy be applied in the context of Yemen? In the context of Yemen where most women prefer to deliver at home assisted by a female family member or through a TBA, and giving the realities facing the country in terms of shortages in manpower the project has trained community midwives as skilled attendants and trained TBAs in the two districts and integrating them into the health care system.

- There has not been any other external factor that could have led to the improvement in the utilisation rate of services by women in the two districts other than the project activities that aimed at removing the barriers in women's access to and utilisation of health care. The barriers identified during the baseline data included: (i) the poor quality of health services and shortage of essential drugs, (ii) lack of female cadre particularly midwives, (iii) health workers lack the skills and the motivation (iii) absence of the health workers. Most project activities were directly and

[1] 1 USD = YER 200 at the writing of this report

indirectly geared towards the removal of these barriers. By the end of the project, the following project outputs are evident:

- ✓ The number of female cadre in health facilities increased remarkably by 9 folds, from a handful of seven in 2003 by 63 females. The now 69 female staff (7 at the baseline + 63 project intervention) have removed the social barrier of lack of female cadre
- ✓ Intensive training and refresher courses for 32 health workers
- ✓ Initiating visits of the mobile clinic team to the 20 remote rural health units
- ✓ The training of 34 TBAs and linking them to the public health system
- ✓ The creation of CBHF with its pro-poor exemption policy attached to each health facility has improved access to health care particularly for the poor
- ✓ The upgrading furnishing and equipping of 10 health facilities (8 health units and 2 health centres) and the provision of essential drugs
- ✓ The project has mounted numerous health awareness campaigns targeting various segments of the population with key relevant messages that created demands for health care
- ✓ Lobbying to get CMWs on the government payroll
- ✓ Increase in the budget for the running costs but it is not sufficient

- The transfer of the CHCs into CBOs has empowered them and resulted in their greater autonomy and made them more accountable towards their local communities.

> *"As members of the Management Board of this CBO we are now accountable to the citizens in this constituency who are members of the General Assembly of the CBO. They are the ones who elected us and they are the ones who can change us. Our work is monitored by inspection committee"*

Sustainability - over time and after inputs provided and external support ceased
Sustainability refers to the continuation of its benefits and impact after the project itself has ended.

- The project was not directly involved in the implementation of its activities, but supported existing institutions to assume responsibilities according to their mandates. For instance, the health services are delivered through public health facilities which are equipped and staffed with cadre who are on the government payroll. The project focused on building the capacity of local institutions to ensure that they effectively deliver the outputs and achieve the expected results during the project life and when the project cease to exist in order to ensure sustainability.

- The project has supported activities, which are in line with the National Health Policy and are key elements of the National Health Sector Reform. Most of these activities are already institutionalized within the health care system and have their own operational costs although not sufficient to effectively result in the intended outcome. Few other activities are innovative and fairly new and still being tested and needs to be further consolidated in order to inform national policy. These innovative approaches are demand driven by the community and should stand a higher chance of sustainability, but the community can not currently afford to fully support the running costs of say *"the mobile clinic"*. The way it was done is that Oxfam sees the needs and starts supporting the activity by paying for the vehicle hire and remuneration for the team, knowing that the initiative will raise the interest of the health office and in a way create pressure through community demand on the health office to take the lead until the health office takes full responsibility and allocates the necessary resources for it. The regularity and frequency of the mobile clinic has been reduced to a minimum since the project stopped its support. During the interview with the Director General (DG) of Hadhramout Regional Health Office for Wadi and Desert, the DG was very pleased about the idea of the mobile clinic and would like it to continue, but cannot yet support it from the government budget. He is following up to include it within the government budget for next year. In the mean time Oxfam is looking into how to resume such activities giving the high demand for it from local communities and from health workers at health facilities as well as from the DHMT and DHC.

- The project has initiated an innovative CBHF scheme with an exemption policy for the poor attached to each health facility. The scheme is relevant and appropriate to the local context, and in line with the national health policy. The scheme, which has been tested is still on-going shows promising signs of success and has gained popularity and acceptance by local communities the District Health Office in each district and the Regional Health Office. The CBHF experience has also raised the interest of the MOPHP for possible replication in similar settings in Yemen. The pilot experience in Sayoun and Sah has paved the way for the replication of the experience in Taiz and Lahej with the EC support to be adapted at the level of the district hospital. The CBHF pilot experience still needs some time to sustain and to learn from its lessons before replication nationwide. The project has been able to link micro level initiatives to macro and policy level and served as a breeding ground for the development of national policy on CBHF. The development on the micro and policy level should serve as a supportive environment for these initiatives. The keen interest shown by the ministry in the project experience of CBHF model gives hopes for optimism that the project approaches are finding corresponding views at the national level. This is very encouraging for the sustainability of the project intervention, and it is also gratifying that Oxfam with the EC funds has been able to play some experimental and demonstrative role in the development of national policy. However, at the local and national level, much remains to be done.

The appointments of new deputy ministers who are technocrat and their new approaches give cause for some optimism, but as yet few noticeable changes have occurred in the improvement of the health services in the country, and it all '*remains to be done*'. Especially at the administrative levels, major changes are notoriously difficult to push through over bureaucratic inertia. Although the CBHF scheme has been successful in achieving its intended aims (enhanced community participation and empowerment, increased accessibility and utilization of health services, raised the MoPH&P interest, replicated by another EC funded health program, attracted the support of the philanthropic individuals and organisations more fund for the next phases of the programme, etc), however, the CBHF still needs to be further supported since the period of their engagement is still too short to ensure their sustainability. They still require further capacity building in bookkeeping, management, leadership and communication, and networking. It is also important to provide them with institutional support in order to consolidate the CBHF schemes. It is also important to expand the experience to other neighbouring areas who has already replicated the experience on an ad hoc basis. This will be ethical and cost effective.

- The project was implemented within the framework of the government funded health sector and the overwhelming majority of the operational costs including staff salaries were covered from the government budget. However, Oxfam paid small enumerations to the accountants of the CBOs (USD 100 per month) who were working as volunteers. The payment was paid for a few months to ensure their availability for the scheme on a full time basis. By the end of the project such payment ceased to exist. The accountants are still working despite the fact the payment stopped. Oxfam also paid for the cost of transport of the DHMTs for their regular supervision and monitoring visits to health facilities. The DHMTs has reduced their supervision and monitoring visits to a minimal since the project stopped payment due to lack of transport means. Oxfam is now working with the district health office in each district and with the regional health office to find out ways to sustain such activity. One possibility is to hand over project vehicle(s) to each district health office for the purpose of supervision and monitoring and take responsibility for its operational cost.

- This project ended in March 2008. At the same time Oxfam is currently preparing a proposal for the for a continued support to sustain and consolidate the current innovations and to further strengthen the DHMT and DHC to assume responsibility under a decentralised setting where major devolution of authorities to local level is expected by the MOPH&P under the forthcoming local governance. Oxfam has secured some funding for the new project from a British Based Trust Fund and is seeking to raise funds to cover the remaining 20% of the estimated budget. Oxfam would obviously approach the EC first as a potential donor to contribute the remaining 20% and thus cherish / cultivate the achievements to-date and forthcoming success.

7.3 Assessing project management and organizational set-up

1. Relevance

While stressing that relevance is about consistency with existing priorities and policies as well as needs, however, we should not lose sight of the fact that many development interventions are conceived as social experiments. The point is obviously not that interventions that challenge established interests or existing ways of doing things are always irrelevant. It is rather that even interventions that go against the grain of existing practice should conform to the needs and interests of those who are intended to benefit from them. When we assess the relevance of an innovation, one of the key questions is whether it has a potential for replication

- **Pertinence of the mission statement to the stated project objectives;**

- Oxfam is leading the way in innovative research. Its partnership with the Government of Yemen on the Voices of the Poor and the Impact of Cost Sharing in the Health Sector are notable. Both studies apply best practice approaches to participatory knowledge generation and contribute insights into how the poor perceive their situation and the impact of policies, institutions and processes on their well-being. Oxfam has likewise supported national NGOs and CBO to follow up and monitor the PRSP. Oxfam is currently preparing to launch a technical committee of all international development partners who are involved in policy development to coordinate efforts.

- Oxfam has secured funding for a four year livelihood program called "Integrated Action on Poverty and Early Marriage" which will be implemented in Hadarmout and Hodeidah. The program in Hadramout will be based in Oxfam's office in Sayoun and aims to provide economic opportunities for women and to campaign against early marriage in Hadramout. The livelihood program plans to work through the existing institutional community structures which was created by the project thus has potentials in creating synergies and can be a risk to what has been built so far depending on how sensitive it is to local culture.

- **Relevance and comprehensiveness of Oxfam Health Project's set of strategies, programmes and types of interventions with regard to project objectives.**

- The type of strategies employed and the range of interventions carried out by the project were quite appropriate to address the health problems, barriers and challenges prevailing in the target population, and to achieve project objectives taken into account the local context and the capacity needs of the local partners and the sustainability issues. These strategies and the range of interventions were developed based on a participatory needs assessment and a planning process through a wider consultation with key stakeholders at various levels, which includes representatives of local communities, DHMTs, SOUL, Oxfam and the MoPH&P.
- The needs assessment which was carried out at the star of the project identified number of barriers identified impeding the achievements of better health which includes: (i) the poor quality of health services and shortage of essential drugs, (ii) lack of female cadre particularly midwives, (iii) health workers lack the skills and the motivation (iii) absence of the health workers. Project activities were therefore geared towards the elimination of these barriers. The project utilized a prop-poor approach through the creation of CBHF with its pro-poor exemption policy managed by

community representatives. This arrangement ensured that health services are more responsive to the local population and improved access to good quality service particularly for women.

- In the context of Yemen where most women prefer delivering at home assisted by a female family member or through a TBA, and giving the realities facing the country in terms of shortages in manpower the project has trained TBAs in the two districts to assist in childbirth and to refer complications when necessary. The project has also been successful in linking TBAs to the public health system in terms of reporting.

- The IMCI strategy introduced by the project was until recently part of the national health policy. It is still used in a number of districts, but the MOPH&P has shifted focus towards HSS which is also an integrated approach.

- The focus of project interventions in rehabilitating and equipping rural health facilities at the peripheries is quite relevant, because well equipped and appropriately staffed peripheral health facilities are the most accessible, especially for the rural poor and particularly for women who need the consents of their husbands to be able to seek care beyond the village boundary. The Regional Director of the Health Office for Sayoun and Sah confirmed the importance of the midwife in the health facility by saying:

  > *"The training of midwives is one of the priorities for the Health Office because it increased women's utilization of health services. We noticed that the health facility, which is equipped and has a midwife, seems to exhibits an increase in utilization rate, because the presence of a midwife enables women to come for checkups".*

- The project has initiated an innovative CBHF scheme, which is relevant and appropriate to the local context, and in line with the national health policy, which the MOPHP has not yet been able to put into practice. The scheme, which in Arabic is called "*Takaful"* meaning *"Solidarity*", which is currently being tested, shows promising signs of success, and has gained popularity and acceptance as oppose to the insurance scheme that might have otherwise been rejected for socio-cultural reasons. The CBHF experience to-date has raised the MOPHP's interest in the scheme for possible replication in similar settings in Yemen.

- **Organisational set-up to its objectives;**

- The project office was setup as a temporary function that did not carry out any service delivery, but supported and strengthened local institutions at district and community level to assume responsibilities for planning, implementation and monitoring of activities, each according to its mandate as stipulated in the Health Sector Reform Strategy:
  - Local institutions at district level involved in implementation included the Regional Health Office being the principle partner, District Health Offices, and DHMTs.
  - Partners at community level involved in implementation included CHCs and CBOs. Therefore: this organisational setup aimed at ensuring the sustainability of project interventions after the project cease to exist.

  - The District Health Office and DHMTs were strengthened to improve the quality of health services within public health facilities and to supervise and monitor service delivery
  - The health staff were trained and new CMWs were trained, got on the government payroll and were deployed in these health facilities

- The CHCs and CBOs were formed from communities around each health facility to represent the community and voice their concerns of the quality and to manage the CBHF schemes

- The project office was managed by Oxfam as the lead partner responsible for the overall management of the project including the responsibility for reporting and financial accountability to the European Commission. Oxfam played a catalyst role in activities related to advocacy and health financing in close consultation with the MOPH&P at district, regional and national level. These are innovative approaches which Oxfam has a track record of experience, and were not within the mandate of existing institutions. Oxfam managed to setup SOUL, a national NGO based in Sana'a, played a leading role in activities related to health awareness and community participation. The involvement of SOUL was said to be due to the fact that there were hardly any local organisations that are competent and well established in Hadhramout at the start of the project. Moreover, SOUL was already involved in project implementation during the inception phase. The involvement of SOUL as the lead partner in health awareness and community participation has overlapped with existing institutions and may have undermined the sense of ownership and threatened sustainability. This however, was pointed out in the Midterm Review and was redressed accordingly.

Activity	Leading Agency
Strengthening of the district health management	**Regional Health Office**, and Oxfam
Improving the quality of health services	**Regional/District Health Office**, and Oxfam
Community participation / co-management	Regional Health Office, **Oxfam** and SOUL
Community Health Awareness/Education	**SOUL**, and Health Office
Policy and advocacy activities	**Oxfam**
Project management	**Oxfam**, and SOUL

- **Demand-driven nature of activities and their responsiveness to needs and priorities of poor communities;**

- The project carried out a participatory needs assessment at the start of the project to identify priority needs of the local communities and - based on this assessment - implemented activities that respond to the needs of these communities. The implementation of project activities was initiated by community organisation and the creation of CHCs and CBOs to ensure that project activities are demand driven and respond to the needs of local communities. This demand driven nature of activities and their responsiveness to the needs and priorities of the poor communities has ensured that project activities are consistent with the socioeconomic and health conditions of poor men and women. For instance, the project was implementing awareness raising campaigns on diarrhoea and acute respiratory infections which were identified through the participatory needs assessment as the top priority health problems among children. However, the project responded to the emerging epidemic of *Leishmania*, an action which was highly commended by the district health authority and local communities.

2. Effectiveness

- **Role and contribution of the respective Oxfam head office and Sana'a Office;**

- The role and contribution of both Oxfam Regional Office and Country Office was not very effective during the planning phase and at the start of implementation. The project proposal was prepared by Oxfam Health Program Officer with inputs from Oxfam Country Office being limited to policy and advocacy, and inputs from Regional Office mainly on district health systems and improving the quality of health service, etc. At the start of implementation the inputs from the Regional Office and the Country Office formed competing priorities with more emphasis from Oxfam Yemen on focusing on policy and advocacy. These issues were redressed by Oxfam as a result of the restructuring process that took place leading to the decentralisation of management to Oxfam office in Sayoun, and the clarifications of roles of Oxfam local office and Oxfam Country Office

- Following this restructuring process the role of Oxfam GB's head office in UK and the Regional Health Office were redefined to assume overseeing roles in the course of the remaining period of the project through regular monitoring and supportive visits to ensure smooth implementation of project activities. Oxfam Regional Office played an effective role during the participatory review at project level to clarify the roles and responsibilities of various actors in the field.

- **Quality of monitoring, role and contributions of the information system in the decision-making process.**

- The management information system (MIS) has been very effective in improving the quality of monitoring of health services and in making monitoring systematic and regular. Records at the district health office in each district indicate that health facilities collect routine data on the utilisation of health services and report monthly to their district health office. The person in charge of statistics in each District Health Office then carries out the data entry and data analysis using the MIS. The DHMTs are involved in the interpretation of the data and in making decision if needed, then give feedback on the findings to health facilities, and reports to other stakeholders such as the Regional Health Office, the project, etc. The DHMTs enthusiastically explained how the MIS have made them keen to review data and statistics from health facilities and raised their interests in monitoring. They confirmed that the quality of monitoring has improved tremendously with the use of the management information system, and indicated that they do indeed use it for decision making when the trends are abnormal, and in preparing their plans and in resource allocations. Quote from the group discussion with the DHMT in Sah revealed the following:

> *"Before we used the MIS, the data was a burden in the entry and analysis….. with the MIS it is much easier for us….. I am a medical assistant working with the DHMT and I enjoy very much doing the data entry and statistical analysis after I have been trained by Oxfam…. Of course I do not want to continue doing this for a long time, because I prefer to work as a medical assistant in a health facility……. The MIS reduced the time it takes us to produce the statistical reports, and we now give prompt feedback to lower level health facilities and at the same time – unless we need clarification from health facilities - we report to the Regional Health Office.*

The interview with the director of the District Health Office have also praised the MIS in improving the quality of monitoring and confirmed using the MIS to advocate and to inform policy makers at the Regional Health Office.

> *"The MIS is very valuable and beneficial in our monitoring work, and instrumental for our planning and budgeting purposes. I used the data generated by the MIS to claim more funds for health facilities. We have had a volunteered midwife working in a remote health unit "Bashhooh" awaiting her formal employment within the civil service. The statistics showed an increase in utilization of service by women evidently by the presence of the midwife. When the midwife got on the government payroll they took her to the hospital arguing that the health unit does not need a midwife. In supporting our claim we used the statistics to convince the Director of the Regional Health Office of the increase in utilization of service due to the presence of midwife, but they did not agree. It appeared that they do not use statistics in resource allocation. I do not understand how people can allocate resources without statistics. We have a saying that says no budget without statistics. The other problem we face is the fact that the Statistics Department in the Regional Health Office is still generates Statistics manually. We used to have the same, but we now have a computerized management information system in place.*

The MIS has therefore been effective in improving data collection, analysis and use in planning and decision making. The MIS has also been effective in influencing the Regional Health Office to support other districts to utilise the MIS as a tool for monitoring and reporting.

- **Appropriateness of targeting mechanisms used to reach beneficiaries at community levels**

- The participatory approach which was adapted by the project is obviously one of the most significant factors contributing to the project effectiveness. The awareness raising activities which were implemented by the project partner SOUL without the involvement of concerned local institutions was redressed in the second phase of the project.

- Basic health services for women and better health provision for children are known factors for improving community health outcomes.

- The project has carried out awareness raising campaigns to reach different beneficiaries through various trusted, preferred and appropriate communication channels that are effective in bringing the anticipated changes in knowledge, attitudes and behavioural practices :

    - ✓ The project targeted community figures and religious leaders as communication channels to raise awareness among men being the main breadwinner and decision maker at household level.
    - ✓ School health education targeting school children is effective knowing that behavioural practices are difficult and less effective to change during adulthood because they are engraved during childhood. Therefore shaping attitude and behaviour is easier and more effective during childhood
    - ✓ TBAs - who are recognized to be the only source of care available during pregnancy and childbirth for many women in remote areas - have been trained and targeted by the project to reach women during pregnancy and childbirth.
    - ✓ Health workers have been trained to raise clients awareness in health facilities

- The project assisted in setting up CHCs / CBOs, which were not only used as a means to reach beneficiaries at community level, but these institutional structures were also partners in project planning and implementation. Such targeting mechanism is one of the significant factors

contributing to project effectiveness, because the CHCs / CBOs are representing the communities to ensure that the quality of care provided in health facilities are up to community expectations. To improve accessibility to these quality health services by all particularly the poor, the project initiated a CBHF scheme with its pro-poor exemption policy attached to each health facility, but fully managed by CHCs / CBOs to improve accessibility of the improved health care to all, particularly the poor. These mechanisms have evidently contributed to the increase in the utilisation rate of health services as highlighted throughout this report.

- The project trained TBAs who are the only source of care available during pregnancy and childbirth for many women in remote areas. The review of project records revealed that the training support provided by the project was quite appropriate and effective in terms of:
    - ✓ Establishing the link between TBAs and the public health care system as it is happening now with TBAs reporting the number of assisted deliveries, and are included in the routine statistics of each district.
    - ✓ TBAs' efforts to increase community awareness of the danger signs, and where to seek care, and where to seek assistance for other reproductive health needs such as family planning, and neonatal immunization
    - ✗ Assisting 130 safe deliveries
    - ✓ Referring 40 cases with danger signs to Sayoun hospital.

From the interview with health care providers the mission had the impression that trained TBAs have been able to perform their tasks effectively, and there is a collaborative work relation between health workers and TBAs, and the latter are always welcomed at the health facility. A quote of health workers confirming this collaborative relation is highlighted below which also shows the trust which TBAs enjoy in their communities:

> *"TBAs come to the health facilities regularly to register childbirths. In a number of occasions we saw TBAs bringing the child to the health facility for vaccination"*

Project annual reports commended the trained TBAs for their contribution in increasing the utilisation of antenatal and postnatal care and other reproductive health services. The mission could not verify from the data available whether the increase in utilisation of antenatal and postnatal was actually attributed to TBAs. Along the same line the mission advises the project and health facilities to beware when TBAs bring the child for vaccination after delivery that it does not result in missing a golden opportunity for the mother to attend postnatal care. Although training of TBAs is effective in reaching women during pregnancy and childbirth and can be entrusted with the abovementioned tasks, however, there is no evidence of the effectiveness of trained TBAs in reducing maternal mortality. The national RH Strategy (2007-2011) limited the role of TBAs to serve as advocates to encourage women to seek essential pre-and postnatal care and to obtain care from skilled attendant[2] during childbirth. They can inform skilled attendants about women who become pregnant in the community so that the skilled attendant can make direct contact with them. The project is therefore advised to continue training existing TBAs building on the trust they built with their communities over the years, but where childbirths should be assisted by CMWs where available.

3. Efficiency

[2] The definition of skilled attendants does not include TBA. The skilled attendant should at least be a CMW, and definition does not include TBA

Assessment of project efficiency revealed that the project has managed with reasonable regard for efficiency, and measures particularly in the second phase of the project to ensure that resources are efficiently used.

- **Legal and organisational set-up of the decision making process at different levels, including the regional offices**

  - The Midterm Review of the project reported hesitation and delay in decision making at the start of the project the due to lengthy discussions over the form of the project required, implementation and coordination arrangements, and the procurement procedures and other contractual issues, which hindered the start of implementation of project activities, A snapshot of the situation and the issues which were prevalent at that time are highlighted below.
    - ✗ The project proposal was prepared by Oxfam Health Program Officer with inputs from Oxfam Country Office Oxfam limited to policy and advocacy, and inputs from Regional Office mainly on district health systems and improving the quality of health service, etc. So when implementation started the inputs from the Regional Office and the Country Office formed competing priorities with more emphasis from Oxfam Yemen on the achievements of policy and advocacy, but less interest in other activities, which were considered of priorities to local communities. This scenario of whether the project should focus on advocacy (to be implemented by Oxfam) or support service delivery through SOUL initially affected the project to respond favourably to local needs and priorities.
    - ✗ Delay was exacerbated by the fact that management decisions were centralised at Oxfam Country Office in Sana'a, which meant that field staff had to make trips to Sana'a to obtain management approval. There was also a high turnover of key personnel from Oxfam and SOUL who were closely associated with the project from the start.
    - ✗ Delay in procurement and supply provision was also caused by the lack of administrative personnel at the project office.
    - ✗ Delay in implementation was also said to be attributed to late recruitment of project staff which in the case of the policy officer proved difficult to do at the start of the project due to lack of national expertise willing to work in the remote areas of Hadhramout were there is no prospects for future.
    - ✗ The project entrusted SOUL as a local partner with awareness raising and social mobilisation work, only to realize during implementation that the capacity of the female social mobilisation field worker needs to be strengthened to be able to build the capacity of local women associations.
    - ✗ A significant time period of the project period has elapsed before the project office was rented although implementation of project activities was already underway. Project staff were scattered in various locations of partners' office and there was no room to convene as a team.

  The abovementioned issues were redressed by the project with the availability of Oxfam Program Officer in the field who helped in reducing overlaps and conflicts to move the project towards a more orderly system to achieve greater efficiency in planning and implementation.
    - ✓ The restructuring process resulted in opening a full fledge office for Oxfam in Sayoun with full decentralised management. Oxfam Office in Sayoun hosted the project office as well as other projects initiated by Oxfam such as the Livelihood Project. With Oxfam's new office in Sayoun joined Oxfam's health program officer and the finance officer.
    - ✓ The project internal review with partners which took place in September 2004 in which participants acknowledged the slow progress in implementation of activities during the first phase of the project such as the community involvement in health financing, monitoring the

quality of care at health facility level, health education campaigns, and the long-term, and CMWs training courses. During this review, roles and responsibilities of each partner were clarified, and the review resulted in reiterating Oxfam's position to build the capacity of various partners to assume the responsibilities in delivering outputs and achieving results. The agreed roles and responsibilities of each partner are outlined below:

Roles and responsibilities	Partner
Strengthening the district health management	**Regional Health Office**, and Oxfam
Improving the quality of health services	**Regional / District Health Office**, and Oxfam
Strengthening quality, management and financing within the district health system.	Regional Health Office with support from Oxfam
Continue to implement health awareness and community participation components, but through concerned actors plus coordinating the CMWs Course in Sayoun	**Concerned actors** with support through SOUL
Capacity building, policy and advocacy	**Oxfam**
Project management	**Oxfam**, and SOUL

- **Quality of the day-to-day management;**

The mission looked at the issues that affected the quality of day-to-day management at the start of the project in respect of staff availability and deployment, overlap in lines of responsibilities, the decision making process in terms of quality and timely managing the budget, including whether allocated resources were utilized as planned, in co-ordination with local and national authorities, institutions, and beneficiaries.

The results of the review revealed that the day-to-day management of the project improved and became more efficient in the second phase of the project compared to the start of the first phase of the project. The improvement in management quality was a result of concerted efforts by the project in consultation with project partners. These concerted efforts included the followings:

- ✓ clarified roles and responsibilities of Oxfam and partners were clarified
- ✓ provided institutional strengthening to partners and build capacity of their staff
- ✓ organised monthly meeting for project staff and quarterly monitoring meetings and annual impact reports which were the basis for consultation

The management of the project has put a lot of efforts into establishing a local network and has obviously been very successful in doing so. The impression obtained by the evaluation mission from various stakeholders (Regional Health Office and the two District Health Offices) is that the project team interacted with them on a collegial day-to-day basis. The project management showed a good capability in managing backdrops and risks and was very efficient in demonstrating flexibility to respond to changes in circumstances.

The quality of management of the rehabilitation works of Kutna, Sakdan and Al-Dhubaiha health units have improved in the second phase of the project with proper procedures for bidding and contract award compared to the first phase when a significant percentage of the contract was paid as advance money for construction without assurances for completion within the period prescribed in the contract and according to specification.

The evaluation mission did not find obvious evidence of waste. Roughly and without checking the results of the final project audit[3], which was still underway at the time of writing this report it is safe to conclude that the value-for-money seemed to be reasonable.

- **Relationship between planning and execution by typology of activities;**

- The delay faced during the identification / planning stage has led to delay in implementation of activities and this reduced project efficiency at the start of the project, and this matter was redressed by Oxfam to move the project towards a more structured organization to achieve greater efficiency in planning and implementation.

- The project carried out a participatory needs assessment at the start of the project in partnership with concerned institutions. This exercise was followed by a participatory planning exercise with these institutions to plan activities based on the needs identified during the needs assessment. Oxfam then strengthened these institutions and built the capacity of their staff. These concerned institutions were then involved in execution of activities each according to its mandate.

  In general, the participatory planning usually takes longer because it involves dialogue and negotiation among stakeholder. Reaching consensus can be quite difficult compared to blue project planning, which can be seen as of low efficiency because of the time it takes to agree among stakeholders on the issues at stake. Nevertheless, the participatory planning contributes to efficiency in execution of activities, because the planning was well thought of stakeholders and most importantly, because those who are involved in execution are motivated and empowered because they were consulted during the planning stage.

- The communities identify their needs and participated in the planning and implementation of activities relevant to them such as the co-management of health services and the management of the CBHFs

- The relationship between planning and execution of project activities was quite efficient in the sense that:
  - Concerned institutions stakeholders i.e. Regional Health Office, the two District Health Offices, the two DHMTs and the local communities were involved in the planning process which has reduced the cost of planning of execution of activities
  - The planning of activities was based on the needs assessment which was carried out in a participatory approach with various stakeholders, and those who were involved in the planning were also responsible for implementation
  - In view of the limited capacity of various stakeholders the project provided support and supervision to the local institutions responsible for execution of activities
  - Community participation is viewed as a means to increase project efficiency
  - The participation of local institutions including local communities in the process of planning and implementation led to their acceptance and support of the services, which increased cost effectiveness.

- **Relationship and co-ordination with the donor community;**

[3] The audit focuses on compliance with agreed financial regulations

The project with the support of Oxfam country office has maintained close relationship and coordination with the donor community through consultations and exchange of information and sharing experiences particularly on CBHF to avoid duplication of efforts and to put the issue on the policy agenda. These consultations were in the form of regular meetings organized by the MOPHP with donors and development partners. Oxfam is also a member of the thematic groups which are formed by MOPIC to plan and monitor PRSP. The project has received a number of visits from donor funded projects including the EC HSDS in Taiz and Lahj Governorates

- **Coordination for the project audit and final evaluation.**

  The project audit was planned to coincide with the final evaluation, however, the results of the auditors were not readily available at the time of drafting this report.

- **Efficiency in identification, preparation and implementation;**

- The identification, preparation and implementation are three stages in the project cycle which the project went through. The evaluation mission looked at the three stages and assessed their efficiency:

  - **During the identification stage** Oxfam carried out a situational analysis and needs assessment in consultation with key stakeholders. The exercise has been quite efficient in generating the initial project idea and preliminary design. The information generated during the identification stage was used during the preparation stage as the basis for the detailed design of the project. During the preparation stage Oxfam started a pilot preparatory phase with SOUL while submitting a proposal for funding from the EC to co-finance the project.

  - **During the preparation stage**, the first year of the project faced uncertainty in the date of signing the grant agreement with the EC. This has **influenced project implementation** which was already underway leading to delay in the recruitment of Oxfam GB management staff. To keep the momentum going, Oxfam recruited and deployed a number of its staff to work under the supervision of SOUL who was already over stretched with other activities. This consequently led to SOUL being overloaded with more activities than was expected to deliver at the expense of progress in implementation of other activities. With the absence of Oxfam senior staff in the field the implementation stage has witnessed overlaps of roles and responsibilities. This situation typically illustrates that the project cycle represents a continuous process in which each stage of the cycle not only depends on information from the previous stage but also on the success of the previous stage. This situation has reduced the project efficiency, but it was redressed with the availability of Oxfam Program Officer in the field who helped in building strong teams around project implementation, ensured full participation of stakeholders, clearly assigned project responsibilities, demonstrated fruitful working relationships, improved implementation by clarifying what information is needed to track project progress, to monitor and if necessary manage the influence of project assumptions and to measure project results and impact. Project stakeholders convened on a quarterly basis to review progress of activities and to address challenges.

- On another positive note the project has utilized a participatory approach during the three stages of the project cycle (identification, preparation and implementation) which together with the capacity building to local stakeholders created a sense of ownership and ensured that implementation is demand driven and enhanced project efficiency.

- **Methods of planning and reporting,**

The mission looked at the planning and reporting functions of the project management and assessed the efficiency of these two functions as well as the extent to which there was efficiency in the use of resources, transparency and accountability.

- The review of annual project reports and the interview with the project team and the Director of the District Health Office in each district revealed that the project has adopted a joint participatory planning approach throughout the project period. At the start of the project the participatory planning was based on situational analysis and the participatory needs assessment. During project implementation project stakeholders formed a monitoring committee that convened on a quarterly basis to review and monitor project activities. The project team then writes annual progress reports based on the quarterly reports as a project requirement for the EC through Oxfam Country Office. The annual reports provide information to stakeholders on what has been accomplished in activities and towards project purpose and overall goals and outline constraints and lessons learnt and recommendations for the coming year.

- The annual report thus feed into the planning process and becomes the basis for planning in the coming year. Planning is therefore flexible to changing circumstances and being guided by local needs. Planning and reporting are therefore an integrated and continuous process. The reports are thus viewed as an opportunity to analyze and collectively reflect on past accomplishments and to learn lessons and for decision making. The planning and reporting methods are therefore transparent, foster accountability, facilitates communication among stakeholders.

4. Impact

- **Delivery mechanisms, particularly with regard to end users/beneficiaries;**

- The participatory approach which was adapted by the project is obviously illustrated as one of the most significant factors contributing to the project effectiveness

- The project utilized a capacity building approach of local institutions rather than a service delivery one to ensure that they effectively deliver the outputs and to achieve the expected results during the project life and when the project cease to exist..

- Basic health services for women and better health provision for children are known factors in improving community health outcomes.

- The project has carried out awareness raising campaigns to reach different beneficiaries through various trusted, preferred and appropriate communication channels that are effective in bringing the anticipated changes in beliefs, attitudes and behavioural practices :

    - ✓ The project targeted community figures and religious leaders as communication channels to raise awareness among men being the main breadwinner and decision maker at household level.
    - ✓ School health education targeting school children is effective knowing that behavioural practices are difficult and less effective to change during adulthood because they are engraved during childhood. Therefore shaping attitude and behaviour is easier and more effective during childhood
    - ✓ TBAs - who are recognized to be the only source of care available during pregnancy and childbirth for many women in remote areas - have been trained and targeted by the project to reach women during pregnancy and childbirth.
    - ✓ Health workers have been trained to raise clients awareness in health facilities

- The project assisted in setting up CHCs / CBOs, which were not only used as a means to reach beneficiaries at community level, but these institutional structures were also partners in project planning and implementation. Such targeting mechanism is one of the significant factors contributing to project effectiveness, because the CHCs / CBOs are representing the communities to ensure that the quality of care provided in health facilities are up to community expectations. To improve accessibility to these quality health services by all particularly the poor, the project initiated a CBHF scheme with its pro-poor exemption policy attached to each health facility, but fully managed by CHCs / CBOs to improve accessibility of the improved health care to all, particularly the poor. These mechanisms have evidently contributed to the increase in the utilisation rate of health services as highlighted throughout this report.

- The project trained TBAs who are the only source of care available during pregnancy and childbirth for many women in remote areas. The review of project records revealed that the training support provided by the project was quite appropriate and effective in terms of:
    - ✓ Establishing the link between TBAs and the public health care system as it is happening now with TBAs reporting the number of assisted deliveries, and are included in the routine statistics of each district.

- ✓ TBAs' efforts to increase community awareness of the danger signs, and where to seek care, and where to seek assistance for other reproductive health needs such as family planning, and neonatal immunization
- ✗ Assisting 130 safe deliveries
- ✓ Referring 40 cases with danger signs to Sayoun hospital.

From the interview with health care providers the mission had the impression that trained TBAs have been able to perform their tasks effectively, and there is a collaborative work relation between health workers and TBAs, and the latter are always welcomed at the health facility. A quote of health workers confirming this collaborative relation is highlighted below which also shows the trust which TBAs enjoy in their communities:

> *"TBAs come to the health facilities regularly to register childbirths. In a number of occasions we saw TBAs bringing the child to the health facility for vaccination"*

Project annual reports commended the trained TBAs for their contribution in increasing the utilisation of antenatal and postnatal care and other reproductive health services. The mission could not verify from the data available whether the increase in utilisation of antenatal and postnatal was actually attributed to TBAs. Along the same line the mission advises the project and health facilities to beware when TBAs bring the child for vaccination after delivery that it does not result in missing a golden opportunity for the mother to attend postnatal care after delivery. Although training of TBAs can be effective in reaching women during pregnancy and childbirth and can be entrusted with the abovementioned tasks, however, there is no evidence of the effectiveness of trained TBAs in reducing maternal mortality. The national RH Strategy (2007-2011) limited the role of TBAs to serve as advocates for skilled attendant. They should encourage women to seek essential pre-and postnatal care and to obtain care from skilled attendant [4] during childbirth. They can inform skilled attendants about women who become pregnant in the community so that the skilled attendant can make direct contact with them. The project is therefore advised to continue training TBAs building on the trust they built with their communities over the years. However, in areas where TBAs building on the trust they built with indemnity their communities in areas where there are no CMWs TBAs can still

- **Relationship and co-ordination with other players and beneficiaries**: DH Office, private sector, local communities, co-operatives, community-based organisations and CBO's regarding their capacity to achieve the desired impact.

  The impression obtained by the evaluation mission from various stakeholders (Regional Health Office and the two District Health Offices) is that the project team interacted with them on a collegial day-to-day basis and has adopted a participatory and a capacity building approach with key actors at local level that stands for a partnership built upon the basis of a dialogue among the various stakeholders, and decisions were based on negotiation and consensus rather than domination. Thus, local institutions became actors rather than simply being beneficiaries.

  The project provided relevant institutional support and capacity building needs to the institutional structures at district level (DHCs and DHMTs) and at community level (CHCs/CBOs) as well as to the health education department and school health education, and upgraded the skills of health care providers in order to sustain access to quality care and to raise the level of awareness. The impact of the project is therefore not only limited to the stated goal of improving

[4] Skilled attendants should at least be a CMW, and definition does not include TBA

the health status, but have also empowered local actors to assume their responsibilities according to their mandates. The stakeholders used to convene quarterly monitoring review meetings, which were used as the basis for coordination and monitoring among various stakeholders.

The project management maintained close relation and coordination with all stakeholders including the Regional Health Office, and sensitized and advocated the latter to increase the government budget for the operational cost of the health facilities. The Regional Health Office demonstrated its commitment by increasing the budget for the running cost of health facilities

> *"We did not have a budget for operational costs for each health facility in the past until Oxfam sensitized us. We used to have YER[5] 50,000 for all the HCs and HUs in the district. Now, each HC has a budget of YER 50,000, and each HU YER 9,000. Now, we do not need equipment and furniture and if we need we can provide the budget for that from our office".* The Director of the Regional Health Office

- **Impact on Oxfam's capacity to address poverty questions;**

Oxfam is leading the way in innovative research on national policies and their impact on the poor and advocate on pro-poor policies. Its partnership with the Government of Yemen on the Voices of the Poor and the Impact of Cost Sharing in the Health Sector are notable. Both studies apply best practice approaches to participatory knowledge generation and contribute insights into how the poor perceive their situation and the impact of policies, institutions and processes on their well-being. Oxfam has in the past focused on research, advocacy networking and capacity building, and now testing policies at ground level to inform national polices.

In addition, Oxfam GB is currently implementing an "Integrated Action on Poverty and Early Marriage" in Yemen funded by the Danish Government. The four-year programme has two main components: Livelihoods Project, aiming to provide economic opportunities for women in the two governorates of Hodeidah and Hadhramout, and Early Marriage Campaign. The Livelihoods component being implemented from Sayoun Field Office aims to provide economic opportunities for women in the two governorates of Hodeidah and Hadhramout, and to conduct institutional advocacy on women's employment in private and government sectors. Overall, the Integrated Action on Poverty and Early Marriage and the Livelihoods component of this programme will work with existing Associations and community Health Committee's established under the community-based health project.

- **Impact on the local economy and on health status /communities**

- The qualitative evidence of project results can be seen in the increased access to and utilisation of good quality health services at low level health facilities at the peripheries, which, before the start of the project, received little investment and insufficient operational budget, and many, if not most, were challenged by a crumbling physical infrastructure, shortage of skilled personnel, biased staffing pattern (exclusively male and often lacked a midwife), serious gaps in basic equipment for obstetric care and lack of essential drugs and supplies, and limited referral capacity, a result, they are often bypassed in preference for hospital level care in Sayoun. This health seeking behaviour of bypassing lower level health facilities to hospital level care where people have no choice results in paying higher costs from their out-of-pocket money for care and for transport to and from the hospital at the expense of their other basic needs. This care seeking

[5] 1 USD = YER 200 at the writing of this report

behaviour also increases the cost for the health system as a whole. Costs of care for men and women and for the health system are lowest at the peripheries.

- Significant changes have occurred in the lives of poor women, girls and children as a result of the project interventions:
    - ✓ The project has trained 63 girls as community midwives and nurses, of which 45 (21 CMWS and 24 nurses) are now working as health care providers and were included on the government payroll. The employment of these 45 girls with 18 to follow in the two districts resulted in the greater equity in income level between women and men, which will undoubtedly improve the status of women in the community, and will improve the socioeconomic status of poorer families. This has undoubtedly raised their status in their community and improved their quality of lives in a place where the rules of the game at the community dictate against girls' education beyond the ninth grade let alone their employment. The project was able to change the statuesque by addressing the social barriers that prevented girls from joining the community midwives training course. For a conservative society to allow their girls to go and train as community midwives outside their areas and stay nights away from home might could have been a killer assumption at the start of the project. The dedication and persistence of the project team and their accumulative knowledge of the local culture together with the keen interest of girls to become midwives have turned this into a success story
    - ✓ Women as health care providers have improved access to health care by other women who were reluctant to seek care where most health facilities we staffed by male. The improved access to good quality health care has led to the increase in utilization rate of health services of services particularly by women. The increase in antenatal care, postnatal care, tetanus texoid for women at reproductive age,
    - ✓ The project has increased vaccination coverage for child under the age of one year which positive impact against the six child illnesses which can be prevented through vaccination. The project has introduced and institutionalized the Integrated Management of Child Illnesses (IMCI), which has profound effects on child health.

- The project has utilized local contractors who used local work crew to carry out the rehabilitation and upgrading work of health facilities. This to some extent has contributed to the distribution of wealth among as many local people as possible.

5. Sustainability

- **Ownership by end-beneficiaries and agencies and continuity of results and prospects for sustainability;**

  In general the project has involved key beneficiaries including end-users in planning and implementation of project activities which they used and from which they benefited, and this involvement process has helped to focus the project on relevant needs and opportunities, increased ownership and resulted in greater chances of sustainability. The project has helped in organizing local communities through the formation of CHCs around each health facility to represent the community and voice their concerns of the quality of care and to assume a leadership role in the management of the CBHF schemes. The CHCs have also taken the responsibility for setting the monthly subscription fee and to decide on exempting poor families who cannot afford to pay. The money collected from the subscription fee is retained by the CHCs to improve the quality of care in the health facility. Of the 24 CHCs which were setup, 7 committees (6 of them were the ones targeted by the project) have registered as formal NGOs with the support of the project, thus giving them the opportunity to be autonomous and can have their own bank account and raise their own funds. This process has fostered a sense of ownership among local communities and empowered them to get more control over their health determinants and to find solutions for their health problems and the solidarity with the poor and the vulnerable groups in their communities, and enabled health services to be accountable to their communities, and increased the prospects and conditions for the future sustainability of the CBHF and for sustaining of the quality of health care. The CBHF is relevant and appropriate to the local context and was developed based on local views and indigenous knowledge; hence it gained popularity among local communities.

- **Ensuring sustainable maintenance and operation arrangements of realised projects.**

- The project did not implement activities, but built the capacity of existing institutions to assume their responsibilities. The staff of these institutions are on the government payroll

- The project has supported activities, which are in line with the National Health Policy and are key elements of the National Health Sector Reform. Most of these activities are already institutionalized within the health care system and have their own operational costs although not sufficient to effectively maintain the improved quality of care. The project advocacy efforts at local level have materialized in influencing the Regional Health Office to allocate more resources for health facilities, particularly for operational costs. This was recognized by the Regional Health Office DG:

  > *"We have learnt a lot from Oxfam's experience. For instance, they started with upgrading, furnishing and equipping the health facilities, and then they advised on the importance of increasing the budget for the operation cost. We followed that up with the local authority and we secured the operational costs for these facilities from the government budget. Of course the success on the ground has helped us to put our case strongly. We did not have a budget for operational costs for each health facility in the past. We used to have YER[6] 50,000 for all the HCs and HUs in the district. Now, each HC has a budget of YER 50,000, and each HU YER 9,000".* The Regional Health Office DG

[6] 1 USD = YER 200 at the writing of this report

There were other few activities initiated by Oxfam to improve access to and utilisation of health services in peripheral health facilities:

[Figure Removed]

- For the 6 CBHF schemes which the project has been accountable the overwhelming majority of families (1,524 families) are subscribed to the scheme of which 82% are paying their monthly subscription fee while 18% are exempted from payment. The relatively high percentage of exempted families reflects the socioeconomic status among people in these remote areas. The prepayment fee slightly varies from one scheme to the other. Some schemes have set the fee at YER 100 (equivalent to USD 0.50), while others have set it at YER 150 (equivalent to USD 0.75). Examination of the process of consultation that was carried out to arrive at these fees shows that the fees are affordable by the majority of families, and those who could not afford them are obviously exempted. Members of each CBHF scheme are eligible for health services and essential drugs in health facilities without paying any additional charges. The amount does not include referral to hospital or hospitalisation. The existing prepayment fee levied from each family generates modest additional resources for these remote health facilities to help improve the quality of care, besides making health services responsive to the needs of the local population. The fee is too small to cover all the needs and to sustain services or for CBHF to become self reliant. Nevertheless, the CBHFs schemes do not necessarily have to exclusively rely on fees from families, and this is evidently the case in Sayoun and Sah where the CBHF seemed to have attracted other financing sources from philanthropic individuals and organizations, oil companies working in the area, and from Oxfam. Some of the funds received by CBOs/CHCs from these financing sources are in-kind donation or money earmarked for specific issues like equipments or drugs for the health facilities, while other donations go beyond the health sector to improve community water scheme. There is thus a high chance for the financial sustainability of these CBO/CHCs, but the institutional sustainability still needs continued training and institutional support to these community organisations to ensure long term sustainability and to sustain existing achievements.

- The mobile clinic was initiated by the project upon the recommendations of the Midterm Review in order to increase access to and utilisation of health services in peripheral health units. Oxfam supported the mobile clinic by paying for the vehicle hire and remuneration for the team knowing that the initiative will raise the interest of the health office and in a way create pressure through community demand on the health office to take full responsibility and allocates the necessary resources for it. The regularity and frequency of the mobile clinic has reduced to a minimum since the project stopped its support. Hadhramout Regional Health Office has expressed commitment to allocate resources for the mobile clinic from next year onwards. In the mean time Oxfam is looking into how to resume such activities giving the high demand for it from local communities and from health workers at health facilities as well as from the DHMT and DHC. The mobile clinic is highly appreciated by local communities and thus should stand a higher chance of sustainability, but the community cannot afford to pay the full cost of the "the mobile clinic in the long run. On the other hand, the CBHF has accumulated sufficient revenues in their accounts, and can and should contribute towards co-financing the operations of the mobile clinic.

[Figure Removed]

- The second batch of CNWs who recently graduated from the CNWs training course are not yet employed. An arrangement has been reached between Oxfam and the Regional Health Office to ensure that they become on the government payroll as soon as possible. In the mean time Oxfam agreed to pay the CMWs small enumerations to start working in their health facilities so that the CMWs do not stay at home and lose interest or momentum for work.

  > *"The batch of midwives graduated in Sayoun has been deployed to work in health facilities and are on the government payroll. There is currently an ongoing course for new midwives for Sah. They will soon graduate and we will get them on the government payroll"*. The Regional Health Office DG

- The project was implemented within the framework of the government funded health sector and the overwhelming majority of the operational costs including staff salaries were covered from the government budget. However, Oxfam paid small enumerations to the accountants of the CBOs (USD 100 per month) who were working as volunteers. The payment was paid for a few months to ensure their availability on a full time basis. By the end of the project such payment ceased to exist. The accountants are still working despite the fact the payment stopped. Oxfam also paid for the cost of transport of the DHMTs for their regular supervision and monitoring visits to health facilities. The DHMTs has reduced their supervision and monitoring visits to a minimal since the project stopped payment due to lack of transport means. Oxfam is now working with the district health office in each district and with the regional health office to find out ways to sustain such activity. One possibility is to hand over project vehicle(s) to each district health office for the purpose of supervision and monitoring and take responsibility for its operational cost.

7.4 Cross cutting issues

The following crosscutting issues were of relevance for the project to achieve its objectives:

- **Use of effective decentralisation and bottom-up approaches; including the role of regional office;**

  Oxfam has effectively used the decentralisation and bottom-up approaches to assist the MOPHP in operationalising the reform process as outline below:

  - ✓ The project was designed based on a participatory needs assessment in partnership with all local actors at district level.
  - ✓ Oxfam did not implement any activities, but supported local institutions through capacity building and institutional strengthening to assume their roles and responsibilities according to the mandates as stipulated in the HSR document. This process has empowered existing institutions and impacted positively on all those who have been involved in the implementation.
  - ✓ The project has developed a sound institutional capacity at the district level with a special focus on leadership, planning, and supervision with the regional health office and the DHO supported and appropriately involved at all stages.
  - ✓ The process increased the ability of the Regional Health Office to lead, plan and coordinate health services between districts
  - ✓ The process strengthened the two DHMTs to plan for and monitor and supervise the implementation of health services in their districts.
  - ✓ The project has setup the MIS which is effective in improving data collection, analysis and use in planning and decision making at district level. The MIS has also been effective in influencing the Regional Health Office to support other districts to utilise the MIS as a tool for monitoring and reporting.
  - ✓ Training of health care providers to improve their skills that have decayed over time
  - ✓ Setup the CHCs / CBOs to co-manage the health services and to be in charge of CBHF
  - ✓ Improved capacity at district and local level is a valuable end in itself

- **Participation and empowerment efforts;**

- The project has adopted a **participatory process approach** in which the project was not involved in direct implementation of activities, but involved existing institutions as key stakeholders including local communities in planning, implementation and monitoring each according to its mandate as stipulated in the Health Sector Reform Strategy. During this process the project has build the institutional capacity of these institutions at district level (DHCs and DHMTs) and at community level (CHCs/CBOs) as well as to the health education department at the Regional Health Office and the School Health Department at the Regional Education Office, and upgraded the skills of health care providers in order to sustain access to quality care and to raise the level of awareness. The impact of the project is therefore not only limited to the stated goal of improving the health status, but have also empowered local actors to assume their responsibilities according to their mandates. The stakeholders used to convene quarterly monitoring review meetings, which were used as the basis for coordination and monitoring among various stakeholders.

- The project has helped in organizing local communities through the formation of CHCs/CBOs around each health facility to represent the community and to voice their concerns of the quality of care and to assume a leadership role in the management of the CBHF schemes. The participation of local communities in project activities through their LHCs/CBOs has undoubtedly fostered a sense of ownership among local communities and empowered them to get more control over their health determinants and to find solutions for their health problems. Empowerment of the poor and the marginalized is seen as an important step that contributes towards a more equal distribution of wealth and power. The seven CBOs who registered as formal NGOs have greater autonomy and can have their own bank account and raise their own funds.

- **Gender aspects and gender mainstreaming;**

- The project has been successful in its gender approach by improving the health status of women and strengthening their position through training and successfully involving them in the public health service. One of the main features of the health facilities before the start of the intervention is their predominately untrained, de-motivated male workforce which creates a cultural barrier for women to seek care and to access the health facility. The project has trained two batches of new community midwives. The first batch was for Sayoun district and girls are already deployed in the health facilities and are on the government payroll. The second batch graduated recently and arrangements are being made to get them on the government payroll.

- The project planned and implemented activities that addressed ***practical gender needs*** related to meeting people's basic needs and improving the conditions for men and women through improving the quality of care while accepting the existing division of labor and without challenging existing gender roles. The "*bias in staffing pattern*" was addressed by the project from the perspective of improving access to health care through the training of female CMWs. During implementation, the project found itself dealing with ***strategic gender needs*** when parents did not allow their daughters to join the course, and worked to address the social norms which were unfair and unjust for cultural reasons. Although the project respected this, however, it worked in the most sensible way to change the statuesque by addressing the social barriers that prevented girls from joining the community midwives training course. For a conservative society to allow their girls to train as community midwives outside their areas and stay nights away from home might have been a killer assumption at the start of the project. The dedication and persistence of the project team and their accumulative knowledge of the local culture together with the keen interest of girls to become midwives have all contributed to this success. The review of baseline data for Sayoun and Sah shows that the *"biased staffing pattern - exclusively male and often lacked a midwife"* was one of the main barriers for women to access health care in remote areas. Therefore addressing gender inequity has improved women's access to health care.

- **Attention for the environmental dimension;**

The environmental dimension is not relevant to this health project. However, the CBOs that have been assisted by the project to register as formal NGOs may address environmental dimensions which are outside the health sector.

The mission noticed a high prevalence of chronic cases notably diabetes and blood pressure. Some of targeted health units have attempted to provide disposable tests others hope to have a laboratory in order to provide the full range of services on demand. Such services have financial implications on the health unit and will stretch the already low budget too thinly among competing priorities. It is therefore important that the project and the health office to identify the root causes of these chronic illnesses and to mount an intensive health promotion campaigns to raise people's awareness, shape their attitude and change their practices in order to prevent these chronic cases.

Chapter 8: Conclusions and Recommendations

Overall conclusion

The results of this evaluation revealed significant changes to project indicators at the output and outcome level beyond the planned targets. These changes are attributable to the project not to any other external factors. These observed changes would have been impossible to occur without the project interventions. The evaluation mission reviewed the project assumptions and tested whether they still hold true in the light of the information collected during fieldwork, and found that most assumptions have held true. Therefore, there is no reason why the overall objective would not be realised. The increase coverage of reproductive health services (for instance ANC) is considered a proxy or indirect indicator for improved health because a high coverage of ANC relates positively to maternal health. Likewise the high coverage of child care which relates to improved child health.

Detailed conclusion

The project overall objective is in line with the National Development Plan for Poverty Reduction and relevant to national health policies. The specific objectives are linked with the pursuit of sectoral goals and contribute to the achievements of MDG goals and targets. Of particular relevance to national health policy is the decentralized district health system in which the project supported the district health structures (DHMTs and the DHCs) in the two targeted districts and built their capacity. The project interventions were technically adequate in reducing the main causes of problems that have persistently faced the health system in delivering quality health care in the remote areas of the two districts. The interventions included innovations that have gained acceptance and popularity at local level and has caught the eyes of the MOPHP leadership at national level and raise its interest in the scheme for possible replication in similar settings in Yemen.

- The project has improved the allocative efficiency by investing in district health system and PHC facilities. The project has increased the technical efficiency which can be seen in the increase in utilization of services at health unit level. The services are produced at lower cost in health facilities which were underutilized. The project has also been efficient in the sense that the CBHF generated additional funding from families contribution and from philanthropic organizations and wealthy individuals as well as from oil companies. Cost effectiveness of the project is high in terms of creating synergies with other programs and projects financed by the EC and by other donors, which means that the project has provided *"value for money"* for the EC and for Oxfam. The flexibility adapted by the project to respond to changing circumstances and the way in which the project was designed has increased the project cost effectiveness to make up for the project low efficiency due to delay in implementation and the relatively high turnover of staff faced by the project at the start

  The project has improved access to and utilisation of good quality health services at peripheral health facilities, which, before the start of the project, received little investment and insufficient operational budget, and many, if not most, were challenged by a crumbling physical infrastructure, shortage of skilled personnel, biased staffing pattern (exclusively male and often lacked a midwife), serious gaps in basic equipment for obstetric care and lack of essential drugs and supplies, a result, they are often bypassed in preference for hospital level care in Sayoun. This health seeking behaviour of bypassing lower level health facilities to hospital level care where people have no choice results in paying higher costs from their out-of-pocket money for

hospitalisation and transport at the expense of their other basic needs. The improved access of women and children to quality health care have resulted in greater equity in access to health care between deprived rural and areas who are relatively better off in terms of access to services. Greater equity has also been realized by reducing the gender gap in access to services between women and men in rural areas due to the increase in female cadre in health facilities which were previously almost exclusively staffed by male cadre.
The project has improved perceptions, shaped attitudes and changed practices at local level. The attitude towards girls' employment in health facilities have changed favorably. Men who are the decision makers at household level are now more likely to accept that their daughters join the CMWs training course and work in health facilities after graduation. Another project impact relates to the advocacy efforts which materialized in an increase in resource allocation for health facilities.

The project planned and implemented activities that addressed *practical gender needs* which are concerned with meeting people's basic needs by improving the quality of health care while accepting the existing division of labor and without challenging existing gender roles. The "*bias in staffing pattern*" was addressed by the project from the perspective of improving access to health care through the training of female CMWs. During implementation, the project found itself dealing with *strategic gender needs* when parents did not allow their daughters to join the CMWs training course. The project respected this and worked in the most sensible way to change the statuesque by addressing the social barriers that prevented girls from joining the CMWs training course. For a conservative society to allow their girls to train as community midwives outside their areas and to stay nights away from home might have been a killer assumption at the start of the project. The dedication and persistence of the project team and their accumulative knowledge of local culture together with the keen interest of girls to become midwives have turned this into a success story.

Most of these activities are already institutionalized within the health care system and have their own operational costs although not sufficient to effectively maintain the improved quality of care. Few other activities such as the CBHF and the regular visits of the mobile medical team were initiated by Oxfam to improve access to and utilisation of health services in peripheral health facilities. The regular visits of the mobile medical team were initiated by the project based on the recommendations of the Midterm Review. The mobile medical team is demand driven by the community and should stand a higher chance of sustainability, but the community can not currently afford to bear the full cost of *the "the mobile clinic"*. Oxfam supported the mobile clinic by paying for the vehicle hire and remuneration for the team knowing that the initiative will raise the interest of the health office and in a way create pressure through community demand on the health office to takes responsibility by allocating the necessary resources for it. The regularity and frequency of the mobile clinic has reduced to a minimum since the project stopped its support. Hadhramout Regional Health Office has expressed commitment to allocate resources for the mobile clinic from next year onwards. In the mean time Oxfam is looking into how to resume such activities giving the high demand for it from various stakeholders including end-beneficiaries.

- The project has been able to link micro level initiatives to macro and policy level and served as a breeding ground for the development of national policy in CBHF. The development on the micro and policy level should serve as a supportive environment for the sustainability of CBHF. The CBOs have accumulated a modest review in their accounts which can be used to sustain the quality of services. The CBOs currently cover first line health facilities and should expand to cover referrals to (say) comprehensive obstetric emergency care and possibly share the operational cost of the mobile clinic.

Overall recommendation

- The project achievements to-date should be seen as the basis to further consolidate and institutionalise the CBHF within the district health system, and to expand the experience in the project area and to inform national policy for scaling up the experience to other areas in Yemen. Aware of this, Oxfam has secured funding from a British Based Trust Fund and is seeking to raise funds to cover the remaining 20% of the estimated budget to sustain and consolidate the current innovations and to further strengthen the DHMT and DHC to assume responsibility under a decentralised setting where major devolution of authority to local level is expected by the MOPHP under the forthcoming local governance. For the remaining 20%, it makes sense to approach the EC first for possible contribution who may like to continue to be part of this success story in the making and eventually cultivate further achievements when they are fully realized and sustained. Along the same line and to capitalise on current achievements, it is recommended to focus the forthcoming support on further consolidating the CBHF and promoting rights based approach to support women and men to gain a better understanding of their rights as an important first step to promote their active engagement to influence policy.

Recommendations for the forthcoming project

- The project organised and facilitated numerous participatory awareness raising sessions to raise awareness and a number of training workshops to increase knowledge and improve skills, but the mission have not come cross the pretest and post test exercise. An increase in the level of awareness of those who participated in training workshops required baseline data before training to be compared with data after completion of training. Similarly the increase in the level of knowledge among men and women at community level who were exposed to messages (except for mass media) required baseline data before the intervention to be compared with the level of awareness after the intervention. The difference between before and after would be the increase in the level of awareness. It is important that all training workshops and awareness raising sessions are results oriented by measuring the outputs at the end of each event

- The project has supported the DHMTs to conduct supportive supervision that aimed to bring about change and impact service delivery as it provided interactive opportunity between supervisors and health workers in terms of joint identification of problems and solutions. Supportive supervision should be based on relevant tools and checklists, which is not the case now.

- The project has achieved its planned target of setting up the CBHF with an exemption policy for the poor in 6 health facilities. This target was exceeded by expanding the experience to another 18 health facilities through communities' own initiatives with the support of the project bringing the total number of health facilities that apply the policy to 24. Of these 24 health facilities there are 7 CBOs that effectively apply the CBHF and exemption policy. As part of the institutional strengthening, Oxfam furnished and equipped the CBO office room with filing cabinet, desk, table and few chairs. Although each CBO has its own bank account, however, most of these CBOs are located in relatively remote areas from where the bank is located, so they need safes to temporarily deposit the revenue. Other priority needs expressed by the CBOs are relevant to their context and include the need for a computer and training in its use to enable them to write their reports and letters. They also need a fax machine to enable them to communicate in writing with the DHMTs, the district and regional health office and the relevant local authorities as well as institutions at central level and donor agencies. Fax machine and computers and provide training to the accountants and training in computers. These CBOs still require institutional and

capacity building support if they are to be strong enough to assume responsibility as agents of change in their communities. It is therefore important that the forthcoming project continues to provide institutional strengthening and capacity building to the 6 CBOs and to expand support to the other committees within the areas targeted by the project. It is therefore important to continue building their capacity and to strengthen their organisations in order to be self sustained. The capacity building could focus on planning, management teamwork, leadership, and proposal writing skills, etc geared towards improving and health status of women, children and men in their communities using a rights-based approach to development. Each CBHF should have written criteria for exemption. Although at community level families know each other, however, it should be clear to all families what the exemption criteria.

- Since enrolment in CBHF is organized on a voluntary basis, it is important to assess its effective coverage (the number of registered and exempted families as a percentage of the total families in the community). This will be an indicator of effective coverage, but can also be a proxy indicator on how attractive the scheme is and as well as it measures the extent to which the scheme is feasible and equitable. Unfortunately, assessment was not possible due to lack of precise information on the denominator. It is important that each NGO makes use of this indicator in its regular reports to prove that it has a high coverage rate. The timing of payment of contributions is said to be done on a monthly basis, but the schemes should also allow some flexibility for people to pay on a quarterly, semi-annual, annual or on a seasonal basis (i.e. during the harvesting of dates of other cash crops. This will probably increase the number of households registered.

- The accountants of the CBHF schemes who are responsible for collecting contribution from families are members of the Management Board who are volunteers. Although this is good, however there is a limitation when this is done on a voluntary basis and may result in low enrollment or members' withdrawal. On the other hand the CBHF may not yet be able to pay for a salary of an accountant.

- The project should further explore the feasibility of creating CBHF Coordination Council in which funds are pooled. The forthcoming project should in the coming period start encouraging CBOs/ NGOs to utilize some of the revenue on improving health care. The CBOs should negotiate with service providers (the health facility at community level and the district hospital in Sayoun) and the district health office to purchase health care which are not currently accessible to the community, but are considered a local priority, socially acceptable, technically appropriate and in line with the national health policy of MOPHP such as the mobile clinic and the early referral of complicated deliveries which require obstetric care, etc. This will increase the credibility of both health services and CBHF and will ensure that the services are demand driven.

- The project has remarkably increased the number of female cadre in health facilities by 89% from a handful of 7 in 2003 to 69 female staff have eliminated the social barrier of lack of female cadre. This 89% increase exceeded the 30% target of the project. The project should invest in organising more CMWs course(s) from areas which are far from health facilities and from areas around the catchment areas of the health facilities in order to sustain the improved quality of services.

- The project has been able to link micro level initiatives to macro and policy level and served as a breeding ground for the development of national policy in CBHF. The development on the micro and policy level should serve as a supportive environment for the sustainability of CBHF. The CBOs have accumulated a modest review in their accounts which can be used to sustain the quality of services. The CBOs currently cover first line health facilities and should expand to cover referrals

to (say) obstetric emergency complications and possibly share the operational cost of the mobile medical team.

- The current health officials at district level and health workers at the health facility level all confirm that the CBHI is socially appropriate and culturally acceptable by the local communities. The CBHF is initiated by community representatives the setup at each health facility built around the CHC. One of the risks is that if there are new members in the local council who are not aware of this initiative may start accusing the CBOs of not paying the percentage of the fee as an income for the Local council according to the law. It all depends on relations and contacts. It is therefore important that the project work with the MOPH&P at national, governorate and district level to develop and institutionalize a working relation between health facilities and the CBOs.

- The project was implemented within the framework of the government funded health sector and the overwhelming majority of the operational costs including staff salaries were covered from the government budget. However, Oxfam paid small enumerations to the accountants of the CBOs (USD 100 per month) who were working as volunteers. The payment was paid for a few months to ensure their availability for the scheme on a full time basis. By the end of the project such payment ceased to exist. The accountants are still working despite the fact the payment stopped. Oxfam also paid for the cost of transport of the DHMTs for their regular supervision and monitoring visits to health facilities. The DHMTs has reduced their supervision and monitoring visits to a minimal since the project stopped payment due to lack of transport means. Oxfam is now working with the district health office in each district and with the regional health office to find out ways to sustain such activity. One possibility is to hand over project vehicle(s) to each district health office for the purpose of supervision and monitoring and take responsibility for its operational cost.

Recommendations for Oxfam:

- The project should document evidence based best practices which can be used for advocacy and policy development at local and national level, and should also be disseminated widely. Two apparent evidence based practices are the CBHF and the training of TBAs and the established means of forging appropriate links between TBAs and health facilities. This is highly needed at for the Reproductive Health at Technical Group at national level.

- As part of the dissemination of this End of Project Evaluation Report Oxfam should approach the EC for a possible continuation of support to cover the 20% funding required for the forthcoming continued support

- Oxfam should make sure that prior arrangements are made to avoid any gaps in financing learning from the experience of the start of this project where the uncertainty in the date of signing the grant agreement with the EC during the first year have led to delay in major project activities.

- The interaction with the local councils varies among CBOs with a mixed experience. During the group meeting with the Board of Directors of Kasdan CBO, the members pointed out that the community received a donation for the water supply project from philanthropic businessman through the CBO. This has made the head of the local council unease about the CBO. Oxfam should assist the district local councils in Sayon and Sah in development their strategic development plans. The development of the plans should be done jointly by the local councils and CBOs. This process will empower communities and will ensure that the strategic development plans of the districts are prepared in a participatory approach with NGOs/CBOs.

- The IMCI strategy introduced by the project was until recently part of the national health policy. It is still used in a number of districts, but the MOPH&P has shifted focus towards HSS which is also an integrated approach. IMCI is an approach which is similar to the newly adapted HSS, however, is important that the project consult the PHC sector at national level on the possibility of continuing with the IMCI or the need to shift to the new approach for reporting purposes.

- The project has trained TBAs and developed and established means of forging appropriate links between TBAs and health facilities. The project refers to the deliveries assisted by TBAs as skilled attendants. However, the debate of who should assist women during childbirth has been going on for decades at the international level. Policies regarding safe delivery have evolved over time, and nowadays W.H.O is promoting skilled attendance during all deliveries, a position which W.H.O adopted since 1997. The definition of skilled attendants includes CMWs but does not include TBAs. The question is how can this policy be adopted in the context of Yemen? In the context of Yemen where TBAs are recognized to be the only source of care available during pregnancy and childbirth for many women in remote areas, and giving the realities facing the country in terms of shortages in manpower, the project has trained community midwives as skilled attendant and trained TBAs in the two districts and integrating them into the health care system. The project is therefore advised to continue training existing TBAs building on the trust they built with their communities over the years, but childbirths should be assisted by CMWs where available. Oxfam should open up a dialogue with the MOPH&P and other concerned development partners (for instance WHO) and reach consensus on this issue.

- Oxfam's advocacy efforts at local level have materialized in influencing the Regional Heath Office to increase the resources allocated for health facilities, particularly for operational costs. These advocacy efforts should continue at regional, district and national level to influence resources allocation in favor or peripheral health facilities.

- The forthcoming project should further explore the feasibility of creating CBHF Coordination Council in which funds are pooled. The project should in the coming period start encouraging NGOs to utilize some of the revenue on improving health care. With the assistance of the project NGO should negotiate with service providers (the health facility at community level and the district hospital in Sayoun) and the district health office to purchase health care which are not currently accessible to the community, but are considered a local priority, socially acceptable, technically appropriate and in line with the national health policy of MOPHP such as the mobile clinic and the early referral of complicated deliveries which require obstetric care, etc. This will increase the credibility of both health services and CBHF and will ensure that the services are demand driven. These organisations still require the support of the project if they are to be strong enough to assume responsibility as agents of change in their communities. It is therefore important to continue building their capacity and to strengthen their organisations in order to be self sustained. The capacity building should focus among others issues on planning, management teamwork, leadership, and proposal writing skills, awareness raising advocacy, and accounting etc geared towards improving and health status of women, children and men in their communities. As part of the advocacy, the project should engage community organisations to the CBOs / CHCs in supporting referrals of obstetric emergencies and support the Regional Health Office in statistics.

- The project planned and implemented activities that addressed *practical gender needs* concerned with meeting people's basic needs and improving the conditions for men and women by improving the quality of health care while accepting the existing division of labor and without challenging

existing gender roles. The "*bias in staffing pattern*" was addressed by the project from the perspective of improving access to health care through the training of female CMWs. During implementation, the project found itself dealing with *strategic gender needs* when parents did not allow their daughters to join the CMWs course. Although the project respected this, however, it worked in the most sensible way to change the statuesque by addressing the social barriers that prevented girls from joining the CMWs training course. For a conservative society to allow their girls to train as community midwives outside their areas and to stay nights away from home might have been a killer assumption at the start of the project. The dedication and persistence of the project team and their accumulative knowledge of the local culture together with the keen interest of girls to become midwives have turned this into a success story

- Oxfam's advocacy efforts at local level have materialized in an increase in resource allocation for health facilities, particularly for operational costs. This effort should be continued in the forthcoming project.

- The project has supported activities, which are in line with the National Health Policy and are key elements of the National Health Sector Reform. Most of these activities are already institutionalized within the health care system and have their own operational costs although not sufficient to effectively maintain the improved quality of care. Few other activities were initiated by Oxfam to improve access to and utilisation of health services in peripheral health facilities through the mobile clinic. The mobile clinic is demand driven by the community and should stand a higher chance of sustainability, but the community can not currently afford to bear the full cost of *the "the mobile clinic"*. Oxfam supported the mobile clinic by paying for the vehicle hire and remuneration for the team. Knowing that the initiative will raise the interest of the health office and in a way create pressure through community demand on the health office to takes full responsibility and allocates the necessary resources for it. The regularity and frequency of the mobile clinic has reduced to a minimum since the project stopped its support. Hadhramout Regional Health Office has expressed commitment to allocate resources for the mobile clinic from next year onwards. In the mean time Oxfam is looking into how to resume such activities giving the high demand for it from local communities and from health workers at health facilities as well as from the DHMT and DHC.

- The mission noticed a high prevalence of chronic cases notably diabetes and blood pressure. Some of targeted health units have attempted to provide disposable tests others hope to have a laboratory in order to provide the full range of services on demand. Such services have financial implications on the health unit and will stretch the already low budget too thinly among competing priorities. It is therefore important that the project and the health office to identify the root causes of these chronic illnesses and to mount an intensive health promotion campaigns to raise people's awareness, shape their attitude and change their practices in order to prevent these chronic cases.

- This project ended in March 2008. At the same time Oxfam is currently preparing a proposal for a continued support to sustain and consolidate the current innovations and to further strengthen the DHMT and DHC to assume responsibility under a decentralised setting where major devolution of authorities to local level is expected by the MOPH&P under the forthcoming local governance. Oxfam has secured some funding for the new project from a British Based Trust Fund and is seeking to raise funds to cover the remaining 20% of the estimated budget. Oxfam would obviously approach the EC first as a potential donor to contribute the remaining 20% and thus cherish / cultivate the achievements to-date and forthcoming success.

Recommendations for the EC:

- The EC should consider contributing the 20% to the second forthcoming support of the "new project" giving the success this project has achieved on the ground and its influence on national policy particularly the CBHF. The support by the EC will have a *high value for money* particularly because there is already an 80% secured funding from a Yemeni migrant through his British based charitable society. The EC contribution will add to the EC visibility and will harness the achievements in this project with other EC funded projects HSDS's targeted areas of Taiz and Lahej

- The EC arrange for regular coordination meetings between this project and other EC projects (say every quarter) to ensure synergies and greater efficiency in the use of resources

Chapter 9: Appendices

First published online by Oxfam GB in 2010.

This document is part of a collection of programme evaluations available from Oxfam GB in accordance with its evaluation policy.

This document was originally written for internal accountability and learning purposes, rather than for external publication. The information included was correct to the evaluator's best knowledge at the date the evaluation took place. The views expressed in this report are those of the author(s) and do not necessarily reflect Oxfam's views.

For further information on the issues raised in this document email phd@oxfam.org.uk

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