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MEMORANDUM AND RECOMMENDATION

OF THE

PRESIDENT OF THE

INTERNATIONAL DEVELOPMENT ASSOCIATION

TO THE

EXECUTIVE DIRECTORS

ON A

PROPOSED CREDIT

OF SDR 18.8 MILLION

TO THE

REPUBLIC OF YEMEN

FOR A

FAMILY HEALTH PROJECT

June 4, 1993

CURRENCY EQUIVALENTS

US$1.00 = Yemeni Rial (YR) 12.00
YR 1.00 = US$0.08

ABBREVIATIONS

FP	Family Planning
ICB	International Competitive Bidding
IDA	International Development Agency
LCB	Local Competitive Bidding
MCH	Maternal and Child Health
MOPD	Ministry of Planning and Development
MOPH	Ministry of Public Health
PCC	Project Coordinating Committee
PHC	Primary Health Care
PIU	Project Implementation Unit
PMO	Project Management Office
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
WHO	World Health Organization

GOVERNMENT OF THE REPUBLIC OF YEMEN

FISCAL YEAR

January 1-December 31

REPUBLIC OF YEMEN

FAMILY HEALTH PROJECT

CREDIT AND PROJECT SUMMARY

Borrower:	Government of the Republic of Yemen
Beneficiary:	Ministry of Public Health
Amount:	SDR 18.8 million (US$26.6 million equivalent)
Terms:	Standard IDA, 40 Years Maturity
Financing Plan:	IDA US$26.6 million Government US$ 3.6 million Total US$30.2 million
Economic Rate of Return:	Not Applicable
Staff Appraisal Report:	No. 11900-YEM dated June 4, 1993
Map:	IBRD 24849

MEMORANDUM AND RECOMMENDATION OF THE PRESIDENT OF THE INTERNATIONAL DEVELOPMENT ASSOCIATION TO THE EXECUTIVE DIRECTORS ON A PROPOSED CREDIT TO THE REPUBLIC OF YEMEN FOR A FAMILY HEALTH PROJECT

1. I submit for your approval the following memorandum and recommendation on a proposed credit to the Republic of Yemen for SDR 18.8 million (US$26.6 million equivalent) to help finance a project for family health. The credit would be extended at standard IDA terms with a maturity of 40 years.

2. Background. Yemen's health status indicators depict serious problems. The current population is 13.1 million (1992), with the growth rate a high 3.6 percent; life expectancy at 48 years is 14 years less than the average for low-income countries, 30 years less than that for industrialized countries; maternal mortality, at 1,000 deaths per 100,000 births, is 100 times that of industrialized countries; infant mortality, at 124 per 1,000 live births, is a reflection of the factors affecting maternal mortality and is also very high compared to other countries of similar socio-economic development. The incidence of endemic diseases is high, reflecting the lack of preventive health services, including effective health education programs, unsafe drinking water, and poor sanitation facilities.

3. The Ministry of Public Health (MOPH) is responsible for managing the health care system. Health services in major urban centers, where about 22 percent of the population lives, are provided by specialized civilian and military hospitals (for tertiary care) and by a thriving private medical practice. Provision of health services outside of the major urban centers rests with the primary health care (PHC) system of 949 health units in villages, supported by 345 health centers in larger towns; 60 district hospitals, the point of referral for the primary health care network, provide secondary care. The country is divided into 245 districts which cover large geographic areas; 35 percent of the districts have a catchment population of over 50,000 people.

4. Government policies give highest priority to improving the quality and quantity of basic curative services and preventive activities, and particular attention is being given to the most vulnerable groups of the population: women of reproductive age and children. Implementation of these policies is, however, hampered by serious constraints. Sector administration is highly centralized in Sanaa and Aden and weak at governorate and district levels. Financial resources from the government budget are largely inadequate, and much improvement is needed in the coordination of donor assistance. Health care delivery is unsatisfactory, in terms of both the quality of services and their coverage. Poor quality of services is due to various weaknesses ranging from the lack of qualified staff and the shortage of essential drugs to the poor condition of the physical infrastructure. The result is inappropriate utilization of the health care delivery system, as patients tend to bypass lower-level facilities, which are generally poorly equipped and staffed, in favor of hospitals. As for coverage, physical accessibility, only 45 percent of the population is served by the existing health care delivery system.

5. Although the government objective to achieve greater coverage of the health care delivery system is fully justified in the long-term, improved quality of existing services deserves higher priority in the short-term. At the same time, however, innovative, cost-effective approaches to service delivery need to be developed to reach the large number of small, isolated communities scattered throughout the country.

6. Rationale for IDA Involvement. The previous IDA projects aimed at developing management and training capacity while establishing the basic infrastructure for health care delivery. The proposed project represents continuity with those aims by specifically focusing on improving three key areas: health staff training and development, health education, and management of medical supplies. These areas are directly relevant to the needs of the population groups at highest risk, particularly among the rural poor. As to health infrastructure, this project represents a departure from the previous ones because it would focus on improving existing facilities, rather than constructing new ones, and on upgrading the quality of health services, especially for women and children, offered at those facilities. In addition, the project would initiate limited pilot activities to examine appropriate ways to improve the coverage of services for remote rural communities. Assistance to expand the health care delivery system would be considered under subsequent projects, conditional to improved quality of current services and based on the lessons learned through the development of outreach services to be supported by this project.

7. The proposed project would address key weaknesses that affect sector performance nation-wide while improving quality of service delivery in selected rural districts. As an initial step toward improving coverage, pilot activities would be undertaken in two districts to examine ways to provide PHC to remote rural communities. The project also presents opportunities for strengthening donor coordination in the sector. In primary health care services, the proposed project would complement other-donor assistance by selecting only those areas (health districts) with no significant support from any other donor. In health education, the project would complement the efforts of other donors by targeting assistance in areas not sufficiently covered, i.e., messages on maternal health and on women's participation in the health sector. And in the pharmaceutical subsector, the project would, in concert with bilateral and other international donors, support the development of a single national drug procurement and distribution system. IDA presence in the sector and continuing dialogue with the Government are significant considerations in some donors' decision to continue with their own assistance programs.

8. Project Objectives. The proposed project would assist the MOPH in contributing to the implementation of the national population policy, articulated in 1991, to reduce fertility and maternal and infant mortality. The objectives of the proposed project are: (i) to improve the access to, and quality of, maternal-child health and family planning (MCH/FP) services within the PHC system; and (ii) to improve management effectiveness in the health sector more broadly.

9. Project Description. The project includes three interrelated components: (i) strengthening the delivery of MCH/FP services in seven

districts in rural areas through the rehabilitation of district hospitals, health centers, and health units, establishment of referral and supervision systems, and conducting pilot activities; (ii) enhancement of training and health education programs sector-wide by increasing the capacity of existing health training institutes, curriculum improvement, strengthening training supervision, and supporting the Government's program for the delivery of media-borne messages in maternal health, family planning and the role of women in the health sector and the delivery of health education messages through interpersonal means; and (iii) improvement of sector management through the development of a health information system, strengthening the research capacity of the MOPH, strengthening the pharmaceutical logistics system, and strengthening the maintenance and procurement capacity of the MOPH.

10. Project Cost and Financing. The total project cost is estimated at US$30.2 million equivalent, of which US$22.2 million equivalent (73 percent of the project cost) is the foreign exchange component. The proposed IDA credit of SDR 18.8 million (US$26.6 million equivalent) will finance about 90 percent of the total project cost excluding taxes and duties. The Government will finance US$3.2 million equivalent. Project costs and financing plan are presented in Schedule A. The amounts and methods of procurement and disbursement, and the disbursement schedule are shown in Schedule B. The timetable of key processing events is in Schedule C, and the status of Bank Group operations in Yemen is in Schedule D. A map of Yemen is also attached. The Staff Appraisal Report (Report No. 11900-YEM) for the project is being circulated separately.

11. Project Implementation. The project would be implemented by the MOPH over a period of six years and disbursed over the period 1994-2000. Project implementation would be overseen by a Project Coordinating Committee (PCC) chaired by the Vice Minister and composed of key MOPH officials, each responsible for a major project activity, and a representative from the Ministry of Planning and Development (MOPD). The PCC would be assisted in overall project coordination by the existing Project Management Office (PMO) which would serve as secretariat to the PCC. The PMO would monitor project performance, accounts, expenditures, costs, and compliance with IDA Guidelines; consolidate progress reports; and serve as the MOPH contact agency with IDA. Implementation of project components would be the responsibility of existing MOPH line departments at the central level, strengthened with the appropriate technical assistance services where necessary; in the project areas, implementation would be the responsibility of training-supervision and district management teams.

12. Project Sustainability. The MOPH has played an integral role in the analysis and development of the project, and project ownership by those responsible for implementation is high. Further, the project components would be implemented by regular units of the MOPH, ensuring operational continuity and institutional memory. Project districts have been selected on the basis of accessibility, population catchment area, existence of facilities, and availability of staff--factors that contribute to the maintenance of sustained operations. In addition, to the extent possible, the district management teams would be recruited from regular MOPH staff at local levels. While incremental recurrent costs are deemed sustainable, Government investments are

needed to maintain an acceptable supply of essential drugs in public health facilities in the field.

13. Lessons Learned from Previous IDA Involvement. Of the four projects in the health sector since 1982, two (amounting to US$18.7 million in IDA credits) have been completed, the two others (amounting to US$19.5 million in IDA credits) are ongoing. For the northern governorates, the First Health Project (Credit 1294-YAR), completed in 1989, financed the construction of essential infrastructure and the training of central MOPH management staff; the ongoing Health Sector Development Project (Credit 2151-YEM) is financing the construction of training institutes, drug warehouses in selected governorates, and medical equipment maintenance workshops. For the southern governorates, the Health Development Project (Credit 1377-YDR), successfully completed in 1989, established PHC facilities in Abyan, Lahej, and Hadramout; the ongoing Second Health Development Project (Credit 1972-YEM) is constructing PHC facilities in Aden, Shabwa, and Mahra.

14. The principal lesson learned from the First Health Project was that creating a Project Implementation Unit (PIU) outside of the mainstream MOPH management structure isolates the PIU and project activities. In the proposed project, MOPH management has been involved in all phases of project development (fostering ownership of the project), and regular MOPH management will constitute project management. The principal lessons learned from the Health Development Project were that project design should be simple, and having many cofinaciers complicates implementation of this type of project. The design of the proposed project is for IDA financing alone, without cofinaciers, but the proposed project has developed a simple methodology for selecting health districts in order of priority, that could be adopted by other donor agencies wishing to assist the sector on the basis of objectives similar to those of the project. Moreover, project component activities are coordinated with other-donor assistance, e.g., WHO and other bilateral programs in pharmaceuticals, and UNICEF and UNFPA programs in health education.

15. Agreements Reached. Agreement has been reached with the Government on: (i) the Government's provision of budgetary allocations for essential drugs; (ii) priority in the selection of trainees and fellows to be given to staff and key managers, especially women, from the districts covered under the project; (iii) a National Drug Policy to be developed by June 30, 1993 and incorporated into the National Health Policy, which would be submitted to the Ministerial Council during FY94; an essential drugs list to be adopted by December 31, 1994; (iv) plans for follow-up actions of the project's pilot activities and for implementing a policy on cost recovery for essential drugs.

16. Environmental Aspects. The project is classified under the Environmental Category C: "No appreciable environmental impact". In the construction and essential drugs components of the project, measures will be taken to ensure that materials are selected, stored and used (and wastes are disposed of) in environmentally sound ways.

17. Program Objective Categories. This project will improve the quality of existing health services generally; specifically, it will improve the health conditions of people deprived of adequate health services, targeting women of

reproductive age and children, almost all of whom are poor. The project will also provide incentives for women to become providers of health care. The longer-term effects of reduced fertility and lower population growth rates should help to reduce disparities in living standards, alleviate poverty, and moderate the deterioration of the environment.

18. Project Benefits. The direct and immediate benefits of the project which would be expected during the project implementation period would be: (i) improved quality and coverage of health care services for about 906,000 people residing in the seven project districts (especially at-risk rural populations); (ii) greater number of trained staff as some 7,000 personnel would be trained under the training component; and (iii) institutional development at both central and district levels of the MOPH. Incentives to attract and retain women as health care providers would include the opportunity to participate in the fellowship program and the provision of housing at the health centers in the seven project districts. The longer-term benefits of the project would be the establishment of a basis for more rapid expansion of quality health care coverage and possible models for a better delivery system based on the experience in the seven project districts and the pilot activities. Finally, the project can well be the springboard for mounting future, possibly sector-wide, projects.

19. Risks. The principal risks are as follows. (i) The recruitment and retention of women as health care providers in the requisite numbers may not be realized, for cultural and socio-economic reasons. This risk would be minimized by strengthening health education messages which focus on women's participation in the health sector and by providing incentives to women to encourage their participation in training (fellowships) and to work in their own communities (housing). Moreover, the pilot activity on community participation would include an assessment of ways in which the community might support women's participation in the delivery of services. (ii) There could also be resistance to the implementation of a national drug program because of a lucrative black market. The Government's commitment to a national program as expressed through the passage of appropriate legislation and the support of IDA and other donors committed to the development of a national program would mitigate the effects of this risk. (iii) The Government may not be able to finance the cost of maintaining facilities and equipment and of essential drugs on a nation-wide basis. In addition to the assurances contained in the project, the dialogue between IDA and the Government would be expected to result in additional allocation of resources to the health sector as well as more effective utilization of resources allocated to the sector.

20. Recommendation. I am satisfied that the proposed credit would comply with the Articles of Agreement of the Association and recommend that the Executive Directors approve it.

Lewis T. Preston
President

Attachments

Washington, D.C.
Date: June 4, 1993

SCHEDULE A

REPUBLIC OF YEMEN

FAMILY HEALTH PROJECT

PROJECT COST AND FINANCING PLAN
(US$ million)

Estimated Project Costs:

Component	Local	Foreign	Total
MCH/FP Services at PHC	3.9	7.7	11.6
Training & Health Education	0.9	2.3	3.2
Sector Management	1.7	8.5	10.2
Total Base Cost	6.5	18.5	25.0
Physical Contingencies	0.6	1.7	2.3
Price Contingencies	0.9	2.0	2.9
Total Project Cost	8.0*	22.2	30.2

*Including taxes and duties of US$0.7 million.

Financing Plan:

Financier	Local	Foreign	Total
IDA	4.4	22.2	26.6
Government	3.6	0.0	3.6
Total	8.0	22.2	30.2

SCHEDULE B
Page 1 of 2 pages

REPUBLIC OF YEMEN

FAMILY HEALTH PROJECT

PROCUREMENT METHODS AND DISBURSEMENTS
(US$ million)

CATEGORY	Procurement Method ICB	LCB	OTHER	NBF[a]	TOTAL
Civil Works					
(a) Construction &	-	8.6	-	-	8.6
Rehabilitation	-	(8.1)[b]	-	-	(8.1)
(b) Architectural &	-	-	0.5	-	0.5
Engineering Fees	-	-	(0.5)[c]	-	(0.5)
Furniture, Equipment, Vehicles & Materials	6.1	-	0.5	-	6.6
	(6.1)	-	(0.4)[d]	-	(6.5)
Pilot Activities	-	-	1.0	-	1.0
	-	-	(1.0)[c]	-	(1.0)
Consultant Services	-	-	1.4	-	1.4
	-	-	(1.4)[c]	-	(1.4)
Studies	-	-	0.2	-	0.2
	-	-	(0.2)[c]	-	(0.2)
Fellowships	-	-	2.1	-	2.1
	-	-	(2.1)[c]	-	(2.1)
Local Training	-	-	1.5	-	1.5
	-	-	(0.9)[c]	-	(0.9)
Essential Drugs	6.3	-	-	-	6.3
	(5.9)	-	-	-	(5.9)
Staff Salaries	-	-	-	0.5	0.5
Operation & Maintenance	-	-	-	1.5	1.5
Financing Requirement	11.9	8.6	7.7	2.0	30.2
IDA Financing	(11.5)	(8.1)	(7.0)		(26.6)

Note: Figures in parentheses are the amounts to be financed by the IDA credit.

a. Non-IDA-financed categories.

b. Local competitive bidding in accordance with procedures agreed with IDA.

c. Procurement in accordance with the Guidelines for the Use of Consultants by World Bank Borrowers and by the World Bank as Executing Agency (August 1981).

d. International shopping for goods costing less than US$100,000 per contract (aggregate US$400,000).

REPUBLIC OF YEMEN

FAMILY HEALTH PROJECT

DISBURSEMENT SCHEDULE
(US$ million)

Allocation of Credit Proceeds:

	Category	Credit Allocation	Percentage to be Financed
(1)	Civil Works		
(a)	Construction & Rehabilitation	8.1	100% of foreign expenditures and 50% of local expenditures
(b)	Architectural & Engineering Fees	0.5	100%
(2)	Equipment, Vehicles, Furniture & Materials	6.0	100% of foreign expenditures 100% of local expenditures (ex-factory cost) and 85% of local expenditures for other items procured locally
(3)	Pilot Activities	0.9	100%
(4)	Consultant Services	1.3	100%
(5)	Studies	0.2	100%
(6)	Fellowships	1.9	100%
(7)	Local Training	0.9	100% of foreign expenditures and 50% of local expenditures
(8)	Pharmaceutical Products	1.4	FY95: 100%
		1.2	FY96: 100%
		1.0	FY97: 90%
		0.9	FY98: 80%
		0.8	FY99: 70%
(9)	Unallocated	1.5	-
	Total	26.6	-

Estimated Disbursements:

	IDA Fiscal Year						
	1994	1995	1996	1997	1998	1999	2000
	US$ million						
Annual	0.2	1.4	9.4	6.8	4.8	2.2	1.8
Cumulative	0.2	1.6	11.0	17.8	22.6	24.8	26.6
Percentage	0	6	40	66	84	92	100

SCHEDULE C

REPUBLIC OF YEMEN

FAMILY HEALTH PROJECT

TIMETABLE OF KEY PROCESSING EVENTS

(a) Time Taken to Prepare Project:	7 months
(b) Project Prepared By:	Borrower, with IDA assistance
(c) First IDA Mission:	July 12, 1992
(d) Appraisal Mission Departure:	January 30, 1993
(e) Date of Negotiations:	May 10-13, 1993
(f) Planned Date of Effectiveness:	January 1994
(g) Relevant PCRs:	No. 9269: Health I (Credit 1294-YAR) No. 9926: Health I (Credit 1377-YDR)

(h) Responsibilities for Preparation:

Task Manager	Alfonso F. de Guzman (MN2PH)
Peer Reviewers	Denis Broun (PHN)
	Frederick Golladay (EMTHR)
	Albert Sales (MN2PH)
Division Chief	Mr. Douglas H. Keare (MN2PH)
Director	Mr. Ram K. Chopra (MN2)
Regional Vice President	Mr. Caio Koch-Weser (MNA)

SCHEDULE D
Page 1 of 2

REPUBLIC OF YEMEN

STATUS OF BANK GROUP OPERATIONS

A. STATEMENT OF IDA CREDITS
(As of March 31, 1993)

Cr. No.	Approved FY	Borrower	Project	Amount in US$ million (Less cancellations) IDA Credit Amount 2/	Undisbursed
		58 credits fully disbursed		450.4	
F019	1984	Republic of Yemen	Education IV	10.4	1.1
1202	1982	Republic of Yemen	Sana'a Urban Dev.	14.7	0.4
1259	1982	Republic of Yemen	Agric. Research & Dev.	6.0	0.1
1340	1983	Republic of Yemen	Education V	10.0	1.1
1346	1983	Republic of Yemen	Wadi Hadr. Agr. Dev. II	9.0	1.4
1413	1984	Republic of Yemen	Highways V	13.0	0.3
1441	1984	Republic of Yemen	Urban Development II	5.5	0.4
1453	1984	Republic of Yemen	Central Highlands Agr.	8.0	2.9
1470	1984	Republic of Yemen	Education VI	10.0	4.3
1547	1985	Republic of Yemen	Industrial Dev. II	5.3	1.0
1556	1985	Republic of Yemen	Tech. Assistance	4.7	3.4
1584	1985	Republic of Yemen	Wadi Al-Jauf Agr.Dev.	10.0	12.4
1617	1985	Republic of Yemen	Highways IV	14.4	4.6
1643	1986	Republic of Yemen	Technical Training	12.7	12.6
1667	1986	Republic of Yemen	Tihama Reg. Ag. Dev. V	10.0	10.0
1701	1986	Republic of Yemen	Power IV	11.7	7.0
1702	1986	Republic of Yemen	T.A. Petroleum	10.9	5.6
1739	1987	Republic of Yemen	Gr. Aden Water Supp. II	5.6	4.2
1772	1987	Republic of Yemen	SRADP	12.3	8.1
1773	1987	Republic of Yemen	Teacher Training	10.4	8.8
1823	1987	Republic of Yemen	Fifth Highway	16.8	10.7
1848	1988	Republic of Yemen	Sana'a Hodeidah Rd. Reh.	10.7	4.9
1886	1988	Republic of Yemen	North. Reg. Agr. Dev.	17.6	13.4
1944	1989	Republic of Yemen	Al Mukalla Water Supply	12.0	10.7
1972	1989	Republic of Yemen	Health Dev. II	4.5	3.8
1983	1989	Republic of Yemen	Eastern Reg. Ag. Dev.	15.0	13.8
2015	1989	Republic of Yemen	Inst. Dev. for Pub. Ad.	10.8	10.4
2045	1989	Republic of Yemen	Wadi Had. Agr. Dev. III	12.0	12.3
2073	1990	Republic of Yemen	Emerg. Flood Reconst.	10.0	7.6
2151	1990	Republic of Yemen	Health Sector Dev.	15.0	15.4
2160	1990	Republic of Yemen	Taiz Flood Disaster	15.0	12.2
2164	1990	Republic of Yemen	Power III	15.5	16.3
2170	1990	Republic of Yemen	Tarim Water Supply	12.0	12.6
2177	1991	Republic of Yemen	Multi-mode Transport	30.0	28.6
2222 3/	1991	Republic of Yemen	Secondary Teacher Tr.	19.4	18.4
2258	1991	Republic of Yemen	Emergency Recovery	33.0	30.9
2265 3/	1991	Republic of Yemen	Fourth Fisheries Dev.	13.2	12.8
2299 3/	1992	Republic of Yemen	Agr. Sector Mgt. Support	14.4	14.8
			Totals	921.8	339.4
			Of which has been repaid	15.4	
			Total Now Outstanding	906.4	

1/ The status of projects listed in Part A is described in a separate report on all Bank/IDA financed projects in execution which is updated twice yearly and circulated to the Executive Directors on April 30 and October 31.

2/ Credits denominated in SDRs. Amount shown is US$ equivalent at time of negotiations for the IDA amount, and the US$ equivalent as of March 31, 1992 for the undisbursed amount.

3/ Not yet effective.

REPUBLIC OF YEMEN

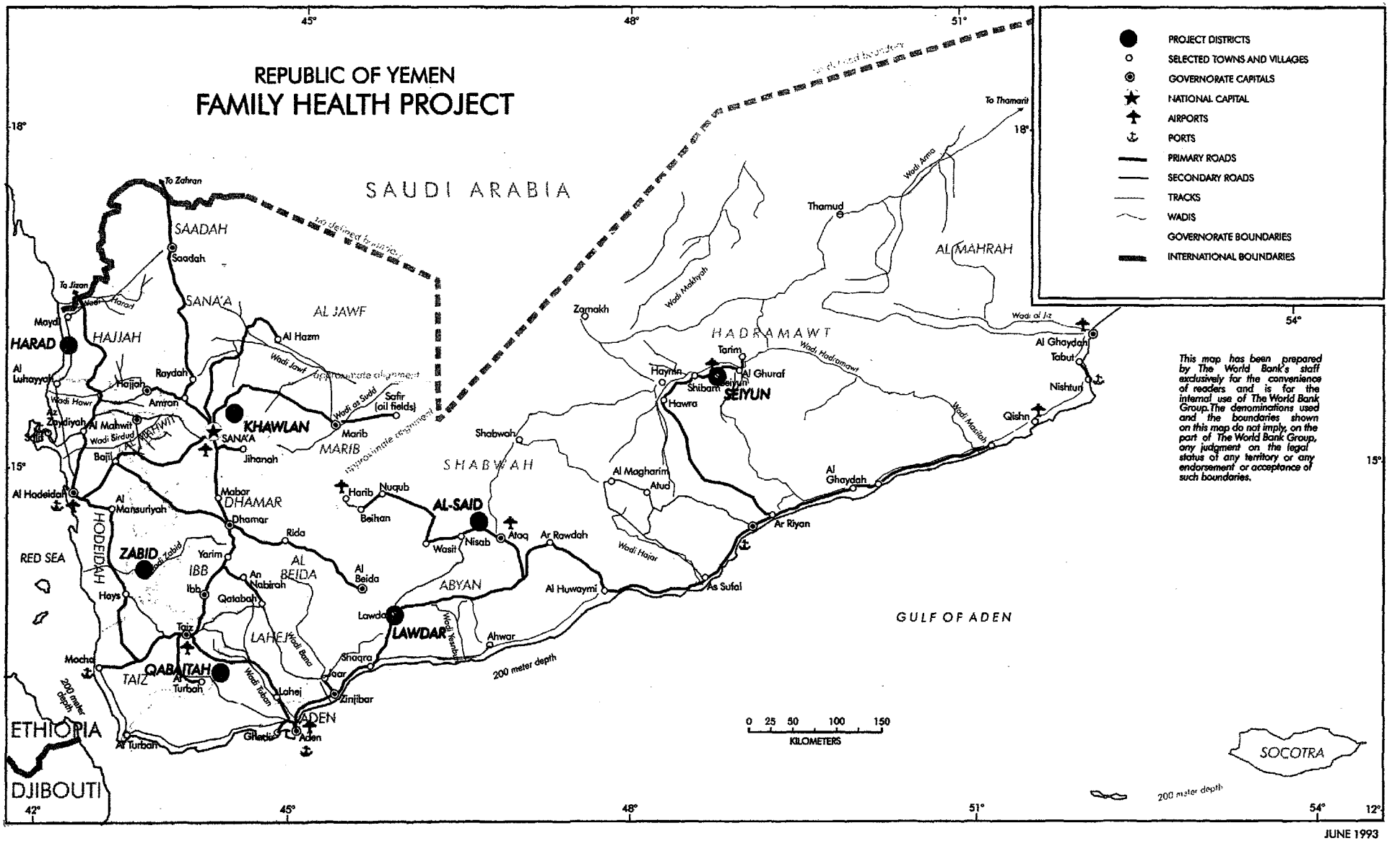
STATUS OF BANK GROUP OPERATIONS

B. STATEMENT OF IFC INVESTMENTS
(As of March 31, 1993)

Year	Obligor	Type of Business	(Amount in $ million) Loan	Equity	Total
78	Yemen Dairy and Juice Products Industries Co., Ltd.	Dairy and Juice Products	3.2	0.00	3.15
84,85	Yemen Battery Manufacturing Co.	Manufacture of Electrical Apparatus	3.3	0.9	4.2
85	National Company for Vegetable Oil and Ghee Industries	Vegetable Oil	4.7	0.0	4.7
86	Yemen Hunt Oil Company	Oil Refinery	9.0	0.0	9.0
87	Marib Agricultural Co. Ltd.	Agr. & Livestock Production	2.4	0.3	2.7
	Total Gross Commitments		22.5	1.2	23.7
	Less: Cancellations, terminations, writeoffs, repayments, sales and exchange adjustments		16.8	1.2	18.0
	Total commitments now held by IFC		5.6	-0.0	5.6
	Total Undisbursed (including participants portion)		0.0	0.0	0.0
	Total Outstanding		5.6	---	5.6

IBRD 24849

REPUBLIC OF YEMEN
FAMILY HEALTH PROJECT



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JUNE 1993