Newsletter

Community-Based Initiatives

Vol. 1 Issue No. 2 June 2005

World Health Organization
Regional Office for the
Eastern Mediterranean

Interview with Dr Mohamed Abdi Jama, Deputy Regional Director, WHO Regional Office for the Eastern Mediterranean

As one of the founders of the community-based approach in the Region what is your vision for community-based initiatives (CBI)?

- I believe that CBI is a tool through which the communities in our Region can identify their socioeconomic needs, in particular their health-related needs, and can plan to fill the gaps through their active involvement. The health-related interventions have to be integrated in all areas in which CBI are introduced.
- CBI empowers communities and local social services providers, including health-care providers, to become self-sustained and less reliant on government support, as governments are already struggling to cope with spiralling population growth, outbreaks of disease, low access to safe drinking-water and sanitation, low literacy rates and complex emergencies.
- CBI brings about a reduction in the level of poverty and places health at the centre of the development process, leaving a sustainable structure for communities to work with independently.
- The people involved in CBI project areas run the projects supported by an intersectoral team from line departments. People involved in CBI learn how to generate resources and how to link their projects with potential partners.

How have you found governments' acceptance of CBI and what has been their commitment to projects regarding the implementation and expansion process? How could this be improved within the Region?

- Bahrain, Islamic Republic of Iran, Iraq, Jordan, Morocco, Oman, Pakistan, Saudi Arabia, Sudan, Syrian Arab Republic and Yemen, have shown a great deal of political commitment through the establishment of a CBI unit within the Ministry of Health. Islamic Republic of Iran, Jordan, Pakistan and Syrian Arab Republic have also allocated an annual budget for maintenance and expansion of the programme. In addition, Jordan, Pakistan, Sudan and Syrian Arab Republic have linked the programme with national and international nongovernmental organizations. Others are in the process of integrating the community-based approach within their health and development plans and institutionalizing it within their national health policy.
- The Regional Office for the Eastern Mediterranean is committed to the CBI approach and has placed a great deal of importance on the programme, deeming it a priority programme. The health, education and economic indicators before and after the introduction of CBI have shown significant improvement and are evidence of the success of the

(Continued on page 3)

Highlights of the Season…

- The Regional Office celebrates World Health Day (page 2);
- Pakistan to study the differential access to and use of health care services by men and women (page 4);
- The Healthy Cities programme in Saudi Arabia has expanded in less than 2 years (page 4);
- Oman establishes CBI department within the Ministry of Health (page 8).

Contents

The Regional Office celebrates World Health Day, 2005

World Health Day aims to give extra attention to one specific health theme every year. This year, the theme was *"Make Every Mother and Child Count."* The celebration of World Health Day organized by the Regional Office in Cairo focused on women and children living under difficult circumstances in the Eastern Mediterranean Region and the huge efforts that have been undertaken to improve their quality of life. Each year 53 000 mothers in the Region die in childbirth or from complications arising from childbirth, and 1.5 million children under the age of 5 years die from a handful of preventable and treatable conditions. Up to three quarters of deaths during the first month and at least 30% to 40% of all infant deaths could be avoided through improved maternal health, adequate nutrition during pregnancy, appropriate management of deliveries, appropriate care of newborns and infants and birth-spacing.

For WHO and other United Nations agencies, maternal and child health is a major issue, as 2 of the 8 MDGs directly address the reduction of child mortality and the improvement of maternal health. Other Goals indirectly touch upon maternal and child health through the control of diseases, such as HIV/AIDS and malaria, as well as girls' education and empowerment of women.

Maternal health care

The Regional Office has adopted the Safe Motherhood Initiative as a priority strategy to protect and promote maternal health in countries of the Region. As a result, maternal health care delivery indicators have improved significantly. In 2003, it was estimated that some 52.5% of births in the Eastern Mediterranean Region were attended by skilled attendants, compared to 36% in 1990, reflecting a 46% increase during this period (WHO/EMRO, 2004). Nevertheless, if current trends continue, countries will not be able to achieve the targets of the MDGs, and therefore concerted acceleration efforts are urgently needed, particularly in the low socioeconomic status countries.

Child health care

For children to survive, they must first be given the necessary care to grow healthily and, therefore become less susceptible to illness. Based on this principle, the WHO Regional Office for the Eastern Mediterranean is continuing to support the scaling up of the Integrated Management of Child Health (IMCI) strategy in countries as an approach to improve the quality of care provided to children both in health facilities and at home. Training of medical doctors, medical assistants and nurses in managing child illnesses, provision of adequate equipment and supplies, as well as the improvement of key family practices are all part

of the IMCI strategy. IMCI is recognized as a key strategy for achieving the MDGs and helping to save the lives of the 1.5 million children under 5 years of age who currently die needlessly every year in the Region.

Reducing child and maternal mortality through community participation

CBI has had a positive impact on mother and child mortality rates in areas where the programme has been implemented. This has been achieved through active involvement of the community, strengthening intersectoral collaboration and partnership with potential donors and decision-makers, and increasing the access of mothers and children to health care services. The experience of different countries of the Region shows that training women health volunteers in mother and child care, family planning, and nutrition produces positive changes in the communities' behaviour and reduces maternal and infant mortality rates. Mothers and young girls should be oriented with MPS and IMCI in vocational centres, literacy centres and any other venues created by CBI.

World Health Day 2005

"Make Every Mother and Child Count"

Interview with Dr Mohamed Abdi Jama, Deputy Regional Director, WHO/EMRO

(Continued from page 1)

programme. Countries, in collaboration with WHO Representative Offices, must promote these indicators as advocacy of the programme's success.

- Our vision to further improve the government's commitment is to continually present the effectiveness of CBI in improving community health and reducing poverty. The Regional Office will also continue its efforts to advocate the programme to line departments, donors, nongovernmental organizations and other UN Agencies.

How do you see linkages between Poverty Reduction Strategies, the Millennium Development Goals (MDG), the recommendations of the Commission on Macroeconomics and Health (CMH) and CBI?

- The goal of CBI is to achieve a better quality of life for all. Poverty Reduction Strategies find country-specific solutions to reduce poverty, allowing governments and citizens to focus on the poor, while improving the socioeconomic needs of deprived areas and increasing production. The main priority and focus of CBI is also on the poor. CBI promotes an improvement in literacy rates and in women's skill and development through the establishment of literacy and vocational training centres. CBI also provides no-interest loans to the poor to improve their economic situation and ultimately their local production. Therefore, both PRSs and CBI have similar goals.
- The MDGs tackle the source of poverty by focusing on the reduction of malnutrition, maternal and child mortality, communicable diseases, improving access to water and sanitation, enhancing partnership in development and by improving literacy rates. CBI's priority is the same—through community involvement, paying special attention to marginalized groups with clear strategies and plans for all health-related MDGs.
- The CMH looked at how we can increase government allocation of funds to the health sector and places health at the centre of the development. The CMH advised governments to reduce the out-of-pocket share that is a burden on the poor and vulnerable groups, in addition to providing a structure for social and health security. Linking CBI with the CMH was the primary reason that the CBI unit became responsible for promoting and implementing the recommendations of the CMH in the Regional Office. At present Djibouti, Jordan, Islamic Republic of Iran, Pakistan, Sudan and Yemen are implementing the recommendations of the CMH. Pakistan, Sudan and Yemen have begun to assess the implementation of community-based health insurance schemes in Basic Development Needs (BDN) areas, and these can provide models for other countries in the Region.

CBI and Stop TB have collaborated to provide an integrated approach in all areas implementing Basic Development Needs, how do you see the role of different technical units in the Regional Office in integrating their programmes within ongoing CBI programmes in the Region?

- This is a commendable effort and we hope to see more of its kind. Tuberculosis is a disease of the poor and DOTS is a strategy that is based on community participation. Thus, combining disease prevention and control with a community-based set-up seems like the most sensible way forward. We are expecting Roll Back Malaria (RBM), mother and child care, water and sanitation, the Expanded Programme on Immunization (EPI), HIV/AIDS control, health education and promotion and health system development programmes to use this opportunity created by CBI in the Region, and to try and link their interventions with existing CBI set-ups where community participation and intersectoral collaboration are possible.

What is your advice and guidance for improving the CBI programme in the Region?

- There is always room for improvement, and as long as we have diseases and poverty we will always need community-based approaches. Listening to communities and identifying their needs should ensure that the programme will constantly evolve and hopefully achieve its goals and targets.
- I would like to highlight the importance of improving health interventions in CBI areas, and the collaboration of all health departments with CBI. Greater community involvement in programme management, improved documentation, supervision and monitoring, identifying new partners and generating resources for programme maintenance and expansion are key areas in which we must have a clear plan for each country. I request all WHO Representatives to personally make sure that CBI is well planned for and expansion takes place through integration in the health services.

This will be the second edition of the CBI Newsletter, what are the benefits of producing this publication?

- The Newsletter is a wonderful tool for disseminating information to the Eastern Mediterranean Region countries and regional partners. We can spread our message and share our experiences with others in order to improve and expand the CBI programme. I would like to thank those countries of the Region who provided materials on a regular basis to the Regional Office and also to thank the CBI unit who initiated this Newsletter. I hope this effort will be sustained and we will continue to provide our full support to maintain it.

Thank you Dr Jama for your wonderful insights concerning CBI.

Promoting gender awareness among health workers

The Department of Gender, Women and Health in WHO headquarters, the Women in Health and Development Unit in the Regional Office and the WHO Representative's Office in Pakistan are partners in this project. This project will use gender analysis to determine the root social causes of the disadvantageous health outcomes women face in Pakistan, such as a lack of decision-making power and health illiteracy. A thorough gender analysis of these causes will ensure more specifically targeted interventions in the future and thus more sustainable and significant outcomes in addressing Pakistan's deeply-rooted health inequities. It is expected that the outcomes of this project will contribute to the development of similar initiatives in other countries in the Region. The Institute for Public Health in Lahore, Pakistan will assist WHO to complete the study methodology. It is important to highlight that high maternal mortality rates in Pakistan are due to high rates of unattended home births, illiteracy and lack of access to health care facilities. Appropriate access to health care and utilization of health services is a crucial factor in determining positive health outcomes. Raising awareness of the barriers facing women in their access and use of health care services will lead to better health for both women and their families.

The Healthy Cities programme in Saudi Arabia

WHO Healthy Cities consultant, Dr Kumars Khoshchashm, visited Saudi Arabia from 25 March to 9 April 2005, to advise the national Healthy Cities Programme Committee on healthy cities and related environmental health issues. In addition, the consultant attended a symposium and the first national workshop on "Towards a Better Environment for the Children in the Healthy Cities" organized by the Ministry of Health. The symposium was attended by the Healthy Cities coordinators and a host of senior technical staff from a large number of ministries, agencies, universities and research centres.

The Healthy Cities programme in Saudi Arabia has expanded in less than 2 years, from 7 to 22 districts. The WHO Consultant, accompanying the national Healthy City coordinator and his senior staff visited the Gizan region. The team met with His Royal Highness the Governor of Gizan, who has provided enormous institutional and material support for the Healthy City concept and programme. The team also visited the Island of Farasan, where a wildlife sanctuary and an untouched marine environment are being protected. At the time of the team's visit, the Healthy Cities programme held an open-air meeting where a large number of citizens attended. During the visit the General Director of Preventive Health and the National Healthy Cities coordinator designated Farasan as a Healthy Island. The island became the first Healthy Island project in the Eastern Mediterranean Region. The team also visited the town of Ardah and met with the governor of the city, community leaders and the heads of various departments.

Basic Development Needs in Afghanistan

Despite the country's long-standing crisis, the BDN programme has continued to develop in Afghanistan. The programme is currently operational in six regions: Kabul, Bamyan, Nangarhar, Ghazni, Herat and Badakhshan. The training component has been strengthened and many more villagers have now benefited from skills-building initiatives. BDN now covers a population of 96 713. While recognizing the

(Continued on page 5)

(Continued from page 4)

key principles of the BDN programme, Afghanistan emphasized the organization of the community, building community capacity and promoting self-reliance.

Recently, BDN in Afghanistan conducted a national workshop in Kabul for all the BDN staff, national health coordinators of WHO sub-offices, representatives of UN agencies, international nongovernmental organizations and other related partners and line-ministries. The national BDN staff were given on-the-job training in the field, in addition to training on the reporting system and in financial management. The communities were briefed on how to accelerate the loan reimbursement process and were encouraged to pay special attention to the health status of the community.

BDN in Afghanistan hopes in the future to:

- expand the BDN programme to Kandahar, Mazar-e-Sharif and Kunduz Provinces;
- increase intersectoral collaboration with line-ministries;
- enhance community awareness, mobilization, and organization;
- strengthen collaboration with UN agencies and international nongovernmental organizations;
- improve capacity-building;
- strengthen reporting and monitoring of the BDN programme.

CBI coverage in the Eastern Mediterranean Region April 2005

Country	Population coverage		
	BDN	HCP	HVP
Afghanistan	96 713		
Bahrain	80 674	103 576	
Djibouti	17 248		
Egypt	35 000		
Islamic Republic of Iran	25 530	7 477 407	
Jordan			35 635
Lebanon	9 398		
Morocco	75 485		
Oman	68 785	52 037	1 000
Pakistan	1 221 568		
Saudi Arabia		4 594 636	
Somalia	101 452		
North Sudan	252 657		
South Sudan	5 211		
Syrian Arab Republic			1 200 000
Yemen	80 674		
Total Population	**2 070 395**	**12 227 656**	**1 236 635**

Feasibility assessment for the introduction of community-based health financing in Pakistan, March 2005

The WHO Regional Office for the Eastern Mediterranean assessed the feasibility and potential of community-based health financing in BDN areas and proposed a related action plan. According to the assessment carried out by WHO, necessary expertise in the country is lacking and needs to be developed.

WHO proposed a package of services that community-based health financing can offer but which should be limited to:

- qualified medical doctor services at no cost to scheme members and fee-for-service for non-members;
- basic laboratory services with a fixed registration charge to scheme members and on a fee-for-service basis for non-members;
- a small portion of funds under community-based health financing which could be set aside to cover the cost of emergency transportation for scheme members requiring urgent referral. Non-members will assume full financial responsibility for the cost of transport;
- the cost of medical care at the referral facility not to be paid by the scheme for a member or non-member. It will be the responsibility of the patient to cover the cost of treatment. Community-based health financing could also secure drugs and offer them for a fee to scheme members. The intention is to improve access to drugs but at the cost to the consumer/scheme member and not at the cost of community-based health financing.

Linking the recommendations of the Commission on Macroeconomics and Health, the Millennium Development Goals and community-based initiatives

The importance of placing health at the centre of development cannot be overemphasized. The nature of persistent poverty has social, moral, economic and political implications. Poor countries have been fighting the shackles of poverty with very little impact on the majority of the poor. The CMH advocated for safety nets against poverty, which is defined by issues such as poor health, nutrition and education, lack of clean water and sanitation and poor access to health services. Beyond these are natural disasters and global crises which affect the poor and must be tackled through the creation of safety nets in every country, such as the provision of health insurance, social security and pension funds. The CMH advocated to policy-makers that investing in health is vital to economic growth.

Data in many of the countries are hard to come by which makes it difficult to assess in real terms the proportion of the population living in abject poverty (i.e. income of less than US$ 1 per day); however, it is clear that in the low-income countries there is a greater burden of malnutrition compared with middle-income countries.

The macroeconomics model that is being utilized to financially strengthen the health sector is based on the concept that if an atmosphere is created that protects communities against falling into the poverty-trap, the health of the community will be improved and will be reflected in the economy. Thus, the CMH initiative complements the microeconomic and social projects that eliminate poverty-traps and that are taking place through CBI in the Region. In addition, Poverty Reduction Strategies and the MDGs are initiatives that complement CBI projects as they focus on poverty reduction strategies that can be implemented at the micro level. CBI has implemented a number of interventions in communities to reduce infant and maternal mortality rates in the Region (see Figures 1 and 2).

MDGs effectively target the roots of poverty

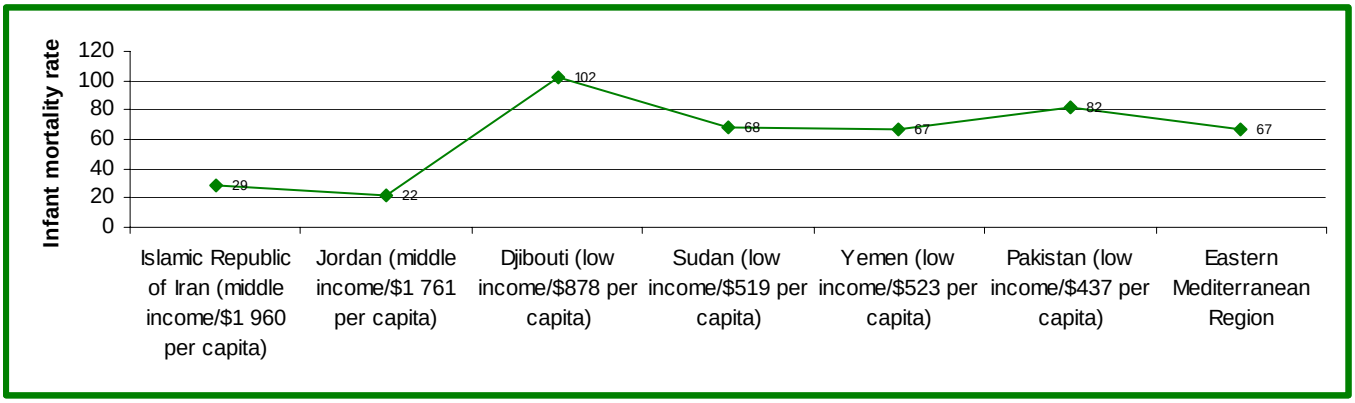


Figure 1 GDP per capita correlated against infant mortality rates for six countries implementing the recommendations of the CMH in the Region

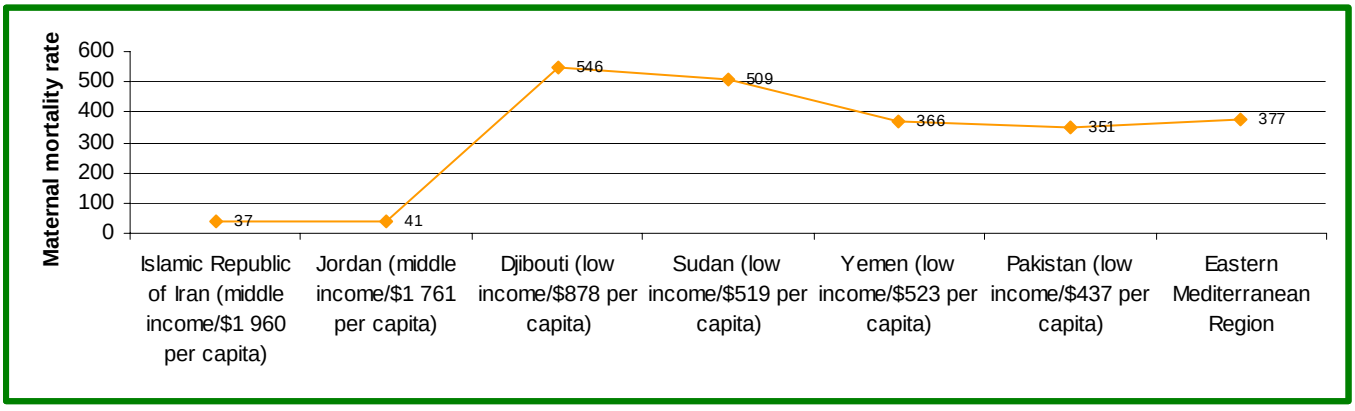
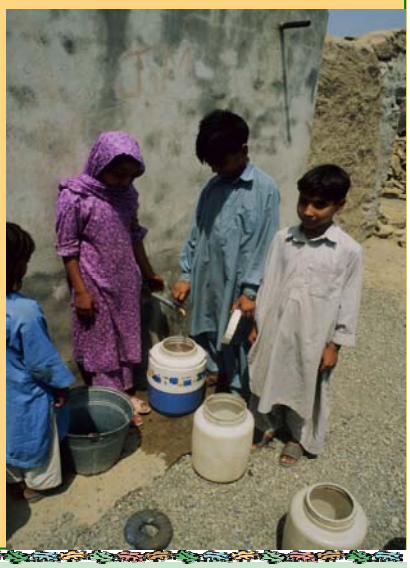


Figure 2 GDP per capita correlated against maternal mortality rates for six countries implementing the recommendations of the CMH in the Region

(Continued from page 6)

and challenge countries to mobilize human and financial resources to reduce poverty-traps. In the six countries implementing the recommendations of the CMH, there is a considerable link between lack of education and poverty. In low-income countries the level of literacy is lower than in the middle-income countries, and is significantly lower among women. Confronting the issue of universal education has become a priority for these low-income countries; however, there is a greater problem than lack of financial resources facing these countries which is a lack of human resources.

The Regional Office recommends that the Member States advocate linkages between PRSPs, Sector-wide Approaches (SWAps), the MDGs and CBI, which all follow the common goal of a better quality of life for all, with special emphasis on poor and vulnerable groups.



New Documents:
The *CMH Annual Technical Report* is now available at http://www.emro.who.int/cbi/CMH-Documents.htm

Integration of tuberculosis directly observed treatment, short course (DOTS) in all BDN areas in the Region

The average estimated incidence of new tuberculosis positive pulmonary cases is 55 per 100 000 population, and of all types of tuberculosis cases is 122 per 100 000. The tuberculosis programme in the Eastern Mediterranean Region in 2003 had the following two objectives to be reached by the end of 2005: to detect 70% of all tuberculosis estimated cases and to successfully treat 85% of these cases. By the end of 2003, 87% of the population of the Eastern Mediterranean Region had access to DOTS, at least in principle, although only 36% of estimated cases were reported to DOTS programmes in the Region during the same year. The regional treatment success rate was 82% in 2002.

Tuberculosis is an important public health problem. Every year more than 600 000 people develop tuberculosis in the Region. Tuberculosis is also known as a disease of poverty. Six countries in the Region have high incidences of tuberculosis and all of them are low-income countries.

The proven, cost-effective tuberculosis treatment strategy known as DOTS is a combination of technical and managerial components. DOTS makes infectious cases non-infectious quickly and breaks the cycle of transmission. Using DOTS also prevents the development of drug-resistant strains of tuberculosis that are often fatal and almost 100 times more expensive to cure. The average cost per patient treated until cured was US$ 243 under DOTS compared to US$ 694 under non-DOTS. For example, a study into the cost–effectiveness of DOTS compared with non-DOTS in the Syrian Arab Republic carried out by WHO and by the National Tuberculosis Programme in 1999 showed that DOTS contributes to the family's future productivity and well-being since rapid diagnosis and effective treatment permit adults to maintain their income and ensures their children's continued access to education and basic nutrition.

In order to increase case detection rates the quality of diagnostic and treatment activities and the monitoring system need to be improved. All tuberculosis stakeholders need to be actively involved, e.g. the public health sector other than the ministry of health, the private health sector, nongovernmental organizations and the community. The role of the community is vital in raising awareness of the people towards prevention and management of tuberculosis through DOTS. It is also important to fight the stigma associated with tuberculosis as this plays a considerable role in the negative health-seeking behaviour of tuberculosis patients.

Finally, community involvement needs to be organized and community-based initiatives are a means by which community involvement in DOTS can be organized and mobilized through the structure of a healthy community that enables systematic access to patients. CBI and Stop TB have jointly developed guidelines to integrate DOTS in the Region, which will be supported through the upcoming Joint Programme Review and Planning Mission (JPRM 2006–2007).

Countries of the season

Community-based initiatives in Oman

CBI in Oman have progressed well with the implementation of three pilot projects: Healthy City in Sur City, Healthy Village in Qalhat and Healthy Lifestyle in Nizwa.

The Healthy City concept was introduced in Sur City in December 2003, covering a population of 52 037. Since then, committees have been established to look at healthy lifestyles and environmental health and social concerns to develop and implement related activities. A number of advocacy, capacity-building and social mobilization activities within the framework of the Healthy City concept and methodology have been conducted with financial and technical support from the Government and WHO.

The Healthy Village project in Qalhat was launched in April 2004 to improve the water supply and sanitation based on the earlier experience in Wadi Ma'awel. WHO Centre for Environmental Health Activities provided technical and financial support for this project including developing and finalizing a proposal for a water supply and wastewater collection and treatment system. Significant financial support was provided by the private sector to build a local sewage treatment facility.

The Healthy Lifestyles project in Nizwa was one of the first community-based initiatives project in Oman. Interventions to promote healthy nutrition, physical activity, road safety, a healthy environment and to discourage tobacco use were identified following a WHO-supported workshop held at the beginning of 2004. Activities implemented included development and distribution of educational materials, a physical activity competition and a healthy cooking workshop with support from local suppliers.

The most recent activity is the Healthy Neighbourhoods concept initiated this year in selected villages in the Muscat region. Staff of the Sur Healthy City project provided training for personnel involved in this initiative.

WHO would like to congratulate H.E. Dr Aly-Bin Mohammed Bin Moosa, Minister of Health, Oman on his establishment of a CBI department within the Ministry of Health. This is a step towards institutionalizing the CBI programme and integrating it with health system development. WHO will provide support to the unit to initiate national planning, monitoring, evaluation and expansion of existing programmes into new districts of Oman.

Oman celebrates World Health Day 2005 in line with the Millennium Development Goals

Oman celebrated World Health Day this year by announcing their achievements toward reducing child and maternal mortality rates.

The Ministry of Health in Oman has begun to address birth-spacing, pre-marital testing, counselling, public education on the potential impact of consanguinity on child health, fetal death notification and a congenital anomalies registry. Increase in literacy of the general population, improvement in the delivery of water and sanitation services and the overall development in Oman, continued increase in the use of contraceptives and initiatives addressing nutrition and micronutrient deficiencies have all contributed to a reduction in mortality among children under 5 (see Figure 3).

The Ministry of Health has also initiated programmes to reduce maternal mortality such as "Making Pregnancy Safer," which encourages hospital-based births, increasing the number of antenatal visits to seven per pregnancy and encouraging birth-spacing. The higher age of marriage for women (18) and the higher levels of education for both men and women in Oman are expected to continue to contribute to the reduction of the maternal mortality rate in the long term.

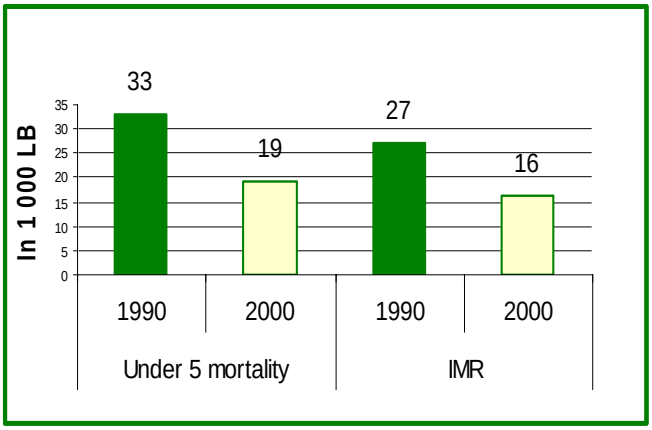


Figure 3 Infant and child mortality in Oman

Training programme for the introduction of community-based initiatives in Iraq

Iraq is endowed with high quality human resources and is potentially one of the richest countries in the Region. However, due to years of conflict, public services and the economic infrastructure are currently at a low ebb. A national seminar has been launched by the Ministry of Health of Iraq, in collaboration with WHO, to introduce and implement BDN, Women in Health and Development and Healthy Cities in selected communities. CBI will be implemented in eight sites, benefiting an estimated 150 000 people.

To implement CBI a national committee has been established with membership of representation from the relevant line-ministries. The members of the national CBI technical committee were trained in a workshop held in Amman from 26 February to 2 March 2005, in collaboration with WHO Regional Office and the country office, and became well-versed in approaches, methodologies and expected outcomes of the programme.

The workshop concluded that CBI action in Iraq is timely, strengthens primary health care and most suitably can address the critical environmental conditions and help in social reconstruction. During the workshop the national committee prepared a plan of action for the implementation of: BDN at a cost of US$ 2 million, over a period of 3.5 years, starting from February 2005 and ending in September 2008, in Halabja (Sulaimanyah), Al Musharah (Missan), Al Shattra (Al Nasiria), Abouskhair (Al Najaf), Al Rumaitha (Al Samawa), Al Hussainiah (Baghdad) and Healthy City programmes in Falluja and Sadr City.

The major components of the plan of action are:

- mobilization of the programme and orientation of key stakeholders at all levels;
- building an organizational framework;
- training and orientation of community and local level staff;
- needs assessment through the community setting priorities;
- development of socioeconomic and health projects;
- implementation, technical backstopping, monitoring and evaluation.

Improving the quality of life for people in post-conflict affected communities, Salara District, Sudan

The WHO Representative's Office in Sudan, in cooperation with the Food and Agriculture Organization (FAO), are implementing a BDN project with the aim of fulfilling the basic needs of these communities. These communities have suffered from conflict and instability for a long time. FAO has provided two varieties of seeds, namely tomato and watermelon, to be distributed in the rainy season to a 100 families from 10 villages of the Salara District in the Nuba Mountains.

The selections were based on a defined set of criteria: acceptability to participate in the project activities, land ownership, ability to work and the poverty level of the family. The project appointed an agriculturist from the Salara District to report on the villagers' progress every week. As a result of the lessons learnt from this experience, the agriculturist will continue to provide sustained technical support to the families. The use of the participatory and poverty-oriented approach for selection of families was successful, and distribution of seeds in the rainy season was timely and targeted those in need. In the future, strategies will be needed for improving marketing possibilities and for integration of other interventions, such as malaria and other communicable disease control activities in order to reduce morbidity and mortality and to increase health awareness.

The Healthy Villages directorate, Ministry of Health, Jordan

The Healthy Villages Directorate in Jordan was established on 6 March 2005, and acts under the authority of the Assistant to the Secretary-General of Primary Health Care Affairs in the Ministry of Health. Activities of the new directorate are related to the reinforcement of primary health care in Healthy Villages and the implementation of projects aimed at developing local communities. All of these activities were adopted for the impact they have on improving quality of life, and by achieving the highest level and quality of health services that can be provided to local communities. They are also aimed at improving the socioeconomic status of the community and limiting poverty and unemployment.

The directorate oversees seven areas: Department of BDN and Environmental Affairs, Department of Community Schools, Department of Training and Health Education, Department of Personnel and Administrative Affairs, linkage officers from the health directorates in governorates, local coordinators in each village and village development councils (village development councils are comprised of representatives from development committees and specialization committees and district representatives). The focal person for the Healthy Villages programme, Dr Nawal Kreishan has been appointed as the Director of the Healthy Villages Directorate. This is in line with the Regional Director's instructions to all WHO Representatives in the last WHO Representatives' Meeting, held in Cairo, during November 2004, to work towards institutionalizing CBI within the government framework.

Monitoring progress towards achieving the MDG targets

The Millennium Development Goals adopted at the United Nations Millennium Summit in September 2000, called for a dramatic reduction in poverty and marked improvements in the health of the poor. Achieving the MDGs is a shared global responsibility for which everyone must do their part, globally, regionally, nationally and locally. The Regional Adviser for Community-Based Initiatives presented a technical paper at the twenty-ninth Meeting of the Eastern Mediterranean Regional Consultative Committee, held from 10 to 12 April 2005 in Cairo available at: http://www.emro.who.int/cbi/MDGs-Documents.htm. The paper highlighted a number of concerns relating to achievements of the goals.

With a decade to go until the deadline for MDGs, it is clear that key targets on health agreed by countries in 2000 will not be achieved, at least in many of the priority countries in the Eastern Mediterranean Region, not for want of knowledge or technical tools but due to a lack of political will and instability, in addition to a lack of resources. All of the priority countries, with the exception of Egypt and Palestine, are lagging in their reduction of poverty and halving the number of those who suffer from malnutrition. Trends in the priority countries illustrate the difficulty in achieving Goal 1, specifically in Afghanistan, Djibouti, Iraq, Somalia, Sudan and Yemen. All of the priority countries are lagging in their efforts to achieve Goal 3 of promoting gender equality and empowering women.

Goal 4 of achieving a reduction in child mortality looks bleak in the priority countries, with the exception of Egypt and Morocco, and it seems that Goal 5 will only be met by half of the priority countries. Although Goal 6 has had a number of interventions, such as Roll Back Malaria and Stop TB campaigns, there has been a lack of achievement in all priority countries with the exception of Egypt, Morocco and Palestine. Currently, Goals 4–7 are a challenge for the priority countries to achieve by 2015, with the exception of Egypt, Morocco and Palestine. There needs to be a greater investment in human development and improvements in infrastructure.

There is a lack of reliable and timely information from the priority countries which makes analysis of the current status and projection of future trends difficult to assess. The priority countries understand that a stronger surveillance and health information system needs to be adopted and maintained in order to achieve better monitoring by both the countries and the Regional Office. The Regional Office will continue its technical and financial

(Continued on page 11)

(Continued from page 10)

support to the 10 priority countries, promote and support health sector reforms, use CBI as a potent tool for poverty reduction, human development and sustainability, to emphasize gender perspectives, to develop a health information system and to assist countries in resource generation and a partnership approach.

Evaluation of Basic Development Needs in Djibouti

A team, comprising WHO and national experts in community and social development, carried out an evaluation of BDN sites in Djibouti. The team was comprised of Dr Mohammed Assai, Regional Adviser for Community-Based Initiatives, Dr Jihane Tawilah, WHO Representative in Djibouti, Ms Moumina Houmed, WHO Representative's Office in Djibouti, Dr Saida Jrondi, WHO Representative's Office in Morocco and Ms Tonia Rifaey, Community-Based Initiatives, Regional Office for the Eastern Mediterranean. The data were collected through questionnaires; direct interviews and focus group discussion; interviews with the communities, beneficiaries, managers (at all levels), policy-makers, and partners; field observations; and analysis of available data and documents. The required data were collected from all related line-ministries and UN agencies. At present, the total population covered by BDN is 17 248 people in seven areas.

Gallamo is a model village for BDN in Djibouti. In Gallamo, Soublaly and Assassan, the Ministry of Agriculture and the World Food Programme are assisting in the training of the community on how to cultivate plots of land for consumption. In Gallamo, BDN and the Ministry of Agriculture distributed 200 trees to the residents to improve environmental health. In addition, Gallamo has become a model of self-reliance. All cigarette smokers in Gallamo stopped smoking and the village is now smoke-free. The women collect refuse from the village and dispose of it in 20 purpose-built holes. The

Village Development Committee has constructed a reservoir with a 1 kilometre pipe connecting it to the village. A school was constructed in which children receive nutritional food everyday. There is a functioning health centre that provides immunization to mothers and children, as well as family planning services and the treatment of simple diseases.

Generating partnerships in BDN in Djibouti has been outstanding as the following examples illustrate. The Ministry of Environment and the World Bank piloted an environmental health project targeting water purification in Goubetto and the school and the health centre are currently in the process of renovation by USAID at a cost of US$ 100 000. In As-Eyla and Sagallou, a women's vocational training centre was constructed in order to produce handicrafts and clothes. In As-Eyla the centre was constructed with support from the US embassy and the initial materials were purchased by the Women's Association, while in Sagallou the centre was constructed with support from the Canadian International Development Agency, the sewing machines purchased by the US Ambassador's Fund and BDN purchased the initial materials to start the project. In Einguiella and Sagallou, the Ministry of Promotion of Women has provided communities with literacy teachers. In Einguilla, through BDN the community was able to receive funds from French Cooperation to build a computer training centre in which 300 youths were trained. Out of them, 80 found jobs. Funds from the World Bank were given to operate an HIV/AIDS prevention centre, and funds from Union Nationale des Femmes Djiboutiennes (UNFD) were given to train people in handicrafts. Finally the Social Fund for Development (SFD) funded income-generating projects to create work for 40 women.

All the BDN communities in Djibouti have begun, or are in the process of instituting, the monitoring of maternal and child health, immunization schemes, construction of water reservoirs and latrines, HIV/AIDS and malaria prevention programmes and health education and promotion activities. In addition, literacy and vocational training are taking place, and a 100% reimbursement rate of income-generating loans

(Continued on page 12)

(Continued from page 11)

has been achieved through community participation in many sites. In Djibouti, the infant mortality rate is 103.2 per 1000 live births and the under-5 mortality rate is 150 per 1000 live births. Both indicators are significantly lower in BDN areas.

On the last day of the mission the evaluators presented their findings in a meeting organized by the Ministry of Health in collaboration with WHO and participated in by all potential partners including line-ministries, UNFD, UNICEF, UNDP and the US Embassy. Two chairmen from the Village Development Councils from Gallamo and Sagallo participated in this meeting in which they had the opportunity to share their experiences, in particular, community involvement in programme management. The evaluators presented their findings and recommendations, which were welcomed by all donors and partners who showed interest in expanding BDN.

BDN in Djibouti has achieved a great deal of success and sustainability. Communities felt that they were standing up on their own and serving themselves due to community empowerment brought about by the BDN. WHO should continue its technical and financial support as well as continuing to assist the Government in generating greater resources and more partners to expand the programme all over Djibouti.

Evaluation of Basic Development Needs in Yemen

A team comprising Mr Abdul Malik Mufadal, national BDN coordinator, Mr Khan Aqa Aseel, WHO Consultant in Yemen and Dr Salah El Badawi, Evaluation Consultant for the Regional Office carried out an evaluation in Yemen. The BDN approach for sustainable community development has been regularly pursued since 2000 under the umbrella of WHO with support from the Ministry of Public Health and Population, also in collaboration with line-ministries through the establishment of a number of pilot BDN areas. At present, the programme is implemented in 10 governorates of the country covering a total population of around 80 674 people. The evaluation involved most of the authorities related to the BDN programme at the national, mid and local levels, including the community representatives and some beneficiaries.

The evaluation of the BDN programme in Yemen had the following objectives:

- to ensure the programme is in line to achieve its planned goals and outcomes;
- to offer a mechanism for improving the health and well-being of individuals and communities, facilitating the process of overall human development;
- to define and gain a better understanding of the principles of the BDN approach;
- to build and provide a resource of common knowledge and experience to aid other development programmes.

The team found that the BDN programme in Yemen is well organized and structured in all areas. The national authorities at all levels are committed to supporting the programme's implementation. The programme has limited partnership with other organizations and development agencies, but there is a great deal of untapped potential in terms of partners who are willing to cooperate.

The programme has had a considerable effect on the improvement of health and socioeconomic indicators, such as an increase in the enrolment of basic education, women's literacy and immunization coverage, and a decrease in infant mortality and low birth weight, besides an evident increase in the income of the direct beneficiary families. The Regional Office will continue its technical support for BDN.

Certain improvement measures were recommended which focused on developing stronger links between health centres and BDN communities, capacity-building in health and nutrition, improving community management skills, strengthening intrasectoral coordination and intersectoral collaboration, in addition to building partnerships.