

Evaluation of the Basic Development Needs Programme in Djibouti



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Foreword

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

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

With this goal in mind, in 2001, the BDN process in Djibouti was established jointly by WHO and the Ministry of Health in four sites. Since then the programme has experimented with the relationship between health and socioeconomic development, using its various tools and guidelines. It has covered a wide range of social and income-generating activities in seven districts in the country.

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

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

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

Dr Jihane Farah Tawilah
WHO Representative, Djibouti

Executive summary

The basic development needs (BDN) approach to sustainable community development has been applied in a number of demonstration areas since 2001 under the umbrella of the World Health Organization (WHO) and with the support of the Ministry of Health and the collaboration of other ministries. The programme currently is implemented in seven districts of Djibouti covering a total population of approximately 16 657 people. To get a better understanding of the status of BDN programmes in countries of the Eastern Mediterranean Region, the WHO Regional Office for the Eastern Mediterranean decided to undertake detailed evaluation of the programme. The experiences of the BDN programme evaluation in Jordan, Pakistan, Sudan and Yemen encouraged the continuation of the process and the evaluation of the BDN programme of Djibouti was carried out in order to assess the implementation process and outputs of the programme.

The evaluation took place from 8 February to 1 March 2005. It involved most of the authorities related to the BDN programme at national, intermediate and local levels, including community representatives and beneficiaries. All seven districts were visited using the evaluation guidelines and tools developed by the Regional Office. 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 trainings are taking place. A 100% reimbursement rate of income-generating loans has been achieved through community participation in many sites.

Generally, the programme was found to be well organized with the required BDN structures in place in all areas. Communities feel that they are standing up on their own and serving themselves as a result of the community empowerment brought on by the BDN programme. Many of the communities have now become self-reliant. The national authorities at all levels have been committed in supporting the implementation of the programme and as a result of the programme's success the Ministry of Health has begun institutionalizing the BDN approach within its national health plan. Through BDN the government has been able to reach people in remote areas who previously were hard to reach. The programme has limited partnerships with other organizations and development agencies although a great many, as yet untapped, potential partners exist and are willing to cooperate.

A number of improvement measures were recommended, focusing on strengthening coordination with UN agencies, nongovernmental organizations and government sectors, maintaining documentation, recording and reporting systems, integrating health-related programmes in BDN areas and partnership building.

Introduction

Good health is a social objective and the desired outcome of a range of development interventions and its attainment should be actively pursued using all available means and resources. Past experiences have revealed that health is related to and influenced by complex environmental, social and economic factors. Through the Declaration of Alma-Ata in 1978, the world community committed itself to achieving the objective of good health for all by bringing together related sectors and local communities to agree upon the multidisciplinary actions and measures required to achieve a better health status for all. The approach embodied in the declaration constituted a major shift from previous approaches and practices as it adopted a more holistic approach to the attainment of health goals.

During the past few decades, the world has witnessed fundamental changes in social, cultural and political areas of life. Economic development has seen the globalization of trade and there has been a shift in market economies from the public to the private sector. These changes have affected underprivileged populations negatively, because in addition to the disproportionate burden of ill health which the poor endure, they also experience unemployment and under-employment, poverty, low levels of education, poor housing and malnutrition which results in social apathy and a lack of will for change. Accordingly, to expect substantial health improvements among vulnerable populations without first removing the constraining conditions to improve their health is unrealistic. It is imperative that multisectoral efforts are undertaken to improve the health status of the poor as the coordination of different sectors is likely to have a greater effect than interventions carried out by the health sector alone.

Acknowledging the need to broaden the coordination of different sectors, the WHO Regional Office for the Eastern Mediterranean Region has actively supported and advocated among its Member States for a community-based approach to health and development. This encompasses initiatives that have focused on basic development needs, healthy cities, healthy villages and women in health and development. Community-based initiatives aim at achieving a better quality of life through integrated socioeconomic development by facilitating active community involvement of all social groups and by promoting self-reliance, management and financing. The initiatives are based on needs-based bottom-up planning which supports intersectoral collaboration in the attainment of overall human development.

By collectively addressing all the determinants of health, community-based initiatives add a broader perspective than narrowly relating better health to the achievements of health services only. The initiatives strongly advocate for and implement strategies which facilitate access to essential social services and appropriate technologies, and provide information

and financial credit with the explicit aim of promoting a fairer distribution of resources to achieve equity at grass roots level. By promoting a better quality of life, the initiatives represent an approach which relies on sustainable intersectoral actions and strong community partnership.

Currently, 12 countries in the Region are implementing basic development needs (BDN) programmes, 16 healthy cities and 6 healthy villages programmes and 21 women in health and development programmes, all of which are in varying stages of development. Regular monitoring reports and rapid assessment surveys of ongoing programmes have demonstrated significant improvements in quality of life indices pertaining to a wide range of areas, including health, nutrition and economic development. To obtain a better understanding of the initiatives in the Region, WHO, under the direction of the Regional Director, is undertaking detailed independent evaluation in countries implementing the BDN programme. Over the past several years, WHO has carried out evaluations for BDN programmes in Sudan and Pakistan and for the quality of life programme in Jordan with significant results and feedback. Evaluations should be continued and further extended to other countries where the programme has reached a sufficient level of maturity will be able to yield strong documentary evidence and strategic feedback to support further programme expansion.

The Regional Office received a request from the Government of Djibouti to undertake an evaluation of the BDN programme in Djibouti and to use the results for advocacy and for programme expansion. The Regional Office assigned the Community-Based Initiatives Unit with the task of evaluation which took place from 8 to 1 March 2005. A mission (Annex 1) comprising the Regional Adviser and a technical officer from the Community-Based Initiatives Unit, in addition to an experienced expert in the field of community development, assisted the Ministry of Health in Djibouti and the WHO Representative in Djibouti to undertake the evaluation using standard guidelines and a questionnaire. The roles and terms of reference for BDN partners in programme implementation and expansion are laid out in Annex 2.

Country profile

Located on the Horn of Africa at the entrance to the Red Sea, Djibouti gained its independence from France on 27 June, 1977. Djibouti is a small country of 23 200 km² with a population of 817 000¹. Twenty percent (20%) of the population live in rural areas as nomadic herders and 80% live in the capital city of Djibouti. The country is divided administratively into the six districts of Arta, Ali Sabieh, Dikhil, Djibouti, Obock and Tadjourah. The population is comprised of Somalis (Issas) 60%, Ethiopians (Afars) 35%, and others 5%. From 1989 to 1994, Djibouti experienced a civil war. President Ismaël Omar Guelleh was elected in 1999.

The country has amassed a large external debt and is currently ranked 154th out of 177 countries on the Human Development Index². Djibouti has a GDP of US\$ 625 million, and a per capita income of US\$ 832 per year³. There is high unemployment which is currently estimated at 59%¹. There have been significant increases in relative poverty in Djibouti. Studies show that in 1996, 45% of the population lived on under US\$ 2 a day, and in 2002 that figure rose to 74%. The country is heavily reliant on the importation of all food items and raw materials. Djibouti has a small agricultural sector due to the lack of rainfall, and has virtually no industrial sector. The economy is based on service activities connected with the country's strategic location which account for 82% of Djibouti's GDP. Djibouti provides services as a transit port for the region and an international transshipment and refuelling centre administered by the Dubai Port Authorities. Due to the country's geographical location, Djibouti occupies a strategic position. The United States Agency for International Development (USAID) has given Djibouti US\$ 7 million a year since 2002.



¹ Demographic and health indicators for countries of the Eastern Mediterranean Region, 2004. Cairo, World Health Organization Regional Office for the Eastern Mediterranean, 2005.

² United Nations Development Programme. Human development report 2004. Cultural liberty in today's diverse world, UNDP, New York, 2004.

³ World Bank development indicators, 2004. Per capita income is based on calculations from WHO and World Bank data.

The health sector in Djibouti continues to face a great number of challenges, the most serious being the lack of qualified medical experts and lack of access to medicines (see Table 1). In remote urban centres there is one doctor or nurse serving areas that have not always been accessible. The Ministry of Health has begun to train community health workers and midwives from remote villages in order to access the entire population and improve the health status of the country.

Table 1. Human resources for health indicators, 2005

| Number of health professionals (per 10 000 population) | |
|--|------|
| Physicians | 2.2 |
| Dentists | 1.93 |
| Pharmacists | 3.26 |
| Nurses | 8.0 |
| Midwives | 0.67 |
| Laboratory technicians | 0.75 |

Source: *Demographic and health indicators for countries of the Eastern Mediterranean Region, 2004*. Cairo, World Health Organization Regional Office for the Eastern Mediterranean, 2005

Table 2. Health status, 2005

| | |
|---|-------|
| Women attended during pregnancy (%) | 67.0 |
| Women attended during delivery (%) | 61.0 |
| Neonates receiving professional care (%) | 73.0 |
| Population with access to safe drinking-water (%) | 84.0 |
| Population with access to sanitation (%) | 85.0 |
| Married women using birth control methods (%) | 6.0 |
| Women suffering from anaemia (%) | 70.0 |
| Immunization coverage (%) for: | |
| BCG | 42.0 |
| DPT 3 | 50.0 |
| OPV | 50.0 |
| measles | 48.0 |
| TT 2 | 35.0 |
| Neonates weighing at least 2.5 kg at birth (%) | 80.0 |
| Children with comparable weight and height (%) | 86.0 |
| Children under 5 years stunted (%) | 23.0 |
| Children under 5 years who suffer from chronic malnutrition (%) | 26.8 |
| Life expectancy at birth per 1000 population | 44.1 |
| Infant mortality rate per 1000 live births | 102.0 |
| Probability of dying before the age of 5 per 1000 live births | 94.6 |
| Maternal mortality rate per 10 000 live births | 54.6 |

Source: *Demographic and health indicators for countries of the Eastern Mediterranean Region, 2004*. Cairo, World Health Organization Regional Office for the Eastern Mediterranean, 2005

Poverty and the lack of access of remote communities to health care services is reflected in Djibouti's health indicators (see Table 2).

The Basic Development Needs (BDN) programme in Djibouti has been instrumental in mobilizing and empowering remote communities to participate in improving the quality of their own lives. Following its implementation 3 years ago, the Government has acknowledged its success as evinced by socioeconomic and health indicators, and is planning to incorporate elements of the BDN programme into its future national health plan.



Objectives of the evaluation

The overall objective was to evaluate the BDN programme and assess the input, process, output and impact of community-based initiatives in Djibouti. The evaluation also aimed at reviewing the methodology of implementation and the processes required for further programme expansion as it is expected that elements of the programme will be institutionalized in Djibouti's health and development sectors.

The evaluation was intended to meet the following principal objectives:

- appraise the BDN programme structure, management, political commitment and partnership;
- analyse the programme implementation process and progress;
- assess the changes in health and other socioeconomic factors within programme areas;
- identify the lessons learned and the major constraints in the programme's implementation and establish guidelines for the future;
- recommend actions for improvements in the programme's approach, implementation and process.

The BDN approach in Djibouti

The Government of Djibouti has embraced the BDN approach, and has begun to engage remote communities in creating solutions for problems within their local health services. The Ministry of Health has initiated the training of two community health workers and one midwife for each village implementing the programme. The Ministry of Women's, Family and Social Affairs, in partnership with the African Development Bank, has reinforced the women's vocational training projects established by the BDN programme in Eingueilla and Sagallou. French Cooperation has supported the computer training project established by the BDN programme in Eingueilla. The World Bank introduced an HIV/AIDS prevention centre. The women's vocational training projects have so far successfully taught 300 youth computer skills, and of these, 80 gained employment after finishing their training.

The Ministries of the Environment and Health, WHO and the World Bank worked together on a community-based malaria control programme in the village of Goubetto. The United States Agency for International Development (USAID) assisted in constructing reservoirs and rehabilitating health facilities. Islamic organizations were also active in constructing schools and mosques in these areas.



Communities involved in the programme have, within a short period of time, gained the skills to mobilize the resources available to them. The community in Eingueilla contacted the Social Fund for Development (SFD) and arranged for 40 income-generating loans to be allocated to 40 women from Eingueilla neighbourhood. In Sagallou, the village development committee created their own fund for those in need through donations from members of the community. The committee in Sagallou has mobilized aid from a number of ministries, nongovernmental organizations, United Nations agencies, bilateral donors, in addition to raising their own funds.

When the BDN programme was first introduced, the BDN coordinating team trained the village development committee, the zonal representatives and the coordinators for each district. In all of the BDN areas, communities were well organized and were mobilized for action. In Guirori, one of the elders described how the villagers had demanded action to reduce maternal mortality rates in their community and how after 6 months of significant mobilization on their part, WHO had constructed a health centre.

The Ministry of Health supplied the medical equipment for the centre and trained two community health workers and one midwife. The community contributed by supplying the labour for the construction of the health centre and for a reservoir. Management of finances was undertaken by the community although this was not documented. There were no baseline surveys undertaken at the older BDN sites but baseline surveys were conducted at three new sites. However, recording and reporting systems are weak. The intersectoral team is still in the process of being assembled and this is a priority as greater supervision of the BDN sites is needed and monitoring techniques need to be improved.



BDN sites in Djibouti

Background

The BDN programme was established in 2001 in four sites (Table 3): PK12, Eingueilla, Sagallou, Gallamo, and was extended in 2004 to four further sites: Soublaly/Assassan, Guirori, As-Eyla and Goubetto. The site of PK12 which was established during the first phase in an underprivileged district of Djibouti City is no longer operational due to an internal conflict between the village development committee and the community. It appears that the lack of a strong community identity among members of this particular community, who were comprised of several ethnic groups and who originated from different villages, contributed to the failure of the programme.

Table 3. BDN programme sites

| District | Programme sites | Date of implementation |
|------------|-------------------|------------------------|
| Djibouti | Eingueilla | July 2001 |
| Tadjourah | Sagallou | June 2001 |
| Dikhil | Gallamo | May 2001 |
| Obock | Soublaly/Assassan | July 2004 |
| Tadjourah | Guirori | September 2004 |
| Dikhil | As-Eyla | September 2004 |
| Ali-Sabieh | Goubetto | January 2005 |

Programme activities and outputs

Central level

Political commitment is evident as the BDN programme has been adopted by the Ministry of Health which has provided two coordinators to facilitate the programme. The BDN programme presents an opportunity for the integration of appropriate health programmes with the aim of reinforcing primary care health. Only two national programmes are currently integrated into the BDN programme: health education and immunization. Those responsible for the various BDN sites expressed a great deal of interest in the development of a national BDN plan that integrates all health needs. There is a common belief that BDN constitutes an entry point for all health-related interventions at community level and can contribute to the improvement of health indicators and the access of the population to health services. Those who have invested in the BDN programme believe that the programme's organizational structure could be employed by various health programmes in order to improve integration of health-related activities. The Ministry of Health envisages institutionalizing BDN by integrating it into the national health policy.

WHO has supported the BDN programme at central and intermediate levels through the recruitment of:

- a technical officer coordinating the BDN programme from the WHO office in Djibouti;
- two members of the central team housed at the Ministry of Health: one focal point person and one administrative assistant;
- four coordinators—one for each district.

Local level

In each BDN site, a village development committee was set up by the community. Each village development committee consists of a president, vice-president, secretary-general, treasurer, a youth representative, women, local association members, employees of the public sector (such as a nurse or teacher) and representatives of the zones. Women are represented in all seven committees, and the committee in Einguella is headed by a woman. There are 29 zones. The members of the village development committee are



notables and are chosen for being most actively engaged in the development of the community. All village development committee members and zonal representatives work on a voluntarily basis.

The BDN approach is based on addressing the essential needs of the community through a plan of action determined by socioeconomic and health needs (health, education, skills development, women's development, the environment, and income-generating activities). The programme empowers the village development committee to identify the community's needs and manage their own projects at local level.



One of the perceived deficiencies of the programme is the absence of any intermediate structure at district level, between the national team and the village development committee.

In Einguella, nine women and five men were selected and trained for four days on the BDN approach and methodology. At present, more than 100 women are involved in women's development activities. The zonal representatives and members of the community development centre were selected by the community according to defined criteria. The members of the community development centre work on a voluntary basis, hoping to improve the socioeconomic status of their community. They are actively involved in mobilizing the community for on-time utilization of available health services, such as immunization, family planning, maternal health and childcare. The members of the community development centre and the zonal representatives receive no financial incentives from the programme.

District level

The Regional Council on Health for Obock is comprised of seven members, including two doctors, teachers, and technical experts from the water and agricultural departments. The BDN programme has introduced new technologies relating to agriculture and the water supply in Soublaly and Assassan. The Ministry of Agriculture provided the community with plants and seeds, and the BDN focal point trained the community on land reclamation and cultivation. A regional committee on HIV/AIDS prevention has also been formed in Obock. Community health workers and midwives pass on information to the community regarding health programmes and refer children to the health centre at Obock for vaccination and for those suffering from malnutrition and diarrhoea. Community health workers also refer pregnant women and adults who are ill.

The mobile health team provides health services to BDN areas in collaboration with the community. During the field visit, the mobile health team tried to identify the most important health-related problems and to find appropriate solutions in consultation with the community. It is accepted that the BDN programme is a platform for health interventions and must be expanded to other areas in Obock in order to improve the access of remote communities to health services.



Partnerships

Representatives of current partners—USAID, World Food Programme (WFP), Agence française de développement (AFD), UNICEF, United Nations Development Programme (UNDP) and the US Embassy—involved in programmes at various sites were met by the evaluation team. Partners have shown a great deal of interest in BDN interventions as they are working in the same communities. In order to avoid duplication of efforts and to ensure a more efficient use of resources, the various partners discussed the needs of the communities, shared information about the strategies for introducing these interventions and established a plan to support communities' needs to be discussed and updated during future collective monthly meetings. The group agreed that in order to avoid duplication of efforts and to utilize all resources efficiently, all UN agencies and development partners should meet on a regular basis to discuss ongoing activities and projects, the needs of communities and how each partner can best serve the communities of Djibouti.



The National Union for Djiboutian Women (UNDF), the Ministry of Health and WHO recently began collaborating in Einguella and will extend this collaboration to further sites. UNDF invited trained women from BDN vocational training centres to participate in national days and to provide them with assistance to sell their products. UNDF also invited women from Einguella to participate in different activities and workshops. A plan is in place for the continuation of capacity-building activities and UNDF has representatives in all districts.

The Ministry of Women's, Family and Social Affairs provided Sagallou with two literacy teachers. The US Ambassador visited Sagallou and was impressed by the women's vocational centre and offered the women the opportunity to exhibit their crafts at the US Embassy in Djibouti. The Canadian International Development Agency built the women's vocational centre, the US Embassy paid for the sewing machines and WHO paid for the initial materials needed to start the project. USAID is renovating the health centre at Goubetto at a cost of US\$ 50 000.

Plan and promotional strategy

The BDN programme does not have a projected, documented plan of action and has not organized any advocacy campaigns. Only one seminar was held for the ministries involved in development in 2001 and a further seminar was held for all the stakeholders from the Ministry of Health in November 2004. The evaluation team observed the presence of organized communities in some sites and significant interventions by other partners. The interviews carried out with various partners highlighted a great deal of interest in the BDN approach. A joint plan of action with partners could help to contribute to the reinforcement of the programme and assist its expansion to other sites.

Mobilization and efficient use of resources

In the sites that were visited, it was evident that the BDN approach encourages and mobilizes the intervention of other partners, such as French Cooperation, the US Ambassador's Fund, USAID, and the National Union of Djiboutian Women. For example, the US Ambassador's Fund donated 15 sewing machines to the training centre for women in As-Eyla and French Cooperation supported the computer training project in Einguella. Currently this partnership is not a formal partnership and is not very well structured. Partnership within the BDN programme need to be well organized in order to ensure a more efficient use of resources and funds.



Programme activities

The BDN programme stresses the importance of training local community members, in particular, members of the village development committee,

zonal representatives, coordinators and members of regional councils, teachers and community health volunteers. The programme's budget was US\$ 9102 to finance the training of 108 people. The training related primarily to the BDN approach and follow-up of planned programme activities. Presidents and treasurers of the village development committees were also trained in financial management of the programme and methods for recovering loans from income-generating beneficiaries.

The Ministry of Health has supported the BDN programme by training community health workers and community health volunteers who perform valuable services for the community by conducting health promotion activities and in providing services to prevent communicable diseases. The Ministry provides mother and childcare services and manages environmental health issues. The maintenance of community health committees has become a challenge for the programme. Initially, there were 16 committees for health, and now only four remain. The programme has defined a profile of the community health organization and has recently identified 28 new representatives among members of the community possessing the necessary educational criteria. The BDN programme plans to prepare a training manual with the support of the Ministry of Health in 2005, and envisages equipping committees with didactic materials adapted to the cultural and linguistic local context. The programme has prioritized certain activities as essential for each community. Common priorities for various sites include the elimination of illiteracy and vocational training specifically in handicrafts and computers.

Intersectoral collaboration

During the evaluation, a number of meetings were held with national decision-makers at the Ministries of Health, Environment, Agriculture and Women's, Family and Social affairs and these meetings yielded one common strategy; all the ministries involved had a department concerned with community development and the reduction of poverty. The departments are supported by several partners: UNDP, USAID, French Agency for Development, the European Commission, the World Bank, French Cooperation, the World Food Programme (WFP), the Islamic Bank for Development and the International Fund for Agricultural Development. These departments have intervened in many of the same BDN sites (e.g. Goubetto in the district of Ali Sabieh, and Sagallou in the district of Tadjourah), but without any real coordination of interventions. These decision-makers expressed their interest in organizing intersectoral collaboration for the harmonization and the integration of their interventions in current sites and for future expansion, as all these interventions fall under the national strategy for the reduction of poverty.

Intersectoral collaboration at district level, does appear to be taking place, in particular, between the agricultural, environmental, youth and sports and the promotion of women departmental sectors. The various departmental sectors are represented within the regional councils for each district. Health is represented by the head of primary health care, who is usually a general practitioner. This collaboration needs to be expanded to all other sectors at district level. The structure of the regional councils is ideal for the integration of the BDN plan of action for the development of the community. The Chief of Tadjourah district expressed a great deal of interest at the prospect of carrying out development activities and professed a keen interest in adopting the BDN approach in his district.

A joint project was initiated by the Ministry of the Environment, in collaboration with the World Bank, in both Goubetto and Ali Sabieh. The objective of the project was to improve the health indicators of the population, particularly their access to safe drinking-water and sanitation. The villages of Goubetto in the Ali Sabieh district and Kalaf in Tadjourah have populations of 800 and 700 respectively. Goubetto is a BDN village that has an organized and mobilized community which will prove to be an asset for the smooth running of the programme.

Community mobilization

Organizing and mobilizing communities in various BDN sites is essential to the programme's sustainability. Members of the village development committee feel responsible for the community's programme and invest themselves in its management and required follow-up. The role of women in BDN is essential to development, and as such, has become an awakening for women in the communities. Women are actively involved in the programme and are represented in all village development committees. A majority of the projects are directed toward the improvement of the socioeconomic and health situation of women (health, elimination of illiteracy, income-generating activities, access to safe drinking-water, etc.).

In Sagallou, the BDN approach has created a feeling of solidarity among the community and has reduced poverty. The programme has also introduced democracy into the community as everyone has an equal opportunity to voice their opinions and benefit from the rewards gained.



Financial management

The financial management of the programme is the responsibility of the administrative assistant of the BDN team at national level. Treasurers in the village development committee are responsible for the collection of repayment of loans and for returning them to the administrative assistant who transfers the repayments to the BDN bank account.

Income-generating activities are administered to the beneficiaries of loans by purchasing the materials and the equipment which is then given to the recipients. Repayments are calculated based on the cost of the materials and equipment purchased plus an additional 10% for administrative costs (this additional 10% is used by the village development committee to finance social projects for the community). Income-generating project proposals are submitted by the poorest members of the community to the village development committee, who approve a number of them and then submit them to the national BDN team at the Ministry of Health and the WHO country office in Djibouti.

The village development committees have instituted a number of social programmes in BDN sites. In the literacy centres, the village development committee provides the equipment and the supplies and contracts teachers for a period of 1 to 2 years. Their wages are paid partly by the village development committee and partly from the 10% charge placed on all income-generating loans.



In all income-generating projects and social projects members of the community and the village development committee contribute to the projects. Contributions can be made in all forms, not only in financial contributions but in human resources and local materials, etc. The administrative assistant administers the loan repayment form to all loan recipients after the loans are signed for by the WHO Representative and the Director of Prevention and Public Health at the Ministry of Health. This process guarantees documentation of all income-generating activities and ensures periodic financial reports.

Monitoring and reporting

The management of all projects is entrusted to the village development committee. The supervision and the monitoring of BDN sites and the individual projects are carried out by the technical officer from WHO and two coordinators from the Ministry of Health.

Discussions and observations carried out at the various BDN sites and at different levels show that the supervision and follow-up are primarily only concerned with the income-generating activities. Very little supervisory attention was given to the activities directed toward socioeconomic and health-related activities. Some community health volunteers and BDN coordinators were inexperienced in relation to a number of health issues. A number of malnourished children and other vulnerable community members were not being adequately taken care of.



During discussions with all individuals involved in implementing health programmes at national level and with district doctors, it was stressed that the organizational structure of the programme was pivotal to reinforcement of the follow-up of the health indicators in all BDN sites. Follow-up can be undertaken by organizing joint missions for supervision and through an exchange of information and visits. Community health volunteers and zonal representatives have an important role to play in coordinating between health centres, the district and the community. These community workers act as liaisons, with a clear definition of their tasks, in coordination with the Ministry for Health. They are also in a position to collect data from the community for various health-related programmes.

Programme reporting

The system of data collection and documentation is very poor. It constitutes one of the principal weaknesses of the programme. Data relating to the activities undertaken in BDN programmes and the socioeconomic situation of the communities in the various sites are not currently available. In older sites baseline surveys were not conducted, which makes it difficult to assess the basic socioeconomic indicators. To rectify this situation, baseline surveys have just been carried out in all sites. The analyses of the surveys are with the Ministry of Health. The preliminary results of these baseline surveys were used to fill A-3.9 form which relates to the socioeconomic status of each site. In the absence of data, the E-2 form which relates to the profile of each zone and the E-4 form relating to information gathered on each family in BDN sites could not be filled. These two forms could be used by the national BDN team and the coordinators periodically to follow the progress of the socioeconomic indicators from the sites.

Table 4. Population covered by the BDN programme

| District | Programme sites | Date of implementation |
|--------------|-------------------|------------------------|
| Djibouti | Einguella | 11 914 |
| Tadjourah | Sagallou | 910 |
| Dikhil | Gallamo | 350 |
| Obock | Soublaly/Assassan | 281 |
| Tadjourah | Guirori | 156 |
| Dikhil | As-Eyla | 2500 |
| Ali Sabieh | Goubetto | 546 |
| Total | | 16 657 |

This eventually will provide evidence of improvement in the health indicators. The programme could then carry a card for each family, each zone and each site. These cards are essential for follow-up, and could be brought up to date periodically according to the needs of the programme.

The need to expand the programme to other sites was expressed by all decision-makers and partners, but in particular, by the people in charge of all health-related programmes and doctors in each district. All Chiefs of District and representatives from the Ministries of Agriculture, the Environment and Women's, Family and Social Affairs also expressed their desire to see an expansion of the programme. Table 4 lists the programme sites and shows the number of people covered by the BDN programme at each site.

Health-related activities

During meetings with people responsible for health programmes at the Ministry of Health, the evaluation team had the opportunity of interviewing those responsible for reproductive health, health education, HIV/AIDS, the Expanded Programme on Immunization and school education. There is collaboration between the BDN team and the sectoral departments of health education and immunization within the Ministry of Health. Common activities and interventions include the training of community health workers and teachers in schools concerning school health. The various departments have supported the training of community health workers, the programme's overhead costs, a manual for the training of community health workers and health education materials.

The principal actions which have been carried out by the BDN programme in the field of health have been the prevention of diseases by sensitizing and informing communities through community health volunteers. These volunteers are sensitizing and informing communities about school health, immunization, nutrition, environmental health, prevention of malaria and HIV/AIDS. The literacy courses have also conveyed similar messages to educate the population, particularly, women, about the necessity of

immunization, the benefits of breastfeeding, the need to monitor pregnancies, the benefits of assisted childbirth, child nutrition and the prevention of diarrhoea and other diseases.

In Guirori, the village development committee, with the support of the BDN programme, constructed a health centre in order to meet the basic development needs of the community. The Ministry of Health then provided the equipment and the personnel (a male nurse and a midwife), and the community contributed to the project by building a water tank for the health centre.

The health centre in Gallamo is run by a male nurse who does not reside in the same village every day of the week. The centre provides mother and childcare, including growth monitoring and immunization. All 34 children under 5 years of age were immunized against vaccine preventable diseases. Diarrhoea, acute respiratory tract infection and malaria are major health problems in Gallamo. Fourteen pregnant women in the community received tetanus (TT) vaccinations, administered by the nurse. The nurse also conducts three check-ups during the antenatal period of care of the women's pregnancies. Although family planning services (oral pills and condoms) are available at the centre they are not utilized by many couples. The recording and reporting system is not well established and needs considerable improvement.

In Soublaly and Assassan, health workers (including one woman) were trained in nutrition, immunization and the health of the mother and child, and they provide health education to the community.

A community-based malaria control programme is active in Goubetto. The community was told that improving the status of environmental health was a key to controlling and preventing the spread of malaria. Three committees on health, the environment and hygiene have since been formed with the active participation of village development committee members and the school principal. Two community health workers are also assisting the nurse in the delivery of health care services.



Although there have not been many projects directed towards health (out of a total of 34 social projects, only 14 were directed towards health), the results as evinced by health indicators have been satisfactory. Infant mortality, immunization coverage among infants (1 month to 1 year), the percentage

Table 5. Health indicators at BDN sites

| Indicators | National level | Eingueilla | Sagallou | Gallamo | As-Eyla | Soublaly Assassan | Guirori | Goubetto |
|--|----------------|------------|----------|---------|---------|-------------------|---------|----------|
| Infant mortality rate (per 1000 live births) | 103.1 | 65 | 17 | 15 | 25 | 14 | 30 | 55 |
| Under 5 mortality rate/per 1000 live births) | 124.4 | 22 | 13 | 12 | 25 | 15 | 23 | 25 |
| Vaccine coverage at less than 1 year (%) | 64.1 | 100 | 99 | 97 | 96 | 99 | 98 | 98 |
| Women vaccinated against tetanus (%) | 64.1 | 100 | 99 | 97 | 96 | 99 | 98 | 98 |
| Children under 5 years followed for their growth (%) | 23.0 | 98 | 98 | 91 | 92 | 96 | 97 | 97 |

Sources: Pan Arab Project for Family Health, 2004, Community survey for the BDN, 2005, and the Ministry of Health.

of children under 5 years followed for their growth and the percentage of women immunized against tetanus show vast improvements against the national averages (Table 5).

Programme managers stressed that the BDN programme works well as a platform for other health interventions and can improve the health and social indicators of communities. BDN is a great port of entry for health initiatives and allows for greater accessibility of the community to health services.

The problem currently faced by the representatives of the various health programmes is duplication of health interventions. This needs to be considered by hygiene and prevention departments in order to strengthen the collaboration between the BDN programme and other health-related programmes.

Community development

The communities expressed concern over the following areas: the environment (refuse and cleanliness), access to safe drinking-water and the lack of food. Some communities managed to organize a refuse collection programme at several sites and to bury the refuse, although refuse disposal has proven to be a problem at some sites. The communities also built and rehabilitated wells and water tanks (Table 6), in addition to arranging agricultural plots (22 agricultural plots at

Table 6. Access to water and sanitary facilities at BDN sites

| Indicators | National level | Eingueilla | Sagallou | Gallamo | As-Eyla | Soublaly Assassan | Guirori | Goubetto |
|---|--------------------------|------------|----------|---------|---------|-------------------|---------|----------|
| Families with access to sufficient water during the year (%) | 52 | 100 | 100 | 100 | 100 | 100 | 100 | 70 |
| Households with latrines (%) | 81 (urban) 19 (rural) | 100 | 50 | 0 | 45 | 0 | 2 | 60 |
| Families with access to a regular system of refuse collection (%) | 15 (urban) 0 (rural) | 98 | 80 | 100 | 90 | 85 | 86 | 50 |

Source: Ministry of Health and community survey of the BDN, 2005

Soublaly/Assassan). The community contributed their own time and effort, materials and oversaw the project management and maintenance.

In Gallamo, the BDN programme also assisted the community in the construction of a water reservoir and installed a one-kilometre water pipe to bring water to the village. The Ministry of Agriculture provided the community with almost 200 trees, which were planted in the area, in addition to a tree for each household. The subcommittee for hygiene and environmental health is run by a woman. The women of the community were motivated to collect their refuse and have it incinerated every two days. Women are being screened for anaemia by the community health workers and referred for treatment at the health centre. The community is assisting the leader of the subcommittee for hygiene and environmental health in this process. The village development committee members believe that their involvement in all development activities has had a positive effect on their own personal lives and on their routine activities.



In Goubetto, a joint Government and World Bank project was created to work on water purification. A team from the Ministry of Health, the Ministry of the Environment and the World Bank visited the village on a monthly basis to assess the safety of the water and to introduce a community-based malaria control programme.

The BDN coordinator is assisting the team in their tasks and encouraging the community's active involvement. There are three water reservoirs in the village from where the women collect their water. The women have difficulty gaining access to the water as there are only a few taps in close proximity to one another. The BDN coordinator and village development committee were asked to improve the situation through the appointment of a woman from the community to oversee the queue and to improve access to the water reservoir.

The objective of any BDN site is to improve the quality of life of the communities. The various representatives of the other sectors and partners who met with the evaluation team expressed a great deal of interest in taking part in joint projects for local development.

Promoting women's development

The Ministry for Women's, Family and Social Affairs was established in 1999 to strengthen the role of the women in development and to improve their socioeconomic status as a vulnerable group in the community. The Ministry of Women's, Family and Social Affairs and the BDN team are coordinating efforts in Einguella and Sagallou, and have expressed a desire to extend their collaboration to other BDN areas. The Islamic Bank has supported the establishment of 120 training centres in the country and these training centres have succeeded in teaching 6000 women to read. A further 3060 women will be given the opportunity to become literate through this intervention by the end of 2005. The Director of the Ministry of Women's, Family and Social Affairs believes that the establishment of literacy centres in the country has provided them with an opportunity to reach women in rural areas. In addition, the introduction of literacy classes into rural areas has provided the Ministry with the ability to assist women in these communities to identify the priority areas for improving their socioeconomic status. The literacy training centres are monitored and supervised by the Ministry of Education at both district and local levels.



The BDN programme in Djibouti puts women at the centre of the development process. Several projects in the programme are directed towards women, such as vocational centres that teach women how to become seamstresses and that teach them other artisan trades. There is also a focus on literacy, computer training and on income-generating activities. The women

expressed a greater interest than their male counterparts in becoming literate and in taking classes, and make up the majority of participants in all literacy and vocational classes offered. Out of a total of 760 people trained, 460 were women. After completion of their training, women have been able to find employment using their newly acquired skills and to take advantage of the income-generating loans offered. Of the 28 recipients currently taking part in income-generating projects, 16 are women.

The creation of accessible clean water sources allows women to obtain water more easily and relieves women of the drudgery of water collection which allows them to spend more time on other daily activities. Ensuring that women become literate guarantees their ability to comprehend health and environmental messages. Socioeconomic changes in the lives of women can be seen in all BDN sites. It will be important to maintain these efforts and further enhance them by enlisting the support of other sectors, such as the Ministries of Women's, Family and Social Affairs, Youth and Education, and international donors.



In Sagallou, 60 women were trained in handicrafts. A number of women left the village in search of better opportunities for employment. Those that remained volunteered to teach others handicrafts and run the women's vocational centre and shop which sells the handicrafts and clothes. This teaches the community that upon completion of training women should be given income-generating loans to guarantee employment in the village. Establishment of village-based handicraft cooperatives should be encouraged and linked to the market to produce demand-based products. The women in Sagallou are also involved in the decision-making process in the community, and equal rights are afforded to both women and men. The women express their empowerment by having gained a source of income and access to literacy due to BDN interventions. In As-Eyla, a women's vocational training centre has been established by the US Ambassador's Fund, and has 15 trainees and a teacher who work on a voluntary basis. The Vice-President of the Gobad Female Association is



supervising this centre. The raw materials and supplies for the training centre are paid for by membership fees from the 90 members of the association.

Income-generating activities

The income-generating projects which were developed in BDN sites are primarily points of sale for a number of products: food, clothing, cosmetic products, prepaid telephone cards, handicrafts, straw, and fodder for animals (Table 7). The income-generating loans which were granted to 28 recipients were fully refunded sometimes even before they were due.

The Ministry of Agriculture collaborated with WHO in Gallamo and Soublaly, through the distribution of 400 trees for Gallamo and agricultural inputs and seeds for both areas. Twenty-two agricultural plots at the BDN site of Soublaly/Assassan were arranged by the community. Through a partnership between WHO, the Ministry of Agriculture and the WFP, the plot caretakers were given the seeds and trees needed for planting.

Table 7. Income-generating activities

| Programme sites | Types of projects | Number of total recipients | Number of loans granted to women |
|-----------------------|---|----------------------------|----------------------------------|
| Eingueilla | 3 shops selling fabric and clothing 2 ice (cream) vendors 1 shop selling prepaid telephone cards | 6 families | 3 |
| Sagallou | 2 handicrafts 2 dressmakers 1 grocer 1 shop selling fodder 1 shop selling straw 2 butchers | 11 families | 6 |
| Gallamo | 3 handicrafts 1 boutique 1 butcher 1 shop selling clothes 1 grocer | 8 families | 4 |
| As-Eyla | 3 boutiques | 3 families | 3 |
| Soublaly/ Assassan | Agricultural plots | 22 families | - |

Source: BDN Programme

The community built the fences around the plots and planted the trees and seeds, in addition to supplying the land. WHO provided all the equipment needed (pickaxes, shovels, sprinkler pipes, wheelbarrows). Two of the agricultural plots are being cultivated by women. There has been a request for 60 additional agricultural plots by the community. The community's interest in cultivating agricultural plots has benefited rural development, improved local resources, in addition to providing families with an income and a source of nutrition.



The Ministry of Agriculture believes that projects in the community can improve the living standards of the local community, especially by targeting the poor. Priority is given to the poor, amongst whom are the farmers in Djibouti as the lack of rainfall inevitably makes farming difficult. As a result of income-generating activities, several people are no longer unemployed in these communities, in particular in the first phase sites (see Table 8).

In Eingueilla, WHO and the Social Fund for Development funded by the African Development Bank, provided income-generating loans to 46 people with a successful return rate. The World Bank also contributed to health educational activities in the prevention of HIV/AIDS by enlisting the active participation of the community. The village development committee selected the poorest members of the community to benefit from income-generating activities. Only one male was selected to receive an income-generating loan, therefore out of 46 projects 45 were directed toward

Table 8. Number of people who are no longer unemployed in BDN sites

| Districts | Programme sites | Population covered in each site | Number of people who are no longer unemployed |
|------------|-------------------|---------------------------------|---|
| Djibouti | Eingueilla | 11 914 | 3 |
| Tadjourah | Sagallou | 910 | 258 |
| Dikhil | Gallamo | 350 | 110 |
| Obock | Soublaly/Assassan | 281 | 52 |
| Tadjourah | Guirori | 156 | 30 |
| Dikhil | As-Eyla | 2500 | 26 |
| Ali-Sabieh | Goubetto | 546 | — |

Source: Community surveys BDN, 2005

women's development. The BDN programme has brought people together, and has fostered a friendly and participatory environment toward ensuring community sustainability. Trainees' tuition fees and the 10% service charge generated from the income-generating loan repayments, in addition to community ownership and active involvement in programme management are supporting programme sustainability.

In Sagallou, the village development committee developed 10 income-generating activities benefiting the poorest of the poor, who now serve the community through providing basic services, such as a grocery shop, a butcher, straw for construction, handicrafts and feed for animals. The community received DJF 310 000 equal to US\$ 2880 from the programme. Only two people from all the beneficiaries of income-generating activities were unable to repay their loans. One woman was unable to repay immediately due to losing her shop in a severe flood. The BDN programme issues reimbursement cards for income-generating activities beneficiaries and there is a marketing plan to sell their products outside the village. Sixty to seventy villagers are now employed through BDN assistance. The programme charges 10% as a service fee to each income-generating activities beneficiary which is invested in social development activities by the village development committee. The BDN fund will remain revolving to be used by other beneficiaries.

In Gallamo, the BDN programme granted income-generating loans to eight beneficiaries at a cost of DJF 470 000/US\$ 2 655. The team had the opportunity of interviewing three of these recipients who repaid their loans after 1 year. One man received 80 000 DJF/US\$ 452 and established a grocery shop in the village. He had been unemployed before receiving the loan but since receiving the loan has generated an income of DJF 20 000/US\$ 113 per month. In addition, he sells BDN products, such as mats in his shop. A widow from the village received a loan of DJF 80 000/US\$ 452 to sell honey and butter to the community which she brings from the city. She was able to repay the loan in 17 months, as she now earns an income of DJF 15 000/US\$ 85 per month. Another recipient, who had also been unemployed, established a clothes shop after receiving a loan of DJF 60 000/US\$ 340. He now generates an income of DJF 5000/US\$ 28 per month. He has recently requested an additional loan in order to upgrade his shop and purchase more items to sell.



Situation of children attending school

The number of children attending schools in BDN areas is considerably higher than those at national level (see Table 9). The BDN programme trains teachers on school health and environmental health, and the school building is also used for literacy classes. The problem of keeping children in school still persists though, particularly for girls. In the BDN sites there are only primary and secondary level schools. In order for children to continue to tertiary level education they must travel to the centre of the district. Unfortunately, most families are unable to accompany their children to district centres and may not have family who are able to house the children, so children are simply unable to continue with their education.



The case of Gallamo was particularly serious. The local school, until this year, included only Arabic in the curriculum and the district of Dikhil does not provide tertiary level education in Arabic. The children of Gallamo had to travel to Djibouti City for tertiary level education. However, at the request of the village development committee, a primary school was built by an Islamic organization located in London. At present, there are 130 students (102 boys and 28 girls) enrolled at the school. The programme then assisted the community in building a playground for the schoolchildren. Despite the success of the school in Gallamo, the school will require additional facilities and equipment in the near future.

Table 9. The situation of schoolchildren in BDN sites

| BDN sites | Children who attend school (%) | | | Children who have dropped out of school (%) | | | Children who have never attended school (%) | | |
|-----------------------|--------------------------------|-------|------|---|-------|------|---|-------|------|
| | (national average 53%) | | | (national average 38.2%) | | | (national average 26%) | | |
| | Average | Girls | Boys | Average | Girls | Boys | Average | Girls | Boys |
| Einguilla | 75 | 78 | 73 | 25 | 20 | 5 | 5 | 7 | 4 |
| Sagallou | 62 | 57 | 67 | 32 | 39 | 17 | 17 | 20 | 15 |
| Gallamo | 54 | 48 | 57 | 60 | 80 | 14 | 14 | 14 | 14 |
| As-Eyla | 40 | 41 | 39 | 32 | 37 | 47 | 47 | 43 | 49 |
| Soublaly/ Assassan | 28 | 26 | 30 | 15 | 14 | 67 | 67 | 70 | 65 |
| Guirori | Not available | | | Not available | | | Not available | | |

Sources: Ministry of Education and BDN Surveys 2005.

The village of Soublaly/Assassan has only a community school and a volunteer teacher. The French Development Agency has begun construction of a primary school which will be completed by the end of this year. The school will also include a canteen. These are some of the examples of successful partnerships in BDN areas. The women of the village have also requested the establishment of a literacy centre that could be funded by development partners.

USAID is allocating US\$ 60 000 for the renovation of the primary school in Goubetto and WFP has contributed flour, rice and oil to the school. The principal of the school is coordinating donations from both USAID and WFP. Food is cooked in the school and distributed to the schoolchildren. At present, 140 students (77 boys and 63 girls) are studying at the primary school, and the school employs seven teachers. The school operates on a shift basis with one shift in the morning and one shift in the evening. Three of the teachers are local residents from Goubetto. A literacy training centre for adults was established in the premises of the school, and has successfully taught 50 women to read and write. The nurse working in the health centre in Goubetto was asked to visit the literacy training centre on a weekly basis and to provide health education sessions for the trainees.

In Guirori, the Ministry of Education, in partnership with a French nongovernmental organization working for children, constructed a school and the French army assisted in the transportation of furniture and equipment for the school.

Funds invested in the BDN sites

According to the BDN approach the participation of the community is essential and their contribution should account for up to 30% of the funds invested. The village development committee is responsible for the management of projects and their mobilization encourages other partners to contribute funds to needed projects. A number of social projects are still paid for by the BDN fund as the project is still in the first phase. Funds so far invested in BDN sites have come from WHO, the Government, the community, French Cooperation, the US Ambassador's Fund, the Social Fund for Development and the World Bank. The contribution of WHO has varied from 29% to 79% according to the age of the sites. The community's contribution was 5% to 21%, depending on the nature of the project and the level of mobilization among the community. The Government contributed 11% to 60% (see Table 10).

Table 10. Funds invested in the BDN sites

| Partner contributions (%) | Eingueilla | Sagallou | Gallamo | Guirori | As-Eyla | Soublaly/Assassan | Total funds invested (US\$) |
|-----------------------------|------------|----------|---------|---------|---------|-------------------|-----------------------------|
| Government | 23 | 11 | 16 | 60 | - | 30 | 37 810 |
| WHO | 29 | 56 | 79 | 28.5 | 58 | 53 | 63 848 |
| Community | 12 | 11 | 5 | 11.5 | 21 | 17 | 18 524 |
| French cooperation | 16 | - | - | - | - | - | 9 700 |
| World Bank | 9 | - | - | - | - | - | 5 813 |
| Social Fund for Development | 11 | - | - | - | - | - | 6 780 |
| US Embassy | - | 22 | - | - | 21 | - | 8 430 |
| Total (%) | 100 | 100 | 100 | 100 | 100 | 100 | 150 905 |

Source: BDN programme

Conclusions and recommendations

The BDN approach has been integrated relatively well in the seven villages chosen in Djibouti. As a community-based approach it has mobilized the villagers to pursue sustainable actions in improving their health status and quality of life. The communities in Djibouti were determined in their attempts to significantly reduce maternal and infant mortality, as well as to increase literacy among the community through social projects which they had deemed as a basic development need. They had enlisted the aid of the Government, nongovernmental organizations, UN agencies and development partners to help them contract staff and equip schools and primary health clinics in their communities. Due to community acceptance of the BDN concept and approach and capacity-building training, they also realized the importance of safe drinking-water and sanitation, and as a result have constructed reservoirs and latrines. This is reflected in a number of indicators (see Introduction) that show the progress achieved by communities in data set against national averages. In a number of BDN sites, health-limited interventions existed.

Income-generating projects have been implemented in a number of communities with a 100% success rate. Communities were encouraged by their success and their ability to employ those who had previously been unable to acquire an income. Part of the success of the income-generating projects was due to the communities enlisting the aid of experts to train

village development committees in sewing and handicrafts, agriculture and fishing. The village development committees then passed their knowledge on to interested parties. The village development committees also created funds for those in need and chose the most impoverished in their communities to be the beneficiaries of income-generating projects.

There are several identified deficiencies in the BDN programme relating to the programme's structure and evaluation. A number of communities have not carried out baseline surveys and very little monitoring and evaluating is being undertaken. Existing documentation is weak. This may be due to the lack of intersectoral collaboration at both national and district levels. At national level, intersectoral teams are crucial for the success and sustainability of the programme. They should actively be pursuing resource generation, mobilization, and coordinating fund-raising efforts. The weak health component of the BDN programme and the lack of national yearly plans of action are also seen as obstacles to programme expansion.

Partnership in all BDN areas has been largely successful. A number of UN agencies and development partners have funded social projects for the BDN communities. More effort is needed in this area as most resource generation is being undertaken by the communities themselves and is only being coordinated by the Ministry of Health without intersectoral or line-department involvement.

The World Health Organization needs to intensify its technical and financial assistance in order to strengthen existing BDN programmes and to allow for programme expansion to other areas. Technical assistance is imperative at this stage to ensure that the programme is run more methodically.

The BDN programme was awarded a satisfactory rating. Communities are actively involved in the programme's implementation and several sites have become self-reliant in a relatively short period of time. The Government of Djibouti is committed to the institutionalization of the BDN programme as part of the national health and development strategy which will help to guarantee programme sustainability. WHO should continue its technical and financial support, and assist the Government of Djibouti in its efforts to generate additional resources and solicit partners for programme expansion.

1. The BDN team recommends that the tools and guidelines developed by the WHO Regional Office for the Eastern Mediterranean should be adopted for programme planning, organization, management, monitoring and for the development of information systems.
2. WHO should provide more technical support, particularly for the improvement of programme strategies and plans of action, documentation and reporting, for strengthening of evaluation and monitoring, and for promoting the exchange of experiences.

Support may be specifically needed for improvements in the information system and for the creation of technical intersectoral teams at national and district levels. WHO should also provide training on the basic principles of the programme.

3. The Ministry of Health and WHO should coordinate efforts toward practical intersectoral collaboration at all levels to avoid duplication of efforts and to ensure an efficient use of resources.
4. Joint programme advocacy is needed by government and partners to institutionalize BDN as an integral part of Poverty Reduction Strategy Papers (PRSPs), United Nations Development Assistance Framework (UNDAF), the Millennium Development Goals (MDGs), Sector-wide Approaches (SWAs) and the implementation of the recommendations of the Commission on Macroeconomics and Health (CMH).
5. UN agencies and nongovernmental organizations should collaborate at national level and participate in regular monthly meetings monthly held by WHO.
6. There should be scheduled meeting at all levels and continual monitoring and evaluation of BDN areas. All meetings should be documented and a plan of action should be created and followed.
7. Project coordinators should ensure that every BDN community holds regular documented village development committee meetings, in addition to ensuring that all financial transactions, such as dispensing income-generating loans are recorded and monitored. Annual surveys should be conducted and the results disseminated to district and national level teams. Project coordinators should also work with their village development committee to create yearly action plans to help achieve the BDN goals.
8. Information systems should be created at local level and information should be disseminated to district and local levels as soon as it becomes available. All health, demographic and socioeconomic information must be collected and updated by the village development committee in each BDN community.
9. An intersectoral support system should be created at national and district levels in line with the BDN approach. The technical steering committees are vital for the sustainability and resource generation of BDN communities.

10. More training on bookkeeping, monitoring and diversity of life skills training is needed.
11. Village development committees should organize technical cooperation between BDN villages and plan for programme expansion according to developmental needs. The village plans should be incorporated in local area plans and district plans.
12. The health component should be strengthened and consolidated by integrating health-related programmes (Roll Back Malaria (RBM), TB DOTS, growth monitoring, Expanded Programme on Immunization (EPI), etc.) in all BDN areas.
13. Diversification in life skills training needs to be addressed. More emphasis needs to be given to developing a greater range of skills in the community to guarantee sustainable development.
14. There should be a greater emphasis placed on the empowerment of the community in order to ensure sustainability.
15. An appropriate marketing system for the promotion and sale of products in project areas should be facilitated.
16. Advocacy to all the government sectors should be performed through periodic national, district and community level workshops. The field visits by senior government officials, media and UN and donor agencies should be encouraged as a part of programme advocacy.

Measuring programme success

At the conclusion of the evaluation of the BDN programme of Djibouti, a rating scale of 1 to 5 was used in order to determine its success, addressing factors stipulated in Table 11. Based on the results of the rating, the BDN programme in Djibouti, according to Table 12 from the Regional Office's evaluation guidelines, falls into category 2 stating that the programme has achieved all planned objectives and WHO should continue technical and financial support for programme expansion.

Table 11. Rating scale for the BDN programme of Djibouti

| Contributing factor | Score out of 5 |
|---|----------------|
| Level of government commitment | 3.0 |
| Institutionalization within government set-up | 2.5 |
| Organization and management | 3.5 |
| Human resources development | 2.0 |
| Intersectoral and partnership development | 3.0 |
| Community self-reliance/ownership | 3.5 |
| Community self-financing | 1.5 |
| Improved health and social development indicators | 3.0 |
| Total | 22.0 |

Table 12. Evaluation guidelines for BDN programme evaluation

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

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Ms Moumina Houmed, Technical Officer, WHO Representative's Office in Djibouti

International Experts/Consultants

Dr Saida Jroni, World Health Organization Consultant

Ms Tonia Rifaey, Community-Based Initiatives Unit, WHO Regional Office for the Eastern Mediterranean

National Counterparts/Associates

Mr Mohamed Nour Saleh, focal point at the Ministry of Health

Ms Fatouma Ali Abdallah, Administrative Assistant

Local/community resource persons (District Coordinators)

Mr Mohamed Ahmed, Obock

Mr Houssein Gadito, Tadjourah

Mr Houssein Abass, Dikhil

Mr Bohoreh Wais, Ali-Sabieh

Annex 2

The role of partners in BDN implementation and expansion

District authorities

Basic development needs should be placed on the agenda of the government district team. A BDN district steering committee may be formed to ensure ownership of the district authorities. District steering committees headed by the chief of the district should be comprised of the heads of the health, agriculture, education, environment, women's, family and social affairs, youth, finance and planning departments. The head of the health department may also act as the secretary of the committee.

Terms of reference for the district steering committee

- preparing the district plan, allocating and mobilizing resources;
- implementing the programme at district level through intersectoral collaboration;
- auditing the finance and accounts of the fund allocated by the Government and international donors through the relevant department;
- providing technical, administrative and logistic support to the BDN team;
- carrying out community mobilization and coordination with local and international nongovernmental organizations;
- facilitating registration of village development committees as community-based organizations/nongovernmental organizations;
- monitoring and supervising the programme;
- disseminating information at national level and to partners;
- facilitating training activities and refresher courses at district level;
- conducting monthly meetings to review the progress of the programme;
- assuring loan recovery and taking appropriate action against defaulters.

National authorities

BDN should be placed on the Government's agenda and integrated with Poverty Reduction Strategy Papers and other development processes

and programmes. A national board of the BDN programme may be formed to ensure ownership of the national authorities. The national BDN board is to be headed by the President and comprised of the Ministers of Health, Agriculture, Education, Environment, Women's, Family and Social Affairs, Youth, Finance and Planning and a WHO representative (on behalf of the UN team). The Minister for Health may also act as the secretary of the national BDN board. The WHO representative will report the progress of the programme to the UN team and encourage further partnership.

Terms of reference for the national BDN board

- designing policy guidelines and principles, approving programme standards and procedures in line with the national strategies for poverty reduction and economic development;
- coordinating BDN efforts with other health-related sectors, international agencies, development partners, district authorities and nongovernmental organizations to promote participatory strategies that comprehensively address community needs with a focus on primary health care interventions;
- mobilizing intersectoral support and community action for health, to enhance human development and develop a strategy to institutionalize the health sector's legitimate role of participating in this national endeavour;
- improving the role of the health system as a viable entry point for integrated community development and as a necessary element in human and socioeconomic development;
- streamlining BDN with national efforts in human development and poverty reduction with the aim of supporting this initiative focusing on health, education, gender equity and poverty reduction;
- mobilizing and allocating resources for BDN programmes and facilitating capacity-building for community-based integrated development at district and grass roots level;
- promoting training and research aimed at enhancing community organization, mobilization and leadership development and sustaining district and local efforts for human development;
- organizing networking and experience sharing between communities, potential development partners, district authorities and other countries to propagate and consolidate the BDN concept of partnership, resource mobilization and skills transfer;
- monitoring and evaluating the programme;

- analysing data and its compilation for dissemination/feedback to development partners and the BDN team at district and community level;
- approving the annual plan for programme expansion.

World Health Organization

- supporting the national BDN board in programme expansion through its technical and central role in the programme;
- assisting the Ministry of Health in monitoring, evaluation, expansion and training activities;
- providing technical and financial assistance in the areas of training of BDN teams, cluster and zonal representatives, village development committees and government officials;
- assisting the Government in preparation of project documents for expansion of the programme;
- assisting the Government in conducting operational research.
- assisting in advocacy and promotion activities.
- assisting in sharing experiences and field demonstration for national and international visitors.