Evolution of the basic minimum needs/basic development needs approach in the Eastern Mediterranean Region

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Rationale

When the basic minimum needs (BMN) approach was first considered all Member States in the Region had adopted the goal of achieving health for all by the year 2000 (HFA/2000) using the primary health care (PHC) approach. The Regional Office was directing the major portion of its support towards strengthening PHC systems and facilities, developing appropriate technology, training suitable manpower and promoting health systems research (HSR). The annual evaluation reports on progress in the implementation of national health-for-all strategies were analysed in-depth. The results of this analysis, together with the findings of HSR studies and reviews of global experiences, highlighted certain issues to be addressed in order to strengthen and speed progress towards achieving health for all in the Region. These issues fell into four major categories:

- problems facing HFA/2000
- the need to broaden the operational meaning of health
- need to mobilize all for HFA/2000
- the need to ensure sustainability and equity in health provision.

After analysing these issues it was felt that the Region needed to develop a paradigm that could encompass the solutions proposed and would be in line with, and strengthen, the PHC approach. The proposed solutions were as follows:

Poor management

- develop leadership to support managerial skills;
- ensure that managers benefit from their successes (thus creating concerned managers);
- develop team approach and collective leadership at implementation level;
- develop bottom-up development and managerial approach.

Inadequate or poorly managed resources

- beneficiaries to participate in providing resources and managing them;
- ensure use of local technology;
- develop self care.

Poor community role

- develop the community participation concept into full community partnership to be built gradually into community leadership.

Poor intersectorality

- develop joint programmes on the basis of joint input and credit sharing.

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Need to broaden operational understanding of health

- build health development on a foundation of fulfilled basic minimum needs (BMN) as it is now realized from regional and global analysis that health status cannot be achieved in their absence. These include PHC, basic education, reasonable income, food, water, sanitation, housing, safety and the right to practice a value system.

Need to mobilize all for HFA/2000

- organize both benefactors and beneficiaries and identify the role of each in supporting the HFA/2000 movement;
- develop a strategy based on a democratic, participatory approach and prioritization;
- develop leadership qualities.

Ensure sustainability and equity

- ensure ownership by beneficiaries;
- ensure needs selected by community;
- change role so beneficiaries become actors supported by public sector workers;
- develop a comprehensive approach for achieving all BMN;
- develop programmes to counteract risks facing health development, e.g., negative lifestyles, dependency, etc.

Evolution of the new paradigm

Some Member States had experience of comprehensive rural development projects; Egypt and Pakistan among other countries had multisectoral rural development programmes started during the early 1970s and supported by the World Bank. In the early 1980s an interagency (UNICEF/WHO) community-based programme had been started in the Nowshera district of Pakistan. The Nowshera programme was an advanced, organized, community intervention effort that could have developed into a breakthrough in social development. However, it used the district rather than the community as the denominator.

A search was launched by EMRO for a successful community-based comprehensive approach that could be replicated in the Region. Three programmes were visited. The first programme was in the Rajasthan Desert in the Rajpur district of India. Operating in only one village it was run by a highly motivated man and wife team, addressing mainly income generation, health education and fighting traditional harmful practices. The second experience was an Indonesian programme called the stratified primary health care programme. It was run mainly by the women's union, and while the programme was very effective it centred mainly on women's development and emphasized health and income generation.

In these early projects the ministries of health had little involvement in the programmes, although WHO was involved in both the Indian and Indonesian programmes. In Thailand a BMN programme was started by the Ministry of Health in collaboration with local government and WHO. Subsequently, a Quality of Life Foundation was established to continue to implement the programme nationally in close cooperation with local government. The Thai programme was a community-based, multisectoral intervention which proved capable of being replicated in different areas and succeeded in fulfilling basic minimum needs where it was implemented. Following the success of the Thai project it was hoped that, with appropriate adjustments, similar projects could be developed in the Eastern Mediterranean Region.

It was initially decided to introduce the programme in the Region through establishing a core group of convinced leaders who could promote the programme in their countries. This was done through three approaches.

First, senior regional WHO staff, WHO Representatives and country intersectoral teams at decision-making levels were invited to informal leadership development conferences organized in provinces in Thailand that were implementing BMN programmes. The objective was to develop leadership skills, and the six-day conference included a one-day field demonstration where participants visited a BMN programme in action. The programme immediately captured the attention of those delegates and leaders with involvement in development sectors, in almost all countries of the Region. Secondly, after the return of the multisectoral teams, ministers of health were invited to see the programme. Thirdly, operational workshops were organized for senior multisectoral officials from countries which had decided to implement the programme. Basic minimum needs approaches were then implemented in selected villages in some countries. Different names for the projects were used in different countries and the programme has developed into various innovative entities as will be explained later.

A description of the BMN approach and programme

To achieve BMN requires a process of organizing and mobilizing community members to realize their health and development needs and to work collectively to achieve them. It is a community-based, community-managed and partly community financed action. It entails role change, whereby people become doers and sectoral workers provide support. The community members decide their needs in a democratic way through interviewing each and every member of the community. The needs are then prioritized according to the scoring each felt need is given. This process operates as follows:

1. A village is selected based on a set of criteria that includes size, acceptability, degree of development and accessibility.
2. The philosophy, objectives and strategy of the programme are explained to villagers through the most appropriate and acceptable medium.
3. The village is then organized by dividing it into clusters, each of 10–15 houses, represented by one male and one female cluster representative (CRs). CRs along with traditional leaders, school teachers and peripheral public workers will constitute the village council (VC). The VC will select from among its members the village development committee (VDC). Parallel to this a village support team (VST) consisting of peripheral workers from the public sector will be created to provide support and training to the VDC and CRs.
4. The VDC, trained by the VST, will conducts a survey to select development needs as visualized by all villagers in a democratic way. These needs are prioritized by the VDC and VST according to the scores they are given by the community.
5. An action plan is put forward for implementing the selected needs. The plan should consist of a series of inputs and activities that can be provided by community members, either partly or in full, and those for which external support is needed. The VST should generate nec-

essary support for any input that cannot be provided by the community.

6. The programme expands through a process of technical cooperation between developing villages (TCDV). An involved village will assist a neighboring village to start the programme.
7. Indicators will be developed jointly by the VDC and VST and will be used to monitor the progress of implementation and to evaluate the impact of the programme.
8. The action plans set for each priority will together constitute the village development plan (VDP). The VDPs of villages in the same subdistrict or district will constitute the area development plan, thus building the social development plan from the bottom up, leading to provincial, state and national plans.

While the basic unit for BMN programmes is the village, higher level involvement is vital for its acceptance, introduction and subsequent success. At national level political commitment should be developed. A core group of convinced, committed and highly motivated multisectoral decision makers should be built through effective promotional efforts, including exposure to experiences and successes in areas where BMN has already been implemented. Multisectoral task forces should be established at national and provincial levels to provide support to the programme. Similarly UN agencies and other multilateral organizations working in the country should create their own interagency supportive task forces.

The benefits of the programme and its positive impact on HFA/2000 strategy implementation are obvious. These can be summarized as follows:

- strengthening intersectorality and interagency coordination;
- strengthening community and sectoral partnership in support of health for all;
- saving on the cost of health services in view of appreciable input by the community and various sectors;
- addressing the issue of poor management through strengthening community based management, strengthening effective coordination and bottom up planning approach;
- ensuring sustainability as ownership by beneficiaries (community members) is established;
- ensuring equity in health and social services in a democratic, participatory way based on real peoples' needs;
- the active participation of people in improving their quality of life and the ownership thus developed will improve their skills, attributes and lifestyle; developing social harmony and a spirit of cooperation and togetherness;
- gaining experience in the community of developing their own financing schemes, reaching a state of self reliance and arranging future surveys to decide on newly emerging needs that build on their development achievements.

Implementation of BMN in the Region

In 1988 the BMN programme was introduced in Jordan, Somalia and Sudan in selected villages. Later the programme expanded locally and regionally and is presently implemented in 13 countries of the Region. In different countries the programme is implemented according to the principles described earlier with minor ad-

justments to suit local situations. In most countries it is implemented as a BMN programme although it sometimes carries different names e.g. quality of life, basic development needs (BDN), basic needs of life (BNL). In three countries the programme is expanded to encompass other components over and above basic minimum needs.

In Shahrikot province of the Islamic Republic of Iran the programme is called the HFA/2000 Acceleration Programme (HFA/AP) and it includes, besides BMN, community schools, self care acceleration of PHC and healthy lifestyles. The objective of the HFA/AP is to reach the targets set for HFA/2000 by 1998 and to support the achievement by other components as mentioned above.

In the Syrian Arab Republic and Jordan healthy villages programmes (HVP) have been introduced. The components of the HVP are open-ended depending on what community leaders consider to be a need to be addressed. Some of the tested components that are being implemented over and above BMN are:

- *Self care.* A family health directory is prepared and sold to families at cost price, supported by health education efforts. The directory explains in simple language, health risks, home care, facts of life and the management of minor ailments.
- *Community school.* The action-oriented school health curriculum is implemented in schools.
- *Village information centre (VIC).* All information on the community concerning such issues as demographics, health status and economic status is collected by community leaders who compile, regularly update and exhibit it in one site at the VIC. Training for this task is provided by a peripheral, multisectoral, support team.
- *Healthy lifestyle.* Local people discuss, analyse and find a solution to one negative lifestyle at a time and pledge to implement the solutions. Positive lifestyles are also analysed and strengthened.
- *Baby-friendly home (BFH).* This aims at securing protection for children, as identified by the Convention on the Rights of the Child. The BFH should fulfill at least 12 criteria that cover areas related to children's rights, health, growth and protection.
- *Baby-friendly community.* The establishment in the community of at least 12 set criteria related to child rights, protection against violence, safety, children's play, etc.
- *Women's development.* This is achieved by assuring that 100% of the women are covered by women and child health services and that they have access to knowledge about methods of contraception, self-care and healthy lifestyles. Women should constitute 50% of village representatives and should be actively involved in all activities of HVP. Women who are unemployed, poor or widows are provided with vocational training and given interest-free loans to start income generating activities. Literacy campaigns are initiated and women's union activities are supported.
- *Protection and promotion of the environment.* A village healthy environment plan is developed and implemented. Tree plantation campaigns are organized.
- *Community-based safe motherhood.* This is encouraged by training women in domestic nursing, ensuring the availability of prenatal and postnatal services

for all pregnant women, providing at least one trained midwife for each village, educating women about safe motherhood and assigning roles in this respect to women leaders and clusters representatives.

- *Community entertainment/sports club.* The establishment by the VDC of a venue where, in collaboration with youth organizations, sports events and training, entertainments, exhibitions and special skills activities are organized. Public and national occasions may also be celebrated in them.
- *Scouting for intellect and innovation.* Community leaders identify individuals with special skills, abilities or potentials and help provide the conditions for further training and development, exposing them to regional and national recognition.

Great support was availed to the BMN programme at EMRO level. Several intercounty meetings and training workshops were organized. Material for promoting the programme and for training purposes, including a BMN kit, was developed and distributed. Managerial tools for monitoring and evaluation of the programme were also developed and tested. Allocations of support for national programmes were earmarked in the biennial regular country budgets. EMRO also cooperated with nongovernmental organizations and other UN agencies in implementing the programme in a number of countries in the Region.

Evaluation of the BMN approach

Regional level

The BMN programme, now nine years old in the EMR, is being implemented in 13 countries in the Region. A BMN kit has been developed by EMRO and the programme is being closely coordinated with PHC activities. Various working tools have been developed. The Regional Director has personally sponsored the programme and undertaken several promotional visits to countries in the Region. Intercountry seminars and training workshops have been organized and a regional training centre is being established in Jordan in cooperation with the Nour Al Hussein Foundation. EMRO has also promoted the intercountry exchange of experience, organizing study tours in which teams from Afghanistan, Egypt, Islamic Republic of Iran, Jordan, Pakistan, Somalia, Sudan, Syrian Arab Republic and Republic of Yemen have participated. Partnership in the programme has been created between WHO and IFAD (Somalia), UNICEF (Syrian Arab Republic and Jordan) and other multilateral and nongovernmental organizations.

Special activities

There are several special experiences in certain areas worth mentioning.

Economic activities

These projects emphasize income generating and are initiated either collectively or individually by members of the community. WHO has provided interest-free loans and conducted training to initiate and strengthen various income generating projects. Such projects have included among others; goat or cattle raising, fish breeding, sewing and netting, and handicrafts.

Health activities

Coverage by health services has been raised tremendously in villages where the programme has been implemented. Health indicators have also improved. In Somalia, for example, IMR has dropped from 88.7‰

to 30.4‰, school attendance has risen from 4% to 33% and malnutrition has dropped from 51% to 37%. In many countries the immunization coverage has risen from 13%–60% to 70%–100% and there has been increased coverage by other health programmes.

Educational activities

Through organizing literacy campaigns and promoting school enrolment, literacy rates have risen from 3%–50% to 40%–80% in BMN villages.

Impact on lifestyle

In many villages where the programme has been implemented the incidence of smoking, alcoholism, use of drugs and accidents involving violence have dropped significantly. Various entry points have been used to counteract negative lifestyles. Such entry points have included the economic, spiritual and health effects of negative lifestyles.

Note: The term "basic minimum needs" has recently been replaced in EMRO by the term "basic development needs".

The basic development needs (BDN) initiative continued its success in many countries of the Region. BDN initiatives are projects identified by the community that integrate social, economic, health and environmental issues. BDN projects are organized and managed by the community, supported and coordinated by an intersectoral team. They target income generation and poverty alleviation by implementing realistic, achievable projects which must include a well designed "basic" health component.

Expansion of the BDN approach took different forms in 1997. In some countries it was more in-depth, looking into fundamental processes; in other countries it was more horizontal. Impressive progress has been made in several countries of the Region.

Source: The work of WHO in the Eastern Mediterranean Region. Annual report of the Regional Director, 1 January–31 December 1997. *Page 36.*