

Basic development needs approach in the Eastern Mediterranean Region: from theory to practice

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SUMMARY Poverty and health are mutually reinforcing and deprivation in one area produces negative effects in the other. Unfortunately at the beginning of the 21st century, the number of people living in absolute poverty continues to rise with grim health consequences. Many studies have clearly established that health is related to and influenced by a complex of environmental, social and economic factors ultimately related to each other. Therefore, actions undertaken outside of the health sector are likely to have effects much greater than those obtained through the health sector alone. Thus, the countries of the World Health Organization Eastern Mediterranean Region have adopted basic development needs to address all the determinants of health collectively through community empowerment in order to transform social lifestyles and enhance human development. This article presents the contribution made by basic development needs in empowering local communities and vulnerable groups to acquire their essential needs through the efficient use of available resources. The assessment surveys of the ongoing programme conducted periodically in different countries have demonstrated significant reduction in poverty levels and improvement in quality of life indices pertaining to a wide range of fields, including health, nutrition and other social sectors.

Introduction

The rich people are not sick because they can afford good houses, clean water, food and health care necessary to avoid diseases. But living in poverty, how can we afford to avoid diseases? (Statement of a poor farmer from Sudan)

Under the *International classification of diseases*, absolute poverty is categorized as a disease [1]. According to Amartya Sen's analysis, poverty is "capability deprivation", where a person lacks the "substantive

freedoms" he or she needs to lead "the kind of life he or she has reason to live" [2]. Presently, about 20% of the world's population, or 1.3 billion people, live in absolute poverty. Despite overall growth of the world economy, studies on health inequities show that differences in health status between rich and poor are growing and that the link between health and poverty runs in both directions. Ill health is both a cause and consequence of poverty. Those living in absolute poverty are five times more likely to die before reaching the age of 5 years and two-and-half times more likely to die between the ages of 15 years and 59

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years compared with those in higher-income groups [3]. On the other hand, improvements in health cause a demographic transition from high to low fertility and mortality [4].

The reasons and mechanisms leading to inequalities in health have been frequently analysed. The wealth of people is their assets and their capabilities. As the World Bank has noted, "the body is poor people's main asset, but one with no insurance" [5]. Health allows poor people the opportunity to participate in gainful and productive activities. On the other hand, ill health can bring disastrous consequences for individuals and their families. Evidently, health, being central to human development, is related to and influenced by a complex of environmental, social and economic factors ultimately related to each other (Figure 1).

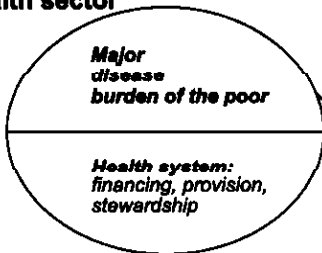
For communities, as for families and individuals, life is a whole and not divided into "aspects" and "sectors". Therefore, the right approach to health matters is within the totality of human needs. That is how "quality of life" can be understood and improved.

During the past two decades, fundamental changes have occurred in economic development and financing approaches and there has been a globalization of trade and knowledge and a shift to privatization. These changes have had negative effects, particularly on the underprivileged populations, as here, in addition to ill health, there exists a persistent combination of unemployment and underemployment, economic poverty, a low level of education, poor housing, malnutrition, gender insensitivity, social apathy and a lack of the will and ini-

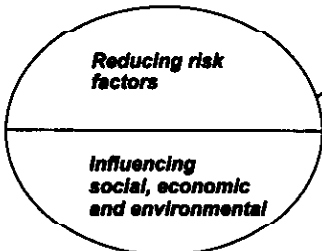
Determinants of health of the poor

Determinants of development

Health sector



Dimensions of health in development



Protection and improvement of health status:
longer life expectancy;
reduced morbidity/mortality;
improved nutritional status;
lower fertility rates

Social development
e.g. more effective learning

Human development
e.g. well-being increased

Economic development
e.g. more days worked per year

Figure 1 Health in human development

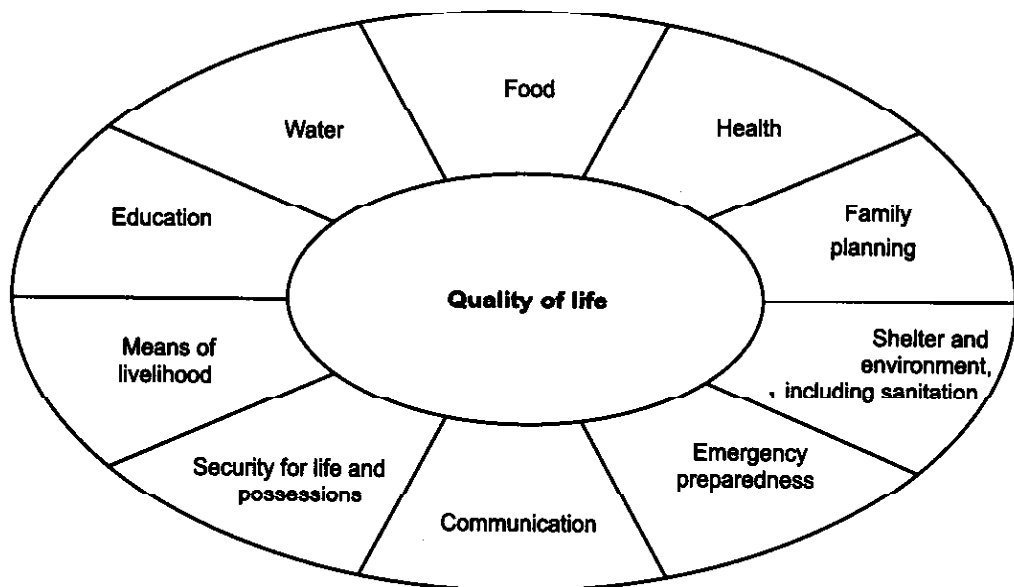


Figure 2 Components of basic development needs and their synergistic effects on quality of life

tiative to make changes for the better. It would therefore be unfair to expect any substantial health improvements in these populations without those constraining conditions first being removed or alleviated.

Recognizing the need to broaden its scope from only health-focused goals to the attainment of better quality of life, the World Health Organization (WHO) Regional Office for the Eastern Mediterranean has actively supported and advocated the basic development needs (BDN) approach among the countries of the Region [6]. It is based on the principle that health is an objective that should be pursued using all available means and the attainment of good health should be central to the entire process of poverty alleviation and human development. BDN aims at collectively addressing all determinants of health through integrated socioeconomic development by facilitat-

ing the active community involvement of both men and women (Figure 2). It has the fundamental understanding that it is where people live and work that health is made or broken. Such a process requires communities to assume greater responsibility in defining their needs, identifying priorities, mobilizing local resources and developing necessary local organizations. BDN strongly advocates and implements strategies that facilitate the access of local communities to essential social services, appropriate technologies, information and financial credit with the explicit aim of promoting fair distribution of resources to achieve equity at the grass-roots level.

BDN was first introduced in the late eighties as a research and development project in a few villages in Somalia. Since then it has steadily evolved and presently 14 countries in the WHO Eastern Mediterra-

nean Region are implementing BDN at various stages of development. The following sections provide a brief description of the salient achievements made through the BDN initiative in the participating countries.

Coverage

The extent of the coverage of BDN in various countries of the Eastern Mediterranean Region has been influenced by the corresponding political situation. Nonetheless, under varying sociopolitical conditions, the programme has proved its effectiveness and sustainability because of its flexibility and locally sensitive operational mechanisms. In 1989, the government of Somalia declared BDN as the priority health programme. After the civil war in 1991, only this programme sustained its momentum due to the firm ownership of the community itself. The programme has since been expanded to 81 villages and 52 satellites in 4 regions. In Jordan, a BDN programme is being implemented by an nongovernmental organization (NGO) in close coordination with line ministries. The government of Pakistan in its National Health Policy has recognized BDN as an effective strategy for poverty reduction and earmarked US\$ 420 million for its replication in 1997.

Since its introduction in Afghanistan, the BDN approach has been considered by different development agencies as a model for community solidarity and commitment. Here, almost two decades of armed conflict, destruction, displacement and the volatile political situation have made the socioeconomic conditions of the people amongst the worst in the Region. This situation has led communities to depend on themselves. BDN advocacy, dialogue and consensus-building were initiated in the

middle of this crisis, culminating in the launch of the programme in Nangarhar province of the eastern region in 1996. This was followed by the establishment of model sites in Herat in 1997, Ghazni in 1999 and Kabul in 2000.

Civil society partnerships

Social preparation in BDN aims to transform the dependency psychology of *aid, assistance, relief and donation* resulting from the paternalistic approach of government workers and aid agencies to real community empowerment through dynamic partnerships among all stakeholders facilitating *self-help, self-financing, responsibility and accountability*. To make this process meaningful and to enable communities to voice their concerns collectively, certain structures have been created in all countries implementing BDN. In each project area, there is a local development committee comprising both formal and informal community leaders. Each committee acts as the prime mover for development activities and is assisted by a support team consisting of representatives from the locally functional public sector departments. The team provides the needed managerial and technical skills to the communities during the planning and implementation of different interventions.

Recognizing that BDN requires not only collaboration between community and government but also partnerships with NGOs, international organizations, donor agencies and the private sector, each country has developed its own network of allies. The main partners include: United Nations Children's Fund (UNICEF), Plan International, Social Security Development Bank and Intermediate Technology Development Group in Sudan; Noorul-Hussain Founda-

tion in Jordan; Italian Cooperation and European Commission in the Syrian Arab Republic; World Bank and Social Development Fund in the Republic of Yemen; International Fund for Agriculture Development, Food and Agriculture Organization, Water for Life, Somalia Red Crescent Society and Life and Peace in Somalia; and United Nations Development Programme, United Nations High Commissioner for Refugees and many international NGOs in Afghanistan.

Addressing the needs

Using consensus-building mechanisms for situation analyses and needs assessments, the communities prioritize their interventions depending on the available human and financial resources. Experience in different countries has shown that income-generating schemes, as a means of livelihood and a source of food, invariably occupy a high position on the list of priorities. The support teams assist local committees in developing relevant, feasible, cost-effective and beneficial projects for the selected priorities. Although each country has undertaken different types of projects, the data in Table 1 clearly demonstrate the comprehensive and broad range of socioeconomic activities that have so far been supported by BDN to address community needs.

Djibouti has projects related to water supply and environmental health, agriculture, microcredit to families and women, immunization and other primary health care activities. In Morocco, women's development, small-scale enterprises and environmental health have received the main attention. Projects to improve the infrastructure, communication network, vocational centres and computer literacy have

been launched in Egypt, while the Syrian Arab Republic has embarked on community schools, safe drinking-water projects and baby-friendly homes. Sudan, Pakistan, Afghanistan and Somalia have implemented a large number of income-generating projects, such as poultry farming, fisheries, livestock and dairy development, agricultural products and rehabilitation of agricultural elements, cottage industry and handicrafts, while social projects include the promotion of environmental sanitation, adult literacy, girl-child nutrition, tobacco-free initiative, school health, mother and child care, social mobilization and youth development.

Making the difference

BDN interventions are directed towards better health outcomes for individuals and families by alleviating poverty, creating awareness, building capacity, enhancing literacy, ensuring adequate nutrition and providing essential health services. Regular monitoring reports and quick appraisals of the ongoing programmes have demonstrated significant improvement in the quality of life indices related to a wide range of socioeconomic areas. For health and social sectors, the direct and indirect impact of BDN interventions is remarkable. The data collected through baseline and rapid assessment surveys show significant and steady improvements. More importantly, these trends have been sustained and further strengthened during various stages of BDN evolution and have been recorded under different socioeconomic and cultural settings.

Numerous examples of improved nutritional status, low mortality during disease epidemics, effective malaria and tuberculosis control measures, increased use of safe

Table 1 Basic development needs — project profile

Health	Social sectors	Income generation
Strengthening of primary health care	Literacy centres and nonformal education	Livestock and dairy development (milking animals, rearing animals, farming)
Diarrhoea control (distribution of oral rehydration salts)	Promotion of energy-saving ovens	Cottage industry (wooden furniture, manufacturing tools, candle-making, steel works, electronics)
Special vaccination campaigns	Drinking-water schemes and sanitation campaigns	Small trades (grocery shops, animal feed and fertilizer, stationery stores)
Healthy lifestyles and healthy homes	Substance abuse rehabilitation	Women's industrial and vocational homes (embroidery, knitting, glass and fabric painting, artificial flowers, hand bags)
Tuberculosis management [directly observed treatment, short-course (DOTS)]	Agriculture awareness and tree plantation	Bee-keeping
Cataract screening and referral	Vocational training centres	Fisheries
Promotion of breastfeeding	Dewatering of base-water ponds	Family poultry
Safe motherhood and family planning campaigns	BDN community library	Agriculture (tube wells, water pumps, improved seeds, fertilizers and pesticides, new crops, fruit gardens, kitchen gardening, packaging and marketing)
Malaria control (bednets)	Food and nutrition	Cooperatives
No smoking campaigns (quit and win)	Youth development	Communication and appropriate technologies

Table 2 Basic development needs (BDN) in Somalia and Afghanistan — social development indicators

Indicator	Pre-BDN		Post-BDN	
	Somalia 1992	Afghanistan 1995	Somalia 1997	Afghanistan 1998
Infant mortality rate (per 1000 live births)	89	180	30	75
Malnutrition (%)	23	36	3	29
Enrolment in primary school (%)	4.2	43	36	-
Immunization coverage (%)	25	60	60	95
Antenatal care (%)	21	14	53	62

*Could not be measured as most schools have been closed due to war
Source: [8]

drinking-water, higher school enrolments and promotional activities leading to healthy lifestyles have been reported from Jordan, Syrian Arab Republic, Republic of Yemen, Egypt, Morocco and other participating countries. In BDN areas of Pakistan, there was a marked decrease in the mean infant mortality rate from 117/1000 live births in 1995 to 54/1000 live births in 1999. Within the same period, immunization coverage of children and pregnant mothers was enhanced to almost 100%, while the use of family planning methods increased from 3% to 30%. Similarly, through concerted advocacy and literacy campaigns, school enrolment among boys and girls rose from 57% and 30% to 75% and 59% respectively (Figures 3 and 4).

In Afghanistan, assessment surveys in 1998 indicated that the vaccination status of the children in BDN villages had reached a level of 95%, while it was around 60% before the introduction of BDN (Table 2). Antenatal care increased from an average of 14% to 62% resulting in a marked rise in the tetanus coverage of the pregnant women despite cultural restrictions. Health and social indicators in project areas of Somalia also registered improvements, al-

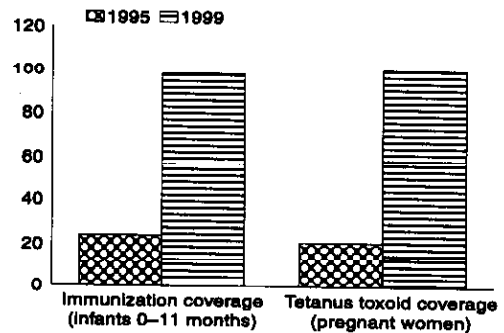


Figure 3 Basic development needs in Pakistan — percentage increase in immunization coverage. Source: [8]

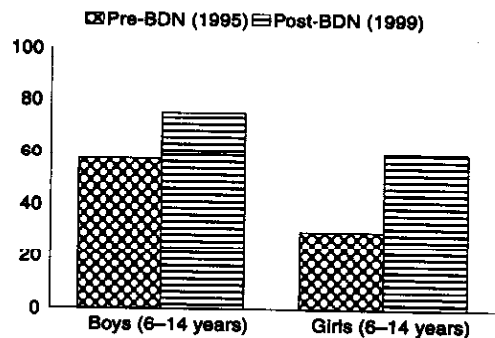


Figure 4 Basic development needs (BDN) in Pakistan — percentage increase in enrolment of schoolchildren. Source: [8]

Table 3 Basic development needs — cost-benefit analysis (Nizampur/Mastung, Pakistan)

Investment area	Families benefited	Total costs per family (capital and recurrent) (Pakistani rupees)	Income per year (1999) (Pakistani rupees)	Cost-benefit ratio
Agriculture and irrigation	2381	11 822	27 557	1:2.3
Livestock	487	22 975	37 722	1:1.6
Small trade	45	6 399	10 755	1:1.7
Women's development	889	19 923	76 100	1:3.8

*US\$ 1 = 47 Pakistani rupees (1998)

Source: [7]

though the entire public system collapsed after the civil war in 1991. In fact, BDN in Afghanistan and Somalia has been a bridge for peace and health as even during the periods of heightened fighting, all warring parties agreed to observe ceasefires during the national immunization days for poliomyelitis. For the same reason, the two countries are now presented as models for other nations going through difficult situations.

Aware of the fact that health risks associated with poverty require a particular combination of social and economic interventions with a strong commitment to equity, the BDN programme extends grants and interest-free loans to communities to undertake non-health interventions, including income-generating schemes, to address the prioritized needs. The schemes are supported on a cost-sharing basis with the beneficiaries and the loans are refundable to a revolving account managed locally. It is worth mentioning that in all countries the rate of return of loans has been consistently high, ranging from 75% to 95%, which indicates the effectiveness of the inbuilt guarantees provided and monitored by local organizations. The scheme also provides

opportunities to reinvest the available resources for the second generation of projects, which leads to self-reliant communities.

In a cost-benefit study performed for selected villages in Pakistan, it was apparent that the benefits clearly outweighed the costs involved in implementing such schemes (Table 3). It was also recorded that, due to better economic viability, the communities were investing more in the protection and promotion of their health as well as other social sectors. The change had a particularly profound effect on women who, with better resources and economic independence, were able to influence actions tailored to improve nutrition and educate children. This made BDN an effective tool to finance and sustain spending required to maintain health at the desirable level through community-managed actions [7]. The study also reported the following qualitative benefits of BDN.

- Poverty alleviation mechanisms have become integral components of local development strategies.
- Communities have gained technical and leadership skills through improved ac-

cess to public services and credit schemes.

- A dynamic platform has been provided for facilitating collaborative links between communities and other sectors of civil society.
- Poor and vulnerable groups have been empowered and better served with focus on their real problems and needs.
- Women have attained higher prestige and leadership roles in dealing with community affairs and social causes.

The road ahead

In the past decade, the WHO Regional Office for the Eastern Mediterranean has taken a leading role in the advocacy and promotion of BDN. During this period, many countries have gained sufficient ex-

perience in comprehensive development and have expressed a firm commitment to sustain and expand BDN model areas to large-scale national programmes. In this regard, these countries have developed a common vision and framework for action [8]. It has been agreed that by 2005, the community-based development initiative in countries of the Region will be central to national development policies and plans to reduce poverty, promote equity and achieve better quality of life. During this period, the initiative will be expanded on a large scale in at least three countries of the Region that enjoy a strong commitment and ownership of the national governments and communities. Partnerships between civil society, donor agencies and international organizations will also be consolidated to assist communities in achieving their desired objectives.

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