A solid base for health

Somalia has taken the first steps in its basic minimum needs programme, which is contributing to the implementation of the national health-for-all strategy through community involvement, intersectoral collaboration and appropriate technology.

A basic minimum needs programme was introduced in Somalia in mid-1987 following visits by Somali officials to Thailand, where the first such programme had been designed and developed. The WHO Representative in Somalia circulated a proposal for intersectoral collaboration, emphasizing the need to meet basic minimum needs through bottom-up planning, community participation and integrated rural development. This led to the formation of an intersectoral team, which has played an important role in promoting the programme. The initiative and support of the Minister of Health have also been significant. In mid-1988 the programme was presented to the authorities in the Lower Shabelle region by two WHO consultants. After an introductory two-day seminar on basic minimum needs, attended by members of regional, district and sub-district (beel) authorities, an intersectoral team was formed. It comprised representatives of various ministries, local government and the women’s association who received training for a month. During the seminar and training course, the proposal was discussed in detail with the authorities and inhabitants of two villages (beel). Revisions and modifications of the programme were made in accordance with the socioeconomic and cultural background of Somalia.

Surveys

A model village was divided into clusters of ten families and each cluster elected a representative. The representatives were trained and assisted by the intersectoral team to conduct and analyse house-to-house surveys. Based on the findings and on priority needs identified by the community, income-generating and social projects were developed and implemented by the community with support from the team.

After a year a preliminary assessment was made in five other model villages. The programme is now being implemented in 36 villages inhabited by some 20,000 people in the Lower Shabelle region. Preparatory activities are under way to extend the programme to six more villages with a total population of about 11,000.
Table 1. Projects in 36 villages, Lower Shabelle, Somalia

<table>
<thead>
<tr>
<th>Type of project</th>
<th>Number of projects</th>
<th>Local share (US$)</th>
<th>Interest-free WHO loan (US$)</th>
<th>Total cost (US$)</th>
<th>Profit in excess of total cost and social project (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture</td>
<td>23</td>
<td>31 000</td>
<td>19 300</td>
<td>50 389</td>
<td>24 090</td>
</tr>
<tr>
<td>Bee-keeping</td>
<td>6</td>
<td>2 300</td>
<td>2 750</td>
<td>5 050</td>
<td>Nil</td>
</tr>
<tr>
<td>Pottery</td>
<td>3</td>
<td>458</td>
<td>1 058</td>
<td>1 515</td>
<td>4 700</td>
</tr>
<tr>
<td>Fishing</td>
<td>4</td>
<td>3 231</td>
<td>2 350</td>
<td>5 581</td>
<td>2 550</td>
</tr>
<tr>
<td>Handicrafts</td>
<td>15</td>
<td>2 853</td>
<td>2 303</td>
<td>7 155</td>
<td>1 050</td>
</tr>
<tr>
<td>Limestone</td>
<td>3</td>
<td>180</td>
<td>Nil</td>
<td>180</td>
<td>3 455</td>
</tr>
<tr>
<td>Dairy products</td>
<td>1</td>
<td>73</td>
<td>200</td>
<td>273</td>
<td>150</td>
</tr>
<tr>
<td>Food security</td>
<td>1</td>
<td>750</td>
<td>750</td>
<td>1 500</td>
<td>Nil</td>
</tr>
<tr>
<td>Poultry</td>
<td>1</td>
<td>206</td>
<td>95</td>
<td>301</td>
<td>125</td>
</tr>
</tbody>
</table>

The demographic and social characteristics of the villages covered by the programme are typical of the Lower Shabelle region.

Basic minimum needs

The basic minimum needs of the villages, in order of priority, were as follows:

- water;
- food;
- shelter and environmental protection;
- means of livelihood;
- social organization and security;
- social services (health, education);
- natural disaster preparedness;
- communication facilities (road, public transport, telephone, etc.).

Communities that became involved from the beginning were able to identify their problems and adopt valid practical instruments to assess requirements, realize the changes that were needed and desired, develop projects and undertake their implementation, management and monitoring. The model villages that instigated the programme have started to share their experiences with other villages.

Income generation

The communities have adopted the programme as their own, addressing the main local problems rather than sectoral objectives, and consequently their financial contributions have been generous. The funds generated by the communities have been supplemented by an interest-free loan provided by WHO. Many of the projects and income-generating activities have been successful as regards returns on investment and the provision of funds for social projects (Table 1). The communities have dug 21 protected wells for domestic and agricultural use.

The income-generating projects were planned, co-financed and implemented by the people, with technical and managerial support from the intersectoral team. The total cost of the 57 projects was approximately US$72 000, of which some $41 000 were contributed by the communities and about $31 000 were provided by WHO as an interest-free loan. Overall, the communities reported a profit of about $253 000 (around $12.64 per person). According to the community contract, a part of this profit was to be spent on social services such as health and education, and in fact the communities have already constructed or renovated their schools, hired teachers, and built or

Bottom-up planning increases willingness in the community to participate in the programme.
Health Systems

renovated health posts, and they are also paying community health workers. Four villages repaid their loans much earlier than had been laid down.

Gains in health and education

A collective effort, including partnership between the people, government and WHO, has resulted in dramatic gains in health and socioeconomic development in the first five villages, the total population of which is 2526. Table 2, showing data collected before and after implementation of the programme, suggests that it may have significantly reduced infant and child mortality rates. Efforts are being made to improve the collecting and reporting of data on maternal mortality but as yet no reliable information is available on this matter.

The 36 villages, through a self-help management primary health care/basic minimum needs approach, fully immunized all their children in less than a year and provided safe drinking-water for both people and livestock.

Primary school attendance, particularly by girls, has improved substantially since the programme was introduced; the overall increase has been from 3.8% to 32.6% of the children eligible to attend.

A literacy campaign was conducted in some villages, where reading and writing sessions were organized by a member of the community. The adult literacy rate has increased from 16.6% to 39.2% thanks to these efforts.

All cattle were immunized against blackwater, haemorrhagic septicaemia, and rinderpest, and villagers were trained in preventive and curative primary health care for livestock.

The income-generating activities (Table 1) helped to reduce the prevalence of malnutrition among children under five years of age from 50.8% to 36.5%.

Improved nutrition

In each of the villages a community nutrition project was promoted and run by a committee selected by the people. Each committee consisted of community health workers, traditional birth attendants, and members of the women's association and the village council. All children aged under five years were weighed with a spring scale once a month at the village health post or in a public meeting place. Weight-for-age charts were produced notwithstanding difficulties encountered in assessing the ages of some of the older children. Malnourished children

Table 2. Infant and child mortality rates in 36 villages before and after implementation of the basic minimum needs programme

<table>
<thead>
<tr>
<th></th>
<th>Births</th>
<th>Infant deaths</th>
<th>Infant mortality rate</th>
<th>Children aged 1 to 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Number</td>
</tr>
<tr>
<td>Before basic minimum needs programme</td>
<td>857</td>
<td>76</td>
<td>88.7</td>
<td>2464</td>
</tr>
<tr>
<td>After basic minimum needs programme</td>
<td>888</td>
<td>27</td>
<td>30.4</td>
<td>2831</td>
</tr>
</tbody>
</table>

* Number of deaths of infants under one year of age in a given year per 1000 live births.

* Number of deaths of children aged 1 to 5 years in a given year per 1000 children in this age group.
Proposed functional relationships and links with government organizational structure for the extension of the basic minimum needs programme in Somalia.

were weighed every two weeks so that there would be more opportunities for educating the mothers in matters of nutrition. Mothers were also taught about the dynamics of child growth. Special attention was given to the use of oral rehydration salts for the treatment of diarrhoea, to immunization, and to the provision of supplementary food, based on what was available in the home, for malnourished children.

* * *

The basic minimum needs programme is helping in the implementation of the national health-for-all strategy through
community involvement, intersectoral collaboration and appropriate technology.

Bottom-up planning increases willingness in the community to participate in the programme. The planning process heightens community awareness about problems and resources, resulting in plans that are more realistic and feasible than ones developed in conventional ways. Successful implementation of realistic plans encourages community involvement, which is strengthened because the people's own priorities take precedence over sectoral considerations. Income-generating activities raise the capacity of the community for involvement and cost-sharing.

The integrated goal of meeting basic minimum needs is preferred to sectoral goals not only by villagers but also by government sectors and development agencies. The relationship between community activities and national and regional structures is shown in the figure.

With community involvement in the various stages of development activities the probability of identifying and promoting appropriate technologies is increased through the processes of learning by doing and by trial and error. Operational research has an important role to play in this area.

Since the population covered by the programme was small and the duration of the experiment was short, the results cannot be regarded as conclusive. Nevertheless, they indicate the synergistic effects of various sectors and in particular of income-generating activities on the health status of the people. As further data are obtained the evidence should become more convincing.

Acknowledgements

We wish to thank the many people at all levels, too numerous to name here, who have made it possible to mount Somalia's basic minimum needs programme.