

# Community ownership and intersectoral action for health as key principles for achieving “Health for All”

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## Introduction

The Alma Ata Declaration of 1978 expressed the need for urgent and unified actions by all governments, health workers and communities to protect and promote the health of all people. The declaration emphasized: equity in access to health services, economic and social development, the community's right and duty to participate in health, access to primary health care (PHC) and intersectoral collaboration for health development [1].

During the past few decades, the health sector has confirmed its catalytic role for health promotion, devising appropriate initiatives for improving health and quality of life of the community. This effort has been promoted in the Eastern Mediterranean Region (EMR) of the World Health Organization (WHO) since 1988 through Community-Based Initiatives (CBI), which have provided opportunities to integrate health interventions in local development processes.

The CBI approach addresses the major determinants of health within a broad perspective of development, and creates access to essential social services for optimum level

of equity at the grass roots level through the active involvement of the community and intersectoral collaboration [2]. The initiative adheres to the recommendations of the Alma Ata Declaration, and provides an excellent, replicable model of community ownership for health development. Currently, CBI covers a population of 18 054 316 in 17 countries of the Region. The major strength of CBI remains the empowered and organized communities who gained the knowledge and capacity to change in order to attain better social and economic status. This has created a move among the communities to achieve self-reliance, self-sufficiency and solidarity. The success of the programme has resulted in improvements in health and other socioeconomic indicators in the implementing sites.

This paper presents experiences from countries in the WHO/EMR, with a focus on community ownership, intersectoral actions and building partnerships for health development. It was prepared on the occasion of the 60th anniversary of WHO, the 30th anniversary of the Alma Ata Declaration and the 20th anniversary of CBI implementation in the Region.

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## Community-Based Initiatives

The CBI is an integrated, bottom-up, socio-economic development concept, which is based on full community involvement, supported through intersectoral collaboration [3]. It is a self-sustained, people-oriented strategy that addresses the diverse basic needs of the community and recognizes health as a social cohesion factor. CBI offers the added value of overcoming inequity, which has positive implications for health. The most salient aspects of this approach are the organization, mobilization and enhancement of community capabilities and involvement in micro-development through social and income generating schemes [4]. The ultimate objective of the programme is to reach the goal of the Alma Ata declaration, "Health for All".

The EMR countries are implementing different programmes under the umbrella of CBI: Healthy Villages, Healthy Cities, Basic Development Needs (BDN) and Gender in Health and Development. The CBI was launched in Somalia in 1988, and has subsequently been extended to support community development in other countries of the Region.

The programme focuses on fostering community action in poor areas and addressing inequities in health. The major strategies of the CBI programme are:

- empowering community and intersectoral collaboration;
- addressing the needs of women, children and youth;
- strengthening health, nutrition and environmental conditions;
- improving economic status to reach self-sufficiency at the local level;
- targeting poor and underprivileged communities;
- encouraging networking;

- partnership with nongovernmental organizations, universities and potential donors;
- linking various health-related programmes.

Intersectoral coordination is an integral part of the CBI concept; it encourages government line departments to work together, and mobilizes communities and involves them in the development process. Intervention sites are identified in response to requests by local residents [5]. For needs assessment and implementation, each site is divided into clusters of 25–40 households. Each cluster elects 1 representative. The cluster representatives nominate a community/village development committee. The CBI intersectoral team provides training and support to the cluster representatives and the development committee to enable them to conduct a baseline survey assessing the socioeconomic needs of the community. The final interventions/development projects are decided on, implemented and managed by the community, which ensures the programme's sustainability [6].

Community-designed projects include: rehabilitating health facilities, training community health workers and volunteers, using the community to accelerate the Expanded Programme on Immunization, raising awareness on reproductive health and nutrition, implementing the directly observed treatment, short course (DOTS) strategy for treating tuberculosis (TB), community-based water and sanitation projects, organizing literacy classes and vocational training centres for women, establishing community-based information centres, supporting agriculture and livestock projects, and tree planting.

The CBI brings into reality community ownership and intersectoral action for health, which are the 2 main principles of

PHC strategy. The CBI experiences are used as a successful model to encourage policy-makers and key stakeholders and seek their support in expanding PHC based on active community involvement.

## Community ownership and political commitment

### Community involvement in pre- and post-conflict situations in Afghanistan

The BDN programme in Afghanistan, implemented for more than a decade, covers a population of nearly 120 000. The programme endured all the challenges of war and political instability, and continued under the protection of the community even in the absence of a government. In BDN villages, the community convinced the authorities to reopen girls' schools while many schools in the rest of the country remained closed.

At the beginning of the post-conflict era in 2002, the government included the BDN programme in the national health policy as a priority and established a special unit in the Ministry of Health to run the programme. The community's active participation in TB-DOTS and Roll Back Malaria initiatives are successful examples of linkages between BDN and PHC services.

Villagers living on the Kabul River continuously suffered from waterborne diseases until the community prioritized the construction of a deep well and the resulting clean drinking water supply alleviated one of their long-standing health problems. Similarly, the establishment of female village development committees motivated the women to utilize the available health services. Currently, 56% of economic projects target women.

An informal assessment in BDN sites showed that social and income-generating

interventions have made a significant difference to the health, social status and livelihoods of families (Afghanistan office assessment, unpublished report, 2007). The programme has created confidence in the community to strive for ownership, self help and self reliance. Table 1 shows changes in some of the key indicators that occurred as a result of BDN intervention between 2003 and 2007. Particularly notable are the greatly increased access to safe drinking water and the proportion of births attended by trained individuals.

### Community health workers and women health volunteers in the Islamic Republic of Iran [7]

Selection and training of the community health workers (*behvarz*) in the Islamic Republic of Iran started in the 1970s, introducing new front-line health workers. *Behvarz* are native, literate, young females and males with intermediate qualifications, selected by the community and trained by the government for 2 years. They are responsible for providing PHC services to a defined population of around 1500. The *behvarz* are stationed at health houses, which

Table 1 Changes in some key health and social indicators between 2003 and 2007 as a result of interventions in Basic Development Needs sites in Afghanistan

Indicator	2003 %	2007 %
Births assisted by trained personnel	29	82
Enrolment of eligible children in school	53	82
Access to safe drinking-water	12	66
EPI full coverage for children aged < 1 year	40	77

EPI = Expanded Programme on Immunization.

is the most peripheral unit of the national health system. In the mid 1980s the district PHC network expanded throughout the country with the *behvarz* being the first line of contact between the community and the health system. Currently more than 25 000 *behvarz* provide the bulk of good quality PHC services in rural areas all over the country. In addition, health houses collect and report vital events using a unique health planning tool called the Vital Horoscope. This is a simple tool that the community health worker can use to register the vital events in his/her catchment area. A number of health indicators can be extracted from the Vital Horoscope, which is now a source of demographic and health information in rural areas of the country.

Another example of community involvement in health development is the use of women health volunteers who are active in urban areas, building bridges between families and the urban health centres. Women health volunteers are trained on priority local health problems and participate in health education, promotion and prevention activities on a voluntary basis.

### **Commitment toward development in Morocco [8]**

The BDN programme in Morocco covers a population of more than 200 000 in 17 provinces. The programme evolved during the past decade, supported by tools such as a territorial approach; institutionalization of local development committees; participative community diagnosis; and community-based health insurance. Apart from the positive impact on quality of life, the programme resulted in improved incomes for poor families through small loans. In addition, BDN played an important role in mobilizing the community towards local development and the fight against illiteracy.

In 2005, His Majesty King Mohamed VI endorsed the National Initiative for Human Development (NIHD), providing a holistic perspective for Morocco's national development goals. This was an opportunity for reforms and structural projects that were launched to promote development and the rights of women and children and to improve the conditions of vulnerable groups. In this context, CBI joined NIHD and used high level political commitment to move the programme forward. As a partner of the BDN programme, the Ministry of Interior assesses and facilitates intersectoral action and ensures submission of community-based projects to NIHD authorities. NIHD provides not only an opportunity to extend the CBI programme, but also a platform to institutionalize intersectoral actions in an integrated development process with a strong focus on equity.

### **Political commitment for expanding the Healthy City Programme in Oman**

CBI started in Oman in 2002. Over the years, community support group volunteers have established themselves as an important part of the PHC network. The Healthy City Programme currently covers a population of 219 274.

Oman is going through a rapid epidemiologic and demographic transition, and health promotion has been identified as the main strategic choice, focusing on key risk factors such as diet (including breastfeeding), physical activity, tobacco and safety. The establishment of the department for CBI within the Ministry of Health has facilitated the consolidation and expansion of CBI and demonstrates Ministry of Health commitment to encouraging community participation and intersectoral action to tackle major health problems.

### **Lady Health Workers in Pakistan**

With the aim of achieving universal health coverage, the Government of Pakistan, in collaboration with WHO, successfully launched the National Programme for Family Planning and Primary Health Care in 1994. The programme aimed to deliver basic health services to the doorstep in rural communities through training and deployment of Lady Health Workers. The programme is currently implemented in almost all districts of the country, with 100 000 Lady Health Workers providing PHC services to nearly 80% of the population.

The Lady Health Workers are trained to provide preventive, promotive and basic curative care, including vaccination, antenatal and postnatal care, and family planning services. They also manage minor health problems, advise families on referral, and keep records of vital events in their catchment areas. An international third party evaluation highlighted the important role played by Lady Health Workers in the provision of a comprehensive package of PHC services and in serving as a vital bridge between health facilities and the community (unpublished report, Agha Khan University, Pakistan, 2008). The programme has become an indispensable part of the national health system, and contributes significantly to overall human resource development and poverty reduction.

### **Community-based information centres in Sudan [9]**

The BDN programme, introduced into Sudan in the 1980s, currently covers a population of 250 000. Community information centres, where the data to be used for planning and decision-making is collected and analysed, have been established in 27 of 72 BDN areas. The required information is collected through a baseline household survey, allotting a number to each family; this

helps in project planning, implementation and management. The village development committee and BDN team members supervise the survey process to ensure quality and reliability. Cluster representatives are trained to collect data on key health indicators on a monthly basis and record it in the community information centre based at the nearest health facility. The information is presented in a simple format and is accessible to communities. It is valuable to health personnel in identifying target groups and to the community at large for priority-setting, developing village profiles, monitoring interventions and evaluating results.

### **BDN bridging access to deliver PHC services in complex emergencies, Somalia**

The BDN initiative in Somalia closely integrated its activities with other PHC programmes, notably the Expanded Programme on Immunization, malaria control and basic hygiene and sanitation. As a result, communities in BDN villages actively participated in the implementation of these programmes, which led to improved access, coverage and quality of services. For example, the coverage rate for a measles catch-up immunization campaign in 3 visited BDN villages in Hargeisa was more than 95%. An assessment in 8 BDN villages in 2005 concluded that "the general health situation is better (than other villages) and there are no children affected by measles after the measles catch-up immunization campaign".

Moreover, the initiative was instrumental in expanding integrated malaria control activities, including distribution of insecticide treated nets; introduction of larvivorous fish to open, shallow irrigation wells; provision of antimalarial drugs and supplies; training of health staff; and raising community awareness for prevention and control measures. These interventions

helped contain frequent outbreaks of malaria in BDN villages. Likewise, the initiative contributed to improved antenatal, delivery and postnatal services in BDN villages through the provision of supplies, training, and supervision.

## **Intersectoral action for health and partnership development**

### **Political commitment and partnership for BDN in Djibouti**

The Minister of Health in Djibouti launched the national strategy and plan of action for expansion of BDN in 2006. The strategy was developed in collaboration with Ministries of Labour, Agriculture, Women's Development and Tourism after consulting with key stakeholders and members of the community. The strategy demonstrated the government's high commitment towards making BDN a tool for reducing poverty. The strategy addressed partnership and set up an organizational structure for BDN management and expansion.

A presidential decree was issued in 2007 to establish an institutional framework for promoting health and involving community in poverty-reduction [10]. The decree was an important step in institutionalizing the BDN programme and achieving the millennium development goals (MDGs) in Djibouti. As a result, 5 regional committees have been established for health promotion and poverty reduction. The Health and Local Development Committee, which is involved in activities related to HIV/AIDS, tuberculosis and malaria, has now been extended to the BDN-implementing sites.

### **Jordan's experience of building partnerships for the Healthy Village Programme [9]**

The Jordanian Ministry of Health, with support from WHO, introduced the Healthy

Village Programme in 1996 with the objective of creating a supportive environment for improving the health and quality of life of the people. The programme implemented CBI and adopted other measures to respond to the needs of the area, particularly those related to health, environment and education. By mid-2005, the programme covered 30 villages in all governorates.

The Ministry of Health established a Healthy Village Programme directorate in 2005, and the programme was later expanded to cover 36 villages. Around 400 income-generating loans were distributed amounting to more than US\$ 283 000. The project targeted improvement of socio-economic status of beneficiaries, of which 70% were women. Over 84% of the projects were sustained, with 92% recovery rate. The programme succeeded in creating the first national network of women volunteers who actively participate in designing local interventions and strategies for health protection, environmental health and adoption of healthy lifestyles.

### **Effective, result-based partnership in Basic Development Needs, Pakistan**

The BDN programme is currently implemented in 9 districts of Pakistan, covering a population of 4 million. The government of North West Frontier Province has provided funds to replicate the programme in 5 additional districts. The programme has established an effective partnership with Khushhali Bank, the United Nations Development Programme, the World Food Programme (WFP), the United Nations Population Fund and local nongovernmental organizations. In addition, a US\$ 2.7 million grant has been approved by Round III of the Global Fund to Fight AIDS, Tuberculosis and Malaria to support communities in the fight against these diseases in 9 BDN districts [11]. In an effort to achieve health equity, the Ministry of Health, in collabora-

tion with district governments and WHO, has taken important steps to institutionalize the programme and involve civil society.

### **The Healthy City Programme in Saudi Arabia**

The Healthy City Programme, implemented in Saudi Arabia since 1998, currently covers a population of nearly 8 million in 23 districts. The programme is supported by the government and is a priority programme under the Director-General of Preventive Health at the Ministry of Health. There is active community participation in all aspects of the programme, including health and environment, with a strong focus on the promotion of women in planning and implementation. Support from princes and governors ensures sustainability, and inter-sectoral collaboration is one of the cornerstones of the programme.

City health profiles are being developed and poverty reduction initiatives are undertaken supporting finance schemes for the underprivileged and poor segments of the community. Health promotion activities are imparted in schools, and children are provided with free supplementary meals. In addition, a project on rehabilitation of disabled people is being implemented through this programme.

### **Integrated community recovery and development; United Nations joint programme in Sudan**

In Sudan, The United Nations Children's Fund (UNICEF), WHO, WFP, the Food and Agriculture Organization and the United Nations Development Programme have joined hands in a collaborative project for poverty reduction and achieving the MDGs in 15 villages. The project attempts to fulfil the basic social and economic needs of vulnerable communities in South Kordofan through the introduction of BDN. This programme

is a model for the joint programming under the United Nations Development Assistance Framework 2009–2011 [12].

### **Partnership with local nongovernmental organizations in the Syrian Arab Republic to increase access of the poor to social services and improve economic status**

The Syrian Ministry of Health adopted the Healthy Village Programme in 1996, with the main focus on health development. The programme, implemented in 615 villages, covers a population of 1.27 million. It has been successful in strengthening health facilities and PHC services, including Integrated Management of Childhood Illness, Mother and Child Health, the Expanded Programme on Immunization, promotion of healthy lifestyles, healthy school initiatives and no-smoking campaigns. UNICEF and WHO are working together in supporting the community school programme, early childhood development, child friendly homes and community initiatives. In 2001, Mrs Asmaa al-Assad, wife of President Bashar al-Assad, visited Healthy Village Programme sites and, acknowledging the concept, supported the establishment of the nongovernmental Fund for Integrated Rural Development to provide assistance to underprivileged communities. WHO, the Fund for Integrated Rural Development, the Agha Khan Development Network and other partners have provided loans to communities for micro-credit schemes amounting to more than US\$ 11 million for Healthy Village Programme activities. These loans created 11 039 job opportunities and the reimbursement rate was close to 100%.

The external evaluation of the Healthy Village Programme in 2005 showed that, in areas where the programme had reached a certain level of maturity, the adult literacy rate improved from 70% to 93%,

access to safe drinking-water from 76% to 98%, and the population with adequate sewage disposal facilities from 65% to 92% [13]. The immunization of children under 1 year old improved from 79% to 100%, and tetanus-toxoid vaccination of mothers increased from 58% to 92%. There was also a significant reduction in the incidences of respiratory infection, diarrhoeal disease and leishmaniasis [13].

### **Healthy and safe school environment project, Yemen [14]**

The healthy and safe school environment for children project was launched by the WHO Regional Centre for Environmental Health Activities in Yemen in 2005 to raise awareness, through community participation and intersectoral action, about the impact of the physical environment in schools on children's health.

The school committees assessed the environmental health status of 65 schools in the BDN areas and prepared and implemented action plans to improve the environmental health status. WHO is assisting the Ministry of Public Health and Population and the Ministry of Education in promoting the project and to generate resources through building partnerships with the World Bank's Social Development Fund, UNICEF, WFP and other partners.

### **Intersectoral collaboration to improve female literacy in Basic Development Needs sites of Egypt**

The recent project launched in BDN sites in Egypt was the result of a combined effort and partnership between the Ministry of Communication and Information Technology, community members, the United Nations Development Programme and WHO. The idea was to enhance the effectiveness of literacy classes by providing a new learning tool called "literacy CD". Class instructors from BDN areas were given the opportunity

to develop their skills through training on these CDs. The training was conducted by the Ministry of Communication and Information Technology, and the community contributed by paying their transportation costs. By the end of the training sessions, literacy instructors were able to go back to their respective communities and teach their students using this new method. The BDN communities were provided with the necessary teaching aids and equipment to commence this endeavour, and the communities have shown great interest and enthusiasm in learning through this new method. The project also generated community-wide interest in learning basic computer skills.

### **Challenges, lessons learned and future directions**

A major challenge for the CBI programme is the issue of sustainability for existing projects and scaling up at the sub-national and national level so that WHO can redirect its support to expansion in new sites. War and civil strife have prevented the governments in Afghanistan, Iraq and Somalia from providing effective support to the CBI programme.

Government support for CBI creates opportunities for programme expansion and obtaining external support. Involvement of civil society organizations can also enhance sustainability, when they assume the responsibility of managing local projects.

The WHO country offices need additional technical assistance to monitor and supervise implementation of the community-based development plans. More emphasis needs to be placed on linkages between MDGs, CBI, poverty reduction strategy, sector-wide approaches and making CBI an integral part of national development and health policies. Partnerships need to be built between CBI, public health institutes

and universities at the country level, making these centres a technical resource for training and research in health and development. Improvements in the health component of CBI through integration of various health interventions/programmes will remain at the top of our priorities.

In an effort to assist countries in achieving the CBI objectives, a greater emphasis will be placed on developing and reviewing national MDG strategies and plans of action. This will be done in consensus with all major stakeholders and donors, with the aim of making Poverty Reduction Strategy Papers and Country Cooperation Strategies documents MDG-oriented. Efforts will be placed on strengthening coordination between intersectoral health-related programmes.

CBI will continue to develop advocacy materials and to encourage Member States to create their own kits in the local language for exchange of experiences, evidence building for programme expansion and resource mobilization.

The experience of CBI in countries of the EMR provides a useful model for other regions in implementing grass roots level interventions that address social determinants of health. CBI is particularly effective in overcoming gender discrimination and in providing a social environment that supports women's development.

The WHO Regional Office for the Eastern Mediterranean is committed to following up and providing technical support to Member States through [15]:

- institutionalizing CBI within the national health policy and plan;
- building the capacity of communities to become partners in health planning and provision of PHC services, with special focus on poor and underprivileged areas;
- intrasectoral coordination for improving access, demand and quality of PHC services;
- implementing local development projects through community ownership and partnership development;
- scaling up CBI expansion, promoting partnerships and linking CBI with ongoing development activities like MDGs, Poverty Reduction Strategy Papers, etc;
- streamlining programme management and the monitoring, reporting and evaluation system;
- integrating disaster preparedness, response and management components in CBI-implementing areas;
- obtaining government support for CBI;
- involvement of civil society organizations.

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