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community-based initiatives

Newsletter

World Health Organization
Regional Office for the Eastern Mediterranean

Contents

Interview with Dr Abdullah Assa'edi, Assistant Regional Director

1. As a senior member of WHO management who has had experience working at country and regional levels, how do you view the potential of scaled-up community-based initiatives in countries adopting the community-based initiatives programme?

In order to scale up community-based initiatives, the initiatives need to be integrated into national health and development policies and strategies. For this reason, there is a need for greater advocacy efforts and for dialogue with other concerned sectors at national, provincial and district levels. National health programmes and units need to more fully utilize the potential and opportunity created by community-based initiatives to streamline their field activities. Therefore, it is strongly suggested that intrasectoral collaboration at district and local levels needs to be strengthened. In addition, efforts need to be continued to promote community leadership and to involve women in the decision-making process to ensure sustainable development. A more concerted effort needs to be made towards creating partnerships between

civil society and UN agencies and donors. This will allow expansion of community-based interventions and generate additional resources for development. Our ability to demonstrate community-based initiatives, successes and to share information will enhance this process. Lastly, it is vital that governments take the lead in advocating and promoting community-based initiatives by making the initiatives an integral part of their health and development policies and strategies and by carefully documenting case studies for use in advocacy efforts and in capacity-building.

2. Poverty and health are interrelated and the community-based initiatives are trying to combat the burden of disease by helping the community to alleviate poverty. What is your advice for countries and for local government to promote health and poverty reduction efforts through mutual efforts with the community?

To understand the link between poverty and health one must recognize all the social determinants of health, and define poverty in relation to its effect on the socioeconomic and health status of people, rather than in terms of monetary simplicity. The poor are less likely to have access to safe drinking-water and sanitation, quality health care services, formal education, proper nutrition and adequate housing, which in turn leads the poor to bear the greater burden of disease. As a result, the capability of the poor to participate fully in society is diminished, which leads to an increase in government expenditure on health and in social security. Thus, by reducing poverty and increasing health coverage, communities can become more productive and improve their socioeconomic status. Community-based initiatives can provide a package of social services and income-generating opportunities to poor members of communities through intersectoral collaboration and community participation (see diagram below).

Services provided for the poor by the community-based initiatives

3. All countries and UN agencies have made a commitment to achieve the Millennium Development Goals by 2015. How do you view WHO's role in assisting countries to achieve the health-related goals and their role in partnering with other UN agencies in the Region?

In the Region, approximately half of the Member States are doing well in relation to achieving the targets of the MDGs. Based on the socioeconomic indicators of different countries, the Regional Office has selected 10 priority countries* which require greater support in achieving these targets. WHO's assistance to these 10 countries will be through the encouragement of political commitment, resource mobilization and through the provision of technical assistance for health system reform. This will allow greater accessibility of the poor and underprivileged to primary health care services. Health information systems need to be strengthened in order to collect reliable data and to plan for the future. The development of partnerships and locally-based resource generation are among the main activities expected from Member States and WHO representatives. Over the past two decades, the Regional Office has enlisted the aid of communities in the Region through community-based initiatives. WHO believes that in order for any global initiative to remain sustainable, communities must be organized and actively participating in the development process. As such, we strongly believe that community-based initiatives represent a valuable tool in achieving the targets of the MDGs.

4. The Commission on Macroeconomics and Health for the past 4 years has advocated for an increase in the allocation of funds for health, specifically targeting the poor and underprivileged. The Islamic Republic of Iran has pledged US$ 1 billion, and Pakistan US$ 157 million, to increase their annual health budgets. How can WHO promote this investment in other countries?

Advocacy at the highest level is needed to promote the evidence that countries, by devoting greater resources toward health which specifically targets vulnerable groups, will increase their productivity and subsequently their rate of GDP, and reduce poverty. Efforts must be made to increase the initialization capacity of the health sector, as well as ensuring that additional funds are equitably directed to those in rural areas who are vulnerable and who lack access to health care services.

The Commission on Macroeconomics and Health which promotes partnership with communities, civil society, UN agencies and donors, is instrumental in creating environments where access to health care, education, skills development, and water and sanitation is ensured. The role of women in development needs to be constantly promoted and encouraged. Community leadership and capacity-building should be sustained. Promoting decentralization and creating communities that are self-sustaining is the only way to achieve sustainable development and to foster positive change.

Policy-makers should see an investment in health as an investment in their economy. If policy-makers allocated greater resources to awareness-building on the prevention of cardiovascular diseases, for instance, then there would be fewer patients requiring invasive treatment and the high cost of open heart surgery and other interventions could be reduced. The same is true for many other diseases that are preventable. Thus, political and financial commitment are needed to place health at the centre of the development process.

5. Health has, theoretically, always been central to the development process, and as such, would you agree that the use of the community-based approach is important as a tool for creating improvements in people's health which are sustainable?

A number of evaluations have been undertaken on community-based initiatives in countries of the Region, such as Djibouti, Jordan, Pakistan, Sudan, Syrian Arab Republic and Yemen. All the findings have indicated that this programme has made a significant contribution to poverty reduction and to the communities' access to health care services. The evaluations have demonstrated the existence of political commitment in assisting communities in the path of development. The socioeconomic and health indicators showed positive results in relation to EPI coverage, growth monitoring of children, women's reproductive care, access to water and sanitation, education and even in relation to levels of household incomes. Thus, the community-based initiatives approach has been successful. However, there is still room for improvement. We have created a base by which countries have been convinced by positive results and are discussing scaling up initiatives in all countries.

6. Dr Assa'edi, we are grateful to you and appreciate the time you have given us for this interview. We would be pleased to hear any other comments you might have.

I would like to thank all ministries of health and WHO representatives who have shared their success stories and experiences with us. The Regional Office will continue its support in the exchange of experiences in community-based initiatives and in poverty reduction efforts through this channel. In this regard I want to urge Member States and colleagues working in community-based initiatives at different levels, from cluster representatives to members of BDN teams and village development committees, to those working with community-based initiatives at the district, provincial, national and regional level to seize ownership of this newsletter and provide us with more evidence and examples of successful experiences which will help advocate and promote the programmes to different partners.

* The 10 priority countries are: Afghanistan, Djibouti, Egypt, Iraq, Morocco, Pakistan, Palestine, Somalia, Sudan, and Yemen.

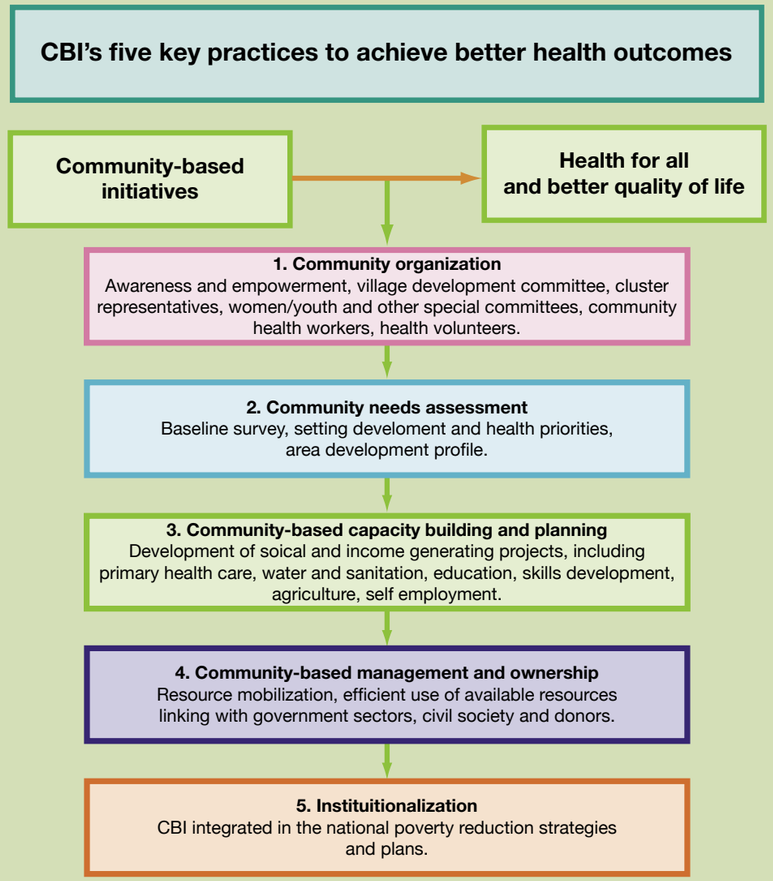
Why are poverty reduction strategies important for health and quality of life?

Under WHO's international classification of diseases, absolute poverty is categorized as a disease. Poverty can be human or economic in nature. Human poverty is defined by depreciation of health, insufficient food and nutrition, lack of education, lack of access to safe drinking-water and sanitation. The poor are less likely to have access to quality health care services, adequate nutrition and basic facilities, which in turn leads the poor to bear a high burden of disease. As such, the reduction of poverty is an essential component in the health-for-all agenda. The diminished capability of the poor to contribute also increases government expenditure on health care and social security.

Despite the overall growth in the world's economy, differences in the health status of the rich and poor are growing, and poverty has emerged as one of the most challenging socioeconomic problems in developing countries. The number of people living in absolute poverty continues to adversely affect countries' health status. Currently, about 20% of the world's population, 1.3 billion people, live in absolute poverty with an income of less than US$ 1 per day, and surviving on less than US$ 2 per day is a reality for almost half of the world's population. In the Eastern Mediterranean Region, nine countries have annual per capita incomes of less than US$ 1000.

Countries in the Region are trying a variety of approaches in the drive to reduce poverty. In recent years through Poverty Reduction Strategy Papers (PRSPs), attempts are made to focus poverty reduction efforts on the poor at local level. WHO, as part of its overall aim of improving health, is promoting the community-based approach, particularly the basic development needs approach, as an important strategy for poverty reduction and health development at the local level.

Based on the successes achieved in health and development at community level, the Regional Office supports extensive community-based initiatives in almost all countries of the Region. The role of WHO has been to introduce the concept, develop models of good practice, train people and increase local capacity in pilot areas. The basic development needs programme, as a component of model development, engages at the local level in community organization, community needs capacity-building and planning, community-based management and ownership, and institutionalization. Great efforts have been made to improve health and health services to reduce poverty in project areas (see diagram).



Intercountry meeting on the implementation of poverty reduction strategies

In the summer of 2003, representatives from the Ministries of Health, Finance, Planning and Budget of countries in the Region gathered in Fez, Morocco, to formulate strategic directions for a pro-poor strategy on sustainable health development and poverty reduction for the Eastern Mediterranean Region, which was subsequently approved by the Fiftieth session of the Regional Committee for the Eastern

Mediterranean in October, 2003. The objective of the regional strategy is to accelerate improvements in the population's health, particularly the health of the poor and vulnerable.

"It was also felt the time was opportune to deliberate on an overall regional plan for scaling up community-based initiatives."

Following the development of these strategic directions, the need was felt to closely examine the progress of the work on poverty reduction, on strengthening health services in community-based initiatives settings and, most importantly, on harmonizing the local-level actions of community-based initiatives and on mainstreaming economic development, in addition to national actions to achieve the targets. After 15 years of intensive promotion and model development, it was also felt the time was opportune to deliberate on an overall regional plan for scaling up community-based initiatives. Thus, an intercountry meeting on the implementation of poverty reduction strategies was held in Cairo, Egypt, from 14 to 16 November 2005. The specific objectives of the meeting were to:

- develop an action-orientated plan to mobilize the regional poverty reduction strategy into national plans, programmes and projects for implementation, including the establishment of operational guidelines;
- share experiences of the work currently being undertaken showing government ownership, community involvement and intersectoral collaboration in poverty reduction and sustainable development programmes;
- develop a strategic approach to assist in the documentation of community-based initiatives experiences to contribute to the knowledge networks developed by the Commission on Social Determinants of Health;
- examine how best to strengthen the health component of community-based initiatives in terms of health services as well as as a key entry point to mobilize communities for development;
- examine how partnerships are best enhanced, particularly through linkages between activities related to the MDGs and community-based initiatives;
- deliberate on advocacy, training, technical support and capacity-building and model development as the main strategic focus for community-based initiatives, and promote and strengthen national ownership.

Participants ranged from focal points of community-based initiatives in all countries of the Region, to WHO representatives and experts in community-based initiatives from selected countries, to Regional Advisers and Directors from the Regional Office and WHO headquarters, to UN partners, such as representatives of the Islamic Educational, Scientific and Cultural Organization (ISESCO), and United Nations Industrial Development Organization (UNIDO), and finally to nongovernmental organizations, such as the Fund for Integrated Rural Development in the Syrian Arab Republic, the Agricultural Credit Cooperation in Jordan, and the Social Development Agency in Morocco.

The participants highlighted significant country experiences and visions related to the stated objectives. They also contributed to the collective deliberations of the meeting through working groups and plenary discussions. Finally, they developed their national operational plans.

Social determinants of health

The social determinants of health refer to both specific features and pathways by which societal conditions affect health and which can potentially be altered by informed action.* Following the announcement of the WHO Director-General at the 2004 World Health Assembly, the global Commission for the Social Determinants of Health was launched by WHO in March 2005 in Santiago, Chile, and called for the renewal of a process that would draw attention to the importance of the social causes of ill-health and inequities in health that prevail between and within countries and regions. Over the next 3 years the Commission will set the foundation for sustained processes to profile and integrate the social determinants of health within public policy and practice.

The Commission's work is based around three broad areas: (1) learning by consolidating, disseminating and promoting the use of knowledge that demonstrates the imperative for action on the social determinants of health that informs both policy and effective, equitable interventions on these determinants; (2) advocacy by identifying and promoting opportunities for action on key social determinants affecting health by policy-makers, relevant agencies and the wider society; and (3) action by catalysing and supporting processes that initiate, inform and strengthen actions to integrate knowledge on social determinants within public health policies and practice.

These will be achieved primarily through the creation of what have been called knowledge networks in important thematic areas. The areas identified are: (i) early child development; (ii) globalization; (iii) urban settings; (iv) health systems; (v) priority public health conditions; (vi) employment conditions; (vii) social exclusion; (viii) women and gender; and (ix) measurement. Additional themes will also be examined as evidence is gathered.

"Addressing the social determinants of health though multisectoral approaches is an integral part of the primary health care approach."

* Krieger N. A glossary for social epidemiology. *Journal of Epidemiology and Community Health* 2001; 55:693–700.

The Commission will work at global level to develop leadership to address the social determinants of health across governments, civil society, academia and other national and international institutions; and will also focus their work at country level.

The WHO Regional Office has not wavered in its solemn undertaking to promote health for all through primary health care since the Alma-Ata declaration over 25 years ago.

Addressing the social determinants of health through multisectoral approaches is an integral part of the primary health care approach. The renewed effort by WHO to highlight the importance of social determinants in influencing health outcomes is a step in the right direction.

The Regional Office has long advocated poverty reduction as one of the effective strategies to facilitate equitable development and to achieve health goals. In support of this policy, the Regional Office has actively promoted community-based initiatives, such as basic development needs, healthy cities, healthy villages and women in health and development. These initiatives require communities to assume greater responsibilities in defining their needs, identifying priorities, mobilizing resources and developing essential local organizations.

Partnership between WHO and the Social Development Agency

The partnership between WHO and the Social Development Agency (ADS) in Morocco is embodied in the tripartite agreement signed by WHO, the ADS and the Moroccan Ministry of Health on 9 June 2003. This agreement aims to reinforce the basic development needs programme and to mobilize additional resources in order to contribute to improvements in the quality of life and the level of health among communities targeted by the programme.

Thanks to this partnership, the BDN programme is going through a process of development. The BDN implementation area used to cover, in most cases, a suburban neighbourhood of two or three villages at the most, but the programme is being further extended to four rural communities in the Azilal province and 12 rural communities in the El Hajeb province.

> **“The BDN experience has proven that community diagnosis mobilizes not only the population but also different local development actors.”**

ADS's intervention in the BDN programme represents an opportunity for the programme's development and expansion. In this respect, the ADS is called on to play a vital role in the implementation of the National Initiative for Human Development (NIHD) thanks to its mission, its strategy, its expertise and competence in the local development domain and its participatory approach. The partnership between WHO and the ADS will be strengthened as a result of the reinforcement of the programme at actual sites and its expansion to other sites.

Programme reinforcement

ADS involvement in the BDN programme is realized through greater capacity-building and training of local development committees and local associations who are concerned with the arrangement and management of community projects; employment and income-generating activities for the benefit of communities targeted by the programme; the equipping and rehabilitation of basic sanitary structures; and implementation of mutual insurance and community funds in order to improve access to basic health care, particularly in rural areas.

Programme expansion to other sites

The ADS plans to take part in the NIHD and to implement the BDN programme in all regions to at least 300 communities, at the rate of 150 communities a year.

The agency's contribution will be through funding (directly, or through the mobilization of additional funds) of a community diagnosis in each of these 300 communities. The ADS will also contribute to the implementation of the local development plan in these areas through income-generating activities, as well as through capacity-building and the training of local actors.

The basic development needs programme provides the NIHD with a working methodology and tools. The BDN experience has proven that community diagnosis mobilizes not only the population but also different local development actors. The local development plan is based on each community's diagnosis and will give the initiative a working framework based on communities' basic needs. In addition, it should be noted that the participatory approach, which is recommended by the community diagnosis's methodology, contributes to the population's mobilization and to their involvement in the local development process.

BDN success story in the village of Savadjoon (Islamic Republic of Iran)

A group of women from the village of Savadjoon requested guidance from the BDN technical steering committee to assist them in exploring the feasibility of a rose plantation project by examining the soil and climate in their area. The women wanted to create an income-generating project to sell rose water.

After receiving approval from the committee, 12 women were selected to participate in the project and were sent for training for two days to Ghamsar in the Kashan, an area well known for its rose plantations, on how to cultivate roses and prepare rose water.

The project began by the women renting two hectares of land with a lease of 10 years. The total cost of the project is nearly US$ 30 000, which has been covered by WHO, the community development fund and the beneficiaries. The women have so far planted 6000 rose bushes. The adviser to the Governor-General inaugurated the project and the occasion was covered by the mass media.

The success of the project in Savadjoon has inspired women in the neighbouring village of Horeh to undertake a similar project.

Healthy Villages programme in the Syrian Arab Republic

The healthy village directorates, in collaboration with a number of international organizations, have produced a series of materials for training and social marketing. These materials have an essential role in improving the performance of the healthy village staff at all levels, which will reflect positively in the working mechanisms of the healthy villages.

During the last 3 years, the healthy village directorates have worked on preparing and printing these materials, in cooperation with UNICEF. The Regional Director has played a critical role in this initiative. The following are a list of the materials:

- A training package on food safety and secure waste disposal. This package comprises 5 brochures, 2 flip charts and 2 manuals and includes a Tobacco Free Initiative kit, and was used to conduct 50 training sessions for district representatives.

- Healthy village brochures for sectors implementing the healthy village programme at all levels. The brochure was distributed among all concerned governorates and sectors working in the prevention of HIV/AIDS.

- A manual on child-friendly homes and communities. The manual was used to conduct 36 training sessions for 100 district representatives.

- The brochure on healthy information centres was distributed among all the governorate bodies and sectors and is intended for programme staff at all levels.

- Training package for first-level care providers. It includes a manual on first aid, posters and identification cards for district representatives in healthy villages. The manual was used to conduct 30 training sessions for district representatives.

A healthy and safe school environment for children in Yemen

A healthy and safe school environment project for school-age children will be implemented as an added component of the BDN programme in all BDN schools in Yemen. An assessment tool was developed during a workshop on healthy and safe school environments that took place between 27 November and 1 December, 2005, in the Lahaj governorate. The workshop was attended by BDN coordinators and intersectoral technical support teams from the 10 governorates implementing BDN projects, as well as by representatives of partner agencies, including the Social Fund for Development, UNICEF and the Ministries of Education and Health. The assessment tool will be translated into Arabic for final use and will be available on the Regional Office's website: www.emro.who.int/cbi

> **Members were trained in the project's implementation process.**

Steering committees for the project have been formed in all of the 10 governorates, and all members were trained during the BDN workshop. Members were trained in the project's implementation process and on the use of the assessment tool. The 10 governorates are also in the process of forming school committees for healthy and safe school environments for children and these committees will also be trained on use of the assessment tool.

South Asia earthquake

The WHO Regional Office for the Eastern Mediterranean would like to offer its condolences to all the people in Pakistan who have lost loved ones in this devastating earthquake. May those who perished on this fateful day rest in peace and may God give strength and patience to those who remain.

> **At least 26 hospitals and 600 health clinics have been destroyed or severely damaged.**

The basic development needs programme in Patikka (Azad Jammu and Kashmir, Pakistan) was one of the best in the Region, and one in which the community was very much involved in the development taking place. The community was involved in the implementation of the programme in registering their village development committee as a community-based organization, which provided them with the opportunity to collaborate with international nongovernmental organizations and to utilize national

resources for development. The Regional Office is confident that the community of Patikka and other parts of Azad Jammu and Kashmir (AJK) will continue their struggle and soon be in a position to rebuild their villages and communities. Our hearts go out to the all the families in Patikka and Langarpoor where many women's vocational centres collapsed, trapping female volunteers for days. Their rescue and other stories of valour and courage are abundant in the relief efforts that are taking place in the affected areas of Pakistan.

WHO has appealed for US$ 21.7 million which is urgently needed to assess overall health needs and the damage to health infrastructure, to provide essential supplies and health experts and to help coordinate the health response. Our thoughts and prayers are with the people of Pakistan, and the Regional Office will do all in its power to support communities in affected areas and to assist them in rebuilding their communities to flourish once more.

"Community village development committee before the devastating earthquake"

"Health workers have been killed, injured or traumatized. Field hospitals have been erected to care for the injured and the sick."

For further information on community-based initiatives contact:

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