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Community-based initiatives

Newsletter

Dr Margaret Chan, the Director-General of WHO and Dr Hussein Gezairy, WHO Regional Director for the Eastern Mediterranean, visit BDN sites during their joint visit to Afghanistan and Pakistan

A joint visit to Afghanistan and Pakistan was carried out by Dr Margaret Chan, Director-General (DG) of WHO, and Dr Hussein Gezairy, WHO Regional Director (RD) for the Eastern Mediterranean, from 28 April to 1 May 2007. They visited several sites implementing the basic development needs (BDN) programme in both countries.

On their first day in Afghanistan, the WHO team had the opportunity of meeting H.E. Mr Hamid Karzai, President of Afghanistan. Late in the evening, the team visited the Malalay Maternity Hospital in Kabul, where they met the female medical staff, female community health workers and the female BDN team. The Deputy Minister of Public Health, General Directors of different departments in the Ministry, directors of hospitals and other high-level officials from the Ministry were also present.

Mrs Bibi Shireen, a widow and female community health worker from Chandal Bayee, a BDN village in Paghman district, Kabul province, described her health-promoting activities within the community: *"I am an illiterate woman, and before receiving training, I had little knowledge about health, but under the BDN programme I received training on health-related issues. My initial training lasted for three weeks and covered one module, and then I worked for one month. The second training module took two weeks, followed by one month of field work. Finally, I completed the last training module which lasted for one week. Now, I can assist the families in my village with minor health problems, such as managing simple diarrhoea, preparing oral rehydration solution (ORS), treating simple acute respiratory infections (ARI) cases and simple malaria cases. Also, I advise pregnant women and lactating mothers on how to take care of their own and their babies' health. Members of my village have received my work very favourably".*

Mrs Bibi told the DG that although she worked voluntarily and did not receive a salary, she was able to support her family by selling handicrafts at the local market. As many as six other women have volunteered as health workers and they conduct between five and six house visits daily. Mrs Bibi showed the audience the pictorial reporting form used by community health workers to record health information following home visits, information on ARI, diarrhoea, family planning, referrals and maternal and infant deaths.

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On the second day, the DG and RD visited the WHO Representative's Office in Kabul and met the office staff. During the meeting there was an exchange of knowledge on WHO activities in Afghanistan and on the various programmes being implemented there. During the meeting, Dr Safiullah Nadeeb, the national BDN coordinator, gave a briefing on the BDN programme in Afghanistan and presented the audience with some examples of how the programme had changed the lives of people. He spoke of a widow in Nangarhar Province, Behsud district, who had five children and no means of income to support her family. She had received a US$ 400 interest-free loan from the BDN programme and had bought a dairy cow. Through her small project she had managed to support her family, and after seven months was able to repay the loan to the village development committee. The DG commented on the sustainability of the BDN programme and reiterated that the health of the people could not be improved without addressing the social determinants of health and supporting the sustainable development of the community.

Visit to Khairabad and Taarkhel by the Federal Minister of Health of Pakistan, Dr Mohammad Naseer Khan

In Pakistan, the WHO team, accompanied by H.E. Dr Mohammad Naseer Khan, Federal Minister of Health, paid a short visit to the Khairabad and Taarkhel areas of the Nowshera district, where they witnessed the ongoing activities of several community-based projects.

The DG visited the community clean water supply project in Taarkhel village, which serves 322 households and a population of 2350. She was briefed by community representatives on the safe drinking-water supply scheme, which had been implemented under the BDN programme, and after the local community had identified the need for clean water as their first priority. Previously, women from the village had to collect drinking-water from a source located more than 0.5 km away from the village in a mountainous area.

The collective efforts of the community with the support of the BDN programme had resulted in the construction of a water tank, with a storing capacity of 75 000 litres, connected through pipes to the source. Clean water is delivered through a network of 15 000 feet-long pipes to every house in the community. The availability of abundant clean drinking-water in every household has not only revolutionized the lives of the local population, especially the women, but has also resulted in a reduction of the number of diarrhoeal and other waterborne diseases among young children. This project is totally managed and sustained by the local village development committee. The community is paying a small amount of water tax to manage, operate, sustain and expand the water supply system. Additional funding has also been made available through the Citizen Community Board scheme and from the district government for expansion of the water supply scheme.

The DG met with local women, exchanged views and listened as they described their difficulties in fetching water in very difficult terrain. She emphasized that the provision of safe water was vital for the prevention of waterborne diseases and to ensure a healthy life.

The DG visited the Pathan, Khairabad health house and met with lady health workers, lady health supervisors, female health volunteers and mothers. She was briefed on operational strategies, selection criteria and the functions of the community-based lady health workers who deliver preventive and promotive services to communities under the auspices of the national programme for primary health care and family planning.

A lady health worker briefed the DG on the key indicators for maternal and infant health in her area. Expanded Programme on Immunization (EPI) coverage among the children in her catchment area is almost 100%, and no maternal or infant deaths were reported from 2006 to 2007. The percentage of contraceptive use is approximately 55%. All pregnant women are referred for regular antenatal care and deliveries are assisted by skilled birth attendants. Malnourished children are also monitored regularly. The health worker, through the local village development committee, had mobilized the members of the committee to conduct case detection of tuberculosis patients, to ensure the completion of their treatment and to promote the use of insecticide-treated bednets (ITN) for malaria prevention. The DG was briefed on the work of female health volunteers involved in nutrition education and health promotion activities. They prepare lists of all children under 3 years of age, measure their weight, plot a growth-monitoring chart and identify malnourished children. The growth-monitoring charts are being maintained for 100% of children under 3 years of age. The volunteers address the root causes of malnutrition and provide various interventions, such as health and nutrition awareness, education on diarrhoeal diseases and the use of safe drinking-water,

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promote breastfeeding and ensure that income-generating loans are linked to families with a malnourished child in the family.

The DG visited a rural health centre in Khairabad to witness the enhanced utilization of health facilities through referral by the communities. Community organization, mobilization and awareness of health issues have created a demand for health services among the community. Motivated community representatives, health volunteers and community-based health workers are referring more cases for immunization, antenatal care, deliveries and suspected cases of tuberculosis to health facilities.

In Khairabad, routine EPI coverage is over 97%, and the tuberculosis case detection rate has increased from 43% in 2000 to 91% in 2006 in BDN areas. The treatment success rate is 100% and no patient has defaulted on treatment. In 2006, 94% of pregnant women in the area sought antenatal care and 95% of all births took place in the health facility attended by skilled birth attendants. The DG congratulated the staff of the health centre and expressed her appreciation at their efforts in providing a very high level of services to the local community.

The DG was also briefed by the Chairperson of the women's village development committee on women's development activities in the area designed to empower women socially and economically in order that they can effectively share responsibilities towards their families and the community. Key areas of women's development include: awareness of maternal and infant health issues, promotion of education and literacy, the development of skills, opportunities for self-employment and participation in local development and decision-making processes.

The DG met with members of the village development committee in Gharibpura. Zarjai Bibi, Chairperson of the women's village development committee explained how the committee worked. The DG was impressed by the efforts of Zarjai Bibi and the local women and asked them to continue with their inspiring work. The WHO team also visited the stalls of handicrafts made and sold by the local women. A variety of products including clothing, embroidery items, design material, coloured fabrics, knitting, paint, glass and leather work, wooden artefacts, a variety of decorative material and carpet weaving were on display. The DG expressed her appreciation of the work of the local artisans and the quality of their products and applauded the programme for its empowerment of women in the area. While exchanging dialogue with the local community, the DG stated that the BDN programme had translated the concept of community participation into a reality. She also expressed her appreciation at the contribution of the Government, saying that the Government had initiated the idea of community participation and had owned it. She also acknowledged the role of men, saying that the outcomes of the project had shown that behind the women, who made the project possible, were successful men. Dr Chan promised to convince WHO's senior management of the success of the BDN programme and said that she hoped that the project would be further strengthened with the passage of time. She urged the Government to further adapt and expand the programme as a means to achieve sustainable health development and to improve the quality of life.

The WHO Representative in Iraq convenes a meeting to review the results of the BDN baseline survey

In May 2006, a survey was conducted to study the socioeconomic status and to screen the needs of the local community in six villages implementing the BDN programme in Iraq: Jalila, Mijbis, Dasim, Al Slaiman, Dahira and Rashdia Intissar.

Following the survey, the WHO Representative's Office in Iraq convened a meeting in Amman in March 2007 to review and finalize the results of the survey with representatives of Ministries of Health, Planning and Higher Education. The results will be used to develop the national community-based initiatives (CBI) policy for Iraq.

The study provided a more focused analysis of the rural community in the six villages distributed across six governorates and covering a population of 17 472 among 2386 families. All surveyors were volunteers residing in these six districts, who were trained by representatives from the Ministry of Planning on the use of the questionnaire and data collection methodology. Results were initially analysed by the Ministry, and later by the Central Organization for Statistics and Information Technology (COSIT).

The study showed that communities are well organized. Almost 74% of the population under the study are below 30 years of age and suffer from poverty with a poor health and educational status. The results revealed that there was no community organization prior to the introduction of the initiatives in these villages. The initiatives are

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intended to promote healthy living conditions, and an employment-generating plan will be developed as almost 60% of the population is in the age range for pursuing productive employment.

The study also showed that almost 36% of the population had either never attended school or were truant from school. This results from a lack of awareness among the population of the importance of education, leading to an increase in poverty and rising unemployment. Another social and economic reason why children are not attending school is as a result of a loss of a family member and a need to work to support the family. One of the conclusions of the study was that there is a need to conduct an in-depth study to reveal the intrinsic reasons for truancy which takes into consideration the current context of Iraq. Ongoing awareness-raising campaigns need to be conducted and efforts to improve the literacy rate need to be expanded. Closer collaboration between the Ministry of Education, community leaders and local experts is strongly recommended as is the establishment of community schools.

The study also showed that there was environmental deterioration in these areas and low practices of healthy lifestyle behaviour. Only 47% of the population has a private latrine, 33% use shared latrine or sanitary facilities, and 20% do not have access to a latrine or sanitary facilities. Almost 83% of the population adopts improper methods for garbage collection and disposal. The study also revealed that almost 42% of water sources are unsuitable for drinking purposes. These figures may be due to the lack of security, worsening economic factors or lack of awareness and weak infrastructure, which makes the community vulnerable and leads to increasing morbidity and mortality rates. As a result, there is a need to conduct an in-depth study on housing conditions and to develop a plan to improve the environmental conditions in CBI locations. This would include the development of environmental preservation committees enlisting the involvement of students, community leaders and women's associations.

The percentage of the population suffering from chronic diseases is high. Moreover, a considerable number of the population is smokers; almost 57% of smokers in Iraq smoke between 11 and 20 cigarettes a day. These indicators imply that healthy lifestyles are not being adopted. The lack of diagnostic services and a lack of awareness may be representative of the underlying reasons for such conditions.

Immunization coverage in the area is lower than the national figures but this study did not provide good indicators for the status of child health; a further study will need to be conducted. The study did reveal that mothers were breastfeeding their babies for a period of between 6 and 24 months, although breastfeeding is usually conducted for longer periods in rural areas. The study clearly demonstrated that mothers were part of the economic process and it was necessary for them to work to provide food for their families. It is also evident that there is a lack of awareness of the importance of child health, particularly early child development. The introduction of Integrated Management of Child Illnesses (IMCI) programmes would improve maternal and child health and is recommended for introduction into BDN sites.

Almost 19% of mothers use contraceptives and 82% of pregnant women receive prenatal care, although the study did not provide information on the underlying causes of maternal mortality. The role of women in community health services, particularly in areas related to maternal and child health, needs to be promoted.

In terms of agriculture, approximately 27% of the population own land, of which almost 79% is agrarian. This indicates that the main source of income and food security is agricultural products although inherited agricultural skills have not proliferated with time. Most owned land is of a small size. The creation of farmers' associations could improve the situation as the study indicated that the use of substitute crops had not been adopted, with most farmers relying on private resources and not receiving any external support. Growing crops of high nutritional value, the development of farmers' associations, the inclusion of all farmers in agricultural educational campaigns and providing external support to farmers to assist them in introducing modern techniques could solve many of the existing agricultural problems.

In terms of livestock, almost 45% of the families own sheep, 27% own poultry, 20% own cows and 4% goats. These figures show that there is private ownership but no significant projects to breed livestock in these areas. It is recommended that new techniques for poultry farms are introduced. A detailed plan should be developed to support improvements in these sectors, ensuring the close involvement of all stakeholders.

Socioeconomic data showed that almost all families need some form of support; 80% require financial support, 14% logistical support and 6% technical support. The data also indicate low investment in development and a lack of economic awareness, skills and desire to seek new means of income generation.

In general, several recommendations resulted from this survey which included the need to build community skills and raise awareness of factors affecting development. The CBI programme does operate in line with the operational context of Iraq and the continuing emergency, and increased morbidity and mortality due to the conflict and violence requires the more active participation of a trained community. In this process, WHO in Iraq is assisted by Dr Omer Sulaiman, WHO Consultant, to whom WHO are extremely thankful. Dr Sulaiman has also supported the development of an outline for the national CBI strategy and the production of a CBI marketing and promotion strategic document that has already been shared with all Member States in the Region.

Training module on community development in Morocco

Acknowledging the remarkable achievements of the BDN programme in Morocco, the Ministry of Health has decided to develop an advanced module for the training of health and social workers in the field of community development to improve coordination between sectors, and in line with the national human development initiative implemented by H.M. the King of Morocco, Mohamed Ben El Hassan, in May 2005, and adopted by the Ministry of Social Development, the Family and Solidarity.

In accordance with the above, Dr Nazar El Faki, a WHO Consultant with the national CBI team within the Ministry of Health, and under the guidance of Dr Raouf Ben Ammar, WHO Representative for Morocco,

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prepared an outline of the training module and conducted a training course to pretest it. The training module is divided into the following three sections:

- Basic concepts as entry points to BDN:
  - the concept of the social determinants of health and the pathways by which these determinants affect the health status of the community and health outcomes;
  - the Millennium Development Goals (MDGs), opportunities and challenges for health to become more central to the development process;
  - concepts of health, poverty and sustainable development and how to apply equity criteria, tackling health disadvantages among targeted population groups and reducing health gaps.
- Management of BDN:
  - BDN management tools and guidelines for implementation;
  - gender mainstreaming as a cross-cutting issue for health and sustainable development.
- Leadership, communication and negotiation skills:
  - management and planning techniques, communication and leadership skills for negotiation with various stakeholders and the mobilization of resources;
  - mechanisms for effective partnerships to support health and development initiatives.

A training course was held from 21 to 24 February 2007 and 15 participants from the health sector from different provinces were identified and invited to attend. The objectives of the training course were to:

- explain the rationale, concepts and approaches of sustainable development;
- encourage the institutionalization of BDN within the national human development initiative and to create clear mechanisms for coordination;
- link social and poverty-reduction activities with health interventions and outcomes and the social determinants of health in improving the quality of life;
- establish modalities for effective partnership with the private sector, donors, UN agencies and nongovernmental organizations interested in health and development activities;
- reinforce leadership and management skills.

The training methodology consisted of technical presentations and discussion, the presentation of case studies and group work, group presentations and panel discussions, video shows and the conducting of a pre- and post-training test.

The participants were introduced to BDN concepts and related management tools. They were able to demonstrate their understanding during group work and plenary sessions and discussions, and also through their encouraging comments following the training course, the objectives of which were successfully achieved.

Training of health managers on integrated health and development using the CBI approach, Muscat, Oman

The WHO Representative's Office in Oman, in collaboration with the Ministry of Health, arranged a training course for health managers on integrated health and development using the community-based approach. The training was held from 20 April to 2 May 2007, and was facilitated by Dr Sumaia M. Al Fadil, National Professional Officer, from the WHO Representative's Office in Sudan.

The training course was attended by 25 programme coordinators and CBI team members from six regions and respective *wilayat*. The course was well received by the participants, whose interest was reflected in the useful in-depth discussions and feedback.

During discussions, participants noted the need for more full-time CBI management staff at regional and *wilayat* levels. They expressed concern about duplication and verticality in establishing many multisectoral committees for each sector at *wilayat* level, each of which is composed of a number of related sectors. A few gaps were identified regarding organization at community level, such as selection processes for community

development committees and cluster representatives. Participants also drew attention to the need to train the community on the financial management of CBI interventions. Discussions also revealed that a supportive environment had been established within the health system involving the establishment of community health support groups, healthy lifestyle projects, healthy cities and the multisectoral health committee at regional and *wilayat* levels.

Participants also highlighted the importance of emphasizing capacity-building activities since very few training opportunities had been provided in the past for technical support teams, and no communities had been trained on CBI management. To date, all interventions in CBI areas have been

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carried out by different government sectors or companies. As the CBI concept is based on community empowerment and self-reliance, it is important to address this aspect and build the capacity of communities in financial management. There is good potential for the external funding of income-generating activities run by different sectors in the country.

Trainees requested translation of the training materials and their adaptation for use by community development committees and cluster representatives, focusing on the roles of communities in programme management. They also requested the organization of future training courses directed towards other health teams, related sectors, nongovernmental organizations and the private sector, etc. They highlighted the importance of deploying greater efforts in exploring means of collaboration with other relevant sectors and funding agencies to gain additional support for projects. They also requested that health activities, currently adopted as vertical projects such as healthy lifestyle and community support group activities, should be integrated into all CBI settings. The participants recognized the importance of the role of the Ministry of Health in building communities' capacities in financial management and encouraging them to seek support from potential partners. Discussions also tackled the roles that governors and high-level managers can play in advocating for the programme and creating a conducive environment prior to programme expansion. At community level, communities should be organized into clusters, and cluster representatives and community technical committees selected in line with CBI management tools. Communities still have lot of hidden potential that community leaders can exploit if they wish to encourage the proactive role of communities in development.

H.E. the President of Djibouti issues a decree on establishing an institutional framework for promoting health and involving the community in poverty-reduction activities

In the framework of institutionalizing the BDN programme in Djibouti, and for its integration into national health reforms, and with the aim of extending this approach to the whole country, H.E. Mr Ismail Omar Guelleh, the President of Djibouti, issued a presidential decree on establishing an institutional framework for promoting health and involving the community in poverty-reduction activities. The decree was issued on 20 June 2007 and represents an extension of the national BDN strategy approach document approved on 24 June 2006.

The presidential decree assures the political commitment of the Government towards the BDN approach, and of its intention to expand the programme to new sites in the country in an attempt to combat poverty and to accelerate local development.

The Government of Djibouti recognizes that poverty reduction is one of the strategies leading to equitable development and to achievement of health-related objectives, hence, it will adopt the BDN programme as a systematic approach for local, global and integrated development built on the community's active participation and multisectoral collaboration.

The presidential decree was also issued to establish a number of new structures within the setting of an institutional framework for health promotion.

Multisectoral national committee for sustainable human development (CNM). This committee is headed by the Minister of Health and comprises members from different concerned departments in the Office of the Prime Minister and the Ministries of Finance, Youth, Education, Labour, Agriculture and Women, and also representatives of development partners, including WHO. The committee will be technically responsible for coordinating national efforts in the area of sustainable human development. As such, it will set the broad orientations of local development, advocate for the BDN approach, develop a national plan of action for local development based on the regional action plans, mobilize resources and monitor progress in implementing regional action plans.

Central bureau for the management of the BDN programme. The bureau will be a permanent structure within the Ministry of Health supporting the multisectoral national committee, coordinating partnership actions between the BDN programme and various stakeholders and supporting the development of regional workplans.

Regional committee for local development and health. The committee will be a planning and assistance organ for the expansion of the BDN programme at the regional level. The committee will comprise representatives of socioeconomic sectors at the regional level, directors of agencies and offices existing in the region, civil society and national and international nongovernmental organizations, as well as regional counsellors. The committee will be responsible for: defining local strategies for programme expansion and related interventions; developing the regional workplans based on local needs; validating and approving the workplans and community development projects; monitoring budget utilization; ensuring correct follow-up, evaluation and documentation of programme activities; and contributing to periodical evaluations.

BDN regional unit in the district hospital. The unit will be managed by an officer from the Ministry of Health under the supervision of the hospital's chief physician. Among the unit's roles will be to: support the regional committee secretariat; promote the health status of the population living in BDN sites; identify the community's priority health needs; promote the BDN programme among the users of health services

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and link health to development; set health priorities at regional level; and liaise between the central, regional and local BDN units.

Local development committee or village development committee. The committee will be elected by the community in each BDN site. This committee is the main management vehicle of the development process at the local level, and therefore, is in charge of: informing the community about the BDN approach and its implementation process; surveying communities and prioritizing their needs; contributing to developing community development plans according to local needs; encouraging and promoting community ownership towards programme interventions and enhancing its participation in other health programme initiatives; linking the community to the regional committee and local partners. In localities where establishing a village development committee will not be feasible, a local health commission will be set up to perform the functions of the committee.

Voice of the community:

Samar Bakr from the Syrian Arab Republic goes back to school in her twenties … it's never too late to learn

Like million of girls around the world, Samar had to quit school at the age of 12. Born in Al-Ahmadeyah village in the Syrian Arab Republic in 1982, Samar attended her village primary school where she completed her primary education. When it was time for her to attend preparatory school, the family was concerned for her safety and refused to allow her to walk the 3 km daily to reach her classroom.

"When the healthy village programme started in Al-Ahmadeyah village in 1999, one of the programme's interventions was to encourage truant girls to continue their education. I first joined the programme as one of the cluster representatives," Samar explains, *"In 2000, the village development committee proposed the setting up of educational classes and encouraged community members to complete their education. Teachers were selected from among university graduates in the village. I, myself, benefited from these free educational classes. I finished high school and am currently, working as a school teacher".*

"I can truly say that completing my studies has radically changed my life. I used to feel that I was a burden to my family but now I earn my own living and can also help them. I feel that I am productive person in the community where I am living. And I am not the only one who benefited from the healthy village programme, many other girls and women in our village were encouraged to return to school and I am so happy for them and for myself".

Joint UN visit to a BDN area in the Hodeidah governorate in Yemen

During the UN retreat, convened from 8 to 9 May 2007, Dr Gulam Popal, WHO Representative in Yemen, proposed the BDN approach as a potential platform for joint programming of the United Nations (UN) system. Dr Popal said that BDN as a multisectoral approach to development created an opportunity for each UN agency to play its role in contributing to this holistic process. Participants in the retreat recommended exploring the possibility of having a joint programme under the leadership of WHO.

Following the retreat, WHO invited other UN agencies working in Yemen to visit the BDN site in the Hodeidah governorate to observe BDN field activities and to identify a common ground for joint programming. A field visit was carried out on 11 June 2007 with the presence of representatives from the International Labour Organization (ILO), United Nations Development Fund (UNDP), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF) and the World Food Programme (WFP). The visit started with a meeting with Mr Mohamed Shamlan, the Governor of Hodeidah, who welcomed the UN team. He explained that Hodeidah is ranked as the second largest governorate in Yemen with a total population of 2.2 million people. The Governor described the BDN programme as one of the most successful programmes that had resulted in notable achievements. He also emphasized the reliance of the programme on intersectoral action, and thus, it encouraged different government departments to work together and to empower community members to

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A technical support team member describes women's development activities

The team visiting an income-generating project: a calves fattening farm

Discussion about the work of trained birth attendants

be part of self-sustained development processes. The Governor expressed his satisfaction with the outcomes of the three model BDN areas in the Hodeidah governorate and expressed his hopes for further programme expansion in the near future. Later on, the General Director of Health, the BDN Coordinator in Hodeidah, the Deputy Governor and the District Administrator accompanied the team to Kashuba'a, a BDN area comprised of five villages with a population of over 6000 people. There, the team had the opportunity to meet the village development committee, cluster representatives, village health volunteers and trained birth attendants.

The Chairman of the village development committee thanked WHO and the Ministry of Health for implementing the BDN programme in their community, and explained that it had brought many positive changes to people's lives in different sectors. He discussed the improvements in the health status of the community as there was now a fully-fledged health facility providing essential health services to the people. In addition, different categories of health volunteers, such as village health volunteers, trained birth attendants, first aid workers and sanitary health workers, had been trained through the programme to serve the community. Through the conducting of several adult literacy courses, many adult women had become literate, and through health education sessions, the level of awareness regarding healthy habits had been increased.

According to the Chairman of the village development committee, among the most important achievements of the BDN programme was the empowerment of people to help themselves, as they were now able to approach different agencies for assistance. In one village, there had been no school building and children had had to sit under a tree, but after a BDN intervention, the village development committee approached the Social Fund for Development (SFD) and they built a school. Also, there had been no irrigation system in the area previously. After a BDN intervention, a deep well was dug and although only a limited amount of land could be irrigated initially, it had represented a good start. Now, there are six deep wells for irrigating agricultural land. Similarly, in 2002 the programme supported the purchase of a tractor in order that eight families could begin a collective agricultural project. Today, five tractors have been purchased by community members.

The Chairman of the village development committee noted that for the provision of BDN loans to needy families, they have also made it conditional that the beneficiary family should practise healthy habits; their house should be always clean, mothers and children must have immunization cards; school-age children should go to school and illiterate women should attend literacy courses.

Regarding the community revolving fund, the Deputy Chairman, who is also responsible for the financial affairs of the village development committee, mentioned that there have been no loan defaulter cases and that the loan return rate was 100%. He added that since the beginning of programme implementation five years ago, the initial investment in income-generating projects had been returned threefold.

The UN team also had the chance to meet volunteers and health workers, including trained birth attendants and first aid workers to discuss their work and how it was conducted. Volunteers have been very enthusiastic about helping people. One of the birth attendants reported that, except for some complicated cases, all deliveries were conducted under the BDN programme.

Mr Hassan El Haig, General Secretary of the Local Council (Deputy Governor), reiterated the famous saying that "prevention is better than cure", and suggested the establishment of health education sessions to raise the community's awareness as an important preventive measure. He also recommended training for more health volunteers. He explained that more support was needed for agricultural development, cattle-raising and the production of traditional handicrafts.

The UN team also had the chance to visit some income-generating projects concerned with cattle-raising, dairy production, the manufacturing of cement blocks and a health-promoting school.

The team was impressed by the work undertaken through the BDN programme and how it brought together various determinants of health and empowered communities to improve their quality of life. A follow-up meeting of UN agencies was convened at the WHO Regional Office on 11 June 2007 to discuss the development of UN joint programming in BDN-implementing sites.

The BDN programme in post-conflict Afghanistan

The BDN programme was implemented in Afghanistan just over a decade ago, when the first village, Tamirat, was selected for programme implementation,

and was at the time in a relatively stable area. The Eastern province, Nangarhar, was peaceful and many Afghan refugees from Pakistan started returning to districts and villages around Jalalabad, the capital city of Nangrahar province. Both the returnees and Tamirat villagers welcomed the programme and clearly expressed their concurrence with, and commitment to, the programme. They reorganized their community Shura committee for development, established a meeting centre and formulated a strategic vision and action plans for implementation of the community-based initiatives.

United behind the principles of the BDN approach, the community embarked on a holistic approach to development. They were especially concerned about girls' education, which had been banned under the Taliban administration. They convinced the authorities to reopen a girl's school in the village while many schools in the rest of the country remained closed. Recognizing their power, the community started looking for partners in various development projects. Living on the bank of the Kabul River, the villagers had never experienced water shortages but were continuously suffering from a high incidence of waterborne diseases. They prioritized the construction of a deep well for drinking-water purposes, and the clean deep-well water source mitigated one of their long-standing health problems.

The community also proposed projects targeting youth to address some of their social problems. More than half of young men were not attending school, and therefore had plenty of time to smoke and become involved in substance abuse. The village development Shura council, through the BDN structure, proposed projects which promoted sports, especially among the teenagers, in the village. They formed teams and procured sport equipment for their teams. Playing volleyball was becoming a common pastime in the area and daily games kept the youth busy and introduced healthy lifestyle activities, which replaced the smoking and substance abuse.

The BDN programme in Afghanistan has endured all the challenges it faced during the crisis. It has always remained under the protection of the community and has expanded from one village in 1996 up to 31 villages in 2007, with approximately 120 000 beneficiaries. During the conflict, the programme continued to expand without a central government. While the participation of women was limited during the conflict, their contribution in identifying priorities for community development and in implementing many projects was very significant. Projects targeting women, such as carpet weaving and illiteracy courses, are central to the programme.

At the beginning of the post-conflict era in 2002, the Government included the BDN programme in the national health policy as one of the country's national priorities. This was indeed a great milestone for a country just emerging from crisis to recognize the importance of community-based programmes. The Minister of Public Health has established a special unit to run the programme. While the health sector has enjoyed the full support of major donors who focus on addressing the major causes of mortality, especially among women and children, and key communicable diseases, such as tuberculosis and malaria, the programme has not been given external assistance and relies on the support of WHO.

Programme activities in the country reflect the country's transition from recovery to development and the programme has reshaped itself to support the national development strategy and improve health care. A description of some of the programme's more salient achievements is provided in the following paragraphs.

The integration of BDN programme and primary health care activities has worked well, particularly in relation to community-based TB DOTS and Roll Back Malaria initiatives. The integration occurs at community level at which cluster representatives have been trained to implement community-based DOTS and the home-based management of malaria. The cluster representatives are functionally linked to health facilities and a two-way communication and support system exists between the two levels. The approach will be assessed and if it turns out to be successful, many more components of primary health care will be integrated into the BDN programme.

The establishment of female village development committees represents another ground-breaking milestone in the CBI programme in Afghanistan. The latest assessment shows that more women are now

(Continued on page 10)

A women's training session in tailoring in Paghman, Kabul province

A handicrafts income-generating project

A village development committee in action, Bamyan-Central Highlands, Afghanistan

A literacy training course for women in Chattah Village, Badakhshan

utilizing health care services in villages where female Shura councils are operating and participating in village development programmes. 56% of economic projects target women and this number is expected to rise as many more projects, such as illiteracy courses have been identified for implementation in the 2008–2009 biennium.

An informal assessment showed that in general income-generating activities have made a significant difference in many families' livelihoods. These projects, although on a small-scale, have had positive effects in lifting families out of abject poverty and destitution. Communities have been empowered through acquiring diverse skills and are able to ensure improved livelihoods for themselves. The programme has created confidence in the community to strive for ownership, self-help and self reliance.

Women's development is central to the overall strategic objectives of the CBI programme. Communities in BDN villages have identified women's literacy as a prerequisite condition for their development and improved quality of life. Only 14% of Afghani women are literate, a situation which has been further aggravated by decades of civil strife and national warfare. Since the introduction of the initiatives, many literacy courses, even among culturally-closed communities, have been conducted. In 2006 alone, 12 courses for 250 women were successfully organized and conducted in the Badakhshan province. Literacy projects are often undertaken in partnership with WFP.

Key indicators in BDN villages include the following.

- The percentage of deliveries assisted by trained personnel has increased from 29% in 2003 to 69% in 2006.
- The enrolment of eligible children in school has increased from 53% in 2003 to 78% in 2006.
- The number of families in BDN villages with access to safe drinking-water has increased from 12% in 2003 to 35% in 2006.
- EPI full coverage has increased from 40% in 2004 to 71% in 2006.

Future plans include to: institutionalize the BDN programme and to integrate it into the broader national development framework; consolidate programme ownership by the Government and the Ministry of Public Health; expand the integration of health programmes into BDN structures; present CBI concepts to major donors; and conduct resource-generation efforts.

Challenges include to: place the CBI programme in governments' top list of national priorities; generate greater resources as more than 90% of programme resources in countries are from external sources and this external influence is strong enough to shape policies and programmes; improve security situations as prevailing conditions in many areas prevent programme expansion; identify markets for BDN community products, as currently, there is poor access to markets.

The CBI Unit in the Regional Office would like to extend its sincere appreciation for the contributions of the following colleagues to this issue.

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2. Dr Safiullah Nadeeb, WHO Representative's Office in Afghanistan
3. Dr Eman Shankiti, WHO Representative's Office in Iraq
4. Dr Khushhal Khan Zaman, WHO Representative's Office in Pakistan
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Summary

In different countries, various important field visits have been conducted to sites implementing community-based initiatives. The visits are indicative of the recognition of the success the programme in combating poverty and improving the living conditions of people in many places where people suffer from a lack of basic social and health services. They also confirm WHO's commitment to its work in the area of health and sustainable development and to advocate the programme among nationals and UN agencies. In this context, Dr Marget Chan, the Director-General of WHO, accompanied by Dr Hussein Gezairy, WHO Regional Director for the Eastern Mediterranean, and other key officers in WHO paid a joint visit to Afghanistan and Pakistan from 28 April to 1 May 2007. On the trip's agenda was a meeting with national officials and the BDN community and a visit to BDN sites in Nowshera. The team had the chance to witness the status of several interventions such as the work undertaken by health volunteers and community health workers, income-generating projects, community water supply projects, literacy classes and activities related to community mobilization and organization.

In Yemen, upon the invitation of the WHO Representative in Yemen, during the last UN retreat that took place from 8 to 9 May 2007, a joint visit to a BDN site in the Hodeidah governorate was arranged for representatives of different UN agencies working in Yemen, namely: ILO, UNDP, UNFPA, UNICEF and WFP. The main aim of the visit was to explore the BDN programme as a potential platform for joint programming in the UN system.

In March 2007, the WHO Representative's Office in Iraq convened a meeting to review the results of the BDN baseline survey conducted in May 2006 and to share the findings of the study with concerned ministries. The survey was conducted to screen the socioeconomic status and community needs in six villages implementing the BDN programme. The main problems found to be facing

the community were: poverty, illiteracy, unemployment, loss of family provider, environmental deterioration, unhealthy lifestyles, a lack of safe drinking-water and a lack of security.

WHO efforts continue in building the capacity of nationals all across the Eastern Mediterranean Region: in Rabat, a training course on community development was held from 21 to 24 February 2007. The aim of the course was to strengthen the capacities of health and social workers in the field of community development in line with the national human development initiative, which was launched in May 2005 by H.M. the King of Morocco, Mohamed Ben El Hassan. In Muscat, a training course was conducted from 20 April to 2 May 2007, targeting health managers on integrated health and development using the CBI approach.

In this issue also you will see that, H.E. the President of Djibouti issues a decree on establishing an institutional framework for promoting health and involving the community in poverty-reduction activities. The decree represents a cornerstone in institutionalizing the BDN programme in Djibouti and evinces high national commitment towards programme expansion.

The issue highlights the BDN situation in Afghanistan in a post-conflict context. The BDN programme there is in line with the national development strategy. The achievements of the programme include the success of community-based TB DOTS and Roll Back Malaria initiatives within BDN interventions, improving women's roles in development activities, improving the income of households who suffer from poverty through the conducting of income-generating activities, and fighting illiteracy among women (14%) through literacy classes. The challenges to be addressed in the future include to: place the programme firmly on national development agendas, consolidate CBI ownership, include a greater number of health programmes in BDN interventions, and finally, to further enhance programme advocacy and marketing.

Résumé du présent numéro

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Dans différents pays, plusieurs visites importantes sur le terrain ont été effectuées sur des sites qui mettent en œuvre des initiatives communautaires. Ces visites montrent la reconnaissance du succès rencontré par ce programme pour lutter contre la pauvreté et améliorer les conditions de vie des populations dans de nombreux endroits où les gens souffrent d'un manque d'accès aux services sanitaires et sociaux de base. Elles confirment également l'engagement de l'OMS dans son action dans le domaine de la santé et du développement durable et la promotion du programme parmi les populations nationales et les institutions des Nations Unies. Dans ce contexte, le Dr Margaret Chan, Directeur général de l'OMS, accompagnée du Dr Hussein Gezairy, Directeur régional de l'OMS pour la Méditerranée orientale, et d'autres fonctionnaires importants à l'OMS ont effectué une visite commune en Afghanistan et au Pakistan du 28 avril au 1er mai 2007. Le programme du voyage prévoyait une rencontre avec des responsables nationaux et la communauté qui applique l'approche des Besoins fondamentaux en matière de développement (BDN) et une visite sur les sites BDN de Nowshera. L'équipe a pu prendre connaissance de la situation relative à plusieurs interventions telles que l'action entreprise par des volontaires de santé et des agents de santé communautaires, des projets lucratifs, des projets communautaires d'approvisionnement en eau, des classes d'alphabétisation et des activités liées à la mobilisation communautaire et l'organisation.

Au Yémen lors de la dernière retraite des Nations Unies qui a eu lieu les 8 et 9 mai 2007, une visite conjointe sur un site BDN dans le Gouvernorat de Hodeidah a été organisée, à l'invitation du Représentant de l'OMS, pour des représentants de différentes institutions des Nations Unies travaillant au Yémen : le FNUAP, l'OIT, le PAM le PNUD, et l'UNICEF. Cette visite avait pour objectif principal d'explorer le programme BDN en tant que plate-forme potentielle pour la programmation conjointe du système des Nations Unies.

En mars 2007, le Bureau du Représentant de l'OMS en Iraq a organisé une réunion pour passer en revue les résultats de l'enquête initiale sur les BDN menée en mai 2006 et partager les conclusions de l'étude avec les ministères concernés. L'enquête a été réalisée pour examiner la situation socioéconomique et les besoins communautaires dans six villages qui mettent en œuvre le programme des besoins fondamentaux en matière de développement. On a constaté que la communauté était confrontée aux principaux problèmes suivants : pauvreté, analphabétisme, chômage, perte du soutien de famille, dégradation de l'environnement, modes de vie malsains, manque d'eau potable et absence de sécurité.

Les efforts de l'OMS visant à renforcer les capacités des nationaux dans l'ensemble de la Région de la Méditerranée orientale se poursuivent. À Rabat, un cours de formation sur le développement communautaire a été organisé du 21 au 24 février 2007. Ce cours avait pour objectif le renforcement des capacités des agents de santé et des travailleurs sociaux dans le domaine du développement communautaire conformément à l'Initiative nationale pour le développement humain qui a été lancée en mai 2005 par Sa Majesté le Roi du Maroc Mohamed Ben El Hassan. À Mascate, un cours de formation a été organisé à l'attention des administrateurs sanitaires, du 20 avril au 2 mai 2007, sur l'approche intégrée de la santé et du développement dans le cadre des initiatives communautaires.

Le présent numéro se fait également l'écho de l'initiative de Son Excellence le Président de Djibouti qui a dernièrement publié un décret portant mise en place d'un cadre institutionnel pour la promotion de la santé et l'implication de la communauté dans les activités de réduction de la pauvreté. Ce décret représente un élément essentiel dans le processus d'institutionnalisation du programme BDN à Djibouti et montre un engagement national élevé en faveur de l'élargissement du programme.

Ce numéro présente la situation BDN en Afghanistan dans un contexte post-conflit. Le programme BDN dans ce pays

va dans le sens de la stratégie nationale de développement. Parmi les réalisations du programme, on trouve le succès des initiatives communautaires Halte à la tuberculose et Faire reculer le paludisme dans le cadre des interventions BDN, l'amélioration du rôle joué par les femmes dans les activités de développement, l'amélioration des revenus des ménages souffrant de la pauvreté grâce à la réalisation d'activités lucratives et la lutte contre l'illettrisme chez la femme (14 %) au moyen des classes d'alphabétisation. Les défis devant être relevés à l'avenir comprennent les suivants : ancrer le programme dans l'action nationale pour le développement, consolider l'appropriation des initiatives communautaires, inclure un certain nombre de programmes de santé dans les interventions BDN, et renforcer finalement le plaidoyer pour les programmes et le marketing.

موجز للمجلد الثالث، العدد 2

لقد تم تنظيم عدد من الزيارات الميدانية الهامة، في مختلف البلدان، إلى المواقع التي يتم فيها تنفيذ المبادرات المجتمعية. وكانت لهذه الزيارات مدلولها في التعرُّف على نجاح البرنامج في تقليص الفقر وتحسين ظروف الحياة في مناطق عديدة يعاني فيها الناس من قصور في الخدمات الاجتماعية والصحية الأساسية. ولقد أكّدت هذه الزيارات التـزام منظمة الصحة العالمية بعملها في مجالَيْ الصحة والتنمية المضمونة الاستمرار، والدعوة لتـرويج البرنامج بين الوكالات الوطنية ووكالات الأمم المتحدة. وفي هذا الصدد، قامت السيدة الدكتورة مرغريت تشان، المديرة العامة لمنظمة الصحة العالمية، ومعها الدكتور حسين الجزائري، المدير الإقليمي لشرق المتوسط، وسائر المسؤولين الرئيسيِّين في المنظمة بزيارة مشتـركة إلى أفغانستان وباكستان، في المدة من 28 نيسان/أبريل إلى أول أيار/مايو من عام 2007. وقد تضمَّن برنامج الرحلة عقد اجتماع مع المسؤولين الوطنيِّين، والمسؤولين المعنيِّين بالمبادرات المجتمعيَّة، كما تضمَّن أيضاً القيام بزيارة إلى المواقع التي تنفَّذ فيها هذه المبادرات في نوشيرا. ولقد أتيحت الفرصة للفريق لرؤية الوضع الخاص بعدد من المداخلات مثل ما يتم عمله من قِبَل المتطوعين الصحيِّين، والعاملين الصحيِّين في المجتمع، علاوة على المَشاريع المدرَّة للدخل، والمشاريع المجتمعية المعنيَّة بالإمداد بالمياه، وفصول محو الأمية، وسائر الأنشطة المتعلِّقة باستنفار المجتمعات وتنظيمها.

وتلبيةً للدعوة التي وجَّهها ممثل المنظمة في اليمن إبان معتكف الأمم المتحدة الذي عُقد خلال اليومَيْن الثامن والتاسع من شهر أيار/ مايو 2007، تم تنظيم زيارة مشتـركة لموقع المبادرات المجتمعية في الحديدة، قام بها ممثلون من مختلف وكالات الأمم المتحدة العاملون في اليمن، وهم تحديداً: منظمة العمل الدولية، وبرنامج الأمم المتحدة الإنمائي، وصندوق الأمم المتحدة للسكان، واليونيسف، وبرنامج الأغذية العالمي. وكان الهدف الرئيسي لهذه الزيارة هو البحث عما إذا كان البرنامج يصلح لأن يكون أساساً محتملاً لمجموعة برامج مشتـركة من برامج نظام الأمم المتحدة.

وفي آذار/مارس من عام 2007، عقد مكتب ممثل المنظمة في العراق اجتماعاً لاستعراض نتائج المسح الأساسي للمبادرات المجتمعية الذي أجري في أيار/مايو 2006، والمشاركة في نتائج الدراسة التي تمت مع الوزارات المعنيَّة. وكان المسح قد أُجري لتحرِّي الوضع الاجتماعي والاقتصادي والاحتياجات المجتمعية في ست قرى تنفِّذ برنامج المبادرات المجتمعية. وكانت المشكلات الرئيسية التي تواجه المجتمع هي: الفقر، والأمية، والبطالة، وفقد العائلات لمن يعولها، والتدهور البيئي، وأنماط الحياة غير الصحية، ونقص مياه الشرب المأمونة، وافتقاد الأمان.

ولقد استمرت جهود منظمة الصحة العالمية في بناء قدرات الوطنيِّين على مستوى إقليم شرق المتوسط: ففي الرباط، عُقدت حلقة دراسية تدريبية حول تنمية المجتمع، في المدة من 21 إلى 24 شباط/فبراير 2007. وكان الهدف منها هو تعزيز قدرات العاملين الصحيِّين والمجتمعيِّين في مجال تنمية المجتمع، وذلك وفقاً للمبادرة الوطنية للتنمية البشرية، التي بدأت في أيار/مايو عام 2005، بفضل صاحب الجلالة الملك محمد بن الحسن، ملك المغرب. وفي مسقط، تم تنظيم حلقة دراسية تدريبية في المدة من 20 نيسان/أبريل إلى 2 أيار/مايو عام 2007، واستهدفت تدريب المديرين الصحيِّين على إدماج الصحة والتنمية باستخدام أسلوب المبادرات المجتمعية.

وفي هذا العدد أيضاً، سوف تجدون، أن فخامة السيد رئيس جيبوتي قد أصدر قراراً رئاسياً بإنشاء إطار عمل مؤسساتي من أجل تعزيز الصحة وإشراك المجتمع في الأنشطة الخاصة بتقليص وطأة الفقر. ويمثِّل القرار حجر الزاوية في ترسيخ برنامج المبادرات المجتمعية في جيبوتي، ويبرز الالتـزام الوطني رفيع المستوى نحو التوسُّع في البرنامج.

ويوضِّح العدد أيضاً وضع المبادرات المجتمعية في أفغانستان في المرحلة التي تلت الصراعات. فالبرنامج يسير وفق الاستـراتيجية الوطنية للتنمية، وكانت الإنجازات التي أحرزها البرنامج تشتمل على نجاح مبادرتَيْ المعالجة الكيميائية القصيرة الأمد تحت الإشراف المباشر لمرض السل ودحر الملاريا بفضل المداخلات الخاصة ببرنامج المبادرات المجتمعية، وتحسين دور المرأة في الأنشطة التنموية، وتعزيز دخل الأسَر التي تعاني من الفقر من خلال أنشطة لجلب الدخل، ومحاربة الأمية بين النساء (14%) من خلال فصول دراسية لمحو الأمية. أما التحدِّيات التي يتعيَّن مواجهتها في المستقبل فتـتضمَّن: وضع البرنامج، بصورة قاطعة، في جداول الأعمال الوطنية، وتوطيد ملكية المبادرات المجتمعية، وإدخال عدد أكبر من البرامج الصحية في المداخلات التابعة للمبادرات، وفي النهاية، العمل على زيادة التـرويج للبرنامج والتسويق له.

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