Vol. 1 Issue 3 September 2005

Community-Based Initiatives

Newsletter

World Health Organization
Regional Office for the Eastern Mediterranean

Contents

Interview with Dr Mohamed Haytham Khayat,

Senior Policy Adviser to the Regional Director

1. As Islam advocates community cohesion and community involvement in decision-making, and the CBI programme is based on community participation, what, in your opinion, are the best ways for advocating CBI initiatives among policy-makers and stakeholders in countries of the Region?

A good starting point would be to brief religious leaders at both community and national levels on the concept of community-based initiatives. Issue number 4 "Health, an Islamic perspective" of the series "The right path to health" published by the Regional Office, could be helpful in achieving this purpose. Briefing religious leaders and community development committees would help to enable them to work together as partners in planning, in intervention activities and in advocating the programme to the community. Religious leaders may further advocate the programme by highlighting linkages between relevant Quranic verses and sayings of the Prophet ﷺ and community development, and in this way, promote the programme to their communities.

> "Islam commands each one of its followers to work for his living"

2. WHO has recognized that poverty is a direct determinant of ill-health and vice versa; how does Islam protect the community from poverty?

Islam commands each one of its followers to work for his living. God says in the Quran: Seek a portion of God's bounty. (62:10) It encourages him to do any type of work which gives him an income to make himself

(Continued on page 2)

self-sufficient. The Prophet ﷺ said: "He who seeks to be contented with his lot, God will help him to be so; and he who seeks self-sufficiency, God will make him so". He also said "For any of you to take a rope and go to a mountain to gather a bundle of dry wood and carry it on your back to sell it, thus sparing yourself the need to beg, is better than seeking other people's help, be it readily forthcoming or denied". He also taught us that "No one ever eats any type of food better than what he buys with his earnings from his own work. The Prophet Dawood used to eat of what he earned through his own work". Thus Islam builds a society which we can aptly term as "the society of the upper hand", meaning a society which is productive. For the Prophet ﷺ said "The upper hand is superior to the lower one".

Islam does not allow extravagance or wastage of resources. The Prophet ﷺ made it clear that wasting wealth is prohibited. God warns us against extravagant spending: Do not hold your fist tight and do not open it fully and irrationally. (17:29) He describes His good servants as: those who spend without extravagance or being stingy. (25:67) He commands us: Do not be wasteful, for He does not like the wasteful. (6:141) The Prophet ﷺ ordered us to economize even when we use water for ablution. Moderation is the best practice in all affairs.

3. In order to pursue the attainment of better health and to alleviate poverty in communities, how can available resources and religious channels in the Region, such as *zakat*, be utilized for this purpose?

To pay *zakat* is a duty of every Muslim. WHO country offices should promote the payment of *zakat* with community-based programmes and explore other religious channels to promote linkages. Our history tells us that most of the public functions in the community were financed by the civil society through endowment *(wakf)*. This is a source that should be studied in depth and reactivated in our modern society.

4. The issue of social security for the poor has long been addressed in all the three major religions, yet until now there are many in our Region without health insurance and who are unable to receive welfare. What do you believe is the role of both the government and communities towards the poor and the vulnerable?

High priority was accorded by the Islamic state to health as a right of humankind, without distinction to colour, sex or religion. The care received by a person from the State should start at birth and continue into old age with the provision of conditions for a healthy life. In between these two stages of life, no person who is ill, disabled, incapacitated or injured should be neglected; all should be covered by appropriate care. This is the example that should be followed.

5. At present, CBI has accomplished a considerable amount of success around the Region. As Policy Adviser to the Regional Director and as a senior colleague who has management experience at different levels of the health system, how do you perceive WHO policy in the next decade in support of the CBI programme?

Pro-poor policies for the Region were approved by the Regional Committee in 2003. The policy emphasizes community-based initiatives as a vehicle for poverty reduction and for achieving a better quality of life. This policy needs to be translated into action by the

"WHO country offices should promote the payment of *zakat* with community-based programmes"

Member States. Creating a forum, such as the intercountry meeting on implementation of poverty reduction strategies in the Region, was a beginning toward a momentum that should be maintained. However, further action needs to be taken by WHO to provide greater technical and financial support to countries in the expansion of the CBI programme; and in order to sustain its positive impact the development of partnerships should be strongly promoted and encouraged. The Regional Office advocates linkages between poverty reduction strategies, the Commission for Social Determinants of Health, the Millennium Development Goals and the CBI programme.

6. How would you advise the Community-Based Initiatives Unit to encourage collaboration with other technical units in the Regional Office to encourage integration of vertical programmes?

By implementing the CBI programme in remote areas WHO is better placed to reach poor and vulnerable groups whose situation leaves them predisposed to ill-health. Organization and mobilization is central to the community-based process and has proven to yield positive results on the health of people living in CBI communities. Communities should be counted as the first level of the health care system as it is the mother who initially realizes her child is sick or the community who suffer firsthand from natural disasters and who are able to maintain the water supply project for years independently. Therefore, it is strongly recommend ed that technical units identify the role of members of households and the community as the first intervention in their programmes and try to increase community capacity and awareness to deal with health-related problems. The initiatives represent the best channel for achieving health-related goals.

WHO
encourages Member States to move forward in achieving the targets of the MDGs

Five years after the adoption of the Millennium Development Goals (MDGs) at the United Nations Millennium Summit in 2000, progress towards achievement of these goals in most countries of the Region has been slow, including in the 10 priority countries that were selected by the WHO Regional Office for special assistance based on their health status. These ten priority countries are: Afghanistan, Djibouti, Egypt, Iraq, Morocco, Pakistan, Palestine, Somalia, Sudan and Yemen.

In order to give momentum to the efforts of countries to reach the targets of the MDGs, the Regional Office hosted an intercountry meeting from 17 to 19 October 2005 for the priority countries. The meeting provided the countries with an opportunity to develop or update their national strategies and plans of action for reaching the targets, and was attended by more than 70 participants. The participants comprised representatives of Ministries of Health, Development and Finance WHO, UN agencies and local partners. The meeting also provided an opportunity to share information, identify gaps and constraints, assess major needs, and find ways and means to develop partnerships, and to estimate the cost of achieving the targets.

> **“The meeting provided the countries with an opportunity to develop or update their national strategies”**

The slow progress towards meeting the targets is evident, especially in regard to Goal 1: “Eradicate extreme poverty and hunger”, and only 4 of the 10 priorities countries will be able to meet Goal 5 “Improve maternal health”. Goal 6, “Combat HIV/AIDS, malaria and other diseases,” has received the most support in terms of interventions, such as the Roll Back Malaria and Stop TB campaigns.

There remains much to be done towards achieving the targets in all of the priority countries, with the exception of Egypt, which has made some progress towards reaching the targets.

One of the objectives of the meeting was to update the country representatives on the work of the recently established MDG Task Force and to share regional strategies to support Member States in achieving the targets. Another objective was in assisting the national authorities to identify gaps in resources or capacity, and to identify social barriers and areas that require further support, in addition to improving partnerships and strengthening collaboration with potential partners, donors and other UN agencies.

Consultation on the CBI training manual for community members and mid-level managers

A training manual on community-based initiatives developed by the WHO Regional Office for the Eastern Mediterranean, in collaboration with the Ministry of Health and the government of Pakistan. The manual was designed for use by people involved in the programme at national or provincial/state levels, and should now be introduced for use at local level. At present, there is no unified methodology or course curriculum for the training of local BDN team members, including community members. Practical training, field visits, viewing local achievements and the exchange of practical experiences are essential in orientating and encouraging community members in the BDN concept, methodology and implementation processes.

The WHO Representative in Pakistan and the Regional Adviser for CBI led a technical committee in collecting and reviewing regional success stories, with a view to compiling and publishing the manual as a training package. The training package will be further tested during a training course for the Afghani community in Pakistan. Regional CBI technical committee members and master trainers in Pakistan (Dr Khushhal Khan Zaman), Sudan (Dr Mahmood Afzal and Dr Sumaia Alfadil) and Yemen (Mr Agha Aseel), collected practical experiences and success stories and presented them at a three-day consultation meeting in Islamabad, Pakistan from 19 to 23 June, 2005. The objectives of the consultation were to:

(i) review experiences and success stories in the Region to highlight the achievements of the CBI programme;

(ii) utilize case studies in the development of the training manual for community members and mid-level managers on CBI planning and implementation;

(iii) test the training manual in the field with the BDN team from Afghanistan who will be trained in Pakistan.

Community support groups' experience in Oman

Community support group volunteers in Oman play a key role in the community in health education and in the promotion of reproductive and child health. The high degree of motivation, enthusiasm and commitment of the 3000 volunteers, who are mostly women, is appreciated both by health staff and the community. The volunteers freely give their time and energy to participate in improving the health of their community.

Community support groups were first introduced in 1992 by the Ministry of Health to assist in promoting breastfeeding and complementary feeding practices within the baby-friendly hospital initiative. In 1994, with the establishment of the birth spacing programme, these volunteers became involved in the national campaign to promote birth spacing within the community. During these early years, this fledgling movement was not always recognized and appreciated, particularly as many volunteers were young women. However, over the years, these volunteers have established themselves as an important part of the primary health care network and are based in primary health care centres.

Recognizing the importance of the work of the community support groups and the key role that communities can play in health, in 1998, the Ministry of Health coordinated the establishment of the wilayat health committee, an intersectoral committee headed by the wali of the wilayat, to serve as a link between community support groups and all government and private sectors. Thus, community support groups became actively involved in the planning process at regional and wilayat level. Recently, they were also involved in the implementation of activities relating to community-based initiatives programmes, such as healthy cities and healthy villages and healthy lifestyles programmes.

> **"Thus, community support groups became actively involved in the planning process at regional and wilayat level"**

Prior to working in the field, new community support group members receive training on topics such as communication, counselling, breastfeeding, complementary feeding, birth spacing and healthy lifestyles according to well-prepared training guidelines. Additional on-the-job training in specific issues and on programmes is also organized as needed. At times, members also assist with national and regional surveys, as well as assisting in additional public health programmes.

A central committee for community support groups headed by the Undersecretary of Health Affairs is responsible for establishing the policy framework and developing the plan of action for community support groups at national level. Well-devised local plans of action, in addition to regulations concerning the work of community support group members have already been developed. These

regulations include the definition of roles, selection criteria and procedures, working methods, training and members' organization and supervision.

A large number of people volunteer to become community support group members, although standardized procedures on recruitment and training have not yet been implemented at national level. Although there is tremendous political support for this initiative, the lack of clearly defined roles and responsibilities agreed upon by all partners has affected their full integration into the health system. The high number of inactive volunteers in some localities is symptomatic of the gaps in the structure and management of the programme.

Recently, the Ministry of Health in Oman established a high-level task force to conduct an in-depth review of community support groups and to explore the main positive and negative elements of this initiative. The task force's main objective is to make recommendations to ensure that volunteers are mobilized effectively and to identify ways and means to support their work in the promotion of better health to communities.

Basic Development Needs programme in Pakistan

The Department of Health in the North West Frontier Province in Pakistan, in collaboration with WHO, began basic development needs projects in five new districts in May, 2005, the different stages of which will be implemented over a period of 3 years. The projects' aim is to empower women and encourage community participation in local development. The programme is being extended to cover new sites following its success in Nowshera where WHO has provided more than US$ 83 542 per annum since 1995. The Department of Health has also approved a computer for each of the five districts: Dera Ismail Khan, Bannu, Upper Dir, Buner and Battagram. The estimated cost of the project is US$ 209 135, of which the Pakistani Government is committed to providing US$ 125 481, with the remainder to be covered by WHO.

The BDN programme was first implemented in Pakistan in Nowshera in 1995. Village development committees were established in 17 union councils. WHO has provided technical and financial support to the village development committees to help identify and implement projects, most of which are aimed at empowering women and women's development at community level.

Women's vocational training centres will be established in each of the five new districts and female health volunteers will be trained. In Nowshera 13 women's vocational

centres were established and 44 health volunteers were trained. These female health volunteers have proven a success in making home visits, maintaining growth monitoring charts and in weighing children. In cases of low weight, which is an indicator of many diseases, children were referred to local health centres for further investigation. As in Nowshera and Peshawar, computers will also be provided for use in vocational centres in order to build the capacity of women. Greater focus will be given to the development of social sectors, such as education, health and skill development of women, basic primary education and embroidery centres.

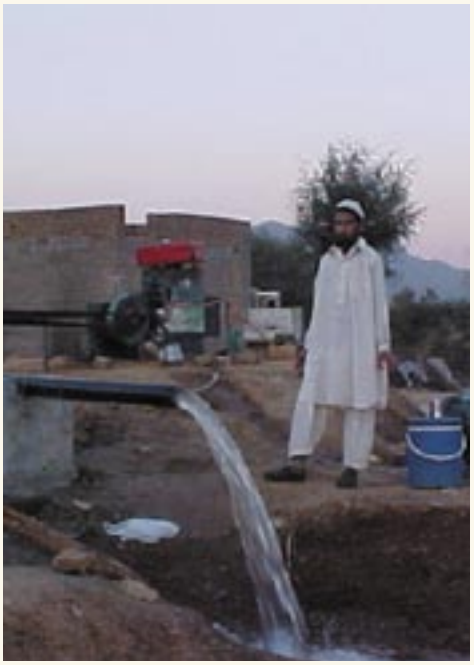
Basic development needs activities have also included the provision of loans, from US$ 335 to US$ 502 for each woman to buy buffalo, to keep honey bees or poultry coups to provide a means of income generation. Micro-credit has become very popular among women in the district as it allows women to earn an income and provide for their families. Loans that are repaid are returned to the community development fund, a revolving fund which allows more women to benefit from the micro-credit process. Similar strategies will be adopted in the five new districts to involve women in mainstream social and educational activities and to reduce poverty at grass-roots level

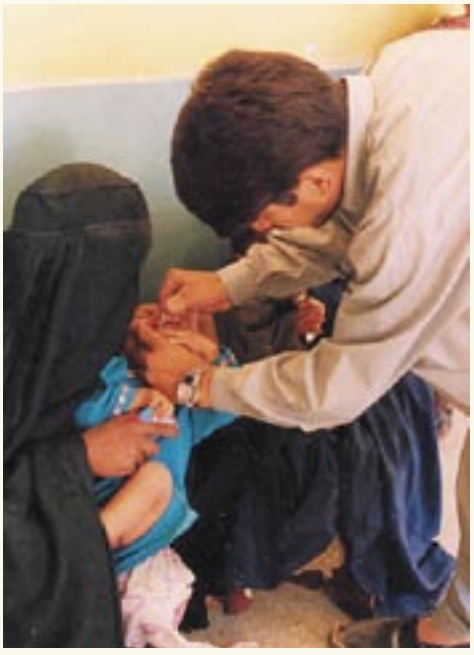
"From unemployed to productive community members through bee-keeping income generating project in Pakistan"

A US-based humanitarian organization, the Global Fund, has contributed US$ 2 million to WHO to upscale efforts to eradicate tuberculosis and malaria from Pakistan. The fund will be spent through the basic development needs programmes in seven districts: Nowshera and Peshawar in the North West Frontier Province, Multan and Kasur in Punjab, Dadu in Sindh, Mastung in Balochistan and the urban belt of Muzaffarabad in Azad Jammu and Kashmir.

"Aladino School has become functional in a boat inside the lake for the poor children who themselves live in boats in the lake. Mr. Aladino, the teacher, personally collects them from their boat houses to his boat school and also drops them back"

"WHO has provided technical and financial support to the village development committees to help identify and implement projects"





H.M. King Mohamed VI's commitment to the National Initiative for Human Development

H.M. King Mohamed VI of Morocco endorsed the National Initiative for Human Development in May 2005. The initiative, which is part of a broader plan of social reform, embraces a holistic perspective that is representative of Morocco's national goals. Considerable reforms and structural projects have been initiated which are intended to promote freedom, improve women and children's rights and improve the conditions of vulnerable groups. A fund to expedite the development process has been established in the name of King Hassan's Fund for Socioeconomic Development which is dedicated to building Morocco's infrastructure (potable water, electricity and roads).

Data indicates that many groups live in difficult situations and experience marginalization and poverty. Many urban and rural areas lack essential social facilities and services. These areas are vulnerable to illiteracy, unemployment and exclusion, and the initiative, in its first phase, plans to target 5 million people. Social rehabilitation is a long complex process and cannot be reduced by offering temporary or conditional assistance. It also cannot depend on voluntary activities or charitable institutions. Sustainable development requires integrated policies within a consolidated process and comprehensive projects relying on multilateral mobilization, in which all political, social, economic, educational and environmental factors are taken into account. It also requires better utilization of all available resources to create greater choices for the citizens of Morocco and to reduce hardship and poverty. It is necessary to learn from previous experiences in Morocco and elsewhere in fighting poverty and exclusion, which have demonstrated the importance of identifying vulnerable areas and groups and the need to enlist community participation through partnerships. Dialogue between communities, the Government and nongovernmental organizations are an essential element for the success of this initiative.

> **H.M. King Mohamed VI of Morocco endorsed the National Initiative for Human Development in May 2005**

The National Initiative for Human Development is based on promoting effective citizenship, and represents a creative policy which links community aspirations and reform

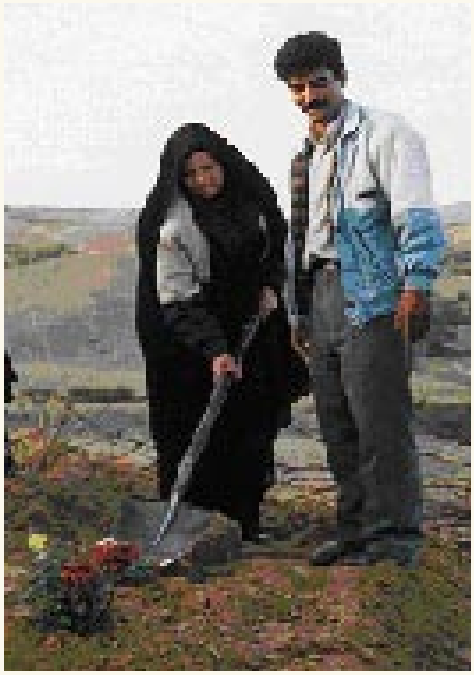
from a platform of sustainable development. The programme addresses social disability, especially among the urban poor and rural populations. This is to be achieved through improving people's access to basic social, health, and educational services and facilities, and through tackling illiteracy, the provision of water, electricity, improving housing, sanitation, roads, mosques, youth centres and sports stadiums. The initiative also endorses activities that will generate income and employment opportunities and which meet the essential needs of vulnerable groups.

The initial phase of the initiative will provide social rehabilitation for 360 of the poorest rural groups and 250 poor urban districts which experience social exclusion and unemployment. Local centres will be opened to assist vulnerable groups and to teach a variety of skills to the community. The vulnerable include abandoned or orphaned children, the homeless, the disabled and the elderly. Although sufficient funding will be allocated from the national budget, it will also be ensured through the development of a mechanism to guarantee sustainable resources, which will not require additional taxation on either citizens or contractors. The initiative is a ongoing activity, not a temporary project, which aims to change previously set priorities and reconfirm Morocco's commitment to rehabilitating human resources and strengthening the national economy. Educational reforms will also be implemented and a scale-up of rural development and the optimization of investment in agricultural resources will be undertaken.

"Dialogue between communities, the Government and nongovernmental organizations are an essential element for the success of this initiative"

Community-based initiatives in the Islamic Republic of Iran

In the Islamic Republic of Iran, the national community-based initiatives secretariat during the past year has presented seven important projects to be implemented in healthy cities and healthy villages in Isfahan, Yazd and Chabahar. The projects are directed towards the following areas: improving waste management (through partnership with the Ministry of the Interior), improving information services (through partnership with the Ministry of Intelligent Technology), creating healthy schools (through partnership with the Ministry of Education), prevention of traffic accidents and injuries (through partnership with the Ministry of Health and Medical Education), improving nutrition (through partnership with the Ministry of Health and



Medical Education), improving the mental well-being of communities (through partnerships with nongovernmental organizations), and maintaining, monitoring and managing the consumption of water supplies, which has already been implemented in Isfahan, Yazd, Semnan and Chabahar.

Orientation meetings on community-based initiatives were conducted for provincial and district authorities in Mazandaran (Noor district), Sistan Va Baluchistan (Zahedan district), Teheran (Shahriyar district), Markazi (Khomein district), Kerman (Bam district), Golestan (Gorgan district) and the Qeshm free-zone. Consultation meetings were conducted by the secretariat with village development committees and technical steering committees in Golestan, Kerman, Sistan va Baluchistan, Charmahal va Bakhtiari and Azarbayejan-e Gharbi to finalize the content of the community-based initiatives guidelines. The chancellors at the University of Medical Sciences were introduced to the principles of the basic development needs programme and the healthy city and healthy village programmes through reports and presentations given. Three consultations were organized by the secretariat to operationalize the workplan of the Bam healthy city programme.

The basic development needs programme has been extended to six new villages in two provinces, the villages of Jalabad, Taraz Nahid and Joshaghan in the Markazi province and Nazar Agha, Faryab and Dehdaran Sofla in the Bushehr province. Community development funds were established in all six villages. The basic development needs programme also supported a rose plantation established by eight women as an income-generating project to produce rose water in Shahrekord in Charmahal va Bakhtiari province.

The national community-based initiatives secretariat continues to monitor and supervise ongoing projects in both the basic development needs programme and the healthy city and healthy village programmes. Monthly meetings with the national committee of the healthy city and healthy village programmes were adhered too. In addition, the secretariat reviewed the basic development needs guidelines and is in the process of preparing guidelines for community-based initiatives, including healthy cities and healthy villages. The secretariat selected and organized an 11-person mission to Thailand to exchange ideas concerning community-based approaches, and facilitated the exchange of Bahraini fellows to the healthy city and

“The secretariat has also begun to consolidate the healthy city and healthy village programme with the basic development needs programme by adopting a healthy district approach.”

healthy village programmes in Saveh, Teheran and Isfahan and introduced them to the basic development needs programme and its activities in the Islamic Republic of Iran. An advocacy document was prepared on community-based initiatives for educational purposes (for policy-makers, intersectoral teams and the local community), and the secretariat is compiling a set of regulations for the strategic council of community-based initiatives, highlighting the role of other organizations and ministries. The secretariat has also begun to consolidate the healthy city and healthy village programme with the basic development needs programme by adopting a healthy district approach. Seventeen districts in the Islamic Republic of Iran have now been introduced to the approach.

The national community-based initiatives secretariat has requested that the WHO Regional Office for the Eastern Mediterranean undertake an evaluation of community-based initiatives in the Islamic Republic of Iran. In addition, the secretariat is planning on training master-trainers on community-based initiatives guidelines.

Introduction of the BDN programme in Old Cairo, Egypt

The Ministry of Health, Egypt, WHO and Rotary Al-Fustat are collaborating to introduce basic development needs projects in Al-Fawakhir and Batn Al-Baqarah in Old Cairo. The BDN programme is being implemented as an integrated component of the Ministry of Health's drive to improve health, nutrition, literacy, and the economic, nutritional and the environmental status of the target area. The programme focuses on community capacity-building, specifically on women's role in development. The programme will: train youth to acquire vocational skills; create healthy environments for children; improve the marketing of local products through the development of entrepreneurship; and provide education. The programme will also increase the awareness and capacity of women through education on health, nutrition, literacy, vocational skills and through their involvement in community development activities. The access of the community to safe drinking-water and sanitation will also be improved. Increasing nutritional awareness among community members is another important objective of the programme. In addition, rehabilitation of the pottery industry is planned as part of the programme's future activities. Rotary Al-Fustat has pledged US$ 12 000 and WHO has pledged US$ 57 326 towards the programme.

Visit of the Director of the UN Millennium Development Project to a BDN village in Yemen

Professor Jeffrey D Sachs, the Director of the UN Millennium Project and Special Adviser to the UN Secretary-General, Kofi Annan, visited a BDN village in Sana'a, Yemen, on 1 July 2005. He was accompanied by the WHO Representative, Dr Hashim Al-Zein, the UN Resident Coordinator, Ms Flavia Pansieri, Deputy Minister of Health in Yemen, Dr Majeed Al-Khulaidi, and Deputy Minister of Planning and International Cooperation, Dr Motahar Abassi, in addition to several other UN and government staff.

During the 3-hour visit, Professor Sachs had a brief meeting with the village development committee in the BDN-supported library, followed by a visit to the women's training and handicrafts centre. He talked to a number of women in the village, including village development committee members, trainers at the vocational centre and traditional birth attendants. The delegation also visited various health centre departments in the community.

For further information on Community-Based Initiatives contact:

Community Based Initiatives
World Health Organization
Regional Office for the Eastern Mediterranean
Abdel Razzak Al Sanhoury Street,
PO 7608 Nasr City,
Cairo, Egypt
Telephone: 00-202-276-5000
Facsimile :00-202-670-2492/4
Web site: http://www.emro.who.int/cbi