

Introduction to the community-based initiatives programme in Iraq



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Introduction

In light of the increased attention paid to the human dimension of health and development and as a result of the current conditions in Iraq, there is a need for intensified efforts to achieve the fulfilment of people's basic development needs in the country. Basic development needs include the provision of primary health care, an adequate income, basic education, safe water, a healthy environment, food, housing, safety, peace and other basic human rights. The fulfilment of basic development needs is essential for both health and development. Social and economic development are dependent on health as a key factor, and health cannot be achieved in isolation—many of the determinants of health lie outside the domain of the health sector.

The most sensitive indicator for measuring health is the infant mortality rate which is, directly or indirectly, related to the extent to which people's basic development needs are in place. Experience around the world has also shown that literacy and income are significant factors in reducing morbidity and mortality of mothers and children.

WHO is promoting a range of community-based initiatives in Iraq to facilitate the attainment of people's basic development needs in the country. Community-based initiatives (CBI) programmes include the healthy village programme (HVP), the healthy city programme (HCP), the women in health and development (WHD) programme and the basic development needs (BDN) programme, and the initiatives include emergency preparedness and response, baby-friendly homes, baby-friendly communities, healthy environments and community schools.

CBI programmes have been successfully implemented in 17 countries of the Region. In Iraq, community-based initiatives in the form of the healthy city programme and the BDN programme were initially introduced in 1999, and in May 2005 were further expanded to nine localities to test their feasibility and impact. Since then, community organization has been strengthened and community capacity built. Socioeconomic surveys have shown that the initiatives are addressing and meeting some of the community's priority needs and are demonstrating great success in the country (Figure 1). Up until now there has been no national strategy for the implementation of the initiatives although a national strategy will be developed based on the valuable experiences learnt in Iraq and in other countries of the Region and will be implemented from 2007 onwards.

Adequate financial support has also been provided to support pilot programme areas as the initiatives have previously demonstrated their effectiveness in post-conflict areas and in those areas experiencing instability.

Objectives and rationale

The objectives of community-based initiatives in Iraq are to build the capacity of communities in order to enable them to address their health and emergency needs and to establish effective community institutions which can carry out various emergency and development interventions. Organized institutionalized communities can act as a vehicle to carry out many development interventions, and the initiatives are flexible enough to address and meet the requirements of the community's development needs. The community-based initiatives approach also:

- reduces morbidity and mortality, especially among women and children;
- improves health status through increased family income and self-care;
- promotes equity and healthy lifestyles;
- promotes community involvement and ownership;
- encourages decentralization and self-reliance;
- reduces the financial burden on governments by contributing to the socioeconomic development of the country;
- alleviates poverty and improves quality of life;
- facilitates peaceful coexistence; and
- encourages the development of a collective team spirit to build health as a bridge for peace and development.



Figure 1. A community survey

The approach of the initiatives is in line with the country's stated policy of decentralization and the adoption of policies which are concerned with the building of democratic institutions and empowering institutions. Under conditions of violence and instability, if communities are strengthened and empowered, they can help to sustain national development and safety. The implementation of community-based initiatives will facilitate the process of socioeconomic development and will enhance the quality of life of vulnerable groups within the country. The current conditions in Iraq require that the community is prepared to deal with emergencies and necessitate the creation of a community-based mechanism to resolve disputes and to reduce instability.

The initiatives provide a framework for the protection of human rights. They also provide a mechanism through which attainment of the targets of the Millennium Development Goals (MDGs) can be achieved.

Main strategic features of community-based initiatives

Community-based initiatives are designed to provide support to the primary health care system and in Iraq are being implemented incrementally to promote a comprehensive holistic approach to health. A survey conducted in villages in Iraq where community-based initiatives have been implemented showed that they were providing support to primary health care in the country, and it is expected that partnerships with health care providers in Iraq will be strengthened as a result of the expansion of the initiatives in the country. To achieve a sustainable improved health status, the initiatives introduce and promote the concepts of collective care for the community and of family and individual self-care. Effective advocacy efforts are now required to encourage behavioural change, and policies which protect human rights and facilitate development need to be promoted.

Community-based initiatives are managed and partially financed by the community and also through partnerships with various stakeholders, including the public sector, nongovernmental organizations, civil society organizations and donors. Communities are organized through a development-orientated and democracy-based approach and are provided with the necessary tools to facilitate attainment of their objectives. Their roles and responsibilities are clearly defined and they receive vocational training when necessary.

A community-based mechanism for the resolution of disputes will be introduced as a component of the initiatives and the community-based organization responsible for the management of dispute resolution will be comprehensively trained. Communication for behavioural impact (COMBI) will be used to assist in the planning, implementation and monitoring of a variety of communication actions and will be supported by the volunteers for health movement. The COMBI programme will be implemented in phases according to priorities and resources available.

Functional and structural organization

The programmes at village level are managed by village development committees which are supported by intersectoral support teams. At institutional level, they are incorporated into the primary health care system. Health committees support peripheral (village) health facilities, and the health facility builds the capacity of health committee members in supervising the promotion and implementation of self-care, domestic care, collective care and in implementing COMBI. The health facility at village level reports to the district health centre. The medical officer in charge of the district health centre is a member of the district intersectoral support team which oversees the implementation of basic development needs at village level (Figure 2).

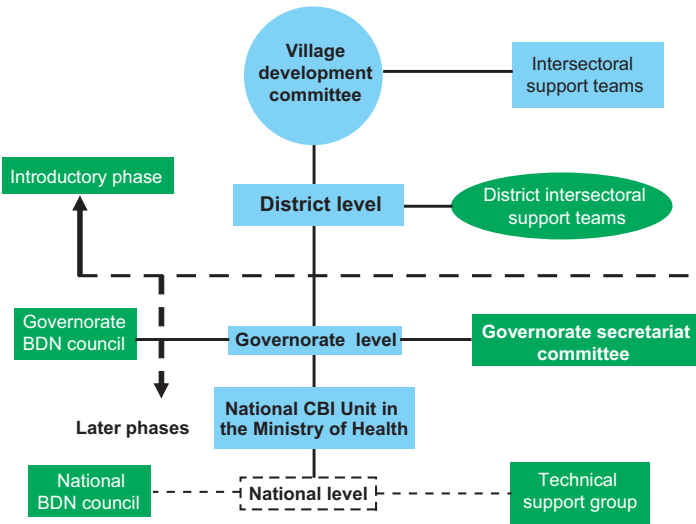


Figure 2. Structural organization of the programme

Socioeconomic information is available at village information centres and is based on the results of house-to-house socioeconomic surveys conducted at village level. Community-based organizations are trained to update and use this information for emergency preparedness and response and development activities.

A village financial system based on both local and modern approaches is being developed. An important component of this system is the village development fund managed by the village development committee and funded through subscriptions, donations and input from the public sector. In some countries, 5%–10% of the amount of the village development loan is charged from each beneficiary to cover service costs and to add to the community development fund. This fund will be used for the development of emergency programmes in the country.

Planning is performed jointly by community-based organizations and other partners and is based on village information centre data, previous development experience, expert views, risk analysis, analysis of facilitating factors and available resources (Figure 3). The setting of indicators and the methodology used in monitoring and evaluation is to be agreed upon by stakeholders. Evaluation will include coverage evaluation, corporate evaluation and impact.



Figure 3. The planning process

Programme relevance to the MDGs

As the initiatives address all of the community's basic development needs, and as 50% of the members of community-based organizations are women and the strategy anticipates the creation of partnerships, implementation of the initiatives will assist in reaching the targets of the MDGs.

Some of the activities implemented under the healthy city and BDN programmes in Iraq have included a sanitation project, the distribution of school bags in Sadr City and training in the production of honey.

Figures 4–6 show the various stages of the community sanitation project undertaken in the healthy city of Swaira in the Al-Swaira/Wassit Governorate. As sanitation represents a major problem in Iraq, this sewage disposal project was identified as a priority for the city and was undertaken in coordination with the Ministry of Municipalities.

The Ministry of Agriculture have provided a farm in Al-Intissar village to be used to train the community to produce honey. The farm is over 6 250 000 m² in size and is used to teach agricultural skills to the youth of the village and to train them to produce honey (Figure 7). Ten adults have each been given one bee hive on a trial



Figure 4. A street in the Al-Swaira/Wassit governorate prior to implementation of the community sanitation project





Figure 5. Community sanitation project



Figure 6. Community sanitation project



Figure 7. Community training in honey production in Al-Intissar village

basis to evaluate the success of the training. The farm also has a small annex that is equipped with computers and where members of the community can receive computer training. The Ministry of Agriculture intends to expand these projects to encompass other BDN areas.

Table 1 shows the time frame for the implementation of community-based initiatives in Iraq. Tables 2–8 provide statistical data and demographic, social and health indicators for the country (see Annex).

Table 1. Plan for the implementation of community-based initiatives in Iraq

Activity	Time frame
Creation of a detailed plan of action for phase 1 of programme implementation, including the marketing and promotion plan	July 2007
Creation of a plan for the expansion of the programme	August 2007
Preparation for funding proposals	August 2007
Initiation of dialogue with the Government to discuss the integration of the programme into national policy and as an integral part of the national health strategy	September 2007
Development of a manual to elucidate the roles and responsibilities of all major partners	October 2007

Annex

Statistical data and demographic, social and health indicators for Iraq

Table 2. Leading causes of mortality, 2006

Cause of death	(%)
Cardiovascular diseases	45.0
Accidents	14.0
Malignant neoplasms	8.0
Renal failure	4.0
Diabetes mellitus	3.0
Congenital malformations	2.0
Asthma	0.8
Pulmonary tuberculosis	0.7
Cerebrovascular accident	0.5
Diarrhoea	0.4

Source: Department of Health and Vital Statistics, Ministry of Health, 2006.

Table 3. Leading causes of morbidity, 2006

Cause of morbidity	(%)
Gastroenteritis	9.7
Accidents	4.2
Abortion	3.6
Cardiovascular diseases	2.6
Bronchitis	2.4
Pneumonia	1.6
Malignant neoplasms	1.4
Cataract	1.1
Diabetes mellitus	1.0
Asthma	1.0

Source: Department of Health and Vital Statistics, Ministry of Health, 2006.

Table 4. Health and education indicators, 2006

Indicator	Value
Gross domestic product US\$ (GDP)	864.0
Gross national product US\$ (GNP)	1180.0
Total expenditure on health (per capita)	23.0
Health expenditure as a % of GDP	2.7
Ministry of Health budget as a % of government budget	4.7
Health expenditure as a % of general government expenditure	4.2
Gross primary school enrolment rate (%)	79.0
- male	83.0
- female	75.0
Gross secondary school enrolment rate (%) *	41.0
Population with adequate excreta disposal facilities (%) *	51.0
Population with access to safe drinking-water (%)	61.0
Neonates with birth weight > 2.5 kg (%) *	3.9
Children under 5 with malnutrition (%) *	9.7
Antenatal care coverage (%)	45.0
Deliveries attended by trained personnel (%)	69.0
Pregnant women at risk (%)	30.0
Children under 5 at risk (%)	10.0
Percentage of caesarian sections performed in:	
- governmental hospitals	19.16
- private hospitals	62.8

Source: *Demographic, social and health indicators for countries of the Eastern Mediterranean*. WHO Regional Office for the Eastern Mediterranean, 2006.

* Information for 2004.



Table 5. Health and human resource indicators, 2006

Health and human resource indicators	
Infants (%) fully immunized with:	
- BCG	95.0
- DPT	84.0
- measles vaccine	85.0
- OPV	83.0
- viral hepatitis B	82.0
Pregnant women (%) receiving two or more doses of tetanus toxoid	48.0
Infant mortality rate (per 1000 live births)	107.9
Under-5 mortality rate (per 1000 live births)	130.0
Married women using contraceptives (%)	32.0
Number of health workers (per 1000 population):*	
- physicians	6.6
- dentists	1.2
- pharmacists	1.0
- nurses	3.4
Maternal mortality rate (per 100 000 live births)	294
Total number of registered live births*	1 035 276
Number of births in:*	
- governmental hospitals	563 653
- private hospitals	90 413
- home births (%)	37.3
Total births (live and still births)*	1 042 717
Still births per 1000 live births*	7.19

Source: *Demographic, social and health indicators for countries of the Eastern Mediterranean, 2006*.

* Infant and maternal mortality survey, Ministry of Health, 1999.

Table 6. Demographic indicators, 2006

Demographic indicators	
Area (km ²)	435 052
Total population:	27 962 968
- urban (%)	66.9
- male (%)	50.37
- female (%)	49.77
Percentage of population above:	
- 1 year	3.7
- 5 years	16.8
- 15 years	43.3
Percentage of population 15–64 years	53.9
Percentage of population above 65 years	2.8
Percentage of women 15–44 years	22.05
Population density (person/km ²)	64.0
Population growth rate (%)	3.0
Total fertility (%)	6.0
Crude birth rate (%)	38.0
Crude death rate (%)	10.0
Life expectancy at birth	58.0
Dependency rate (%)	85.0
Population natural increase (per 1000)	28.0

Source: Department of Health and Vital Statistics, Ministry of Health, 2006.



Table 7. Human health resources and health facilities, 2006

Human health resources and health facilities	
Total number of government hospitals	210.0
- pediatrics	9.0
- pediatrics and obstetrics	16.0
Total number of beds in government health facilities (per 1000 population)	8.0
Total number of government hospital beds	36 850
Government hospital beds devoted to:	
- paediatrics (%)	13.2
- gynecology and obstetrics (%)	11.0
- general surgery (%)	11.0
- internal medicine (%)	12.9
Bed occupancy rate (%)	54.8
Government beds (per 1000 population)	13.2
Private hospital (per 1000 population)	0.75
Total number of private hospitals	80.0
Total number of beds	2221
Consultative medical clinics	187.0
Outpatient clinics*	87.0
Specialized dental clinics*	26.0
Total number of primary health care centres (per 1000 population)	0.66
- managed by physician (%)	51.0
- managed by health personnel (%)	49.0
- specialized medical centres	46.0

Source: Department of Health and Vital Statistics, Ministry of Health, 2006.

* With the exception of the Kurdistan region.

Table 8. Human health resources, 2006

Human health resources	
Physicians	18 126
Practitioners*	4056
Specialists*	5326
Percentage of specialized physicians:	
- paediatrics (%)*	13.9
- internal medicine (%)*	12.4
- general surgery (%)*	13.5
- gynaecology and obstetrics (%)*	13.0
Dentists	3496
Dental practitioners*	1703
Specialized dentists*	351
Pharmacists	3028
Practitioners	1853
Specialized pharmacists*	90.0
Nursing staff:	35 713
- male	26 187
- female	9526
- laboratory personnel	3058
- health personnel	33 385
- health engineers	1329
- statisticians	638

Source: Department of Health and Vital Statistics, Ministry of Health, 2006.

*With the exception of the Suleimania Governorate.