WHO-EM/CBI/054/E

Community-based initiatives
Success Stories
from the Eastern Mediterranean Region

World Health Organization

Regional Office for the Eastern Mediterranean

WHO-EM/CBI/054/E

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Foreword

Health is a fundamental human right and interventions to improve the quality of people's health are essential elements of social investment. In improving the health of communities, it is necessary to address all the determinants of health, including the social, economic and physical determinants. Poverty, illiteracy and lack of awareness all represent fundamental obstacles to health and development. Poverty, in particular, as an important determinant of health, cannot simply be defined in monetary terms but rather, must be seen in its wider context. Poverty can be characterized by factors such as poor health, inadequate nutrition and a lack of access to education, safe water and sanitation. The poor are less likely to have access to good quality health-care services and basic facilities, which in turn, means they bear a higher burden of morbidity and mortality. The capacity and the potential of the poor and vulnerable in society are diminished by ill-health, social exclusion and unemployment.

To address the problem of ill-health and poverty, the WHO Regional Office for the Eastern Mediterranean began the Basic Development Needs (BDN) Programme in 1988. The programme was first implemented in Lower Shebelle, Somalia, but has since been extended to cover most countries in the Region. The programme has been successful in reducing poverty and improving health at the local level and in organizing and empowering communities in order to facilitate their participation in development projects. During the past two decades, community-based initiatives have demonstrated, in an effective and practical way, that community involvement, intersectoral collaboration, decentralization and grass-roots planning, all important elements of the primary health care system, can be activated within existing local mechanisms to improve community health and reduce poverty.

These success stories from 10 countries in the Region demonstrate how community-based initiatives have improved people's health and quality of life and illustrate the achievements and the sustainability of the programme. They demonstrate to policy-makers, professional bodies, local government, international partners and other stakeholders involved in development the efficacy of the programme in reducing poverty and in addressing all social determinants of health.

WHO has been actively promoting community-based initiatives for over two decades through the Basic Development Needs Programme, the Healthy Cities and Healthy Villages Programmes and the Women in Health and Development Programme.

It is hoped that these models of good practice provide examples of approaches and methodologies to other partners and stakeholders for the expansion of community-based initiatives aimed at improving the health and well being of communities in this Region and beyond. I sincerely thank all colleagues involved in the programme for their efforts.

Hussein A. Gezairy, M.D., F.R.C.S

Regional Director

Introduction

The approach and the success of community-based initiatives are dependent on the full involvement and participation of communities in integrated, bottom-up, socioeconomic planning supported through the collaboration of all sectors involved in the development process. The programme's methodology is based on the concept that reducing poverty is important in improving the health of communities and that improved public health leads to the reduction of poverty. It is a self-sustaining, community-orientated strategy which aims to address people's basic development needs and recognizes health as of central importance in the process. The programme aims to find ways of addressing disparities in the health-care system and create equitable solutions for these shortcomings. The initiatives recognize the intrinsic relationship between poverty and public health, and aim through community empowerment and leadership, to improve access to basic needs, such as nutrition, safe water, sanitation, shelter and access to preventive and curative health. The most important elements of this approach are community organization, mobilization and skills building and the involvement of the community in micro-development social and income-generating projects to improve the health, quality of life and productivity of communities. Great efforts have been extended in all project areas to improve health and health-care services in order to reduce poverty.

Based on the successes achieved in health and development at the community level, the WHO Regional Office continues to supports community-based initiatives in many countries of the Region. The Organization's role has been to introduce the programme concept, to develop models of good practice, to train communities and to increase community capacity in pilot areas. The BDN Programme, as a component of community-based initiatives, engages at the local level in community organization, community needs, capacity building and planning, community-based management and ownership, resource mobilization and institutionalization (Fig. 1).

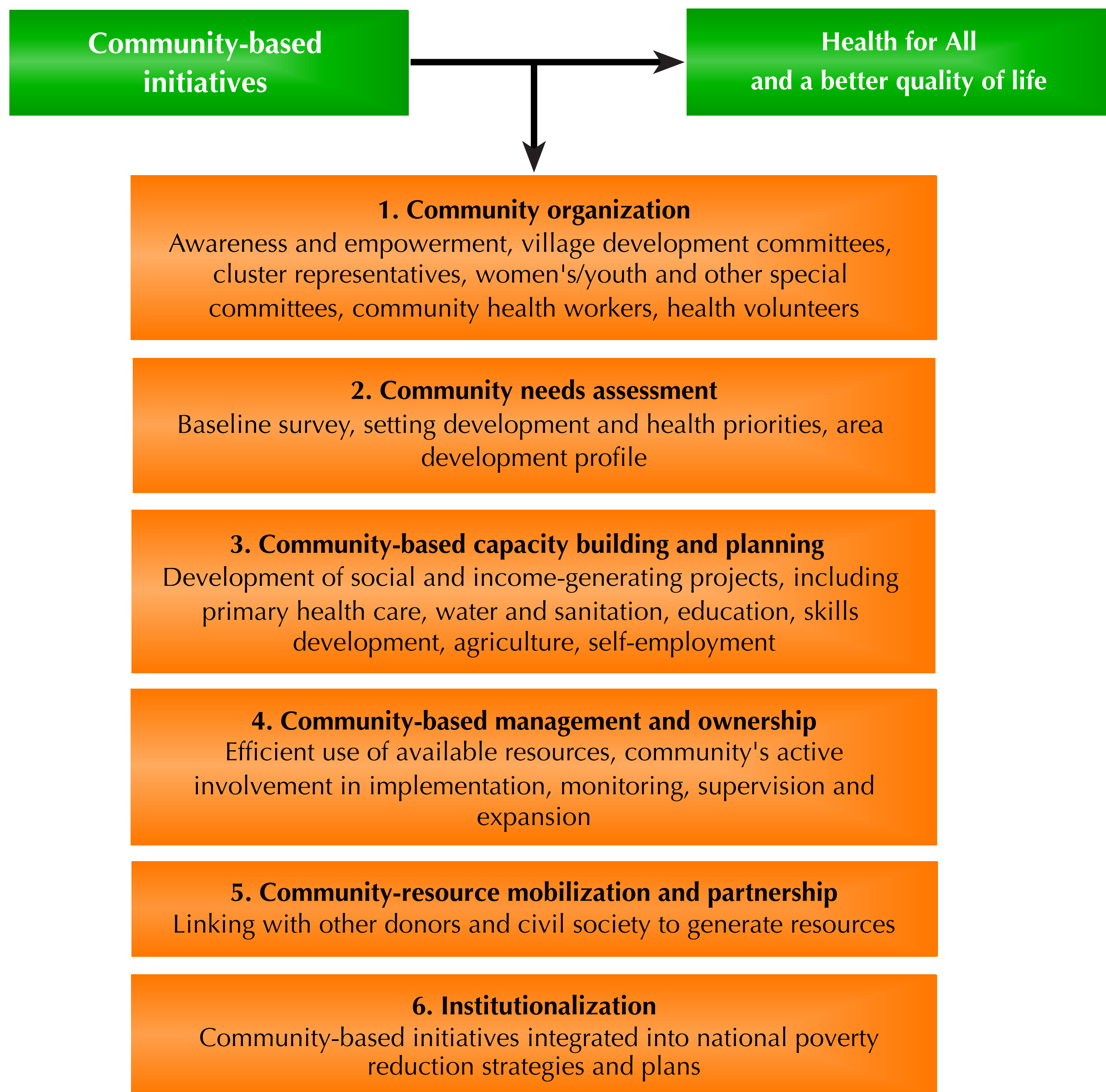


Fig. 1. Six CBI key practices to achieve improved health outcomes

The organizational structure of the programme depends on the formation of community and technical committees, the election of cluster representatives who are responsible for between 30 and 50 households, the provision of income-generating loans and the importance of local-level decision-making. Community stakeholders identify priorities that best address their local and regional needs and the community, through their representative committees, in partnership with their line agencies, agree on community priorities. CBI committees include representatives from various line agencies who provide guidance in strengthening local organizations in order to increase community involvement and to assist in the implementation of social and income-generating projects. The technical line agencies act as a bridge between the community and the relevant line departments in the district government (Fig. 2).

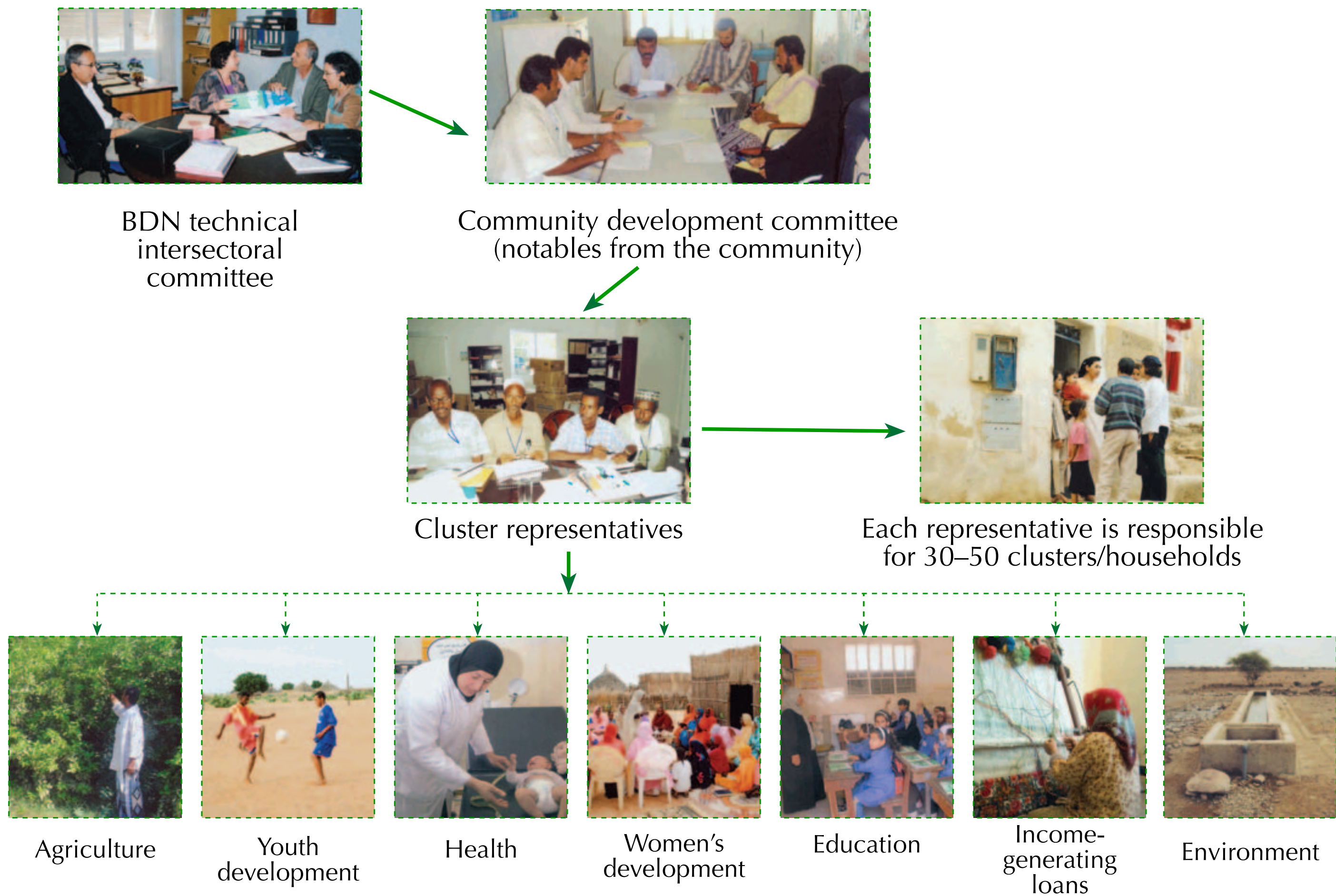


Fig. 2. The organizational structure of the BDN Programme

CBI committees are thus able to generate the trust and confidence that is necessary to ensure that solid partnerships are created and developed between government and civil society organizations. In most areas implementing community-based initiatives, women's committees and organizations have been established to lead women's development activities at the community level and this has been crucial in enlisting the full involvement and participation of women. The initiatives, crucially, engage communities at the local level and build their capacity in order that they are able to find local solutions to local problems and are able to create and manage sustainable development activities, not only for their own future but also for that of their children.

The BDN Programme includes the provision of interest-free, income-generating loans for poorer members of communities that are awarded through local CBI committees. The committee reviews the feasibility of an income-generating project and if the proposal is accepted, the loan is awarded. Loan recipients contribute 25% of the share of the loan either through money, labour or in using their own assets to run the income-generating project they are involved in. Loans are then repaid in instalments and standard procedures and guidelines are in place to ensure financial transparency.

An opportunity was created for the initiatives to be used by the Commission on Social Determinants of Health, following its formation in March 2005. The Commission is charged with recommending interventions and policies to improve health and to narrow health inequalities through action on social determinants and the initiatives provided a vehicle through which the Commission could convert its policies into practice (Table 1). Regionally, the Commission is collecting evidence in order to raise awareness and to build the commitment of policy-makers in recognizing the importance of the social determinants of health in health policy agendas. The Commission advocates for the inclusion of social determinants of health in national health and development policies and aims to identify best practices to address problems. It also aims to develop a regional strategy through which to address the social determinants of health and to facilitate the implementation of this strategy through community-based initiatives.

Table 1. Social determinants of health and community-based initiatives

Social determinants of health	Community-based initiatives
Early child development and education	Literacy training centres (female literacy); Children's immunization; Healthy school initiative; Strengthening primary schools.
Employment conditions	Income-generating projects targeting the poor; Skill development (local capacity building); Creating job opportunities at local level; Finding markets for local products.
Social exclusion	Empowering poor and marginalized groups through community organization/mobilization.
Priority public health conditions and access of the poor to health-care services Women's empowerment and gender mainstreaming	Access to safe drinking-water and sanitation; Building community health awareness; Ensuring availability of priority health-care services e.g.: Expanded Programme on Immunization (EPI), TB directly observed treatment, short-course (DOTS), Roll Back Malaria (RBM), Nutrition for Health and Development (NHD), Making Pregnancy Safer (MPS), Tobacco-free Initiative (TFI)); Promoting volunteers and cluster representatives. Women's vocational training centres; Income-generating projects targeting women; Women's involvement in development and as decision-makers; Formation of women's and youth groups.

The Commission on Macroeconomics and Health

The Commission on Macroeconomics and Health (CMH) has been advocating to countries that monetary increases in their health sector budget will benefit their economies in the long term and that health must be placed at the centre of development agendas in order that all the determinants of health are addressed. Poverty has social, health, moral, economic and political implications and despite the efforts of poorer countries to tackle poverty, very little impact has been made on the majority of the poor in these countries. The Commission advocates for the protection of the poor against poverty-traps, such as ill-health, poor nutrition and lack of access to education, water, sanitation, and health services and against natural disasters and crises through the provision of health insurance, social security and pension funds.

The Commission advocates to policy-makers that investing in health is vital for economic growth and that if communities can be protected against falling into poverty traps this will be reflected by visible improvements in health indicators, and subsequently in countries' economic indicators. Thus, the Commission's initiative complements the microeconomic and social projects aimed at eliminating poverty that are taking place through community-based initiatives in the Region. In addition, Poverty Reduction Strategy Papers (PRSPs) and Millennium Development Goals (MDGs) are also initiatives that complement community-based initiatives as they focus on poverty reduction strategies that can be implemented at the micro-level.

Six countries in the Region (Djibouti, Islamic Republic of Iran, Jordan, Pakistan, Sudan and Yemen) are implementing the recommendations of the Commission and a regional task force has been established to support these countries with advocacy, analyses, implementation of the Commission's macroeconomics and health strategy and tracking outcomes. In 2003, at the WHO Regional Committee for the Eastern Mediterranean, Ministers of Health and other delegates approved the Regional Strategy for Sustainable Health Development and Poverty Reduction, which advocates for a greater focus on the health needs of the poor and the vulnerable in development agendas. This strategy is in line with the recommendations of the Commission and strives to meet the targets of the health-related MDGs, all of which build on previous sustainable development initiatives.

The MDGs effectively target the roots of poverty and challenge countries to mobilize human and financial resources to reduce poverty. In the six countries implementing the recommendations of the Commission, there is a significant link between the lack of education and health and poverty. In low-income countries literacy rates are lower than in middle-income countries and are significantly lower among women in all countries. Confronting the issue of universal education has become a priority for these low-income countries, in addition to addressing the problem of the lack of human resources that is an even greater problem than the lack of financial resources.

Progress in the six countries that are implementing the recommendations of the CMH has so far been promising with all countries moving closer towards their goals and although current investment in the health sector remains low in the low-income countries, there has been an increase in resource allocation in most countries. Djibouti carried out a study on national health strategies and policies and proposed recommendations for improvements to the quality of health-care services and an increase in the access of the poor to primary health care. The Islamic Republic of Iran commissioned three studies to review the situation, the role and the effects of foreign financial aid to the health system. These studies looked at the establishment of a multisectoral health and economic information system and the development of macroeconomic projections on the health sector and reviewed the performance of health-care services for the poor covered by the national relief committee (Komite Emdad). A document on the devolution of health-care services in Pakistan was developed as an advocacy tool for increasing budgetary allocation to the health sector and for improving the access of the poor to health-care services.

All six countries have conducted evaluations to assess their progress. The national CMH in Jordan sensitized mid-level and high-level managers to the recommendations of the Commission and preliminary studies were undertaken by a WHO consultant from Lebanon to develop a health investment plan. Government support in Jordan has been strong in its efforts to support the recommendations of the CMH and Jordan will be the first country to produce an investment plan for health. A national CMH was established in Sudan in December 2003 and a full-time officer was appointed to review the existing situation, to identify information gaps and to prepare a proposal for the health investment plan. The health component of the PRSP was prepared by the national CMH and was discussed with the national PRSP team at the Ministry of Finance. A number of advocacy and training activities were also undertaken,

including the publication of leaflets and pamphlets, and training sessions for policy-makers and health managers were conducted. In Yemen, a health investment plan, which included both needs' assessment and costing, was formulated to achieve the targets of the health-related MDGs.

The objective of this publication

The WHO Regional Office supports community-based initiatives in many countries of the Region and encourages communities to identify local priorities and to build community capacity in order to meet their health needs. The objective of this publication is to provide evidence to policy-makers and donors of the success of community-based initiatives, which have already proven their efficacy as evinced by the decision of policy-makers to scale up essential health interventions at the community level due to the success of programme activities. Member States are encouraged to share this publication with key policy-makers, potential partners and UN agencies to advocate for the institutionalization of the programme into national development strategies and for the subsequent expansion of the programme.

These 18 case studies (Table 2) elucidate some of the hardships that are faced by the poorest communities in the Region but demonstrate how, through the initiatives, communities are able to improve the quality of their own lives simply by becoming active participants in the development process. They also demonstrate how through the establishment of cooperatives communities can work together to improve their income, health, nutritional status and environment. These stories of success and achievement show how additional investment in human development can improve the socioeconomic and health status of the poorest communities through enabling them to undertake sustainable development activities to improve the quality of their own lives. Men and women have been empowered as a result of the programme through a range of activities including health education, literacy classes, vocational training and skills building and the provision of micro-credit loans to create income-generating projects. Many stories contain a particular focus on women's development, gender mainstreaming and youth development. Although national nongovernmental organizations have been critical in facilitating this process, the role of the whole community in decision-making and programme activities is emphasized at every stage of the CBI process.

Table 2. Community-based initiatives projects in various areas

Number	Location	Type of project
1	Badakhshan, Afghanistan	Women's empowerment in remote areas
2	Assassane, Obock district, Djibouti	Income-generating farming
3	Gallamo, Djibouti	Village development
4	Batn al-Baqureh, Old Cairo, Egypt	Skills development for improved health and income
5	Savadjoon, Islamic Republic of Iran	Women's cooperative and community development
6	Saveh healthy city initiative, Islamic Republic of Iran	School health initiative
7	Al-Zmalia, Irbid governorate, Jordan	Improving nutritional status through income-generating projects
8	Al-Jezzazeh, Jarash governorate, Jordan	Women's empowerment and capacity building
9	Sidi Moussa, Sela, Morocco	Youth development
10	Sehreej Kanawah, Fes, Morocco	Supporting handicrafts and local production
11	Manchar Lake, Sindh province, Islamic Republic of Pakistan	Community-based school
12	Balloki, Kasur district, Punjab province, Islamic Republic of Pakistan	Community-based maternal and child health care centre
13	BDN implementing areas of all provinces of Pakistan	Basic development needs and DOTS
14	Dar Mali, Sudan	Village self-reliance
15	Ragwa, Al-Gezira, Sudan	Community-based implementation of Integrated Management of Childhood Illness
16	Masoud village, Syrian Arab Republic	Community organization and mobilization for health and development
17	Al-Kazhubaá, Hodeidah governorate, Yemen	Female literacy, skills building and healthy initiatives
18	Qshawba, Yemen	Community-based nursing clinic

Country

Afghanistan

Type of programme and the number of villages covered

31 BDN villages

Population coverage of programme

129 163

Date of initiation of the BDN Programme at national level

1996

Major outputs

births assisted by trained birth attendants (TBAs) (29% in 2000 to 59.3% in 2005);
increased immunization coverage of children under one year of age (26% in 2003 to 65.8% in 2005);
lower rates of malnutrition among children under 5 years of age (11% to 5%);
increased number of youth gaining skills (187 in 2000 to 949 in 2005);
improved tuberculosis treatment success rates (84% in 2002 to 89% in 2004 nationwide, including BDN villages);
increased school enrolment of 5–12 year olds (53% to 74%);
improved female literacy rate (4% to 12.4%);
population with increased access to safe water (4746 in 2002 to 11 000 in 2004);

- reduced infant mortality rate (102 per 1000 live births to 64 per 1000 live births);*
- number of families directly benefiting from income-generating loans (3179 to 5500);
- TT immunization rates among pregnant women (12% in 2002 to 39% in 2005);
- population with increased access to sanitary latrines (4075 to 7400).

Partners

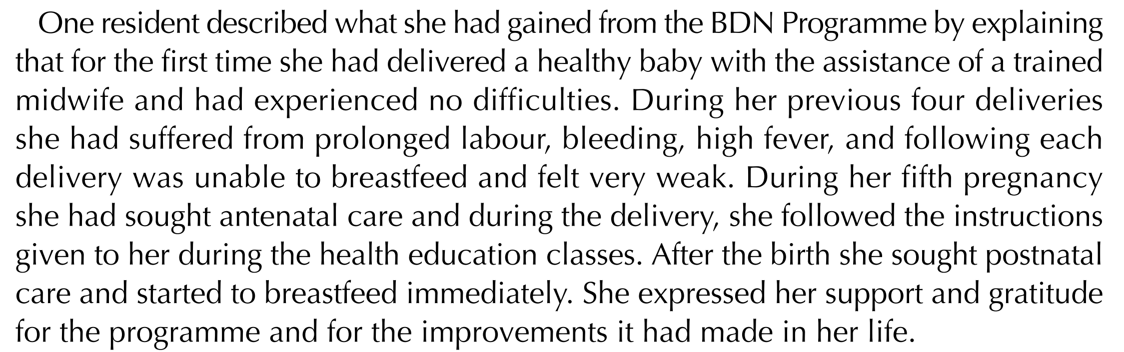
Ministry of Public Health, Ministry of Agriculture, Ministry of Education, UN World Food Programme (WFP), local nongovernmental organizations and the community.

** Data from the results of a small-scale study conducted in several villages in 2004.*

Women's empowerment in remote areas, Badakhshan

Afghanistan has some of the worst development indicators in the world, including a maternal mortality rate estimated at between 1600 and 2200 maternal deaths per 100 000 live births. Although this is the national average, some provinces such as Badakhshan, have the highest maternal mortality rates ever recorded in Afghanistan and probably in the world. An estimated 6500 per 100 000 maternal deaths have been recorded in this province. Badakhshan is a very remote, poverty-stricken and neglected area. Its communities live in one of the least developed places on earth, without roads, schools, health centres, water pumps, adequate shelter or veterinary clinics.

The BDN Programme was introduced in Badakhshan in 2002, to communities who had not previously been involved in any kind of development project. Interestingly, communities in seven villages decided to prioritize female literacy as a foundation for improving the quality of life. The BDN Programme presented people, particularly women, with an opportunity of voicing their needs for the first time in their lives. One thousand three hundred and sixty one (1361) women from seven villages have attended literacy courses. In addition to reading and writing, these women are also provided with health education on a wide range of essential topics. The baseline literacy rate among the women had initially been assessed at 6% but after 3 years had increased to 9.7%. As a result of the literacy courses, women's awareness of good nutrition, hygiene and sanitation, family planning/birth spacing, infant and newborn health and health care-seeking behaviour have significantly increased. The number of deliveries attended by trained health workers has also increased from 32% to 52%.



One resident described what she had gained from the BDN Programme by explaining that for the first time she had delivered a healthy baby with the assistance of a trained midwife and had experienced no difficulties. During her previous four deliveries she had suffered from prolonged labour, bleeding, high fever, and following each delivery was unable to breastfeed and felt very weak. During her fifth pregnancy she had sought antenatal care and during the delivery, she followed the instructions given to her during the health education classes. After the birth she sought postnatal care and started to breastfeed immediately. She expressed her support and gratitude for the programme and for the improvements it had made in her life.

Country

Djibouti

Type of programme and the number of villages covered

7 BDN villages

Population coverage of programme

17 248

Date of initiation of the BDN Programme at national level

2001

Major outputs

population with increased access to safe drinking-water (52%* to 100%);
improved vaccination of children under 1 year old and pregnant women from the national average (64%* to 98%);
lower unemployment rates;
partnerships developed with ministries, civil society, UN agencies and donors.

Partners

Ministry of Environment and Health, Ministry of Agriculture, Ministry of Education, Ministry of Women's, Family and Social Affairs, National Union of Djiboutian Women, World Bank (WB), United States Agency for International Development (USAID), US Ambassador's Fund, Social Fund for Development (SFD), French Cooperation, Canadian International Development Agency (CIDA), Agence française de développement, Islamic Bank for Development (IBD), International Fund for Agricultural Development (IFAD), United Nations Development Programme (UNDP), World Food Programme, United Nations Children Fund (UNICEF), United Nations Educational, Scientific and Cultural Organization (UNESCO).

** Baseline data is based on national averages from Ministry of Health and Environment data.*

Income-generating farming, Assassane, Obock district

Ms Roumana learnt about the BDN Programme from her village development committee in August 2004, and from that point on, her life was to change. She identified two areas of land that were suitable for farming around her village and requested an income-generating loan to start an agricultural project. Ms Roumana was awarded a loan and, in addition to 21 men from her village, also received training in basic farming techniques.

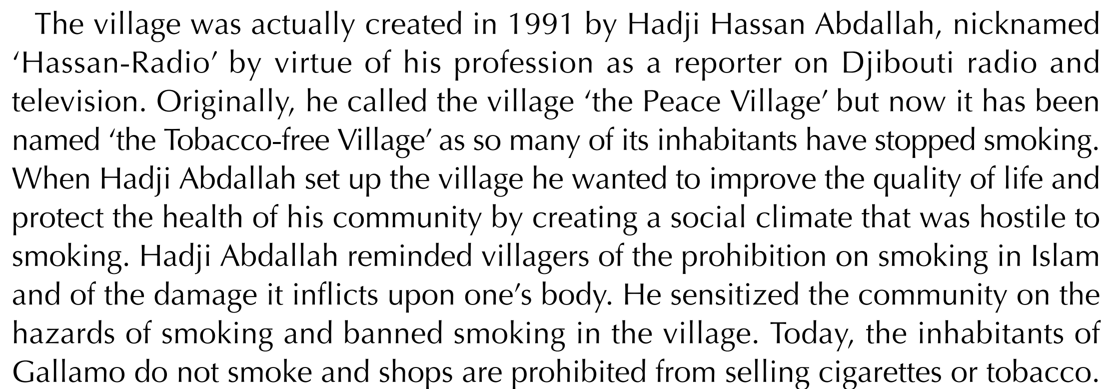
As soon as her training was completed, she fenced off her land and was supplied with seeds and farming equipment, such as spades, mattocks and wheelbarrows by the BDN Programme, in short, everything she needed to farm effectively. The first seeds were sown in September 2004 and Ms Roumana had the pleasure of reaping the rewards of her labour in February and March 2005. The vegetables, including onions, tomatoes, carrots and peppers, were harvested and used to feed the village. This produce has improved the nutritional and calorific intake of many in the community and surplus produce is sold in the market in the town of Obock. This summer, new seeds have been sown and will produce a harvest of watermelons and melons.

Ms Roumana, whose self-esteem has grown as a result of her success, is now planning to increase the size of her plot. She is earning an income and is playing a crucial role, not only within her family, but within the community, and along with the other community members who received agricultural training has been able to provide enough fruit and vegetables for the entire community.

Village development, Gallamo

Gallamo is situated 16 km from Dikhil City, the main administrative centre of the Dikhil district along Route Nationale 1, Djibouti's main highway. The clean landscape around Gallamo is in striking contrast to the urban areas of the country and Gallamo is one of the first sites in Djibouti to have implemented a BDN project. The programme was implemented in May 2001 and one of its primary focuses has been to develop the villagers' awareness of the need to protect their physical environment. Sessions to raise awareness on cleanliness and hygiene, particularly targeted towards women, were held by the village development committee, and the village was provided with practical tools by the programme such as wheelbarrows, rakes, brooms, buckets and pick-axes to improve and maintain their environment. Preserving the environment and maintaining the general cleanliness of the collective living area have now become an established part of Gallamo village life.

Goumati Aboubaker is one of the most influential women in the village. She is a member of the village development committee and has become a role model for her community as she strives to create a healthy living environment. Her energy and commitment have earned her the esteem of her fellow villagers who follow her advice and directives for the welfare of the community. Goumati explained that communities can not expect to live well if they do not take care of their local environment and underlined how important it was to fight each day for cleaner living standards. In the fight to improve living conditions in Djibouti, women have always been on the front line and the women in Gallamo are no exception.

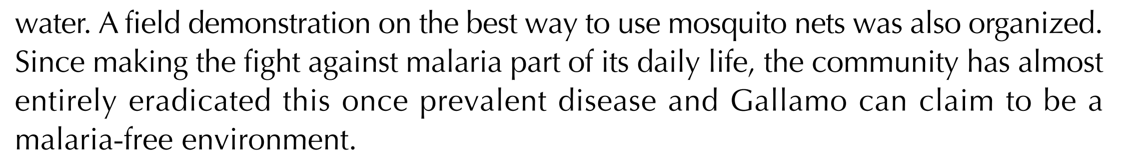


The village was actually created in 1991 by Hadji Hassan Abdallah, nicknamed 'Hassan-Radio' by virtue of his profession as a reporter on Djibouti radio and television. Originally, he called the village 'the Peace Village' but now it has been named 'the Tobacco-free Village' as so many of its inhabitants have stopped smoking. When Hadji Abdallah set up the village he wanted to improve the quality of life and protect the health of his community by creating a social climate that was hostile to smoking. Hadji Abdallah reminded villagers of the prohibition on smoking in Islam and of the damage it inflicts upon one's body. He sensitized the community on the hazards of smoking and banned smoking in the village. Today, the inhabitants of Gallamo do not smoke and shops are prohibited from selling cigarettes or tobacco.

The idea of creating the village came to Hadji Abdallah during the civil war when many in his community had been dispersed as far away as Ethiopia. The civil war presented the country with a catastrophic situation which had resulted in increased infant mortality and greater health complications for everyone, but in particular for pregnant women and women experiencing childbirth. Hadji Abdallah wanted to bring people together using health as a bridge for peace and security for the people of his village. The village initially was nothing except an empty site and Hadji Abdallah and his wife were the only residents. After some time, other people came and settled in the village and eventually it grew to become a small town. There are now nearly 350 families living in Gallamo and the surrounding areas.

Thanks to the Islamic Institute, the village has a school which currently runs seven classes for 130 pupils although has places for more than 200 pupils. Nineteen (19) pupils have already been given places at the Islamic Institute in Djibouti City, the capital. Primary education for all is within the Government's mandate for education and the President of Djibouti has promised the villagers a canteen for the school which will encourage herders in the region to enrol their children.

In striking contrast to Dikhil City, which is known to be mosquito-infected, Gallamo is almost completely free of the harmful malaria-carrying insects. The BDN Programme has made the fight against malaria one of its main health priorities and at a World Health Day event organized on 7 April 2005, focusing on mother and child health, 300 impregnated mosquito nets effective for 5 years were distributed to the community. Through the village development committee, awareness-raising sessions have been held on malaria and have addressed issues such as cleanliness, hygiene and stagnant



water. A field demonstration on the best way to use mosquito nets was also organized. Since making the fight against malaria part of its daily life, the community has almost entirely eradicated this once prevalent disease and Gallamo can claim to be a malaria-free environment.

Through the BDN Programme, WHO and the Ministry of Health have provided a great deal of assistance to the village, particularly through the granting of micro-credit, the creation of a reservoir for easy access to safe water and the establishment of a health dispensary. WHO was the first organization to support the plan to create the village and also supplied plastic pipes for the water supply. Hadji Abdallah used his own savings and then enlisted the remainder needed for the necessary infrastructure from others in the village. Initially, he experienced many problems, but fortunately with the support of WHO and a mobilized organized community, Gallamo is now self-sufficient, smoke-free, malaria-free and healthy.

Country

Egypt

Type of programme and the number of villages covered

3 BDN areas

Population coverage of programme

40 000

Date of initiation of the BDN Programme at national level

2001

Major outputs

improved refuse removal;
establishment of nurseries;
establishment of women's clubs;
environmental project undertaken to repair water pipes;
partnerships developed between the Ministry of Health and Population and civil society.

Partner

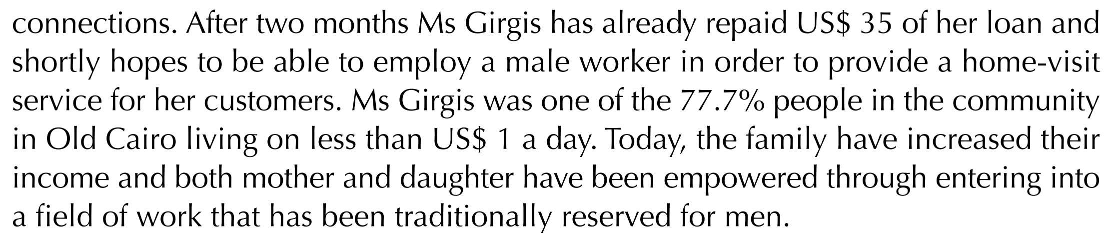
Ministry of Health and Population, Alexandria Governor's Office, GTZ, New Horizon Association for Social Development and Rotary al-Fustat.

Skills development for improved health and income, Batn al-Baqurah, Misr al-Qadima (Old Cairo)

The BDN Programme was implemented in Old Cairo in August 2005 in collaboration with the Ministry of Health, the New Horizon Association for Social Development and Rotary al-Fustat. The programme was introduced to the area through the New Horizon Association for Social Development, a local nongovernmental organization, and was implemented as an integrated part of the health sector to improve the health, nutritional, educational, economic and environmental status of the area. Under the programme, a solid waste site of 1 km^2 that had been responsible for causing a plague of flies and mosquitoes was removed from the area as an activity to improve the environment.

Ms Tahia Milad Girgis is a 60-year-old resident of the area. When her husband died several years ago, Ms Girgis was left with an electrical equipment shop that she did not have the experience to run. However, her daughter had learnt a great deal from her father, and so when she learnt that the BDN Programme issued loans for income-generating projects, Ms Tahia's daughter convinced her mother to apply for a loan in order that they could continue the family business.

Ms Girgis received US$ 104 that she was able to use to buy electrical stock for the shop. With the profits she bought more stock, including neon bulbs that were attractive to her customers as they consumed less electricity. Ms Tahia's daughter assists her mother in the shop by advising customers how to perform simple wirings and



connections. After two months Ms Girgis has already repaid US$ 35 of her loan and shortly hopes to be able to employ a male worker in order to provide a home-visit service for her customers. Ms Girgis was one of the 77.7% people in the community in Old Cairo living on less than US$ 1 a day. Today, the family have increased their income and both mother and daughter have been empowered through entering into a field of work that has been traditionally reserved for men.

Ms Sabra Saiad Mohamed is a 41-year-old, married woman with three teenage children who also lives in Batn Al-Baqurah. She ran a small fruit shop but as she was not always able to sell enough produce, the business did not always provide her with an adequate income. Ms Sabra decided to diversify and applied for an income-generating loan through the BDN Programme. She received US$ 52 to buy popular music cassettes and to purchase a machine to manufacture a type of pasta that was widely eaten in the area. Ms Sabra has been successful in her endeavours; her pasta is now sold out within an hour from the time it is produced. She is also the only vendor in the area who sells cassettes and local residents appreciate the opportunity of purchasing popular music cassettes locally rather than from the market which is outside the area.

Ms Sabra brings into her household an income on which she can support her children and which allows her to meet her family's nutritional needs. She has also been able to send her children to school and through doing so has been able to break the cycle of poverty for them by providing them with the education and skills they need for their future. Ms Sabra has also begun to visit the primary health care clinic regularly and to take her children for regular health check-ups.

Country

Islamic Republic of Iran

Type of programme and the number of villages covered

17 BDN villages and 41 healthy villages

Population coverage of programme

27 730 in BDN villages and 78 856 in healthy villages

Date of initiation of CBI Programme at national level

2001 (BDN) and 1998 (healthy villages)

Major outputs

improved sanitation including refuse collection and indoor baths;
greater collaboration between Ministries;
establishment and involvement of nongovernmental organizations;
avoidance of mass immigration to city;
increased employment opportunities;
improved capacity-building and participation at provincial, district and municipal levels to manage urban problems;
communities including vulnerable groups, particularly women, empowered to play leading roles in health and development;
community encouraged to work as partners in planning, implementation and monitoring of the development process.

Partners

Ministry of Agricultural Jihad, Ministry of Education, Ministry of Labour, Ministry of Interior, Ministry of Islamic Guidance and Cultural Heritage, Welfare Organization, Environment Protection Organization, Teheran Municipality, National Broadcasting Company, Management and Planning Organization, United Nations Industrial Development Agency (UNIDO), UNICEF

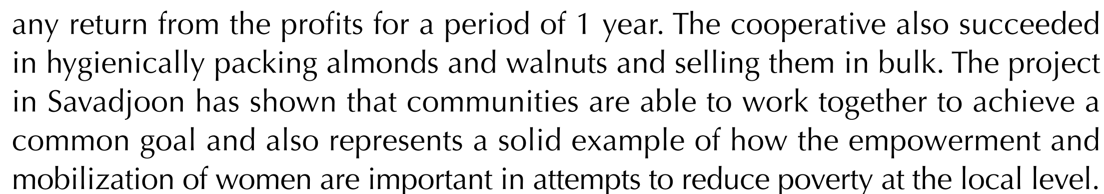
Women's cooperative and community development, Savadjoon

Empowering women

A group of women from the village of Savadjoon requested guidance from a BDN technical steering committee to assist them in exploring the feasibility of a rose plantation project by examining the soil and climate in their area. The women wanted to create an income-generating project to sell rose water. After receiving approval from the committee, 12 women were selected to participate in the project and were sent for training for two days to Ghamsar in the Kashan province, an area well known for its rose plantations, on how to cultivate roses and prepare rose water.

The women rented two hectares of land with a lease of 10 years. The costs of the project were covered as follows: WHO (42%), Government (25%) and the community (33%). The fund was used to level the land, buy the rose bushes and purchase three pots for the traditional extraction of rose water. The cost of each pot was US$ 767. It is possible to extract two tonnes of rose water from 1 tonne of flowers and the women expect to produce 4–10 tonnes of flowers per hectare every year. The success of this project has inspired women in the neighbouring village of Horeh to undertake a similar project.

In addition, a female cooperative comprising 180 women was formed in Savadjoon. The purpose of the cooperative was to remove some of the barriers which exist for women in the village. The cooperative began by opening a shop in the village to be used and run by the women and has so far raised US$ 13 143. The head of the village development committee provided the land for the shop but did not expect



any return from the profits for a period of 1 year. The cooperative also succeeded in hygienically packing almonds and walnuts and selling them in bulk. The project in Savadjoon has shown that communities are able to work together to achieve a common goal and also represents a solid example of how the empowerment and mobilization of women are important in attempts to reduce poverty at the local level.

Youth-centred activities

The youth committee was provided with sports wear from the physical education organization and organizes social activities such as sports tournaments between neighbouring villages. The physical education organization also encourages smokers to quit and 25 people became non-smokers as a result of the programme. The youth committee were also provided with a computer and a printer in order to access the WHO website for health information and to prepare health messages in Farsi and a nongovernmental organization for youth called Boye Baran (smell of the rain) was also established in Savadjoon.

Community cooperatives

One thousand five hundred and sixty (1560) members of the village contributed to the Islamabad project in Savadjoon—the cultivation of almonds and peaches over 3000 hectares of land. The almond plantation was created 4 years ago and the peach trees were planted 3 years ago and 52 people currently work on the land. It is expected that the almond trees will blossom next year and this year peaches have already been collected from the trees. The agricultural department contributed US$766 703 to the project and the land is divided among the shareholders.

Another activity that was encouraged by the community was the plantation of vegetables on the roofs of houses and on doorways because of the lack of suitable land in the mountainous area of Savadjoon. This produce is used to barter by some families for vegetables, eggs and other dairy products. Each loan applicant received between US$ 110 and US$ 164.

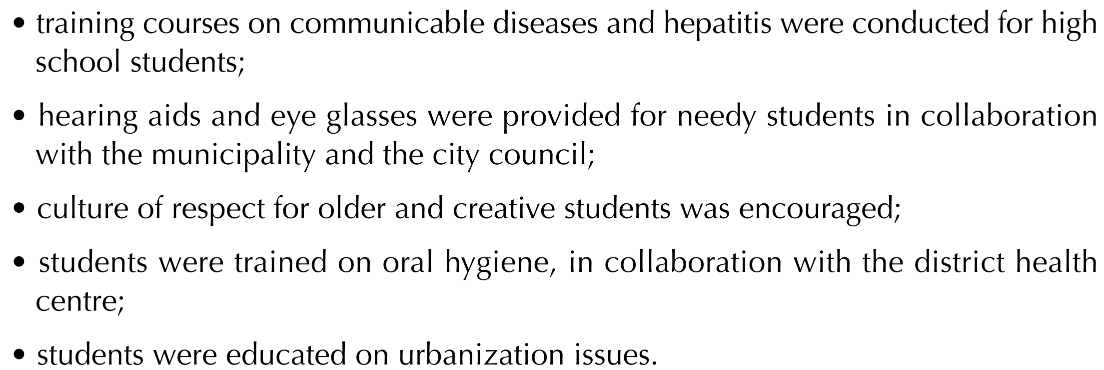
The community development fund also assists in a whole range of activities which benefit the community including gardening, carpet weaving, and in providing dowries for new couples. The community development fund consists of 5% to 20% of contributions from recipients of income-generating loans for social projects.

School health initiative, Saveh healthy city initiative

In 2004, the National Healthy Cities and Healthy Villages Coordination Council comprised 15 ministers and heads of organizations prioritized seven project areas for the implementation of the Healthy Cities and Healthy Villages Programme. The healthy school project was among one of the projects selected for the district of Saveh and 15 pilot schools in several villages were selected to implement the healthy school concept.

As part of this programme the following activities were conducted:

- green areas and playgrounds were established in the schools;
- the use of liquid soap in the schools was encouraged for improved hygiene;
- students' saving accounts were established in order to raise students' awareness of saving money;
- direct phone lines were installed for students' use;
- healthy food booths were established inside the schools to raise students' awareness of good nutrition and food hygiene;
- personal hygiene was promoted among students;
- awareness of a rational use of resources was developed, i.e. students' awareness of recycling was raised;
- school health promotion groups were established in each school;



- training courses on communicable diseases and hepatitis were conducted for high school students;
- hearing aids and eye glasses were provided for needy students in collaboration with the municipality and the city council;
- culture of respect for older and creative students was encouraged;
- students were trained on oral hygiene, in collaboration with the district health centre;
- students were educated on urbanization issues.

Country

Jordan

Type of programme and the number of villages covered

17 healthy villages

Population coverage of programme

25 000

Date of initiation of the Healthy Village Programme at national level

2002

Major outputs

reduced infant and child mortality rates;
immunization rates of children and mothers (almost 100%);
mothers practising safe motherhood (95%–100%;)
improved family-planning awareness and practices;
low rates of low-birth-weight infants;
improvements in environmental health and sanitary conditions;
increased access to safe water from (70%/80% to 90%);
increased school enrolment (95% to 99%);
lower unemployment rates;
partnerships developed between governmental institutions and nongovernmental organizations.

Partner

Ministry of Agriculture, Ministry of Education, UNDP, UNICEF

Source: Baseline data is from the Ministry of Health Year Book

Improving nutritional status through income-generating projects, Al-Zmalia, Irbid governorate

Mr Mahmoud Al-Safori who supports his wife and five children and his mother, received an income-generating loan in November 2004 to buy a cow. After four months, he sold the cow and bought two goats which subsequently delivered a further four goats. Mr Al-Safori then bought six more goats. The socioeconomic and health status of his family has been improved through the preparation of diary products from the goats' milk and by selling the surplus milk to people in the village. The programme has had a positive effect on the family's well being. Cluster representatives in the village were trained on preventive health measures and were able to advise the community and direct them to the primary health care clinic when the situation warranted it. One of Mr Al-Safori's daughters was anaemic but as a result of the information that the cluster representatives gave to him and his family, Mr Safori began to ensure that his daughter received the correct nutritional intake and she is now in better health. Mr Al-Safori's wife was also empowered through training provided by the programme to take care of livestock and to prepare products from the goats' milk. Her husband's awareness of the importance of her rights and her role in the community was also raised as a result of the programme.

Women's empowerment and capacity building, Al-Jezzazeh, Jarash governorate

Ms Rasmeya Ahmed Khaled Faraihat is a 34-year-old widow who has relied on her uncle and her brothers to support her and her four children since her husband died. She applied for a loan to begin an income-generating project to sell diary products and was granted US$ 1059 to be repaid in monthly instalments. Each instalment amounted to US$ 30 and she was given a 3-month period of grace before she had to begin repaying the loan. Initially, she produced dairy products in her home but then turned her home into a shop to sell clothing, shoes and other materials bought at the Syrian border. Ms Rasmeya also started to buy seeds and tended four hectares of land near her house to cultivate crops such as okra, peas and chickpeas. She then sold the produce in her village, which benefited the community by providing them with food to fulfil their nutritional needs and saved them the necessity of travelling for their supplies. Her success encouraged her to establish an olive–almond grove in order to sustain her income and to guarantee a better life for her children by saving the money required for their future education and by being able to provide them with nutritional food.

As Ms Rasmeya's income has increased, her economic status has improved and she is now totally self-reliant. She makes regular loan repayments and is very happy with all that she has achieved with the assistance of the programme. She now also employs her previously unemployed brothers to assist her in cultivating the land, and thus is also providing them with an opportunity of earning an income.

Country

Morocco

Type of programme and the number of villages covered

15 BDN villages

Population coverage of programme

117 449

Date of initiation of the BDN Programme at national level

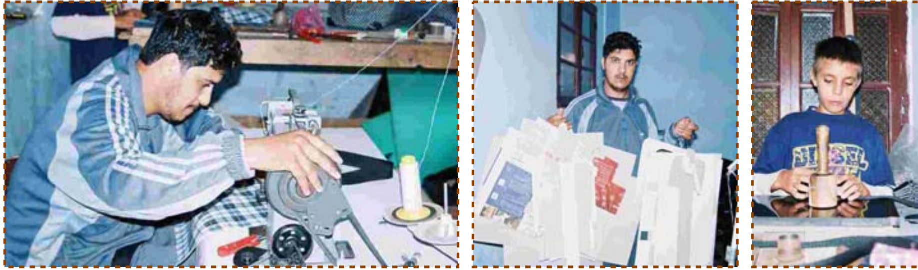
1995

Major outputs

greater empowerment of women through literacy and income-generating projects;
improved literacy rates;
lower unemployment rates;
reduced maternal mortality rates;
improved intersectoral collaboration;
Institutionalization of the BDN Programme in the national development plan.

Partners

Municipal government, Ministry of Health, Ministry of Foreign Affairs, L'agence de développement social, L'association de développement et de protection de l'environnement, L'office de développement des coopératives, UNICEF, UNFPA, civil society.



Youth development, Sidi Moussa, Sela

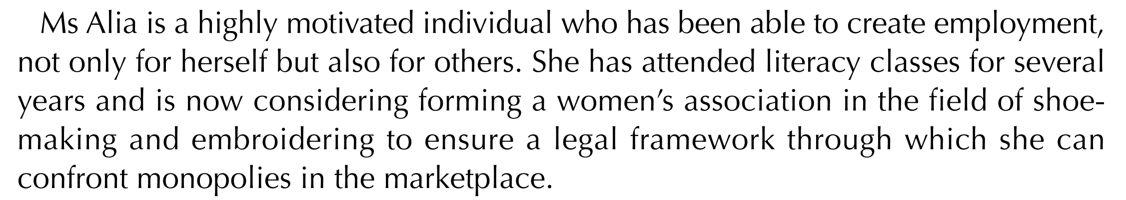
Mr Saed is 26 years old and lives with his mother and four siblings in Sidi Moussa, one of the oldest and most marginalized slum areas in the city of Sela. His father had been the sole provider for the family but died when Mr Saed was a child of 10. As a result of his father's death, Mr Saed had been forced to drop out of school and had become a child labourer making traditional bags. His income barely supported his mother and his siblings and his mother was also in poor health. To overcome the problem of poor pay and exploitation, Mr Saed wanted to start his own business but due to his poor economic status was unable to obtain a bank loan. Fortunately, through the BDN programme, he was able to apply for an income-generating loan and received US$ 1102 to start his own business. Mr Saed also contributed US$ 220 of his own money and with the loan bought a sewing machine and some leather.

Due to his years of experience working with craftsmen he was able to contact a wholesaler to market his leather products. As a result of his new income, he was able to cover his mother's medical bills, repay the loan and buy another sewing machine to expand his business. Mr Saed not only became empowered through owning his own business but also benefited from the many training courses offered to young men and youth in slum areas in order to raise their awareness of various issues, particularly in relation to risky lifestyle behaviours and HIV/AIDS.

Supporting handicrafts and local production, Sehreej Kanawah, Fes

Ms Alia Gebelio is 39 years old and lives with her husband and five children in Sehreej Kanawah, near the city of Fes. She moved with her family to this village in the wave of extensive rural migration that was taking place and which has since led to the creation of poor slum areas in the cities. Ms Alia and her family were living on a very low income as she was working in a factory embroidering traditional footwear, as many other women in the area, and her husband, Mohamed, 45, was reliant on the market in Fes for employment.

In 1999, the BDN Programme was implemented in Sehreej Kanawah and Ms Alia was chosen to teach her craft to other women after informing the technical steering committee of her abilities and experience as a seamstress in the shoe factory. During the second phase of funding of income-generating projects, Ms Alia received a loan of US$ 770 to buy a sewing machine and an embroidering machine and was able to work at home and spend more time with her young children. She repaid her loan and applied for another loan and was granted US$ 1100 to buy two embroidery machines. Ms Alia and her husband's dream of comfort and independence became a reality when they were able to move from their shared apartment to a new two-bedroom apartment with a separate kitchen and bathroom. One room was allocated for her embroidery work and Ms Alia employed two women to work with her. She was also able to negotiate with the shoe sellers and sell directly to them, thus making a greater profit on the shoes she sold.



Ms Alia is a highly motivated individual who has been able to create employment, not only for herself but also for others. She has attended literacy classes for several years and is now considering forming a women's association in the field of shoe-making and embroidering to ensure a legal framework through which she can confront monopolies in the marketplace.

Country

Pakistan

Type of programme and the number of villages covered

365 BDN villages

Population coverage of programme

1 249 568

Date of initiation of the BDN Programme at national level

1995

Major outputs

increased EPI coverage (37% to 93%);
increased TT vaccination among pregnant women (19% to 82%);
reduced infant mortality (153 per 1000 live births to less than 40 per 1000 live births);
increased contraceptive usage (14% to 42%);
reduced rates of malnourishment in children under 3 years (34% to 13%);
increased antenatal check-ups by skilled health care workers (40% to 80%);
increased primary school enrolment among girls (30% to 80%);
reduced school drop-out rates (25% to 13%);
population with increased access to safe drinking-water (50% to 80%);
access to sanitary latrines doubled in BDN areas;

more than 25 000 families involved in BDN income-generating projects;
improved monthly incomes (2075 Rupees to 5075 Rupees);
lower unemployment rates;
partnerships developed between ministries, civil society, UN agencies and donors.

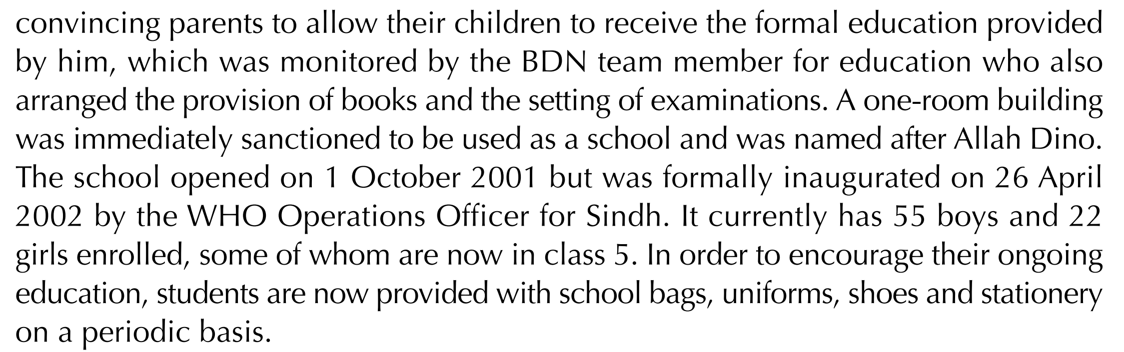
Partners

Federal and Provincial Ministry of Health, District Government, district-line departments: health, education, social welfare and women's development, agriculture, irrigation and livestock, USAID, GFATM, UNDP, WFP, UNICEF, UNFPA, Lajnat al Dawa al Islamiah, Kashmir International Relief Fund (KIRF), Sarhad Rural Support Cooperation, Aurat Foundation, Eni Lasmo (petroleum exploration company).

Community-based school, Lake Manchar, Sindh province

Lake Manchar was once the largest sweet water lake in Asia, however, during the late nineties the water table in the Indus River fell substantially and this resulted in a shortage of fresh water in the lake. As a result, the water became stagnant and owing to the agricultural waste from northern Pakistan, which contained nitrogenous fertilizers, the water became poisonous. This resulted in great economic hardship for the residents in the area as their main source of income was fishing and the fish had died in their thousands. Before long, the relatively prosperous fishing community found itself drifting below the poverty line towards abject poverty. Their hardship was confounded by the fact that their area lacked sufficient infrastructure for health and educational facilities. It was, however, a BDN-designated area and through the programme an experimental dispensary had been established near the lake, which also acted as a treatment centre for patients registered under tuberculosis directly observed treatment, short course (DOTS). The main challenge for the community still lay in the lack of provision of educational facilities; the community were not willing to send their children to the nearest school outside of the area and many preferred that their children did odd jobs to earn money.

In its search for educated youth within the community, the BDN team noted a young man called Allah Dino who was articulate and had risen to the challenge of educating the youth of his area. He used his boat, which he had once employed for fishing, to transport children to and from their homes to assemble and teach them. The BDN team were impressed by the efforts of Allah Dino who had succeeded in



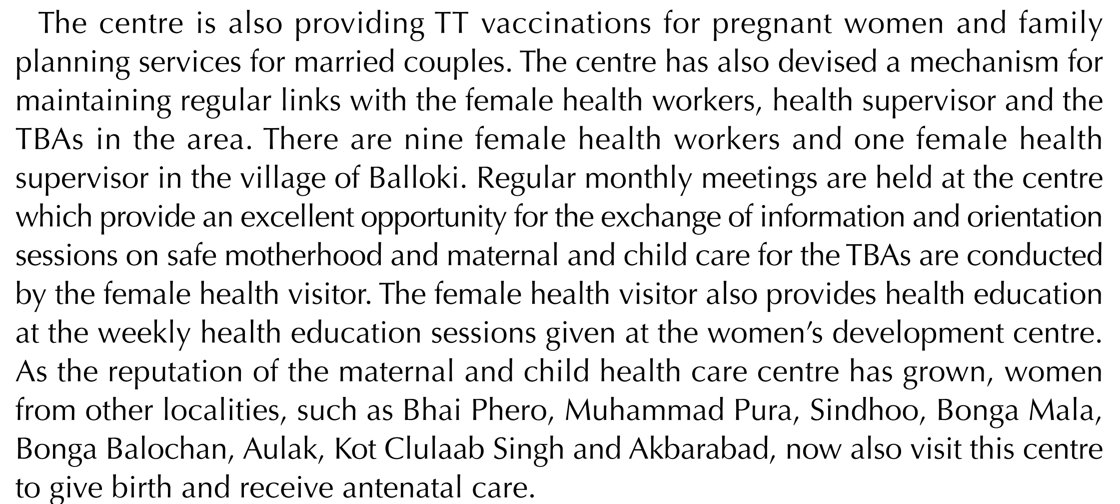
convincing parents to allow their children to receive the formal education provided by him, which was monitored by the BDN team member for education who also arranged the provision of books and the setting of examinations. A one-room building was immediately sanctioned to be used as a school and was named after Allah Dino. The school opened on 1 October 2001 but was formally inaugurated on 26 April 2002 by the WHO Operations Officer for Sindh. It currently has 55 boys and 22 girls enrolled, some of whom are now in class 5. In order to encourage their ongoing education, students are now provided with school bags, uniforms, shoes and stationery on a periodic basis.

Community-based maternal and child health care centre, Balloki, Kasur district, Punjab

Balloki is a remote village located in the Kasur district of Punjab. It has a population of more than 11 000 people, most of whom live below the poverty line. Social indicators, including health indicators, portrayed a very unsatisfactory situation in the village. There was no health centre prior to the establishment of the new maternal and child health care clinic and the community had to rely on the services of unskilled birth attendants, thus putting the health of mothers and newborn infants at risk. As a result, maternal and child mortality rates were high in the area.

Acknowledging the problem of poor maternal and child health during a BDN planning exercise, the community proposed the establishment of the new maternal and child health care centre through the mobilization of local resources requiring minimal support from partners. The BDN team agreed to provide equipment and the initial stock of medicines. The village development committee approached a resident in the village to request the use of two rooms in her house for the establishment of the centre for a monthly rent of US$ 17, she agreed and was happy for her rooms to be used to provide this service.

The recruitment of trained staff represented a big challenge as so few trained health staff were available in the area. The BDN team helped the community to find a trained and experienced female health visitor, a resident of Pattoki (a town about 25 km from Balloki), to work in the centre. The community also hired two TBAs from Balloki to assist in the centre. Although the female health visitor has to return to her village in the evening, the TBAs are available at all times to assist with uncomplicated deliveries.



The centre is also providing TT vaccinations for pregnant women and family planning services for married couples. The centre has also devised a mechanism for maintaining regular links with the female health workers, health supervisor and the TBAs in the area. There are nine female health workers and one female health supervisor in the village of Balloki. Regular monthly meetings are held at the centre which provide an excellent opportunity for the exchange of information and orientation sessions on safe motherhood and maternal and child care for the TBAs are conducted by the female health visitor. The female health visitor also provides health education at the weekly health education sessions given at the women's development centre. As the reputation of the maternal and child health care centre has grown, women from other localities, such as Bhai Phero, Muhammad Pura, Sindhoo, Bonga Mala, Bonga Balochan, Aulak, Kot Clulaab Singh and Akbarabad, now also visit this centre to give birth and receive antenatal care.

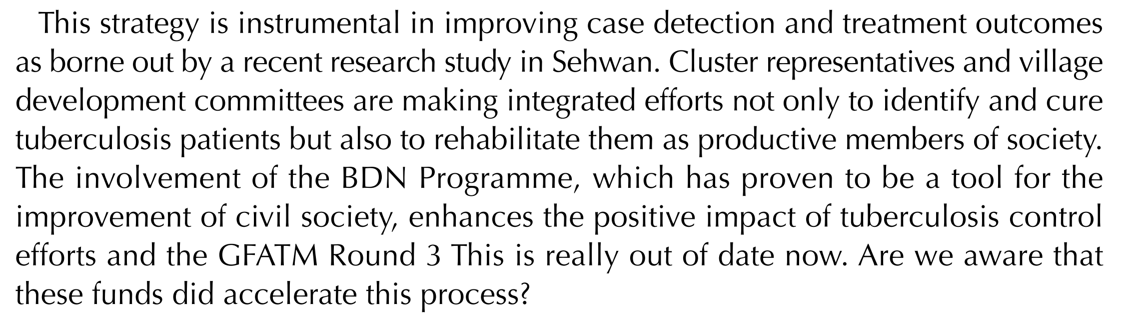
Since it opened in April 2003, the centre has provided services to about 11 507 clients with zero maternal or child mortality recorded and has conducted 188 deliveries. The village development committee manages the centre and pays the operational costs through collecting service charges from patients. Medicines are also purchased by the community through contributions and with money from the community development fund. A population of nearly 20 000 are benefiting from the services being provided by the centre which is accessible to all the villages around Balloki. The centre provides a range of services in collaboration with the district health department including antenatal and postnatal care, childcare, assisted deliveries, family planning services including the provision of injectable contraceptives and IUDs, general outpatient services, injections and dressings, referrals at *tehsil* and district level, health education and vaccination.

The president of the village development committee commented that the BDN Programme had changed the community's way of thinking as previously they had considered that it was the Government's responsibility to provide basic health facilities but following the establishment of the maternal and child health care centre the community had recognized the strength of their own potential and saw themselves as able to serve their own local communities.

Basic development needs and DOTS

The BDN Programme is now operating in the seven districts of Dadu/Jamshoro, Mastung, Multan, Kasur, Nowshera, Muzaffarabad (now badly affected by the earthquake) and FP Peshawar and covers a total population of more than 1.25 million people. The programme has now also been linked with tuberculosis directly observed treatment, short-course (DOTS). Community mobilization in the prevention and treatment of tuberculosis is being encouraged and a behavioural, change, communication (BCC) strategy is being developed through community meetings and the use of audio-visual materials. Trained community workers participate in regular monthly village development committee meetings to discuss various aspects of tuberculosis care including the problem of stigma, gender mainstreaming and socioeconomic and cultural issues in access, compliance and the importance of treatment adherence.

Three thousand (3000) male and female community volunteers and village development committee members are being trained and involved in the community mobilization and treatment support process on a periodic basis. The BDN Programme aims to strengthen and expand its socioeconomic rehabilitation facilities in the seven districts to help tuberculosis patients and their families access services, including the provision of small-scale micro-credit and vocational training schemes. The cluster representatives and village development committee are developing and implementing strategies and activities to facilitate the preferential access of tuberculosis patients and their family members to these facilities, and with the support of intersectoral BDN teams propose relevant areas for skills development and for improvements in social services, such as the provision of safe water and sanitation.



This strategy is instrumental in improving case detection and treatment outcomes as borne out by a recent research study in Sehwan. Cluster representatives and village development committees are making integrated efforts not only to identify and cure tuberculosis patients but also to rehabilitate them as productive members of society. The involvement of the BDN Programme, which has proven to be a tool for the improvement of civil society, enhances the positive impact of tuberculosis control efforts and the GFATM Round 3 This is really out of date now. Are we aware that these funds did accelerate this process?

Country

Sudan

Type of programme and the number of villages covered

64 BDN villages

Population coverage of programme

113 077

Date of initiation of the BDN Programme at national level

1997

Major outputs

institutionalization of programme within 11 states and 21 districts;
surrounding communities inspired by the success of programme activities;
consolidating peace, community coherence and conciliation in post-conflict settings;
improved access to safe water in 100% of needy areas;
vaccination coverage of children under 1 year of age at 80% in all areas;
greater empowerment of women;
community information centres established in 86% of BDN areas.

Partners

Ministries of Agriculture, Education, and Industry, Sudanese Saving and Social Development Bank, Zakat Chamber, national women's and youth unions, Shendi, Ahfad and Gezira Universities, International Italian Cooperation, Netherlands Embassy, Food and Agriculture Organization (FAO), UNICEF, UNESCO,UNDP, Canadian Aid Development Action Now, Plan International, Sudan Red Crescent, Azza, nongovernmental organizations

Village self-reliance, Dar Mali

A farming community of 2194 people live in Dar Mali, of which 307 are under 5 years old and 558 women are of childbearing age. The villagers keep livestock, such as sheep, goats, cattle and camels. The village has one health centre that deals with prevalent health problems, such as malaria, diarrhoeal diseases, acute respiratory infections and scorpion bites. In 1998, Dar Mali was selected by the Government of Sudan to implement the BDN Programme. The programme started with the formation of a village development committee, cluster representatives and subcommittees to address the various needs of the community. A technical support team was also formed to train, guide and support community organization and a national BDN training centre was established in the area.

One of the priority projects that was chosen for Dar Mali was the construction of two water tanks with a capacity of 20 000 gallons and a distribution network that reached all 313 households in the community. This allowed families who previously had not had access to clean water to tend gardens and plant trees. The community also successfully introduced the Integrated Management of Childhood Illness (IMCI) programme and in 2002 improved health and social indicators reflected the success of the programme in Dar Mali, in some cases showing a 100% improvement (Table 3). The success of Dar Mali has shown how through effective community organization the community has been able to take the initiative, identify their own needs and find solutions to the problems that they faced.

Table 3. Health and social indicators for Dar Mali from 1999–2002

Indicator	1999 %	2000 %	2002 %
Population with access to safe water	zero	87.0	100.0
Population with access to refuse disposal	10.7	72.1	100.0
Immunization coverage	11.8	96.0	100.0
Children under 5 years of age with diarrhoea	17.9	27.0	8.3
Children under 5 years of age with acute respiratory infections	31.3	27.0	2.4
Children under 5 years of age with malaria	9.0	45.9	5.6
Breastfeeding of children under 2 years of age	–	51.0	100.0
Balanced diet	40.9	68.3	92.0
School enrolment	67.5	66.7	74.3

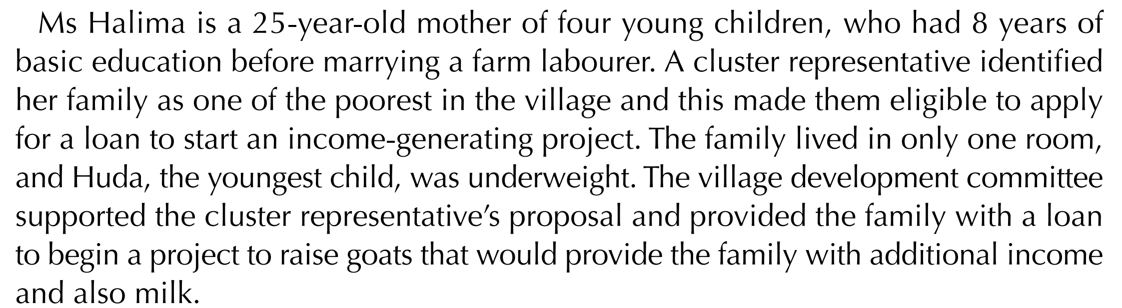
Community-based implementation of Integrated Management of Childhood Illness, Ragwa, Al-Gezira

The Integrated Management of Childhood Illness (IMCI) was introduced in Ragwa, an organized community with motivated community representatives willing to abide by the IMCI strategy. Ragwa also had a health facility with an IMCI-trained health worker. The village development committee, in consultation with the national and district teams, decided to implement a health education programme which focused on nutritional education and health care-seeking behaviour. The programme targeted women in particular, especially mothers of children under 5 years of age. Community representatives acted as health promoters in the community and although the focus was directed towards mothers, fathers were also provided with health education and were taught to understand the importance of using local resources as food rather than selling them.

A few months following its implementation, the national IMCI and CBI teams decided to launch a competition for mothers of children under 5 years of age, community representatives and schools in the area.

The competition was based on the following criteria:

- regular growth monitoring of children under 5 years of age;
- longest duration of breastfeeding of children under 2 years of age;
- children of normal weight;
- completed immunization at less than 1 year old;
- schools producing posters on health;
- schools with a clean environment.



Ms Halima is a 25-year-old mother of four young children, who had 8 years of basic education before marrying a farm labourer. A cluster representative identified her family as one of the poorest in the village and this made them eligible to apply for a loan to start an income-generating project. The family lived in only one room, and Huda, the youngest child, was underweight. The village development committee supported the cluster representative's proposal and provided the family with a loan to begin a project to raise goats that would provide the family with additional income and also milk.

One of the female cluster representatives who lived in Ms Halima's village discovered from a survey conducted to assess the knowledge, attitudes and practices of caregivers of children under 5 years of age that Ms Halima's knowledge about breastfeeding, complementary feeding, vaccination, growth monitoring and home management during illness, was very poor. Ms Halima most often fed her family Kisra, a locally-produced flake from maize and potatoes, okra and eggplants cooked with tomato paste but did not use the white and black beans grown on the farm, where her husband worked, as they were sold in a market in Khartoum as were the carrots that were also grown in the area. Although Halima kept chickens she did not use the eggs to feed her children but sold them in the village. The cluster representative advised Ms Halima on good nutrition and improving the health of her children and encouraged her to visit the health facility regularly to monitor the growth of her youngest child. She was also provided with training on food processing and sewing and on how to preserve food for dry seasons.

Ms Halima was empowered through the programme and the health of her children was improved. She was selected as one of the winners from the community and has become a role model for other women. She was awarded a certificate and presented with a prize by the deputy mayor of the district in a ceremony that was attended by federal, state and district officials, the media, the technical support team, the village development committee and the whole community.

Country

Syrian Arab Republic

Type of programme and the number of villages covered

525 healthy villages

Population coverage of programme

117 248

Date of initiation of the Healthy Village Programme at national level

1996

Major outputs

improved adult literacy rates (70% to 93%);
increased access to safe drinking-water (76% to 98%);
population with adequate excreta disposal facilities (65% to 92%);
increased immunization of children under 1 year old (79% to 100%);
improved TT vaccination of mothers (58% to 92%);
institutionalization of programme in the national development plan.

Partners

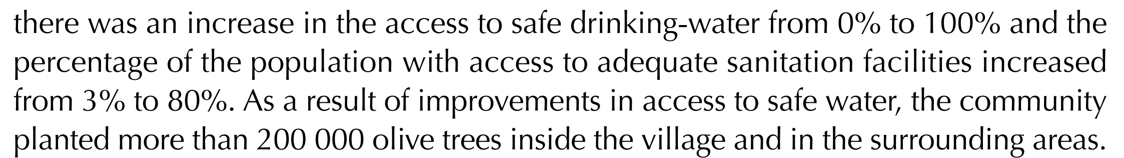
Ministry of Health, WHO, UNICEF, UNFPA, European Union (EU), Aga Khan Development Network (AKDN), Fund for Integrated Rural Development of Syria (FIRDOS), Women's Union.

Community organization and mobilization for health and development, Masoud

The village of Masoud is located in the province of Hama in the Syrian Arab Republic and has a population of 980 people living in 193 households. The Healthy Village Programme was implemented in Masoud in 2002 through the collaborative efforts of the community, the local health authorities and the municipality. At the start of the programme, the community selected a village development committee and cluster representatives and several subcommittees for water, education, health, the environment, women and youth were also established. Following the baseline survey that was conducted by the cluster representatives, the village development committee and subcommittees identified priority village problems and selected activities aimed at achieving the highest possible level of health for all villagers.

The programme aimed to improve adult literacy rates, particularly among women. As a result of the establishment of literacy classes, the literacy rate dramatically improved and the enrolment rate for these classes increased from 22% in 2000 to 92% in 2004. Forty-four (44) girls who had dropped out of school enrolled for the classes, and of these students, 43 managed to obtain the higher secondary school certificate. Consequently, the drop-out rate decreased from 34% in 2002 to 2% in 2004 (Table 4).

The majority of health interventions in the village were targeted towards the provision of safe water and sanitation. The community managed to mobilize their resources to extend their network of water pipes and connect their latrines to the sewerage system in close collaboration with the local government. Over 3 years,



there was an increase in the access to safe drinking-water from 0% to 100% and the percentage of the population with access to adequate sanitation facilities increased from 3% to 80%. As a result of improvements in access to safe water, the community planted more than 200 000 olive trees inside the village and in the surrounding areas.

The cluster representatives, in close collaboration with the health team, have played a tremendous role in following up mothers and children for immunization and since 2002 immunization coverage of children under 1 year old has increased from 63% to 100% and TT vaccination coverage has increased from 21% to 96%. As a result of ongoing awareness-raising sessions, contraceptive usage has increased from 0% to 74%. In addition, the cluster representatives, after having received adequate health promotion, first aid and communication skills training, began providing health education to mothers and undertook follow-up home visits on mothers and children. They encouraged the community to improve sanitation through refuse collection, promoted breastfeeding, improved personal hygiene, the control of communicable diseases, healthy lifestyles and discouraged malpractices among the community, in addition to promoting the concept of child-friendly homes and communities. Smoking was also reduced in the village from 45 smokers to just three and the names of those smokers who quit appeared on posters in village health facilities.

The village established a community-based information centre situated in the health centre and all information is updated regularly by the cluster representatives, including information on the family register. The village development committee uses the information to monitor activities and also for planning purposes.

Table 4. Indicators for Masoud from 2002–2004

Indicator	2002	2004
Population (no.)	957.0	980.0
Households (no.)	191.0	193.0
Literacy rate (%)	5.0	99.0
School enrolment rate (%)	22.0	92.0
School drop-out rate (%)	34.0	2.0
Access to safe-drinking water (%)	zero	100.0
Access to sanitation facilities (%)	3.0	80.0
TT vaccination (%)	21.0	96.0
Immunization coverage of children under 1 year of age (%)	63.0	100.0
Contraceptive usage (%)	zero	74.0
Acute respiratory infections (no.)	63.0	10.0
Diarrhoea (no.)	66.0	7.0
Smokers (no.)	45.0	3.0

Source: Information updated by cluster representatives through annual surveys and home visits.

With support from the local government, the community have also established cultural and agricultural centres where the majority of the awareness-raising activities take place. The community uses the cultural centre during the summer holidays to conduct special English and mathematics courses for students and this has resulted in high success rates in the competition for university places.

Country

Yemen

Type of programme and the number of villages covered

23 BDN villages

Population coverage of programme

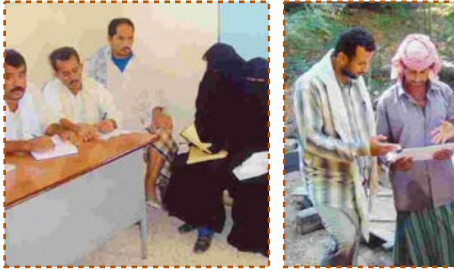
104 919

Date of initiation of the BDN Programme at national level

2000

Major outputs

improved sanitation and the establishment of a solid waste management system in all BDN areas;
increased coverage of health services through the training of community sanitary workers, first aid workers, village health volunteers and TBAs in all BDN areas; establishment of community pharmacies in some BDN areas; and establishment and/or upgrading of health facilities in a number of BDN areas;
improved adult literacy rates;
increased school enrolment rates;
increased participation and role of women in development activities through the establishment of women's associations in most BDN areas;
increased youth participation in cultural, recreational and development activities through the establishment of youth groups;



- increased self-employment of women through empowerment and skills building in vocational activities;
- improved accessibility to potable water in the majority of BDN areas;
- improved nutrition through increased agricultural productivity as a result of many irrigation schemes, dairy cows, cattle raising;
- improved incomes as a result of income-generating projects;
- increased access to safe drinking-water and sanitation facilities;
- introduction of the concept of healthy and safe school environments;
- partnerships developed between government organizations, civil society, UN agencies and donors.

Partners

Ministries of Public Health and Population, Agriculture, Education, Social Affairs, local administration, Social Fund for Development, GTZ, OXFAM, Embassy of the Netherlands, UNDP, WFP, UNICEF, United Nations Population Fund (UNFA).

Female literacy, skills building and healthy initiatives, Al-Kashuba'a, Hodeidah governorate

Ms Najah is a 27-year-old mother of two children and a teacher who has coordinated several adult female literacy classes in Al-Kashuba'a. As a community representative she maintains a detailed record of the socioeconomic status of the families in her cluster area and uses the data for the monitoring and management of BDN activities. All school-age children in her area have been enrolled in school and the majority of women who were illiterate in her cluster have attended BDN literacy classes and can now read and write. Many of these women also received vocational training in sewing, embroidery, weaving and other handicrafts. As a result of the programme, health indicators have also increased significantly including prenatal, natal and postnatal coverage and the immunization status of women and children (Table 5).

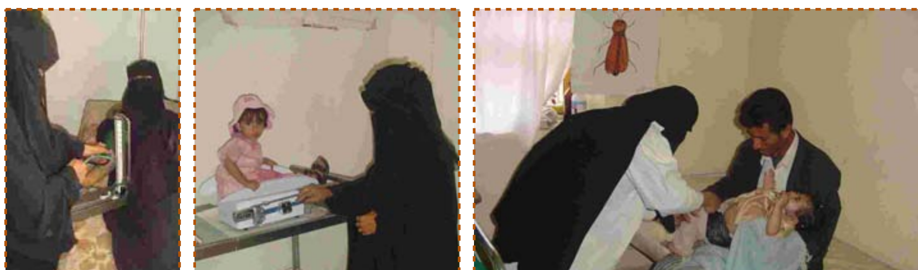
Ms Najah has also been responsible for granting a number of income-generating loans and none of the loan recipients have defaulted in the repayment of their loans. Due to the awareness training provided by the BDN Programme, Ms Najah's house has become an excellent example of a healthy house in the village, adopting all necessary healthy habits, including healthy cooking, cleanliness, clean water storage and facilities for the disposal of solid waste. Ms Najah also won an embroidery machine which was given to her as an award by the village development committee for being the best community representative.

In early 2004, Ms Najah received training as a TBA and now, with her newly-acquired skills, can better serve her community. She is in regular contact with the families of her cluster, documents all changes and reports them to the village development committee and the health centre for the process of data collection and necessary follow-up.

Table 5. Health and social indicators in Al-Kashuba'a, 2000–2006

Indicator	2002 (%)	2004 (%)
Prenatal, natal and postnatal coverage*	zero	90.0
TT vaccination of pregnant women	12.0	80.0
Immunization status of children	60.0	95.0
Female literacy rate	7.0	50.0
School enrolment rate	47.0	90.0
Sanitation (solid waste management system)	zero	80.0

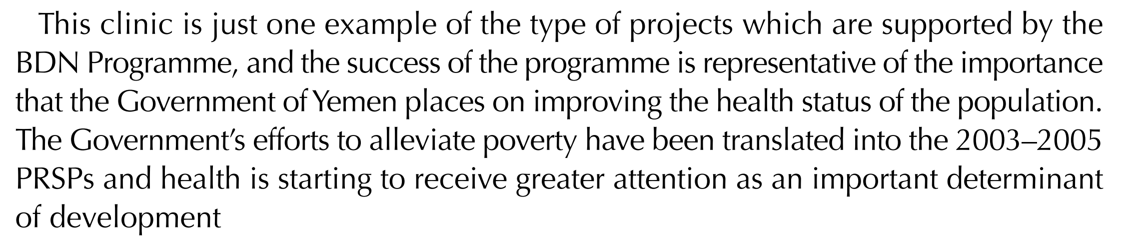
**As a direct impact of the establishment of a health centre and the training of 20 TBAs.*



Community-based nursing clinic, Qshawba

Ms Hamouda Ibrahim lives in the small village of Qshawba. Her village is one of 36 000 villages scattered across Yemen where the majority of the population live in rural settings. The city of Qshawba, and the governorate which carries the same name, is one of the designated four poorest areas in the country. Estimates indicate that 77% of women are illiterate and 17% of the population live on an income of less than US$ 1 a day. Although efforts have been made over the past 30 years to increase and expand the network of basic health-care services, 52% of rural areas remain deprived of even the most basic health services. Ms Hamouda underwent her vocational training as a nurse in Hodiedah and explained that although the community, including her family, complained of various illnesses and required access to health care, she was unable to provide this care as the village lacked a health centre and this forced the community to travel to the city to access health-care services.

She applied for a loan through the BDN Programme to build a small clinic for the 6000 inhabitants in the area to provide primary health-care services and since establishing her clinic receives between 15 and 20 patients daily who pay a small consultation fee. She also works as a volunteer nurse at the public health centre in the morning before running her private clinic in the afternoon and at all times is in close contact with and under the supervision of the primary health care authorities. Ms Hamouda explained how the programme had allowed her to reduce the burden of disease incurred on the community as a result of simple illnesses that were easily treatable.



This clinic is just one example of the type of projects which are supported by the BDN Programme, and the success of the programme is representative of the importance that the Government of Yemen places on improving the health status of the population. The Government's efforts to alleviate poverty have been translated into the 2003–2005 PRSPs and health is starting to receive greater attention as an important determinant of development

For more information contact the

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