



Community-based initiatives success stories²



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Regional Office for the Eastern Mediterranean

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Document WHO-EM/CBI/061/E/01.09/

Designed by: Punto Grafico

Printed by: Printed by WHO/EMRO Printshop



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Foreword

Health is a resource and human right that allows people to achieve goals, contribute to society and live a life that they can value. The poor health status of a population translates into reduced human capital, and therefore, suboptimal economic development. Likewise, poverty, illiteracy and environmental degradation all contribute to poor health. Furthermore, the poor have a higher burden of disease as they have less access to good quality health care services. To tackle social determinants of health and poverty, community-based initiatives programmes have been being implemented in the Eastern Mediterranean Region by WHO since 1988. These initiatives promote community organization and leadership to achieve development. It is a process through which communities are empowered to identify their own needs and mobilize existing resources with little external input. Community-based initiatives have proven that community engagement, decentralization and intersectoral coordination provide effective and sustainable routes through which to achieve community development and improve health.

Community-based initiatives have enjoyed two decades of success in the Eastern Mediterranean Region; projects have targeted illiteracy, sanitation, immunization and micro-credit schemes, in addition to many other areas. Communities who have participated in the projects have seen marked improvements in their quality of life. The first community-based initiatives programme was implemented in Lower Shebelle, Somalia, in 1988. At present, 17 countries in the Region are implementing at least one programme. This brochure presents some of the evidence-based success stories from the Region, which demonstrate the effectiveness of community-based initiatives, and provides examples of good practice on which future projects could be based. It is suggested that Member States share



this brochure with civil society, donors, academia, partners, policy-makers and other UN agencies in order to encourage:

- institutionalization of community-based initiatives as part of national health policy;
- the linking of all health and development programmes at national level;
- community leadership for health and development;
- the strengthening of intersectoral partnerships and resource mobilization for health and development.

Working together to achieve these objectives will ensure an efficient use of resources in a unified effort to improve the well-being of communities, in particular, poor and disadvantaged groups in the Region.



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Introduction

WHO defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.¹ The importance of the social determinants of health is further emphasized in the Ottawa Charter for Health Promotion:

*To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living.*²

The United Nations Development Programme (UNDP) emphasizes the multidimensional character of human well-being and development: “The

most basic capabilities for human development are to lead long and healthy lives, to be knowledgeable, to have access to the resources needed for a decent standard of living and to be able to participate in the life of the community”.³ Health and development work synergistically to promote human well-being. A population with a poor health status has low productivity, and poverty translates into poor access to health care and other prerequisites for health, such as food, shelter, water, sanitation and a stable environment.⁴

The community-based initiatives (CBI) programmes being implemented in the Region are aligned with the above principles. They complement primary health care by targeting the socioeconomic determinants of health. The programme has adopted a bottom-up process of development which aims to increase equity of access to social services at the grass-roots’ level. This is achieved through six fundamental steps as shown in Figure 1.⁵

¹ www.who.int/governance/eb/constitution/en/index.html.

² http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf.

³ <http://hdr.undp.org/hd>.

⁴ Assai, M. (2007) Community-based initiatives and their relation to poverty reduction and health development: experiences in the Eastern Mediterranean Region. *Eastern Mediterranean Health Journal*, 13(6).

⁵ *Community-based initiatives success stories from the Eastern Mediterranean Region*. Cairo, WHO Regional Office for the Eastern Mediterranean, 2006 (http://www.emro.who.int/cbi/pdf/CBI_SuccessStories.pdf).





Figure 1. Components of community-based initiatives programmes

Recognizing that needs vary between communities, the programme relies on active community involvement and leadership to identify and address these needs. Community involvement is achieved through the formation of community/village development committees. These committees consist of elected members of the community. As the final goals of development are selected and implemented by the local population it gives them a feeling of ownership of the development project and ensures project sustainability.⁶

Regardless of the project chosen, the programme encourages increased awareness of health issues, the active participation of community members, gender equality and self-sufficiency.⁴

Another important role of the initiatives is to encourage intersectoral collaboration and form a platform between communities and government departments. This allows communication of local needs to local governments and encourages the integration of the programmes into national health policies.

Community-based initiatives programmes comprise the basic development needs (BDN) programme, the healthy city programme, the healthy village programme and the

⁶ Assai M and Rizwan H. Community ownership and intersectoral action for health as key principles for achieving Health for All: experiences of community-based initiatives in countries of the Eastern Mediterranean Region. Cairo, *Eastern Mediterranean Health Journal*, 14, Special Issue.

gender in health and development programme. Seventeen countries of the Region are implementing at least one of these programmes, which cover a population of nearly 18 million.

In areas where the initiatives have been implemented, various indicators of health and development have shown an upward trend. Improvements have been reported in nutritional status, access to safe drinking-water, rates of school enrolment, immunization coverage, reduction of child and maternal mortality and morbidity and the income of the poor (see Figures 2 and 3).

The future goals of the programme are to ensure continuing sustainability of existing projects, as well as expansion of the programme over larger areas. This requires the commitment and cooperation of local and national government, civil society and some external financing agents.⁴ This brochure presents some of the evidence-based success stories from the Region which demonstrate the effectiveness of the initiatives. Member States are requested to share this brochure with donors, civil society, academia, partners and policy-makers with a view to scaling up and institutionalizing CBI programmes at national level.

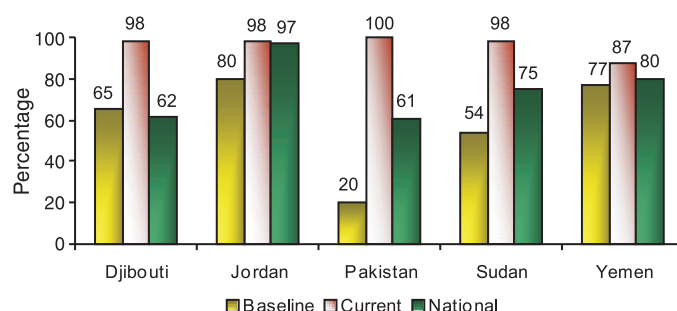


Figure 2. Measles immunization in CBI areas

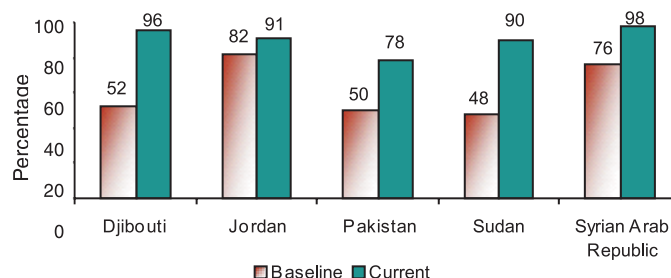


Figure 3. Access to safe water

Afghanistan: community development and self-reliance

The village of Ghaizan located on the outskirts of the city of Herat in Afghanistan received US\$ 38 500 in funding from the National Solidarity Programme in order to construct a community centre. The National Solidarity Programme is a project of Afghanistan's Ministry of Rural Rehabilitation and Development.¹ The BDN village development committee played a remarkable role in the mobilization and organization of the community to ensure implementation and completion of this project.

The total cost of the project was US\$ 45 100, of which the local community had to contribute US\$ 6600 (15% of the cost). The motivation and participation of the community was such that labourers from the community voluntarily contributed to the construction and supervision of the building.

Since its completion, the community centre has played a pivotal role in the development of the community. It is

host to a range of activities, including the conducting of literacy classes and vocational training courses and acts as a health post. The basement has been converted into a youth's sport and community centre. A part of the building is rent out to the public for gatherings, such as weddings and religious events, and the money obtained from this covers the maintenance costs of the building.

The benefit of conducting different social activities under one roof is that the community is able to utilize a variety of available services, share experiences and benefit from each other to improve their physical, mental and social well-being. Community centres are places where the community can organize and mobilize available resources for local development. They are also a symbol of community leadership at the grass-roots level.



¹ National Solidarity Programme (<http://www.nspafghanistan.org/default.shtm>).

Egypt: community action for school enrolment

The community development committee of the Batn Al Baqarah area in Old Cairo identified low levels of school enrolment as a priority social problem that needed to be addressed. Several obstacles to school enrolment were identified by community members and Toyoor Al Salam, a nongovernmental organization located in Old Cairo. According to Eman Mohamedein, a literacy teacher in the area, the most common of these were an inability of families to pay school fees and lack of awareness regarding the importance of education. Many parents preferred to send their children to work as the parents' income alone was insufficient to support the entire family. Another obstacle was that many children in the area did not have a birth certificate which was a prerequisite to enrolling in school.

Once these obstacles were identified, the community development committee, with the help of Toyoor Al Salam, raised funds to finance two

years of education for 20 students who were unable to pay the fees. In addition, from the same fund, school uniforms and books for 200 students were provided. Also, members of the community worked with parents to raise the community's awareness of the importance of education and the issuance of birth certificates. They arranged issuance of birth certificates for 35 children enrolled at school for the next academic year.

These measures to improve enrolment rates in the community and provide education to children will have long-term benefits for the community. The impact of community mobilization was visible to its members and will serve to motivate them to continue making efforts in community development. As Shabaan Ali, one of the founders of Toyoor Al Salam, said: "This is something we are really proud of".



Islamic Republic of Iran: control of communicable diseases

Leishmaniasis is a protozoan infection transmitted by the bite of a female sandfly. As no vaccination exists for leishmaniasis, the key to preventing epidemics is control of sandfly populations. Sandflies lay their eggs in rodent burrows and other animal shelters, in household waste and old cracks and crevices of old homes.⁸

A leishmaniasis outbreak was prevented in the village of Koushak-e-Hezar in the province of Fars through improved environmental sanitation as part of the healthy village programme. The healthy village programme was introduced to Koushak-e-Hezar in January 2007. Six months later there were reported cases of leishmaniasis in a neighbouring village, as well as in the nearby city of Sheikh Aboud and Lapouyi.

In an example of intersectoral collaboration, there was an immediate response from the village development

committee, the community health worker and the rural administrator. Pamphlets raising awareness of leishmaniasis were distributed in the village and local authorities were lobbied to control the spread of the disease. As a result, roads were paved and asphalted, the gutter system and canals were enhanced, rodent control and stray dog control was put in place, collection of household waste was instituted throughout the village and the community received training and education regarding disposal of waste and the use of insecticide-treated nets. Due to this rigorous programme to improve environmental sanitation no cases of leishmaniasis have been reported in Koushak-e-Hezar even though the affected neighbouring village was only 5 km away.

⁸ http://www.who.int/leishmaniasis/disease_epidemiology/en/index.html.



Iraq: community-based initiatives addressing community needs and improving the quality of life

Physical infrastructure is an important determinant of health, economic prosperity and quality of life and is one focus of community-based initiatives-related activities in Iraq. Thiqr, Najaf and Muthana are some of the most impoverished districts where a dearth of safe drinking-water has led to residents drinking unpurified river water. These are districts where community-based initiatives are in operation. The Directorates of Agriculture and Water Resources worked together to purify water and ration the supply among local farmers. Similarly, there has been an improvement in the water networks in Missan, Najaf and Intissar as part of CBI interventions.

Efforts have also been made to improve transport infrastructure. Roads and small bridges have been constructed and are being maintained to provide access to the city for the surrounding villages of Babel, Missan and Muthana. This will open up access

to various services in the cities, such as better health services and higher education.

Community-based initiatives were adopted by the Ministry of Health in Iraq as one of the most successful programmes to address community needs and to improve the quality of life in a cost-effective manner, during the national health system conference held in June 2008.





Morocco: empowerment of women and capacity-building

Ms Souad is a 28-year-old woman from the Oulad Sebbah district in Morocco. She is a member of the BDN local development committee and is a regular participant in awareness-building activities in the community, such as the Safe Motherhood Programme. Though Ms Souad has had very little formal education, she was very keen to set up a rabbit farming project. She applied for a small loan from the BDN programme and was awarded US\$ 963 (7000 Moroccan Dirhams). In addition to this, she was supported by the Moroccan Ministry of Agriculture through the provision of technical assistance, essential skills training and 12 rabbit hutches. The technical assistance and training she received proved to be of great assistance in managing a species of rabbit new to the area.

Three years on from the commencement of her ambitious project, Ms Souad has managed to increase her income, is meeting her loan repayments and is entirely self

reliant. Her success has gained her great respect and credibility among the other inhabitants of the district. This has enabled her to act as a facilitator at health education awareness campaigns for other women.

Furthermore, Ms Souad's experience is an example to the entire district of the importance of empowerment of women in underprivileged areas and promotes the capacity of women to be able to transform the local community.

"I was conscientious about the necessity of working hard as a woman and also as responsible for the project. During the community meetings I always advise people involved in the BDN programme that working hard is the key to success. Opportunities exist, such as receiving a loan from nongovernmental organizations but having a feasible idea and a good management project is another story."





Oman: community action for a healthy lifestyle

The Nizwa healthy lifestyle project in Oman is a community-based intervention that focuses on reducing morbidity and mortality related to noncommunicable diseases.⁹ As a result of public awareness programmes and healthy school promotion initiatives implemented by this project, a group of teachers at the Nizwa school for girls decided to take action to tackle their sedentary lifestyle. They identified a high level of obesity among staff and attributed part of this as due to lack of public or private venues for women to exercise.

During the academic year of 2004–2005, the 60 female teachers raised 200 Omani Rial, equivalent to US\$ 520 among themselves. This amount was sufficient to purchase five fitness machines to equip a room provided by the school in support of this healthy

lifestyle project. It is hoped that the use of the gym will be extended to the 1000 female school pupils and then to other women in the community. Many of the teachers have already experienced some weight loss and their example will motivate students to adopt healthy lifestyles.

This project has helped to promote physical exercise to women in the community, who will benefit by reducing several risk factors for noncommunicable diseases, such as obesity, high cholesterol levels and hypertension.



⁹ http://www.emro.who.int/TFI/wntd2008/pdf/Oman_Nizwah_Project_Report.pdf.



Pakistan: vocational training and supporting local handicrafts

Gul Afrooze is the eldest child in a family of six children, living in the village of Kamal UC Soregaz. One of her siblings lives with the effects of having had polio. Her father's income is insufficient to send her and her four sisters to school. Her village is located in Mastung, one of the least developed districts of Balochistan although five women's vocational training centres and four female literacy centres have been set up by the community-based BDN programme in the district.

Gul Afrooze attends one such women's vocational training centres. Here, she has been taught various handicraft skills, such as knitting and embroidery, in addition to receiving health education and home health care and skills training. The centre is run by two highly motivated and enthusiastic women; Ms Hameeda provides vocational training and Ms Gul Seema

is the health educator. Already more than 500 women and girls have benefited from this centre over the past few years.

As for Gul, attending the training courses offered by this centre and having acquired skills has enabled her to fund her own and her sisters' education, thereby securing a better future for her entire family:

Thanks to Baji Hameeda (an instructor at the centre) who taught me a range of skills including knitting and how to make handicrafts, I am now able to afford mine and my sisters' education. I am in grade ten at school.





Saudi Arabia: intersectoral collaboration for a healthy city

The city of Bukariyah in central Saudi Arabia is famous for its agriculture, however, the diet of the local population lacks adequate intake of fibre from fruit and vegetables. Furthermore, a lot of the fresh fruit and vegetables are contaminated with harmful pesticides. To address this problem, the local community decided to build a chemical-free vegetable market in the main market. The vegetable market would not only facilitate access to healthy food but also raise community awareness of the benefits of a balanced diet and help change the culture of unhealthy diets.

The market was built in 2007 with the involvement of the municipality, Ministry of Agriculture, Al-Qaseem University, private companies and the local community, in an example of intersectoral collaboration. The market serves a population of 45 000.

In addition to this, the community-based initiatives healthy city committee prepared pamphlets to raise community awareness of the nutritional benefits of fruit and vegetables.



Somalia: partnership with primary health care services to control communicable diseases

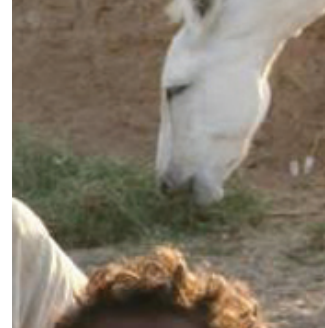
In Somalia, the BDN programme has played a vital role in the control of communicable diseases. The initiatives have complemented primary health care services to increase immunization coverage, improve hygiene and environmental sanitation, as well as to prevent the spread of malaria. In villages in North-west Somalia, the BDN programme has assisted in the implementation of an integrated malaria control programme. This programme includes raising awareness of malaria prevention, distribution of insecticide-treated tents, provision of anti-malarial medication to various health centres and introduction of larvivorous fish among other activities involving community mobilization.

Three villages in the Hargeisa region, which are part of the BDN programme, have shown impressive immunization coverage. Following a measles catch-up immunization campaign, 95% of children had received the vaccine.

Delivery of BCG and measles vaccines as part of the EPI programme to children under one year of age was also excellent.

An assessment team visiting eight BDN villages in Somalia in 2005 noticed a visible difference in the health status of the community in these villages compared to the villages in which community-based initiatives were not being implemented: *“the general health situation is better (than other villages) and there are no children affected by measles after the measles catch-up immunization campaign in the area”*.





Sudan: community-based initiatives to promote healthy practices

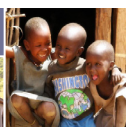
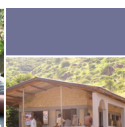
Community-based initiatives were introduced in nomadic villages along the River Nile in 1997 in: Saadabia, Banat, Dar Mali, Khyrab, Nabawia and Salama. There were many socio-economic determinants of health which needed addressing, including low literacy rates, lack of permanent housing, lack of sanitary latrines and the use of harmful traditional medicines.

After implementation of community-based initiatives, there was marked development in the area. Housing in the community began to change from tents to more permanent and secure mud houses; in 2005 there were only 72 mud houses in all six villages, this increased to 150 in the space of one year. The residents also began to use the space around their house to make kitchen gardens. These gardens helped tremendously in allowing families to have a more varied and balanced diet.

Traditionally, the villagers had a diet composed principally of wheat porridge and milk.

The community also employed their own resources to build pit latrines. The use of latrines was considered by the nomads to be against their culture, and hence, prior to implementation of the initiatives there were no pit latrines. By 2006, 90 latrines had been constructed.

Community-based initiatives have had a huge impact on improving the quality of life and the environment of the residents in these villages.





Yemen: community mobilization for development

The BDN programme has transformed life in Al Zafeer, a subdistrict of Yemen. Prior to April 2005, when community-based initiatives were first introduced in the region, this area was one of the poorest in the district; there was no health care facility and travelling to the nearest health centre in the neighbouring city of Hajjah took at least one hour although it was a mere 15 km away.

The BDN programme led to a radical change mainly through promoting community awareness and participation. The subdistrict was organized into groups with each group focusing on a specific area of development. As a result of community mobilization, technical support from the BDN team and cooperation of different government departments, the community of Al Zafeer managed to achieve impressive results. Firstly, a village development committee was established and registered with government authorities as a legal entity. This empowered them with the government authority to directly liaise

and make agreements with different agencies working in the area.

A health centre was built in partnership with the health office of the Hajjah governorate to serve the local population of 5554 people. It consisted of 10 health care workers, including a physician and laboratory technician. The road linking the area to Hajjah City was asphalted by the government reducing travelling time to 15 minutes and thereby facilitating access to larger health care centres.

Every household in the community has been linked to piped safe drinking-water and efforts have been made to establish a sewerage system for the community, consisting of two septic tanks. More recently, Al Zafeer has been selected by the WHO Centre for Environmental Health Activities (CEHA) as a pilot site for the implementation of a solid and health care waste management project.



Measures were also taken for the empowerment and involvement of women in the community. A women's association was set up which conducts vocational training, in addition to conducting other activities for the development of women.

Finally, the community also formed an emergency preparedness team,

trained in vulnerability risk reduction and emergency preparedness. So far, the team has identified and mapped potential natural and man-made hazards threatening the area and is discussing measures to reduce the consequences of these.

All of the above measures required very little financial input from the BDN programme; local resources, intersectoral cooperation and community mobilization allowed the development projects to succeed.



