Volume 7 Issue 1 | 2012

CONTENTS

World Health Organization
Regional Office for the Eastern Mediterranean

Community-based initiatives newsletter

The Regional Office welcomes Dr Ala Alwan

Dr Ala Alwan assumed his duties as WHO Regional Director for the Eastern Mediterranean on 1 February 2012. From 2008 until the end of 2011, he was Assistant Director-General for Noncommunicable Diseases and Mental Health at WHO headquarters, where he led WHO's work that resulted in the adoption by the United Nations General Assembly in September 2011 of the Political Declaration on the Prevention and Control of Noncommunicable Diseases.

A native of Iraq, Dr Alwan graduated in medicine from the University of Alexandria, Egypt. He practised medicine in Scotland and obtained his postgraduate training and qualifications in the United Kingdom. Following his return to Iraq, he held several positions in clinical and academic medicine and public health. He was Professor and Dean of the Faculty of Medicine, Mustansiriya University, Baghdad, Iraq.

In 1992, he joined the Regional Office for the Eastern Mediterranean as Regional Adviser for Noncommunicable Diseases. He then served as WHO Representative in Oman, and Director, Division of Health Systems Development in the Regional Office for the Eastern Mediterranean. In 1998, Dr Alwan moved to WHO headquarters as Director for Noncommunicable Diseases Prevention and then Director of the Department of Noncommunicable Diseases Management. In 2001, he became WHO Representative in Jordan. From 2003 to 2005, he was Minister of Education and Minister of Health in the Government of Iraq. From 2005 to January 2008, he was Representative of the Director-General and Assistant Director-General for Health Action in Crises.

Dr Alwan was appointed as Regional Director by the WHO Executive Board at its 130th session in January 2012. In his acceptance speech, Dr Alwan drew attention to the current challenges facing the Region. "This is a region with considerable health, socioeconomic and political challenges as well as diverse needs. But it is also a region with solid historical achievements and great promise," said Dr Alwan. "I will focus on achieving the results that we, collectively, know are essential, especially in tackling the health challenges impacting the region during the current economic and political climate." Dr Alwan also noted the importance of community-based initiatives, gender and human rights as key areas that cut across all health programmes. He highlighted the importance of Urban HEART (Health Equity Assessment and Response Tool) as a tool that could contribute to work in the area of social determinants of health. He said that the planning process needed to be strengthened in WHO as a whole. "We need to come up with a concrete, well-coordinated WHO plan. Our credibility depends on 'one WHO' and I will do my best to see this happen … It is not enough to identify the challenges and gaps; more important is to take well-studied action and apply proven approaches."

Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean

Progress of the healthy city programme in Tripoli, Lebanon

A healthy city maintains and improves its social and natural environment. Citizens are supported through the development of their potential to promote health and social status. A healthy city expresses a commitment by the urban community to improve its members' health through sustainable development. World Health Day 2010 provided an opportunity to promote the urbanization and health agenda by securing the political commitment of more than 200 cities in the Region. It also encouraged community participation and intersectoral collaboration through joint actions for health. The municipality of Tripoli, northern Lebanon, expressed their interest in implementing the healthy city programme in Tripoli, with the technical support of WHO. The municipality and the city's coordinating committee tailored the programme to meet their specific needs through a local assessment conducted in early 2011. The programme was launched in Tripoli in May 2011. Four priorities were identified by the city's coordinating committee – food safety, school health, solid waste management and tobacco control.

In May 2011, WHO assisted Tripoli city planners by conducting a workshop attended by members of the programme's steering committee to draft a one-year plan of action, based on the identified priorities, with clear tasks and responsibilities for each sector, members of the community and interested nongovernmental organizations. The following interventions have been introduced.

Tobacco control project

On 31 May 2011, the tobacco control subcommittee and municipality, in collaboration with WHO, scouts, university students and local nongovernmental organizations conducted an anti-smoking campaign, in which advocacy banners were hung in the main streets of the city. Tobacco control communication materials, including flyers, posters and banners, were developed and distributed to the citizens of Tripoli. Many people signed a petition to support the "No Smoking Law" and pledged to vote for it. The tobacco control law was successfully passed in the country in August 2011. Another activity related to the smoke-free schools initiative was a campaign to raise awareness of the hazards of smoking in 60 public and private schools, targeting 12–15-year-old schoolchildren. In addition, an awareness-raising campaign to ban smoking in public and closed places began in December 2011.

World Health Day campaign in Lebanon 2010

Solid waste management and environmental health project

In July 2011, the WHO Centre for Environmental Health Activities in Amman provided technical support in the development of an appropriate solid waste management system in selected slum areas of Tripoli, and in schools. The municipality of Tripoli identified 12 public schools that needed water supply treatment, following the results of a water analysis. Work has begun, in collaboration with the Ministry of Education and the municipality.

Food safety project

The objective of this intervention was to ensure that 15 restaurants and 35 meat shops in Tripoli complied with good manufacturing and good hygienic practice standards. Awareness-raising sessions on a food safety plan of action were conducted in Tripoli. Restaurant owners, ten volunteers from the municipality and three public health inspectors from the Ministry of Health attended these sessions.

Tobacco control banners used in the campaign in Tripoli

Environmental needs assessment field visits, Tripoli, 2011

Urban HEART in Sale, Morocco

The impact of urbanization on population health, health equity and its adverse effect on the environment has become a key concern for municipal authorities across the Eastern Mediterranean Region. WHO's Urban Health Equity Assessment and Response Tool (Urban HEART) is a guide for policy- and decision-makers at national and local levels to identify and analyse inequities in health between people living in various areas in cities, or belonging to different socioeconomic groups within and across cities.

The health sector in Morocco is facing challenges related to the social determinants of health that lead to health inequity in disadvantaged areas, including Sale, which is located just outside Rabat.

In an attempt to provide technical support to the Ministry of Health to achieve health equity, WHO organized an intercountry meeting on health and development in slums and urban areas in September 2010 and shared the Urban HEART approach and methodology. Although the poverty rate in Sale is 6.45%, significantly lower than the national average (16.5%), and that of Rabat (11.1%), due to old infrastructure, insufficient access to safe drinking-water and low quality primary health care services, Sale was selected as a model area for the Urban HEART study. To address the challenges, 140 383 inhabitants of Bab-Lamrissa, a district in Sale, and 1159 families in Sale were targeted. A set of interventions were agreed upon by local stakeholders and partners to reduce health inequity in urban settings.

A comparative study was designed to compare health and social indicators between the neighbourhood within the city of Sale and the national level. The study compared equity indicators in four areas of Sale. The comparative matrix revealed that:

- the prevalence of tuberculosis is highest in Médina and Grand Sidi Moussa and much higher than the national level
- the level of postnatal care is only higher than the national level in Said Hajji area 14, and is much lower in the other three areas of the city
- access to safe drinking-water is only 57% and 60% in Médina and Grand Sidi Moussa, respectively, compared to nearly 100% in the other two areas
- the female illiteracy rate is much higher than the male illiteracy rate at 61%, 75.2% and 67.3% in Médina, Grand Sidi Moussa and Said Hajji resettled, respectively, which is nearly three times higher than the rate in Said Hajji area 14

health insurance coverage is 18.6% and 7.9% in Médina and Grand Sidi Moussa, respectively, while it is above 50% in the other two areas of the city, and is 80% at national level.

The information provided in Table 1 can guide city planners on required actions and interventions according to the needs of each geographic area within the city. However, the similarities between vulnerable populations warrant the development of a comprehensive action plan focusing on income, housing, illiteracy and the improvement of health care services.

The study showed that female

Table 1. Comparison of health, social and economic indicators between four areas of Sale with the national average

Policy domain	Indicators	Médina	Grand Sidi Moussa	Said Hajji resettled population	Said Hajji area 14 population	National level
Health indicators	Fully immunized children under one (%)	98.2	99.2	100.0	99.4	95
	Exclusive breastfeeding until 6 months (%)	76.6	81.5	78.1	72.3	50
	Skilled birth attendance (%)	93.9	83.1	84.4	96.4	90
	Maternal mortality (per 100 000 live births)	0.0	0.0	0.0	0.0	83
	Incidence of tuberculosis (per 100 000 population)	197	170	NA	72	65
	Postnatal care (%)	49.70	50.5	60.60	85.10	80
	Contraceptive use rate (%)	52.3	55.7	61.9	66	65
Physical environment and infrastructure	Access to safe drinking-water (%)	60	57	96.6	100	100
	Access to sanitation (%)	84	68	100	100	100
Human and social development	Male adult illiteracy rate (%)	36.1	57.7	42.1	10.4	28.1
	Female adult illiteracy rate (%)	61.0	75.2	67.3	20.4	50.8
	Health insurance coverage rate (%)	18.6	7.9	52.4	65.1	80
Economics	Households earning less than 50 Moroccan Dirham (MAD) a day (%)	56.0	73.2	25.2	5.8	NA
	Male (fathers) employment (%)	75.2	77.3	76.7	82.0	75.3
	Female (mothers) employment (%)	20.6	15.6	10.1	76.7	25.8
	Total household annual expenditure (MAD)	1876	1398	1973	3629	1158

Note: 1 Moroccan Dirham = US$ 0.12
NA = Not available

Indicates poor performance in comparison to the national level.
Indicates performance below the planned goals and slightly lower in comparison to the national level.
Indicates good or similar performance in comparison to the national level.
The indicator is not available to compare.

literacy had a direct impact on some or all health indicators, i.e. 42.4% of illiterate women received four recommended prenatal visits against 59.7% for literate women. In addition, 92.4% of illiterate women deliver at home, while 85.7% of literate women deliver in health facilities assisted by skilled birth attendants.

The risk factors for noncommunicable diseases reported by families showed that between 9.2% and 16.9%, and 6.4% and 8.9% of households have at least one person in their household with diabetes and hypertension, respectively. Concerning the economic level of families the study showed that 50% of families earn a very low income (under 50 MAD a day), while more than 40% of families are middle income (about 50 MAD a day). Some families have no fixed salary per month and 40.4% of adult males work as labourers. In addition, 40.1% of adult females are housewives and only 3.3% of households in Sale work in agriculture.

Health centres are accessible to most households with over 96% reporting a less than 30 minutes' walk from their homes to the health facility. Although the level of client satisfaction with services offered is low for families in Medina and Sidi Moussa, with 68.3% reporting waiting times of over 2 hours.

As a response to the Urban HEART study, the Ministry of Health will build partnerships with potential partners and stakeholders to improve health and social equity of citizens. Priorities and strategies will be identified to minimize equity gaps and select interventions according to available resources. Active community participation will be sought in identifying problems, assessing needs and implementing local solutions for local problems.

Community participation in data collection, Sale, Morocco, Urban HEART Project, 2011

Urban HEART in Gezerit El Warak, Giza, Egypt

The Ministry of Health of Egypt has found that adoption and use of the Urban HEART tool by national and local governments can guide policy-makers and key stakeholders in identifying the social determinants of health and their impact on health equity. In addition, the tool provides evidence that can support local authorities in prioritizing urban problems and encourage city planners to allocate resources for needed interventions to achieve health equity. Local health authorities also acknowledge that Urban HEART can sensitize, mobilize and empower communities to advocate for health equity.

The study in Gezerit El Warak was planned during meetings at the governorate level to identify the main criteria for site selection. The Ministry of Health, the governorate of Giza and WHO agreed on selection of Gezerit El Warak due to its location as an unplanned residential slum area on the river Nile with no access to motorized public transport, extremely narrow streets and no other means of transport except the local ferry. Only two ferries run services daily (one private and the other public) but the service finishes at 8 pm. This makes life difficult for those in emergencies who may need to get to a hospital quickly. In addition, there is no sewage disposal system in the area and it lacks sanitary environmental facilities.

On 30 June 2011, an orientation workshop was organized by the Ministry of Health and WHO to brief local stakeholders about the Urban HEART concept and methodology and how to proceed with conducting the study.

The main objectives of the study were to:

- assess the determinants that affect the health of the citizens in Gezerit El Warak
- compare the social determinants of health of Gezerit El Warak with the standards of Giza governorates and at national level
- determine the gap in health equity between Gezerit El Warak and the national level and share the results with policy-makers and key local stakeholders.

In July 2011, a door-to-door household survey was

Mode of transportation for the citizens of Gezerit El Warak

conducted in Gezirat El Warak, supported by the local government and community, in partnership with WHO (Table 2). The results of the survey found that:

- the prevalence of female overweight in the target area was 34.5% (national average 38.4%)
- connection to piped water is 84% in the target area (national level 98%)
- there is no connection to public drainage sewers (national average 56%)
- the illiteracy rate is 36.4% (national average 25.2%)
- full vaccination of infants is 95.1% (national average 91.7%)
- skilled birth attendance is 72.2% (national average 71.7%)
- unemployment rate is 7.9% (national average 11.9%)
- voter participation is 52.7% (national average 41.0%)
- 28% of respondents used a local primary health care centre and 31.5% reported to private doctors.

City planners agreed to share the results of the Urban HEART study with local, national and international partners on 18 January 2012. City planners will pay more attention to improve health-related behaviour, such as smoking, poor nutrition and lack of physical exercise. Access to quality primary health care services and maintaining the current coverage of the Expanded Programme on Immunization are the major focus in Gezerit El Warak. Local authorities will also improve the environmental health status, including access to water and sanitation, local transportation and will work with different stakeholders to increase the literacy rate among adults. Future directions include: ensuring community ownership at all stages of planning, implementation and monitoring; enhancing partnerships and mobilizing resources; and ensuring that collaboration is effective and sustainable.

Table 2. Comparison of indicators from Gezerit El Warak with national averages

Health outcome indicators	Core indicator	Gezerit El Warak	National level
Disease-specific	Infant mortality rate per 1000 live births	12.0	25
	Neonatal mortality rate per 1000 live births	6.0	16
	Male hypertension >140/90 (%)	12.8	10.5
	Female hypertension (%)	14.5	12.8
	Male overweight (%)	36.7	34.3
	Male obesity (%)	21.1	18.2
	Female overweight (%)	34.5	38.4
	Female obesity (%)	38.0	39.6
	History of diabetes mellitus (%)	3.3	3.1
Physical environment and infrastructure	Access to piped water (%)	84.0	98.0
	Water safety for drinking purposes (%)	17	100
	Water supply interrupted (%)	100	30.7
	Access of the households to drainage public sewers (%)	0.0	56.0
Social and human development	Illiteracy rate among adults (%)	36.4	25.2
	Fully immunized infants (%)	95.1	91.7
	Delivery assisted by skilled birth attendance (%)	72.2	71.7
	Prevalence of male tobacco smoking (%)	55.9	43.9
Economics	Unemployment (%)	7.9	11.9
Governance	Voter participation (last constitutional voting) (%)	52.7	41.0

Indicates more than 20% difference in performance compared to national level.
Indicates less than 20% performance compared to national level.
Indicates good or similar performance compared to national level.

Measuring blood pressure

Limited access to safe drinking-water

Low level of environmental sanitation

Children playing in non-sanitary conditions

urban community of Ariana, Tunisia

Urban HEART in Ariana, Tunisia

Tunisia is experiencing a fast rate of urbanization as a result of demographic growth and migration. Urbanization has highlighted many challenges at the community level, especially poverty and health inequities. Globally, multiple strategies have been used to address health inequities. Three main approaches applied to measure and tackle inequities in health include: targeting disadvantaged populations or social classes and narrowing health inequities throughout the whole population.

The urban area of Ariana is situated on the northeast coast of Tunisia and is the capital city of the Ariana governorate. Ariana is ranked the sixth most populated city in Tunisia with 500 000 inhabitants in four districts.

Among the urban community of Ariana there are continuing efforts to improve infrastructure and the access of the population to many services, such as safe drinking-water, sanitation, electricity, education and primary health care services. However, these efforts face many challenges due to the limitation of resources and the rapid rate of urbanization.

The need for equity assessment emerged when the municipality of Ariana found that there was a lack of information to develop an evidence-based strategy to solve current health-related problems, lack of multisectoral approach to assess health inequities and to choose appropriate interventions in response to community needs.

As a result "Urban HEART" has been introduced in Ariana Ville, which is the most populated district in Ariana. This district has the highest rate of infant mortality, prevalence of noncommunicable diseases and related risk factors, mental illness, higher prevalence of tobacco smoking, illiteracy and low levels of primary education. In addition, Ariana households pay a higher share of health expenditures, which is a real burden and constraint that affects the utilization of health care services. The municipality and the regional Directorate of Public Health in Ariana has played a central role in networking and building partnership to conduct the assessment.

The sample of this study covered 1200 households (3000 individuals) in four districts (Table 3) – Ariana Ville (36%); Ariana Superior (18%); Ennasr City (18%); and El Manazeh (28%).

According to the results of the study a response to reduce health inequity should be examined and planned with all partners and stakeholders and should take the following points into consideration.

- Given the high prevalence of risk factors for cardiovascular disease, it is recommended to implement an approach with respect to social and environmental factors within Ariana.

Policies to ban smoking in public places to increase tobacco-free areas should be enforced and promoted.

- Green areas should be maintained.
- The public should be encouraged to use sporting facilities for physical exercise.
- Environmental health should be improved.
- The capacity of local health care services should be enhanced through the development of prevention strategies for chronic disease, community-based prevention programmes, risk factor prevention, healthy lifestyle promotion and regular health monitoring of at-risk populations.

Table 3. Comparison of main indicators between four districts in Ariana, Tunisia

Domain	Indicators	Ariana Ville	Ariana Superior	Ennasr City	El Manazeh
Health outcomes	Infant mortality[1]	18.1	17.3	11.5	10.6
	Diabetes (known)	12.6	9.8	5.9	9.9
	Hypertension	42.0	38.1	23.0	36.1
	Death-related to road traffic injuries (100 000 inhabitants)	0.0	8.4	3.1	0.0
	Under-five mortality rate	19.6	19.1	12.7	11.7
	Maternal mortality ratio	0	0	0	0
	Life expectancy at birth[2]	75.5	75.9	76.4	76.7
	Prevalence of all cancers	2.3	1.9	0	2.3
	Prevalence of cardio vascular diseases	11.6	5.6	13.2	17.3
	Prevalence of respiratory diseases	29.5	45.8	29.4	16.5
	Prevalence of mental illness	17.0	0	4.4	2.3
Physical environment and infrastructure	Access to safe drinking-water	99.5	99.6	99.6	99.5
	Access to improved sanitation	99.3	99.6	99.6	99.5
	Households served by municipality solid waste management system	100	100	100	100
	Work-related death accidents (100 000 exposed workers)	0.0	9.0	6.6	0.0
	Work-related injuries (100 000 exposed workers)	0.0	9.0	6.6	0.0
	Alcohol outlets (density per 100 000 inhabitants)	2.74	0.00	0.00	6.05
	Access to green spaces	6.5	2.8	5.4	6.3
Social and human Development	Completion of primary education	96.0	97.0	98.0	98.0
	Prevalence of tobacco smoking	20.7	27.5	28.5	28.9
	Literacy (over 10 years)	9.0	8.5	5.5	5.2
	Overweight and obesity (IMC>=30)	30.1	31.3	17.6	16.7
	Physical activity	54.5	58.2	61.1	57.2
Economic	Unemployment rate	7.7	7.6	5	4.6
	Extreme poverty	1.2	1	0.9	0.8
	Share health expenditures to total households expenditures	11.3	9.4	8.4	8.2
	Indicators of catastrophic health expenditures	45	29	5	21
	Percentage of population with social health insurance	81.6	56.3	92.9	86.6
	Women in workforce rance	37.5	39.1	40	41
Governance	Insurance coverage (complementary)	2.4	1.6	8.2	7.1
	Government spending on education	33.5	21.6	29.9	15.1

The target is to reduce the infant mortality rate by 50% by 2015 (Millennium Development Goals)
For life expectancy at birth, the target is to increase it by 2 years by 2014.

Indicates poor performance in comparison to the national level.

Indicates performance below the indented goal but slightly lower in comparison to the national level.

Indicates good or similar performance in comparison to the national level.

The indicator is not available to compare.

Progress in community development in health in Oman

The Ministry of Health of Oman is addressing community participation in primary health care through a variety of channels. *Willayat* (district) health committees and community support groups advocate for community-based initiatives through community capacity-building and motivation for local health development. Some key achievements made during 2010 and 2011 are highlighted below.

Training of community support groups, Nizwa healthy lifestyle project, Oman

- To build the capacity of community support groups, the Ministry of Health, in collaboration with UNICEF, has developed a training manual that uses the latest training methodologies (auditory, visual and sensory). The manual will be used as a reference tool for all trainers of community support groups and cluster representatives. The manual covers communication skills, reproductive health, nutrition, household and road traffic injuries, tobacco control and physical activity.
- A pocket manual for community support groups has been developed. It contains key messages and so far, 36 master trainers have been trained on the use of this manual.
- Community support group health promotion success stories have been documented and shared for advocacy via video and advocacy kits distributed at different national events.
- A guideline for *willayat* health committees has been developed to build the capacities of members in 2011. It aims to provide standards on operational mechanisms for members to implement their activities at the community level.
- The *willayat* health committee participated in a national award competition for community-based projects. A total of 18 projects reached the final stage of the award, six of these addressed noncommunicable diseases; seven addressed environmental health; and five focused on the health of special groups. Seven projects were recognized for their work in a formal award ceremony.
- The healthy lifestyle project in Nizwa was evaluated in 2009 using a comprehensive CBI evaluation tool. It assessed the effectiveness of interventions in changing peoples' behaviour and its positive impact on the health of the community. The preliminary results were also presented at the 57th Session of the Regional Committee for the Eastern Mediterranean, which was held in Cairo from 3–5 October 2010. A validation workshop will be conducted before dissemination of the results. Results of the intervention evaluation will ultimately be shared with policy-makers and the community.

New Director of the WHO Centre for Health Development, Kobe, Japan

WHO would like to welcome Dr Alex Ross as the newly-appointed Director of the WHO Centre for Health Development in Kobe, Japan. Prior to this new appointment, Dr Ross was the Director of the partnership programme and of UN reform, Office of the Assistant Director-General, General Management at WHO headquarters. The WHO Regional Office will continue working with the Kobe Centre in different areas, particularly urbanization and health, health equity assessment and response, emergency risk reduction and health in all policies.

The efforts of Dr Jacob Kumaresan, the former Director for the last four years, have been highly appreciated. During his time Dr Kumarsan provided technical support to the Regional Office to initiate the Urban HEART in six countries of the Region. In addition, he led global movements on urbanization and health during World Health Day 2010. The Regional Office will always remember his efficient and timely support to our joint interventions towards health development for all. Dr Kumaresan has been appointed Executive Director of the WHO office at the United Nations, New York. We wish him all the best and success in his future role.

Dr Alex Ross newly-appointed Director of the WHO Centre for Health Development

Dr Jakob Kumaresan, Former Director of the Centre

Community mobilization to control anaemia at Kafr Hakim, Giza, Egypt

Kafr Hakeim is a small village in 6 of October City near Kerdasa, in the Giza governorate of Egypt. It is a slum area with a high percentage of poverty and illiteracy. The population is approximately 15 586. There is one family medicine health centre and four private clinics in the village.

Implementation of CBI programme activities started in Kafr Hakim during 2010 and 2011 through "Future Girls Association for Development", a local nongovernmental organization and under the supervision of the Ministry of Health. Illiteracy classes are being conducted and women's empowerment is being achieved a through the training of 100 women on carpet-weaving. Cluster representatives and heath volunteers have been trained by the Ministry of Health on priority health issues.

Many in the community are suffering from anaemia and intestinal infestations. The Ministry of Health and the WHO country office in Egypt took action through mass screening to address the high prevalence of diarrhoea, anaemia, poor sanitation and poverty and to ensure the early detection and management of anaemia and intestinal parasites and infestation. They also determined to address the root causes of these health-related problems.

The intervention targets the whole population. People receive physical examination and laboratory examinations at health centres. They fill out a questionnaire to identify their risk factors and are then provided with consultations on suitable solutions and needed interventions.

The study has been designed to determine the prevalence of anaemia and intestinal parasite infestation and associated risk factors. The campaign involved networking with the community and potential local partners to work on identifying efficient and needed interventions to tackle the root causes of the problems.

The Ministry of Health, WHO, local development committees, community leaders and the Governor's office participated in the study. Almost 600 people from all age groups attended the clinic from 9:00 a.m. to 4:00 p.m. on 6 September 2011 to participate. The results revealed that the overall prevalence of anaemia among the study population was 48%. Children under 6 years old showed the highest prevalence of anaemia in comparison to other age groups. Girls under 6 years old showed the highest prevalence rate at 65% (Figure 1). Females, in general, showed higher rates of anaemia than males (Figure 2).

Community happiness at the programme's intervention

The presence of parasitic infestation, such as schistomiasis (bilharzia), is accompanied by an significant increase in the percentage of anemia. Income was not associated with anaemia in this survey as the majority of families earned a similar monthly income.

Food is an important factor associated with the prevalence of anaemia. People consuming fruits and vegetables on a daily basis showed significantly lower levels of anaemia, in comparison to those who did not. Also, the amount of fruits and vegetables per day played an important role in the occurrence of anaemia. Those consuming four servings of fruits and vegetables per day showed the lowest levels of anaemia in this survey at 28.6%.

According to the study results, partners and stakeholders will determine interventions according to the root causes of anaemia in the target area.

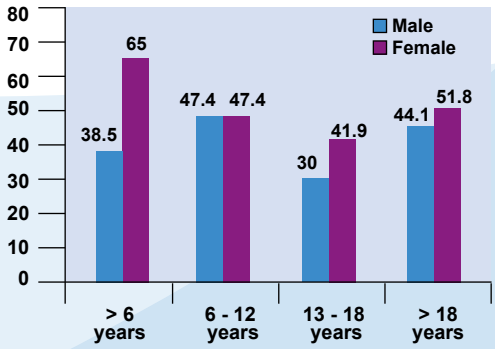

Figure 1. Percentage distribution of anaemia according to age group and sex

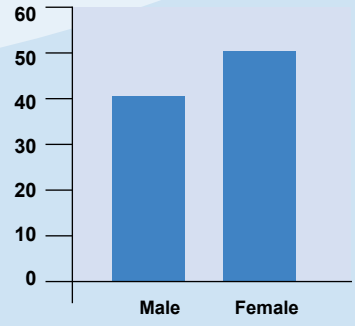

Figure 2. Prevalence rate of anaemia according to sex

Filling out questionnaires at health clinics, 6 September 2011

Mass screening for anaemia, 6 September 2011

WHO awards certificates on urbanization and health to mayors of healthy cities in Islamic Republic of Iran

Presentation ceremony

About 70 cities in the Islamic Republic of Iran received WHO's urbanization and health certificates due to the cities' actions for World Health Day 2010 and their registration in the global initiative "1000 cities 1000 lives".

All of the cities managed to conduct healthy lifestyle-related activities, such as: physical exercise, tree plantation, safe driving, cleaning, no-smoking campaigns and free medical check-ups. These community-based interventions were implemented in close collaboration with mayors, governors, universities of medical sciences and health services and members of the community. WHO and the mayors of participating cities signed a letter of collaboration that sealed the commitment of WHO and the Government on the sustainability of these healthy lifestyle practices. The event took place on 1 January 2012 in Isfahan and was attended by the Chancellor of Isfahan University of Medical Sciences and Health Services, governors, mayors and public health officials involved in urbanization and health activities during 2010 from all over the country.

The positive experience in implementation of healthy cities, including Saveh, was reflected in a broadcast made about health activities conducted in cities in the Islamic Republic of Iran during 2010. WHO presented the certificates to 70 mayors from the various cities. The meeting was covered extensively by the media.

Healthy lifestyle-related activities

Expansion of the basic development needs (BDN) programme in Pakistan

Group work to agree on the road map for BDN expansion

The Ministry of Health implemented the basic development needs programme in Pakistan in 1995, initially in the Nowshera district. Now the programme covers nine districts and a population of nearly 2.3 million. It focuses on community organization and empowerment, the active participation of women in literacy classes and income-generating activities. The BDN programme evaluation revealed the effectiveness of literacy and vocational training centres in improving maternal and child health and family planning coverage in different BDN-implementing sites.

In a large country, such as Pakistan, with more than 180 million, WHO alone is unable to run and support the programme for long periods of time and so strong government support and ownership is needed to institutionalize and expand the programme.

To support BDN institutionalization and expansion in Pakistan, WHO Regional Office conducted a mission in September 2011, during which a two-day workshop was held and attended by key policy-makers and all BDN focal persons at the provincial level. It was agreed that for programme institutionalization local government should work on building partnerships, encourage community participation in the leadership of local health and social development and incorporate the programme in provincial health policies and plans.

WHO recommends that main strategic directions for programme expansion in Pakistan should focus on: government leadership, community ownership, enhanced local capacities for sustained health and social development.

WHO will support in the programme by:

- building the capacity of the volunteers and community health workers
- documenting evidence and conducting advocacy activities
- training cluster representatives and health volunteers on priority health-related programmes and financial management
- establishing community-based information centres
- empowering the community in emergency preparedness and response.

Meeting with BDN provincial focal persons in Pakistan, September 2011

Acknowledgements

- Dr Mohsen Abdel-Hamid Ahmed Gadallah, Former Chairman of the Department of Community Medicine, Director of Family Medicine Centre, Faculty of Medicine, Ain Shams University
- Dr Aisha Benarafa, Public Health Consultant, Morocco
- Mr Chokri Rafa, University Professor, Health Economist, University of Tunisia
- Dr Nazar Elfaki, Director of Policy and Planning for Human Resources for Health, Federal Ministry of Health, Sudan
- Dr Nohaol Al Homsi, CBI Focal Point, WHOs Representative's Office Lebanon
- Dr Samira Jabal, CBI Focal Point, WHOs Representative Office Morocco
- Dr Ali Garraoui, Technical Officer, WHO's Representative Office, Tunisia
- Dr Soad Abd El Megid, CBI Focal Point, Ministry of Health and Population, Egypt
- Dr Mona Abo El Naga, CBI Focal Point, WHO's Representative's Office, Egypt
- Ms Ruth Mabry, Technical Officer, WHOs Representative's Office, Oman
- Dr Hanan Abdo, CBI Focal Point, WHOs Representative's Office, Sudan

Expansion of the basic development needs programme in Gezira, Sudan

El-Gezira State is located in the eastern central area of Sudan. It lies just southeast of the confluence of the Blue and White Nile rivers. Most of the population is engaged in agriculture. The basic development needs programe was introduced in Gezira in 2002, covering 15 communities with a population of 18 000. The programme in Gezira has had a big impact. In one village known as Biriab in which the programme was implemented in 2006 achievements have included:

- the establishment of a computer centre and vocational training centre supported by local resources
- the training of more than 150 females in handicrafts, embroidery and knitting
- the establishment of a community information centre
- addressing health issues related to the prevention of tuberculosis, malaria, vaccine preventable diseases, the promotion of eye care and the construction of two girls' classes in the school
- construction of a female development centre with training sessions on nutrition and skills training
- construction of a new mosque by the committee
- renovation of the youth development centre.

In 2011 the State Minister of Health requested the Federal Ministry and WHO to provide support to the expansion of the programme at state level. The requirements for expansion were discussed at a meeting on 12 July 2011, which was attended by representatives of health departments from different localities, the Women's Union and health programme managers.

Areas in which the BDN programme is being implemented generally experience a higher socioeconomic status. Some of the features of programme-implementing areas include:

- greater planning capacity
- improved communication skills
- evidence-based planning to address community needs
- better health and education coverage
- greater health awareness
- women's empowerment and involvement in local decision-making
- a greater number of skilled women able to contribute to the economy of their families

Women's handicraft products

- lower female school drop-out rates.

During a joint Federal Ministry of Health and WHO mission to Gezira State, the Women's Union with a representative in 3000 villages of state and rural schools for agricultural development were identified as potential partners in women's empowerment and to improve agricultural production. BDN programme expansion could be conducted in phases over three years through a state plan to cover 4 million people in Gezira State. The State Minister of Health proposed to introduce the programme in 2012 in Madani, Um-Ul-Qura and south Gezira localities to cover a population of nearly 1 million. This will be followed by introduction of the programme in two localities in 2013 and a further two localities in 2014.

During expansion phases the following activities have been recommended.

- Obtaining high-level political commitment to reduce poverty and move towards human development within the BDN approach.
- Training master trainers at state and local level to train service providers at the peripheral level, health care providers and teachers.
- Establishing a multisectoral committee at local level.
- Establishing a strong and supportive intersectoral team at state and local level to follow-up and fill gaps for implementation of planned interventions.
- Identify stakeholders and map potential partners, their interests and possible contribution to programme expansion.
- Encouraging ownership by health programme managers (Expanded Programme on Immunization, reproductive health, disease control, nutrition, health education, etc.). Planning for sustained and effective programme monitoring and evaluation at state and local level using the WHO tool *Community-based initiatives self-monitoring tool – 100-point checklist,* a publication in both English and Arabic.

As preparation for programme expansion in Gezira, an orientation meeting of authorities of three localities was organized, a technical intersectoral support team was trained in Madine, Um-Ul-Qura and South Algazira localities, and plans were finalized and orientation conducted for 15 new communities that will be implementing the programme soon.

Listening to community needs, Biriab, Gezira

Institutionalization of the community-based initiatives programme in Sudan

CBI expansion meeting Sudan

Strong government support and ownership is needed to institutionalize and expand the community-based initiatives programme to become an integral part of national health, social and development policies. Setting up an effective infrastructure within the health sector at all levels of care to implement the initiatives and allocate sufficient financial and human resources to implement, monitor and supervise community-designed interventions are among key actions towards programme institutionalization.

The Federal Ministry of Health in Sudan organized a meeting in July 2011, chaired by the Director-General of Public Health and Emergencies and attended by staff and managers involved in the community-based initiatives programme.

The objectives of the meeting were to assess the current status of the community-based initiatives programme in Sudan and to agree on future actions to institutionalize and expand the programme.

The following actions were agreed at the meeting.

- The Federal Ministry of Health should prioritize community and local needs.
- The selection of members of community development committees should not be political.
- There should be active ownership of different health-related programmes using existing opportunities at local level. Organized and mobilized communities can be active in the Expanded Programme on Immunization, control of communicable and noncommunicable diseases, improving access to safe drinking-water and sanitation, maternal and child health services and local health planning and management.
- Programme advocacy directed towards policy-makers should begin at the start of programme expansion.
- People's involvement in local health planning and management should be well organized and planned.
- Public health universities should be encouraged to use the initiatives for research and training field studies.
- Village profiles should be developed to streamline programme management and planning.

BDN Expansion Sudan

Résumé

Le Bureau régional souhaite la bienvenue au Dr Ala Alwan comme nouveau Directeur régional de l'OMS pour la Méditerranée orientale. succède au Dr Hussein Gezairy, le Directeur régional sortant. Lors d'une réunion avec le personnel de l'OMS, le Dr Alwan a souligné les domaines de travail prioritaires et a fait remarquer l'importance des initiatives communautaires, des questions de parité homme-femme et des droits de l'homme comme domaines intersectoriels clés devant être pris en compte pendant la planification, le suivi et l'évaluation des programmes en rapport avec la santé.

Hussein M. Jiciir, maire d'Hargeisa, a lancé l'initiative des villes-santé dans le nord-ouest de la Somalie, en collaboration avec l'OMS et le ministère de la Santé. Cette région se relève des effets d'une longue guerre civile et de maigres ressources. M. Jiciir a joué un rôle mobilisateur, permettant des réalisations remarquables. Grâce à cette initiative villes-santé, des activités ont été mises en œuvre : adoption d'une gestion décentralisée de la ville, établissement de partenariats public-privé pour s'attaquer aux problèmes de traitement des déchets solides. Aujourd'hui, plus de 60 % des foyers et tous les marchés, hôpitaux et bâtiments publics sont desservis par le système de gestion des déchets solides. L'OMS maintiendra son soutien à la municipalité pour assurer la pérennité de l'initiative à Hargeisa et encouragera des méthodes plus innovantes.

La Journée mondiale de la Santé 2010 a permis de faire avancer le programme d'action sur l'urbanisation et la santé par l'engagement politique de plus de deux cents villes de la Région. Elle a encouragé la participation de la population et la collaboration intersectorielle à des actions conjointes pour la santé. La ville de Tripoli, au nord du Liban a appliqué le programme des villes-santé en mai 2011, Après l'avoir adapté à ses propres besoins. Le comité de coordination de la ville a dégagé quatre priorités : la sécurité sanitaire des aliments, la santé scolaire, la gestion des déchets solides et la lutte antitabac.

Les conséquences de l'urbanisation sur la santé des populations, l'équité en santé et l'environnement sont devenues une préoccupation majeure des autorités municipales dans la Région. L'outil d'évaluation et d'intervention pour l'équité en santé en milieu urbain, mis au point par l'OMS, est un guide destiné aux responsables politiques et aux décideurs nationaux et locaux. Il les aide à identifier et analyser les inégalités en matière de santé entre les habitants des quartiers urbains, ou appartenant à différents groupes socioéconomiques des villes. Une étude a permis de comparer les indicateurs sanitaires et sociaux d'un quartier de la ville de Salé (Maroc) avec les moyennes nationales, pour aider les urbanistes à prévoir les actions et interventions nécessaires à chaque zone géographique de la ville. Suite à cette étude, le ministère marocain de la Santé va conclure des partenariats avec des parties prenantes pour renforcer l'équité entre les citoyens dans le domaine social et sanitaire. Des priorités et stratégies seront fixées pour réduire au minimum les écarts d'équité et choisir des interventions, selon les ressources disponibles. Les communautés participeront à l'identification des problèmes, l'évaluation des besoins et la mise en œuvre de solutions locales.

Le ministère égyptien de la Santé estime que l'adoption et l'utilisation de l'outil d'évaluation et d'intervention pour l'équité en santé en milieu urbain par les autorités nationales et locales peuvent aider les responsables politiques et les principales parties prenantes à mettre en évidence les déterminants sociaux de la santé et leurs effets sur l'équité en santé. Une étude a été réalisée à Geziret El Warraq (Giza), une zone informelle d'habitat insalubre sur les bords du Nil, aux transports publics qui a un accès limité et ne possède pas de système pour les eaux usées. Les urbanistes ont accepté de communiquer les résultats de cette étude aux partenaires locaux, nationaux et internationaux. Ils accorderont davantage d'attention à la modification des comportements en matière de santé, à l'accès à des services de soins de santé primaires de qualité et au maintien de la couverture actuelle du Programme élargi de vaccination. Les autorités locales, quant à elles, amélioreront la salubrité de l'environnement, les transports locaux et le taux d'alphabétisation des adultes.

La Tunisie connaît une urbanisation rapide, qui est due à la croissance démographique et aux migrations, soulignant les nombreuses difficultés des populations, notamment la pauvreté et les inégalités en santé. Des stratégies ont été utilisées dans le monde pour lutter contre les inégalités en santé. Aprés l'étude réalisée à l'aide de l'outil, les partenaires et les parties prenantes ont sélectionné des activités, dont la mise en œuvre de politiques d'interdiction de fumer, l'entretien d'espaces verts et le renforcement des capacités des services de santé locaux.

À Oman, le ministère de la Santé aborde la question de la participation communautaire aux soins de santé primaires à divers niveaux. Les commissions sanitaires des wilayat (districts) et les groupes de soutien communautaires encouragent les initiatives locales par le renforcement des capacités des populations et la promotion du développement sanitaire. Parmi les principales réalisations 2010 et 2011, citons le manuel de formation destiné aux représentants de groupes et aux volontaires de santé, des actions de sensibilisation et l'évaluation des activités programmatiques pour communiquer les résultats aux responsables politiques et à la population.

Le Dr Alex Ross a été nommé directeur du Centre OMS pour le développement sanitaire de Kobe (Japon). Avant, il était directeur des partenariats et de la réforme des Nations Unies au bureau du Sous-Directeur général chargé de l'administration, au Siège de l'OMS. Le Bureau régional OMS maintiendra sa collaboration avec le centre de Kobe dans différents domaines: relations entre urbanisation et santé, évaluation et prise en compte de l'équité en santé, réduction des risques associés aux urgences et introduction de la santé dans toutes les politiques.

Le ministère de la Santé du Pakistan a mis en œuvre le programme des besoins fondamentaux en matière de développement (BDN) en 1995, en premier lieu dans le district de Nowshera. Celui-ci couvre neuf districts, soit environ 2,3 millions d'habitants. Il se préoccupe principalement d'organiser et de responsabiliser la population, et d'obtenir la participation des femmes aux cours d'alphabétisation et aux activités génératrices de revenu. L'OMS soutient l'institutionnalisation et l'extension de ce programme au Pakistan ; le gouvernement, quant à lui, met en place des partenariats, encourage la communauté à jouer un rôle directeur dans le développement sanitaire et social au plan local et intègre le programme BDN dans les politiques et plans de santé des provinces.

Kafr Hakeim, un quartier de la ville du 6 octobre près de Kerdasa, dans le gouvernorat égyptien de Giza est une zone d'habitat insalubre au taux de pauvreté et d'analphabétisme élevé. Le programme d'initiatives communautaires y a été mis en œuvre en 2010 et 2011. De nombreux habitants souffrent d'anémie et de parasitoses intestinales. Le ministère de la Santé et l'OMS ont pris des mesures de dépistage pour lutter contre la forte prévalence de la diarrhée et des anémies et détecter et prendre en charge rapidement ces affections. Ils ont aussi mis en œuvre des actions pour résoudre les problèmes d'assainissement et de pauvreté. Ils sont déterminés à agir sur les causes profondes de ces problèmes de santé.

Le programme des BDN est en vigueur dans l'État d'El Gezira, au Soudan, depuis 2002 ; il couvre une population de 18 000 habitants. En 2011, le ministre de la Santé de cet État a demandé au ministére fédéral et à l'OMS de soutenir l'extension de ce programme au niveau national. En effet, dans les zones où ce programme a été appliqué, les conditions socioéconomiques se sont en général améliorées. Son extension pourrait être réalisée par phases en trois ans, dans le cadre d'un plan national visant à couvrir quatre millions de personnes dans tout l'État. Le ministre a proposé d'introduire le programme à Madani, à Umm Al Qura et dans les localités du sud en 2012, ciblant environ un million de personnes.

Il est nécessaire que le gouvernement adopte et soutienne le programme d'initiatives communautaires, dans le but de l'institutionnaliser et de l'étendre pour qu'il fasse partie intégrante des politiques nationales dans les secteurs de la santé, de la société et du développement. Pour ce faire, il faut essentiellement mettre sur pied une infrastructure opérationnelle à tous les niveaux du secteur de la santé, pour mettre en œuvre les initiatives et allouer des ressources financières et humaines suffisantes pour réaliser, suivre et encadrer des interventions conçues par la communauté.

الموجـز

يرحب المكتب الإقليمي بالدكتور علاء الدين العلوان، مديراً إقليمياً جديداً لإقليم شرق المتوسط، خلفاً للدكتور حسين عبد الرزاق الجزائري. وفي اجتماعه مع العاملين بالمنظمة، سلّط الدكتور العلوان الضوء على مجالات العمل ذات الأولوية، مُنَوِّهاً بأهمية المبادرات المجتمعية، والمساواة بين الجنسين، وحقوق الإنسان، باعتبارها من المجالات الشاملة التي يتعيّن مراعاتها عند تخطيط وتنفيذ ورصد وتقييم جميع البرامج ذات الصلة بالصحة.

أطلق السيد حسين الجسير، محافظ هيرغيزا، بالتعاون مع وزارة الصحة ومع منظمة الصحة العالمية مبادرة المدن الصحية في المنطقة الشمالية الغربية من الصومال، وهي منطقة لاتزال في مرحلة التعافي من آثار الصراعات الأهلية الطويلة الأمد، وتعاني من شح الموارد. وقد تم تحقيق إنجازات بارزة تحت قيادة المحافظ، ونفذت طائفة من الأنشطة في إطار المبادرة، بدءاً من اعتماد أسلوب اللامركزية في إدارة المدينة، وصولاً إلى إنشاء شراكات بين القطاعين العام والخاص، للتصدي للقضايا المتعلقة بالتخلص من الفضلات الصلبة. وفي الوقت الحاضر فإن أكثر من 60% من الأسر ومناطق الأسواق والمستشفيات والأبنية الحكومية مغطاة بنظام صارم للتخلص من النفايات. وستواصل منظمة الصحة العالمية تشجيعها لمزيد من الأساليب المبتكرة.

وقد قدَّم يوم الصحة العالمي فرصة سانحة لتشجيع جدول أعمال التحضُّر والصحة، وذلك بالحصول على الالتزام السياسي لما يزيد على 200 مدينة في الإقليم، كما شجع هذا اليوم إسهام المجتمعات والتعاون بين القطاعات من خلال تنفيذ إجراءات مشتركة من أجل الصحة. وقد نفذت بلدية طرابلس، في شمال لبنان، برنامج المدن الصحية في شهر أيار/مايو 2011، وكيف تلبّي احتياجاتها الخاصة؛ وقد حددت لجنة التنسيق في المدينة أربع أولويات لها، وهي سلامة الغذاء، والصحة المدرسية، والتخلص من النفايات الصلبة، ومكافحة التبغ.

لقد أصبح أثر التحضُّر على صحة السكان، والعدالة الصحية، وما للتحضُّر من آثار ضائرة على البيئة من الشواغل الرئيسية للسلطات في البلديات في جميع أرجاء الإقليم. وتُعَدُّ أداة منظمة الصحة العالمية لتقييم المساواة الصحية الحضرية والاستجابة لمقتضياتها (Urban HEART) دليلاً يستهدي به أصحاب القرار السياسي ومتخذو القرارات على الصعيد الوطني والمحلي، بقصد التعرف على جوانب انعدام المساواة في الصحة، وتحليلها، بين من يعيشون في مختلف المناطق في المدن، أو بين من ينتمي إلى مختلف المجموعات الاقتصادية والاجتماعية ضمن المدن، وبين مدينة وأخرى. وقد تم تصميم دراسة مقارنة للمؤشرات الاجتماعية والصحية بين المناطق المجاورة لمدينة السيل بالمملكة المغربية وبين المستوى الوطني، لتوجيه القائمين على تخطيط المدن حول الإجراءات التي ينبغي القيام بها والتدخلات اللازمة، لتلبية احتياجات كل منطقة جغرافية ضمن المدينة على حدة. واستجابة للدراسة باستخدام أداة منظمة الصحة العالمية لتقييم المساواة الصحية الحضرية والاستجابة لمقتضياتها (Urban HEART)، ستبني وزارة الصحة في المغرب الشراكات مع الشركاء المحتملين وأصحاب المصلحة المعنيين من أجل تحسين الصحة والمساواة الاجتماعية بين السكان. وسوف يتم تحديد الأولويات والاستراتيجيات من أجل إنقاص الفجوة في المساواة إلى أقل قدر ممكن، وانتقاء التدخلات وفقاً للموارد المتاحة. وسوف يتم التماس المشاركة المجتمعية في التعرُّف على المشكلات، وفي تقييم الاحتياجات، وفي تنفيذ الحلول المحلية للمشكلات المحلية.

وجدت وزارة الصحة في مصر أن اعتماد واستخدام أداة منظمة الصحة العالمية للتقييم (Urban HEART) من قبَل الحكومة على الصعيد الوطني والمحلي يمكن أن يوَجّه أصحاب القرار السياسي وأصحاب المصلحة المعنيين في التعرُّف على المحدّدات الاجتماعية للصحة وأثرها على المساواة الصحية. وقد أجريَت دراسة في جزيرة الورَّاق، في محافظة الجيزة، باعتبارها منطقة سكن عشوائي على ضفاف نهر النيل، تعاني من نقص في المواصلات العامة، ومن عدم كفاية نظام الصرف الصحي. وقد وافق القائمون على تخطيط المدينة على اطلاع الشركاء المحليين والوطنيين والدوليين على النتائج التي تمخَّضت عنها الدراسة بأداة منظمة الصحة العالمية لتقييم المساواة الصحية الحضرية والاستجابة لمقتضياتها (Urban HEART)، وسوف يولون المزيد من الاهتمام من أجل تحسين السلوك المتعلق بالصحة، وإتاحة خدمات الرعاية الصحية الأولية الرفيعة الجودة، والمحافظة على التغطية الحالية بالبرنامج الموسَّع للتمنيع. وسوف تقوم السلطات المحلية بتحسين الأوضاع الصحية والبيئية، والمواصلات المحلية، ومعدلات تعلم القراءة والكتابة بين البالغين.

تعاني تونس من معدل سريع من التحضُّر، نتيجة للنمو السكاني، ونتيجة للهجرة. وقد أسفر التحضُّر عن العديد من التحديات على مستوى المجتمع، ولاسيّما الفقر، وجوانب انعدام المساواة الصحية. وعلى الصعيد العالمي، استخدم العديد من الاستراتيجيات للتصدّي لجوانب انعدام العدالة الصحية. ونتيجة لاستخدام أداة منظمة الصحة العالمية لتقييم المساواة الصحية الحضرية والاستجابة لمقتضياتها (Urban HEART) تعرَّف الشركاء وأصحاب المصلحة المعنيون على طائفة من الأنشطة، تشمل تنفيذ السياسات التي ترمي إلى حظر التبغ، والمحافظة على مناطق خضراء، وتعزيز القدرات في الخدمات الصحية المحلية.

إن وزارة الصحة في عُمان تتعامل مع إسهام المجتمع في الرعاية الصحية الأولية من خلال مختلف القنوات، فالمجالس الصحية في الولايات ومجموعات الدعم في المجتمع، تدعو إلى المبادرات المجتمعية من خلال بناء القدرات في المجتمع والتحفيز من أجل التنمية الصحية على الصعيد المحلي. ومن الإنجازات الكبرى التي تحققت عام 2010 وعام 2011 إعداد كتيب تدريبي لدعم الفئات المجتمعية وممثلي القطاعات والمجموعات، وتنفيذ إجراءات برنامجية للدعوة والتقييم، بُغْيَة إيصال النتائج إلى أصحاب القرار السياسي وإلى المجتمع.

وقد عُيِّن الدكتور أليكس روس مديراً جديداً لمركز التنمية الصحية التابع لمنظمة الصحة العالمية في كوبي، اليابان، وقبل هذا التعيين، كان الدكتور روس مديراً لبرنامج الشراكة وإصلاح الأمم المتحدة في مكتب مساعد المدير العام لشؤون الإدارة العامة، في المقرّ الرئيسي لمنظمة الصحة العالمية. وسيواصل المكتب الإقليمي لمنظمة الصحة العالمية لشرق المتوسط تعاونه مع مركز كوبي في مختلف المجالات، ولاسيّما في مجال التحضُّر والصحة، وتقييم المساواة الصحية، والاستجابة لمقتضياتها، وتخفيف مخاطر الطوارئ، وإدراج الصحة في جميع السياسات.

نفَّذت وزارة الصحة في باكستان برنامج تلبية الاحتياجات التنموية الأساسية عام 1995، بدءاً من منطقة نوشيرا، أما الآن فإن البرنامج يغطي 9 مناطق، وما يقرب من 2.3 مليون نسمة. ويركز البرنامج على تنظيم المجتمع وتمكينه، وعلى الإسهام الفعال للمرأة في صفوف محو الأمية، وفي أنشطة استدرار الدخل. وتقدِّم منظمة الصحة العالمية الدعم لإضفاء السمات المؤسسية على برنامج تلبية الاحتياجات التنموية الأساسية الذي بدأ من كفر حكيم عام 2010 وعام 2011، إذ يعاني الكثير من أفراد المجتمع من فقر الدم ومن العدوى بالطفيليات. وقد عملت وزارة الصحة مع منظمة الصحة العالمية على اتخاذ الإجراءات للتحري الجموعي، من أجل التصدّي للمشكلات الواسعة الانتشار، وهي الإسهال، وفقر الدم، وسوء الإصحاح، والفقر، وذلك لضمان الكشف الباكر والمعالجة لفقر الدم وللطفيليات المعوية والعدوى بها. كما عقدت منظمة الصحة العالمية ووزارة الصحة العزم على التصدّي للأسباب الجذرية لهذه المشكلات ذات الصلة بالصحة.

وقد تم إدخال برنامج تلبية الاحتياجات التنموية الأساسية في ولاية الجزيرة في السودان في عام 2002، ليغطي 000 18 نسمة من السكان. وفي عام 2011 طلب وزير الصحة في الولاية من وزارة الصحة الاتحادية ومن منظمة الصحة العالمية تقديم الدعم لتوسيع البرنامج على مستوى الولاية. وتتمتع المناطق التي تم تنفيذ برنامج تلبية الاحتياجات التنموية الأساسية فيها بشكل عام بوضع اقتصادي واجتماعي أعلى من غيرها؛ ويمكن لتوسيع رقعة البرنامج أن يتم على مراحل خلال 3 سنوات في الولاية ليغطي 4 ملايين نسمة في ولاية الجزيرة. واقترح وزير الصحة في ولاية الجزيرة إدخال البرنامج في عام 2012 في كل من مَدَني، وأم القرى، والمناطق المحلية في جنوب الجزيرة لتغطية ما يقرب من مليون نسمة من السكان.

تمسُّ الحاجة إلى الدعم وإلى الإحساس بالملكية بقوة، من أجل إضفاء السمات المؤسسية وتوسيع برنامج المبادرات المجتمعية حتى تصبح جزءاً لا يتجزأ من الصحة الوطنية، ومن السياسات التنموية والاجتماعية، ويُعْتَبَر إعداد البنية التحتية ضمن القطاع الصحي على جميع مستويات الرعاية، من أجل تنفيذ المبادرات، وتخصيص الموارد المالية والبشرية الكافية واللازمة لتنفيذها ومراقبتها، والإشراف على التدخلات المصممة مجتمعياً، من الإجراءات الرئيسية الهادفة إلى إضفاء السمات المؤسسية على البرنامج.

World Health Organization

Regional Office for the Eastern Mediterranean

For further information contact:

Community-based Initiatives
World Health Organization
Regional Office for the Eastern Mediterranean
Abdel Razzak Al Sanhoury Street,
PO 7608 Nasr City,
Cairo, Egypt
Telephone: 00-202-2276-5000
Facsimile: 00-202-2670-2492/4
e-mail: CBI@emro.who.int
web site: http://www.emro.who.int/cbi

Write to us at: CBI@emro.who.int