Community-based initiatives
Future directions

The CBI programme will strive to build the capacity of its staff at country level by creating a core group of well trained staff in different sectors involved in implementation of workplans for CBI and pro-poor policies. More emphasis needs to be placed on the linkages between the Millennium Development Goals (MDGs), CBI, Poverty Reduction Strategy Papers (PRSps), Sector-wide Approaches and making CBI an integral part of national development and health policies. In an effort to support countries in developing CBI, greater emphasis will be placed on developing and reviewing national MDG strategies and plans of action. This will be done in consensus with all major stakeholders and donors to ensure PRSps and Country Cooperation Strategies are MDG-oriented. Efforts will be made to strengthen coordination between intersectoral health-related programmes and create a monitoring and supervisory team composed of representatives from the different health-related programmes.

Furthermore, MDG monitoring tools for evaluation and reporting will be developed and greater efforts will be made to align partnerships and harmonize efforts. Partnerships will be built between CBI and public health institutes and universities at the country level, making these centres a technical resource for training and research in health and development.

Improvements in the health component of CBI, through integration of various health interventions/programmes, will be one of the priorities. Based on the guidelines for implementation of directly observed treatment, short course (DOTS) for tuberculosis control in basic development needs programme (BDN) areas it is expected that by 2007, DOTS will be implemented in all BDN areas of the Region through the community's active involvement. A plan is being prepared to generate a community-based insurance scheme using the community development fund or social welfare fund, or any other available source to support health and welfare of the poor in Pakistan, Sudan and Yemen. Policy-makers and city planners need to be oriented to the hazards of the rapid growth in urban slums and develop specific strategies to address the health and quality of life of people as part of the healthy cities programme.

CBI will continue to develop advocacy materials and encourage Member States to create their own in local languages for exchange of experiences, evidence-building for programme expansion and resource mobilization. On behalf of the CBI unit, I would like to thank all Member States and colleagues who contributed to the four issues of the CBI Newsletter in 2005. We look forward to receiving further news of your successes and collaborations with potential partners, donors and UN agencies interested in sustainable development.

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Interview with
Dr Ahmad Mohit,
Director, Health Protection and Promotion

1. In your 12 years at WHO and with your vast experience in working with people's behavioural patterns, what would you say is the most effective means to improve the health and lives of people living in poverty in our Region? How would you mobilize people for health from a behavioural and lifestyle perspective?

This is a fundamental question which needs a rather comprehensive answer. Let me start by saying that as important as behavioural patterns and lifestyle are, they are but a part of a larger system and unless we combine them with other determinants, like real improvement in the living conditions of the poor, their maximum effectiveness cannot be realized. Therefore, let me answer this question by looking at different levels of the system.

Let us start at the global level: the challenges and complexities today's world is facing have unparalleled proportions. In general, the greatest challenge of today's world is an increasing disparity between different worlds existing on the same planet. For instance, look at the paradox of globalization. On the one hand, it promises more dialogue among

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civilizations; a world with fewer boundaries and a planet with more communication and expanded relations between all the inhabitants, which by promoting fair trade would bring prosperity to all. On the other hand, and in reality, the same concept of globalization means more poverty for the globalized poor and more prosperity for the globalized rich.

Another related issue with a high level of complexity is poverty. Although there is no agreement on the definition of poverty, I think we can at least agree on one fact that poverty is, in addition to the lack or deficiency of material needs like food and shelter, the lack of knowledgeand know-how and the lack of means to defend one's rights. It also has deeper human dimensions which affect the educational and cultural life of the poor; in general a poor person has less opportunity to grow. There are also other aspects, for instance, rapid, unplanned urbanization causes the emergence of a sub-class of the "nouveaux-poor". These are impoverished new slum dwellers, who did not experience the deprivation and alienation of living in and around the large cities in their villages of origin. Although they might have been poor in their own villages, the village community was more cohesive and they knew how to deal with that type of poverty. Now, they are poor without knowing how to be poor and it makes their misery deeper. Another important issue regarding poverty is that there are no simple solutions to overcome it. Over-simplistic ideas like distribution of wealth cannot work alone and above all else, we need to empower the poor developing their potentials to increase their productivity, consequently this will lead to a more meaningful participation in the democratic process.

In addition, there are issues related to governance. Globally, the role of governments is changing and as this change advances, new possibilities and new problems arise, which can affect health, and we need to predict and address them. At a more local level, the diverse definitions of what is called "community" and the role communities play in both governance and stewardship of change are important. The effect of such a role in creating initiatives for improvement of different aspects of people's life, including their health, is increasingly important and will most probably be more important in the future. There are also issues related to further environmental degradation, unhealthy patterns of food consumption and unprecedented psychological stresses caused by breakdown of families and social cohesion, and seemingly unending conflicts and injustice.

At the level of our Region, we need to deeply study what constitutes "community" and this takes me to the point of addressing your question more specifically: In order to influence the life of the people living in poverty and mobilize them for health we need to first understand their language, concerns, real behavioural patterns and lifestyles. This requires concentrated studies in different areas of health and behaviour. We also need to understand what really influences the people and to whom the people really listen. In other words, we need to discover the real community leaders and talk to the people through them. We cannot sit in our rooms and theorize about peoples' needs and what influences them. It should come from them, and we, as honest observers, researchers and planners, should find ways of honestly understanding these factors and plan for action based on this understanding. We also need to understand our limitations as an organization. We can address poverty in relation to health. For the rest, we need to develop true interagency cooperation, promote national involvement and support regional and national nongovernmental organizations and the like. Then we need to develop target-specific and realistic materials and programmes for different levels, taking into account their needs, sensitivities, liabilities and assets. I know that together we are doing a lot, but there is always room for improvement.

2. Can you share with us successful examples of integrated mental health programmes in primary health care in the Region and what can communities do to reduce the hazards of mental disorders and substance abuse?

Let me start by saying that thanks to my predecessor, Dr Wig, our Region was a pioneer in the development of the concept and programmes for integration of mental health within primary health care. Development of mental health as a part of general health started during the decades of 1960s and 1970s when the late Dr Tigani El Mahi, and later Dr Taha Ba'ashar, held the position of Regional Adviser, Mental Health in this Region. Experience with patient-friendly hospitals in Sudan was an example of the innovative approaches created by Drs El Mahi and Ba'ashar. But it was Dr Wig who brought the idea of integration of mental health within primary health care to this Region. Dr Wig had experienced this during the 1970s in Chandighar, India, and this was perhaps one reason that he was invited to join WHO in this Region as the Regional Adviser. After joining WHO/EMRO in the early 1980s, he started a regional effort for development of national mental health programmes, and in two countries, Egypt and Pakistan, two pilot projects of integration were developed, respectively in Fayyum and Gujar Khan near Rawalpindi. At the same time, a real change was happening in the health system of the Islamic Republic of Iran and that was the nationwide development of a health network and integration of health provision and medical education. It was a golden opportunity which we were able to use for integration of mental health within primary health care. Thanks to the efforts of a number of dedicated professionals, like the late Dr Davoud Shahmohammadi who eventually lost his life in a plane crash on his way to inaugurate a new project, it developed on a nationwide scale, providing coverage to millions of people. Perhaps that project was also one reason that I was invited to join WHO. During the 1990s, national mental health programmes were developed in all countries of the Region and programmes for integration have been developed with different levels of coverage. The examples are many and here I mention countries like Afghanistan, Bahrain, Iraq, Jordan, Morocco, Saudi Arabia, Syrian Arab Republic and Tunisia. We have recently, and with the efforts of Dr Murthy, Medical officer for Mental Health, started programmes for Djibouti, Somalia and Sudan, and I have great hope for the success of these programmes. I must say that any success in any of these countries would not have been possible without the existence of dedicated national professionals and WHO Representatives and many thanks to all. Finally, let me say that what we need now is to move towards new horizons and find ways of responding to the new demographic realities and increasing stress in the Region. I am sure Dr Yasami, our new Regional Adviser for Mental Health, is planning that.

> "In order to influence the life of the people living in poverty and mobilize them for health we need to first understand their language."

3. As the Director of the Health Protection and Promotion Division in the Regional Office since October 2003, you have been responsible for some of the most important health interventions such as those on nutrition, child and adolescent health, reproductive health, mental health, noncommunicable diseases, promotion of healthy lifestyles, food and chemical safety and environmental health. These are all areas that we are planning on integrating within CBI areas in the Region during 2006–2007. What do you see as the responsibility of the various technical units in helping us with this endeavour and what do you believe is the role of the community and households in ensuring these health related interventions are sustained and enhanced?

There are many areas related to the work of our division that can benefit from different levels of community-based initiatives. Environmental health, nutrition, child health and programmes like IMCI, mental health and particularly substance abuse and introduction of new approaches like harm reduction, school health, health education and promotion in general, and issues related to the elderly, are among these areas and we need to develop joint programmes and approaches in each of these areas. However, I would like to specifically concentrate on one highly important issue for our Region where collaboration and joining of efforts and approaches is absolutely essential, and that is decreasing maternal mortality. The reasons for high maternal mortality in some countries of the Region range from lack of sufficiently trained local birth attendants to deficiencies of referral facilities and higher level obstetrics care, to cultural beliefs. In order to meaningfully decrease maternal mortality, we need to develop a comprehensive programme addressing all these issues and community-based programmes are indispensable for such an approach. I am certain that decreasing maternal mortality needs serious involvement of the community, which at our level means close collaboration and planning between concerned units.

4. Dr Mohit, you are an esteemed and valuable member of the development and international civil servant community. What would your advice be to CBI in their future endeavours?

I am humbled with this question. All of you are experts in your field, and are doing great work for a programme which the Regional Director attaches much importance to. I can share a few observations:

- We need to study the real meaning of concepts such as community and participation in this Region and in our cultures.
- We need to always remember our mandate, which is health, and always concentrate on health. Our community-based approaches should in one way or another be translated to health goals and targets.
- Links with different programmes and a holistic approach with emphasis on interdepartmental joint planning is an absolute necessity.
- Communities and their leaders are extremely important in development of new attitudes and behaviours. As the epidemiological and demographic patterns change, we need to adjust and be creative in finding new ways of using communities to promote health. The greatest ally of a programme for health and behaviour are community-based initiatives.

Thank you for this unique opportunity.

CBI
achievements in 2004 – 2005 by Member States

In 2004–2005 the regional community-based initiatives programme (CBI) continued to emphasize the pivotal role of health in poverty reduction and sustainable development. Linking global initiatives such as the Millennium Development Goals, Second Generation Poverty Reduction Strategies and Social Determinants of Health with the community-based initiatives became a strategy for the Regional Office and Member States during the two intercountry meetings on Millennium Development Goals (MDGs) and operationalization of poverty reduction strategies. CBI assessed the introduction of basic development needs (BDN) programmes in Djibouti, Syrian Arab Republic and Yemen, as well as expanding the programme in different countries of the Region to new areas, and countries such as Iraq, a country facing complex emergencies.

CBI and Stop Tuberculosis jointly developed guidelines to integrate directly observed treatment, short course (DOTS) in the BDN programme areas of the Region and this was supported through the Joint Programme Review and Planning Mission 2006–2007. A website was launched and four newsletters were published to exchange information and innovative experiences.

Afghanistan

The BDN programme was consolidated and expanded to have functional BDN sites in 10 provinces of Afghanistan. The BDN programme is currently operational in 7 provinces, 18 districts and 31 villages: Kabul, Nangarhar, Ghazni, Herat, Bamyan and Badakhshan, covering a population of 96 713. The BDN programme has been strengthened and improved in the existing villages through a number of interventions. Training courses were conducted for community members, for district health staff on the linkages between primary health care and CBI, and for cluster representatives on health, nutrition and their role as health promoters in the area. A visit was organized by the district authorities for the BDN national and provincial teams, to advocate for partnership and resources for the BDN programme.

The existing healthy cities programme in Nangarhar was further strengthened, and strong linkages between BDN and healthy cities programmes have been developed in all those locations. The cluster representatives were trained on the promotion of a healthy environment, which had an impact on a number of services in the community, such as drainage of wastewater, proper disposal of waste, safe food preparation, safe drinking-water, ventilated houses, sanitary latrines, good nutrition and breastfeeding and family planning.

Djibouti

A standardized regional evaluation tool was developed and used in the evaluation mission to Djibouti, 6–14 February 2005. The evaluation showed that the programme has achieved all planned objectives and WHO should continue its technical and financial support for programme expansion.

The BDN programme is currently running in 7 sites in 5 districts, and covers 17 248 persons. A total of 34 projects have been implemented which include 2 health posts; health promotion and diseases prevention through community sensitization, particularly through health community workers and teachers; literacy classes, including health education; waste disposal projects in seven sites; building and rehabilitation of water tanks and pipes in 4 villages; 2 agriculture projects to cultivate land for farming; and 6 projects directly related to women, including training centres on sewing/handicrafts and computers, literacy classes, and income-generating activities.

“Evaluation of BDN Programme in Djibouti, 2005.”

Thirty-five beneficiaries were granted micro-credit that allowed families to generate income, improve the nutrition of their families and repay the loan, benefiting in total 1820 people. A workshop was held in Djiboutiville in June to share experiences and information.

Egypt

In Egypt, the Ministry of Health and Population, WHO and Rotary El-Fustat joined hands to introduce BDN in al-Fawakhir and Batn al-Baqarah, slum areas in Old Cairo. The project is being implemented as an integrated part of the health sector to improve the health, nutrition, literacy, economic, nutrition and environment status of the target area. The project is thus far responsible for removing a solid waste site that measured 1 km from the heart of the area, which was responsible for a plague of flies and mosquitoes.

“Fawkhir community, Old Cairo, Egypt, before implementation of BDN, 1 square kilometer of the area was used as a dumping ground for garbage from surrounding areas, 2003.”

“Community and Municipality, Old Cairo, Egypt, work together for a better environment; December 2005, Fawakhir, Old Cairo, Egypt.”

Islamic Republic of Iran

In the Islamic Republic of Iran, a CBI expansion plan was developed whereby 30 healthy districts and one healthy city will be added in the next biennium, and the BDN programme will be expanded to 4 new provinces (16 villages). All expansion activities will be carried out through the Universities of Medical Sciences.

The national CBI secretariat presented 7 important projects to be implemented in healthy cities and healthy villages in Isfahan, Yazd, Saveh, Qeshm, Nour and Chabahar. The projects are directed towards the following areas: improving waste management (through patrtnership with the Ministry of the Interior), improving information services (through partnership with the Ministry of Information Technology), creating healthy schools (through partnership with the Ministry of Education), prevention of traffic accidents and injuries (through partnership with the Ministry of Health and Medical Education), improving nutrition (through partnership with the Ministry of Health and Medical Education), improving the mental well-being of communities (through partnerships with nongovernmental organizations), and maintaining, monitoring and managing the consumption of water supplies, which has already been implemented in Isfahan, Yazd, Saveh and Chabahar.

“Training of cluster representatives in the BDN programme in Nazaragha village, Borazjan District, Bushehr, Iran, October 2005.”

A Memorandum of Understanding was signed between the Regional Office and the Imam Khomeini Relief Foundation for collaboration on poverty reduction.

A Memorandum of Cooperation was signed between the Regional Office and Ministry of Welfare and Social Security to develop and implement joint initiatives for the promotion of health and quality of life of local communities.

The first phase of a CBI evaluation was started by a national multisectoral team. This will be followed by the second phase whereby the results produced by the national team will be validated by an international team of experts.

A gender briefing package was prepared in collaboration with other UN Agencies to advocate for more gender mainstreaming. As part of its ongoing efforts to contribute to the reconstruction of the city of Bam following the earthquake of 26 December 2003, WHO has been using the fund it received from the Australian Government for immediate rehabilitation of health in the city. To this end, the Bam healthy city approach was adopted in collaboration with other partners to improve environmental conditions, with health becoming the focus, promote healthy lifestyles, support social activities that generate income, improve education, and address the needs and issues of women and children.

Iraq

The CBI programme was adopted by the Ministry of Health in January 2005 in coordination with WHO as part of strengthening the primary health care system. A CBI workshop was carried out in Amman in March 2005 during which the plan of action was prepared and agreed upon. New ministers were briefed after the election of the transitional government to ensure their continuous support and the delegation of their authorities to their representatives. A national technical ministerial committee was established and 6 BDN programme areas and 2 healthy cities were selected based on their poverty level and security. CBI committees were established at governorate and district level with representatives of the line directorates and village developmental committees elected from among teachers, religious leaders and prominent women in the village. The proceedings and 3-year plan of action of CBI were prepared and disseminated to all stakeholders and especially to donors during the meeting held at the Dead Sea, Jordan, July 2005.

A total of 19 meetings were conducted during the reporting period, 3 meetings in each BDN programme area and 2 meetings in each healthy city, and monthly meetings were held for the national technical committee at central level. Around 440 persons participated, of whom 185 were women, in these meetings, which were held at district, governorate, village development committee and cluster representative levels.

Six workshops were conducted, one in each BDN programme area, and 156 persons were trained on the proper method

"Re-establishing a school in Iraq, 2005."

to carry out the baseline survey. In May 2005, data was collected and analysed at the district level. This was followed by prioritization of needs, and solutions were found based on a bottom-up approach.

A study tour to Thailand was completed during December 2005 with 14 participants, 5 of whom were from line ministries (Municipalities, Agriculture, Environment, Higher Education and Social Affairs) and the rest were project coordinators in the CBI areas. A study tour to the Islamic Republic of Iran also took place in December for 15 participants comprising community and civil society representatives.

Safe water projects were initiated in three BDN programme areas (Aldasem, Almichbis and Alintissar). Mobile clinics, health education sessions and an expanded programme of immunization (EPI) campaign were carried out in most of the BDN programme areas. A campaign to eradicate illiteracy was initiated in three BDN programme areas and secondary level classes were established in Al-Dasem, Al- Sulaiman and Al-Dahira to create an opportunity for school drop-outs, especially females, to complete their education.

Jordan

In March 2005, a healthy villages programme directorate was established to institutionalize healthy villages programme as an integral part of the Ministry of Health. This directorate is linked to the general secretariat of primary health care which supports the directorate with a well-established office, 7 full time technical staff and financial support for programme implementation. The programme expanded to include clusters of villages in the northern, middle and southern parts of Jordan with a focus on empowering women and youth.

"Youth development activities in Jordan, 2005."

In collaboration with WHO and 2 local consultants, the High Health Council developed a tool for assessing access of the poor to health care services and assessing the responsiveness of the health care system in meeting the health care needs of the poor.

A review of the national situation in relation to social determinants of health was carried out by WHO. A national multisectoral seminar will be organized to discuss the draft report and identify areas of potential intervention and links with MDGs and national poverty reduction strategies.

A research study, entitled "Pattern of health problems in poverty pockets in Jordan and the availability and adequacy of essential interventions", was conducted by 2 consultants from JordanUniversity and Jordan University of Science and Technology, using both quantitative qualitative methods to determine unmet health needs and identify health priorities in poor communities.

Technical support was given to developing the National Health Investment Plan.

Morocco

In Morocco, WHO, the Social Development Agency and Ministry of Health signed a partnership agreement in June, to reinforce the BDN programme and to mobilize additional resources in order to contribute to improvements in the quality of life and the level of health among communities targeted by the programme.

H.M. King Mohamed VI of Morocco endorsed the National Initiative for Human Development, which is a holistic perspective that represents Morocco's national goals. The King Hassan Fund for Socioeconomic Development has been established to expedite the development process, and has provided for drinking-water and electricity to villages.

"Training of youth as community members in Tabant Ait Bougemmaz, Azilal, Morocco, October 2005."

Oman

Three pilot community-based initiatives have been implemented in Oman including the healthy city project in Sur, healthy village project in Qalhat and healthy lifestyle project in Nizwa.

A healthy neighbourhood project was initiated in Muscat region and includes three neighbourhoods and a village in different wilayats (districts) of the region. Steps have taken place to replicate the Sur healthy city project in Sohar, North Batinah region. The Ministry of Health has taken preliminary steps to introduce the concept of BDN in a selected underprivileged wilayat, Wadi Bani Khalid. A healthy lifestyle project in Salalah is under discussion.

One of the major developments at the central level is the establishment of a community-based initiatives unit within the Ministry of Health. It is intended to provide technicalsupport, management and leadership to the regions/sites implementing various CBI programmes. The department is headed by Dr Halima al Hinai who is a public health specialist. In August 2005, she paid a visit to the Regional Office to acquire a better understanding of the various health interventions WHO provides through community-based initiatives.

In mid-2005 a high-level task force in the Ministry of Health in Oman conducted an in-depth review of community support groups to explore the main positive and negative elements of this initiative. The task force made recommendations to ensure that volunteers are mobilized effectively and to identify ways and means to support their work in promoting better health to communities.

"Community ownership in Oman, 2005."

Pakistan

The quality of women's vocational training centres in Pakistan was strengthened. This includes skills development, promotion of entrepreneurship (self-employment opportunities through production of handicrafts for women at the BDN programme centres), building networks with other nongovernmental organizations and marketing linkages for the promotion of handicrafts prepared by women for income-generation. The vocational centres are also involved in health activities in each area, the trainees are involved as volunteers in acceleration of EPI, growth monitoring, nutrition, tuberculosis DOTS, Roll Back Malaria and safe motherhood activities.

The Department of Health in the North-West Frontier Province, in collaboration with WHO, began the replication of the BDN initiative in 5 districts in May 2005. The provincial government has accordingly allocated financial resources for the replication. The project aims to encourage community participation in local development to improve quality of life and health.

A regional consultation meeting was held in June 2005 in Islamabad todevelop a training manual on community-based initiatives for community members, mid-level managers and intersectoral technical team members. Participants from Pakistan, Sudan, Yemen and the Regional Office discussed success stories/case studies from the various community-based initiatives in the three countries and the resultant manual will be field tested by a BDN team from Afghanistan.

The introduction of a community-based health insurance scheme in the BDN programme areas was assessed.

Two BDN programme model districts (Dadu and Muzaffarabad) were selected to manage intestinal worm infestation among primary level schoolchildren through implementation of a comprehensive school health programme, in partnership with the local community, education and health departments, Azad Jammu Kashmir and Sindh, and the World Food Programme.

A project document for replication of the BDN programme in 24 districts with a total cost of US$ 28.2 million (Pakistani Rupees 1700 million) (during 2006–2010) was prepared in collaboration with WHO and approved by the Federal Ministry of Health.

Substantiating the community's role in the prevention and cure of malaria and tuberculosis through innovative community-driven strategies, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) approved the BDN programme communities' proposal for its third round and signed project agreements with all the seven district BDN organizations as subrecipients on April 7, 2005. GFATM will provide a grant of US$ 2.72 million over a two year period.

"Community mobilization for access of the poor for safe drinking water in Pakistan."

Saudi Arabia

The healthy city programme expanded to cover 23 cities, a city for each region. The programme now serves about one third of the total population.

A database was developed among healthy cities. An updated national healthy cities profile was discussed in a series of meetings with healthy cities coordinators. A pilot study was implemented to test the validity of the profile as baseline data for each city and to provide quantitative assessment of the programme progress in the coming years.

The first national workshop on "Towards a Better Environment for the Children in the Healthy Cities" was organized by the Ministry of Health, Saudi Arabia. The workshop was attended by 180 men and 220 women from different universities, governmental and nongovernmental organizations. Participants discussed the priorities of the healthy cities (e.g. water supply and sanitation, traffic accidents, healthy homes, household poisoning, violence against children). Participants recommended the establishment of a national committee including representatives of different related governmental and nongovernmental organizations, as well as universities, to coordinate activities related to child health. In addition, a national workshop was organized in Riyadh to develop a common plan in collaboration with different related sectors. The workshop was attended by Ministries of Education, Municipalities, Planning, Interior and Agriculture as well as members from the National Guard, Social Insurance and Labour, and the School Health Programme.

The healthy cities programme in Saudi Arabia launched a website www.hep.gov.sa .

A national survey to assess the school environment and lifestyles of schoolchildren with a focus on their health-risk behaviours was conducted in 10 healthy cities (2 boys' and 2 girls' schools from each city). Health risks and lifestyles were assessed using Global School Health Survey (GSHS) forms approved by WHO. The GSHS was translated into Arabic and modified to be suitable for implementation in Saudi Arabia and other Arab countries. The study included 658 male and 683 female students aged between 12 and 16 years old.

Seven workshops in 7 healthy cities were organized on the role of schools in promoting healthy cities, a study on estimating the burden of diseases related to water, sanitation and hygiene among children is being conducted, and a guideline for healthy cities programme coordinators was published in Arabic by the General Directorate of Preventive Health.

"National workshop on "Towards a Better Environment for the Children in the Healthy Cities" Riyadh, Saudi Arabia, 2005."

Somalia

Communities gained technical and leadership skills through refresher training, and orientations were conducted for senior managers, as well as training courses on the BDN concept, partnership development and capacity building. The BDN programme organizational set-up was completed and village information centres were established.

Women have acquired experience of higher leadership roles in dealing with community affairs and social causes, and the success of the programme has created demand for the introduction of the BDN initiative in neighbouring villages.

Integration of primary health care and communicable disease prevention was coordinated in BDN programme areas through the WHO Representative's Office and the Ministry of Health.

A Memorandum of Understanding was signed between WHO and the Somalia Red Crescent Society (SRCS) to implement BDN programme in 14 villages where the SRCS is operating. WHO will support expanding the BDN programme. Community-based financing schemes were established along with a community development fund.

A healthy cities programme was introduced in Hargeisa and Guori, with priority given to environmental health and the role of women in development.

> "Women have acquired experience of higher leadership roles in dealing with community affairs and social causes."

Sudan

The Federal Ministry of Health advocated for CBI in 32 localities, when 16 Ministers signed an agreement in the presence of the Vice President to expand the CBI in 2 areas in each of two localities within 2 years as part of the incremental reform of the local health system. A national CBI strategy was developed. The comprehensive BDN approach was sustained and expanded in 62 areas in 21 localities (districts) in 11 states.

The introduction of community-based health insurance schemes was assessed, and the national health insurance was expanded in CBI areas where village development committees acted as employers for community members paying their premiums. The committees sought national funds, like zakat, to cover poor families.

The WHO Representative's Office in Sudan, in cooperation with Italian International Cooperation and the national nongovernmental organization Development Action Now (DAN), are implementing a BDN project with the aim of fulfilling the basic needs of the communities living in post-conflict areas in 13 villages of the Salara District in the Nuba mountains. The project includes capacity-building of local communities.

in management, collective and team work, vocational training for women and agriculture extension as income-generation. The Food and Agriculture Organization of the United Nation (FAO) supported the agriculture project by providing two varieties of seeds, namely tomato and watermelon, to be distributed in the rainy season to 100 families in the area.

Partnerships were strengthened to include more nongovernmental organizations, government sectors (e.g water, education), local mayors (*muatamads*) and student unions. Orientation sessions on BDN were held for the World Bank and the United Nations Development Programme (UNDP)/local governance programme.

Local councils for sustainable development were established as an initiative in some states and between some villages in Gezira and River Nile states.

"Women vocational training at a women's development centre in Eldanagla, Greater Wad Medani locality, Gezira State, Sudan, September 2005."

Syrian Arab Republic

The standardized regional evaluation tool was used in the evaluation mission to the Syrian Arab Republic. The evaluation showed that the programme has achieved all planned objectives and WHO should continue its technical and financial support for programme expansion.

The healthy villages programme expanded to reach 500 villages and intersectoral collaboration was strengthened.

"Community mobilization for health development in healthy village programme in Syria."

Yemen

The regional evaluation tool was used in an evaluation mission to Yemen during April 2005. The evaluation showed that the programme has achieved all planned objectives and WHO should continue its technical and financial support for programme expansion. The BDN programme was expanded to Abar Othman village in Abyan, Ozalat Al-Feush in Lahaj, Al-Zafeer area in Hajjah, Hami area in Hadramaut, Ozlat Al-Roass in Ibb, Janadia Sofla in Taiz and Mengaza (part II) in Dhamar governorate. The seven new BDN programme areas increase the population coverage from 50 000 to 104 000. In addition, 133 traditional birth attendants and 39 first aid workers were trained in several of the BDN programme villages. In the field of women's empowerment, 1642 women and young girls became literate, 250 women were trained in a vocational skill and 6 new women's associations were established in BDN programme areas.

"Children going to the school in Mandhar, Hodida governorate, Yemen, October 2005."

Newsletter summary in French

Durant 2005, le Programme Initiatives communautaires a mis en évidence le rôle essentiel joué par la santé dans la lutte contre la pauvreté et dans le développement durable. Les initiatives communautaires sont axées sur le renforcement des partenariats, l'évaluation et l'examen du programme dans la Région et la diffusion et l'échange d'informations. L'établissement de liens entre des initiatives mondiales telles que les objectifs du Millénaire pour le développement, les stratégies de lutte contre la pauvreté de deuxième génération et la Commission des déterminants sociaux de la santé, et les initiatives communautaires est devenue une stratégie pour le Bureau régional et les États Membres au cours des deux réunions interpays consacrées aux objectifs du Millénaire pour le développement et à la mise en œuvre des stratégies de lutte contre la pauvreté. L'évaluation de la capacité des pays dans la Région à réaliser leurs objectifs, l'établissement du coût de leurs activités et l'utilisation des initiatives communautaires en tant qu'instrument sont devenus des priorités pour les États Membres pour atteindre les objectifs du Millénaire pour le développement.

Le Bureau régional a encouragé tous les programmes liés à la santé à utiliser les opportunités créées par les initiatives communautaires et à intégrer leurs programmes là où l'engagement communautaire et la collaboration intersectorielle sont organisés et mobilisés. En 2005, le Bureau régional a également évalué l'introduction du programme des Besoins fondamentaux en matière de développement à Djibouti, en République arabe syrienne et au Yémen. Les initiatives communautaires ont été élargies à de nouveaux domaines dans différents pays de la Région, notamment en Iraq, un pays confronté à des situations d'urgence complexes.

ملخص العدد باللغة العربية

خلال عام ٢٠٠٥ قام برنامج المبادرات المجتمعية المرتكز بإلقاء الضوء على الدور الحيوى للصحة فى تقليص الفقر وفى التنمية المضمونة الاستمرار. وقد ركزت المبادرات المجتمعية المرتكز على المشاركات الأكثرمتانة وقوة وعلى تقييم ومناقشة البرنامج فىالإقليم، إضافة إلى نشر المعلومات و التشارك فيها. أما المبادرات العالمية مثل المرامى الإنمائية للألفية، والجيل الثانى من استراتيجيات تقليص الفقر، واللجنة المعنية بالمحددات الاجتماعية للصحة، فقد أصبحت ،مع المبادرات المجتمعية المرتكز ، تمثل في الوقت الحالى استرتيجية يسير على نهجها كل من المكتب الإقليمى و البلدان الأعضاء، وذلك عقب انعقاد الاجتماعين البلدانيين حول المرامى الإنمائية للألفية وتنفيذ الاستراتيجيات الخاصة بتقليص الفقر. و بغية تحقيق المرامى الإنمائية للألفية أعطيت الأولوية الأولى فى البلدان الأعضاء إلي عمليات تقييم مقدرة هذه البلدان على تحقيق مراميها، ومعرفة تكلفة أنشطتها ،بالإضافة إلي استخدامها للمبادرات المجتمعية المرتكز.

ولقد شجع المكتب الإقليمى جميع البرامج ذات العلاقة بالصحة على استخدام و اغتنام الفرص التى وفرتها المبادرات المجتمعية، وعلى دمج برامجها في المجالات التي يتم فيها تنظيم و استنفار المشاركة المجتمعية و التعاون بين القطاعات . كما قام المكتب الإقليمي عام ٢٠٠٥ بتقييم عملية إدخال برنامج الاحتياجات التنموية الأساسية فى جيبوتى، وسورية، واليمن . وقد توسعت المبادرات المجتمعية المرتكز فى مختلف بلدان الإقليم و انتشرت فى مناطق جديدة، من ضمنها العراق مع ما يواجهه هذا البلد من حالات طوارئ معقدة.