حزيران/يونيو ٢٠٠٦. وقد أبدت حكومة جيبوتي التزاماً قوياً باستثمار مبادرة تلبية الاحتياجات التنموية الأساسية في تقليص وطأة الفقر، وبإدخال هذه المبادرة في استراتيجية تقليص الفقر في جيبوتي.

وسوف تنفذ وزارة الصحة العمومية في تونس، بالتعاون مع المكتب الإقليمي للمنظمة ومركز كوبي للتنمية الصحية، المتعاون مع المنظمة، مشروعاً إرشادياً في محافظة أريانة التونسية. وقد وافق المدير الإقليمـــي على تخصيص ٥٠٠٠٠ دولار أمريكي للمشروع، اعتباراً من مستهل عام ٢٠٠٧، وسوف يوفر مركز كوبي باقي المبلغ المطلوب في الثنائية ٢٠٠٧-٢٠٠٨.

وقد أطلق مركز أنشطة صحة البيئة، التابع للمكتب الإقليمي للمنظمة، مشروع (( بيئة مدرسية صحية ومأمونة ))، في عام ٢٠٠٥. ويستهدف هذا المشروع إذكاء الوعي بتأثير البيئة المادية المدرسية على صحة التلاميذ، وذلك من خلال مشاركة المجتمع والإجراءات التي تشارك فيها عدة قطاعات. وتم تقيـــيم الوضع المتعلق بصحة البيئة في ٥٨ مدرسة في المناطق التي تغطيها مبادرة تلبية الاحتياجات التنموية الأساسية، في عشر محافظات، وذلك من خلال لجنة مشكَّلة من مديري المدارس وأعضاء لجان تنمية القرى.

وسوف يتم إعداد قاعدة بيانات تضم المعلومات الواردة من ١٨ من بلدان الإقليم التي تنفِّذ برنامج المبادرات المجتمعية. وسوف تساعد قاعدة البيانات هذه على تحديث المعلومات المتاحة حالياً عن مجالات تنفيذ المبادرات المجتمعية، من أجل تحسين عملية التخطيط والدعم على جميع المستويات. إضافةً إلى ذلك، سوف تتيح قاعدة البيانات هذه تبادل المعلومات مع الشركاء والمانحين المحتملين من أجل التوسُّع في تنفيذ البرنامج.

وتعكف وحدة المبادرات المجتمعية حالياً على إعداد قائمة بجميع الشركاء الذين يعملون في مجال تنمية الصحة والمجتمع في جميع بلدان الإقليم. ومن المهم للسلطات الوطنية أن تصمم نظاماً لتحديد الشركاء المحتملين في مجال تنمية الصحة والمجتمع وتقليص الفقر، بغية تحقيق الانسجام وتنسيق جهود الشراكة في هذه المجالات.

وقد عقد المكتب الإقليمي ومركز البحوث الاجتماعية، بالجامعة الأمريكية بالقاهرة، حلقة عملية حول وضع منظور إقليمي للمحددات الاجتماعية للصحة، وقضايا العدالة في الحصول على الخدمات الصحية، وتأثيرها على السياسات الصحية، وذلك في القاهرة، بمصر، من ٥ إلى ٧ حزيران/ يونيو ٢٠٠٦.

وتم إطلاق وثيقة جديدة للدعوة والتوعية، بعنوان المبادرات المجتمعية: قصص نجاح من إقليم شرق المتوسط. وتروي هذه الوثيقة قصص نجاح من ١٠ من بلدان الإقليم، وتبين كيف أسهمت المبادرات الاجتماعية في تحسين صحة الناس ونوعية حياتهم، ويمكن الاطلاع على هذه الوثيقة في الموقع التالي على شبكة الإنترنت: http:www.emro.who.int/cbi.

يُرْجَى ملاحظة أن العدد الأول من المجلد الثاني من الرسالة الإخبارية لوحدة المبادرات المجتمعية، الصادر في كانون الثاني/يناير ٢٠٠٦، ورد به خطأ في عنوان موقع برنامج المدن الصحية في المملكة العربية السعودية. والعنوان الصحيح هو: www.hcp.gov.sa.

For further information on community-based initiatives contact:

Community-based Initiatives
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Community-based initiatives

# Newsletter

World Health Organization
Regional Office for the Eastern Mediterranean

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## Interview with

## Dr Zuhair Hallaj,

### Director, Communicable Disease Control Acting WHO Representative, Egypt

**1. Tuberculosis, malaria and HIV/AIDS have traditionally been seen as afflicting the poor. Poor living conditions, lack of access to safe drinking water, low utilization of and access to essential health care services, malnutrition, etc., are some of the predisposing factors for the spread of communicable diseases. In this regard, and based on your vast experience in communicable disease control, how do you see the role of the Community-based Initiatives (CBI) programme in combating diseases of poverty?**

Tuberculosis, malaria, HIV/AIDS and poverty can constitute a vicious cycle if proper measures are not taken. While the prevention and treatment methods for these diseases are well known, successful implementation is often challenged by barriers to making them accessible for the persons and communities that are most affected.

For example, lack of awareness about HIV/AIDS is a major obstacle to effective prevention, as well as to access to treatment and care, as people are less likely to know their HIV status. Stigma and discrimination are also major


(Continued on page 2)

barriers to effective HIV prevention, treatment and care. In the world there are several examples of how communities affected by HIV and groups of people living with HIV have become organized and contributed efficiently and effectively to the response to the HIV epidemic. These examples range from community-based awareness raising to care and support for people living with HIV, and advocating for political commitment to ensure access to HIV prevention, treatment, care and support. In our Region, we have a good example from the Islamic Republic of Iran where the success of harm reduction initiatives started by community-based-nongovernmental organizations has been the basis for a national response that is now acknowledged as a global best practice. In Sudan, people living with HIV have become organized and formed their own nongovernmental organization, and are an indispensable partner in the national HIV response, working explicitly to alleviate stigma and discrimination, and to transmit strong messages linked to personal experiences and tangible evidence to fight HIV/AIDS and to promote the rights of people living with HIV/AIDS. In Lebanon, members of the hard-to-reach and most-at-risk populations have been instrumental in reaching out to their communities for HIV awareness raising and prevention. There exist examples from other countries also.

If we move to malaria, we find that CBI has a very important role in combating malaria and vector-borne diseases. One of the main vector control interventions in malaria endemic areas in highly afflicted countries (Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen) is bednets. Collaboration between Roll Back Malaria (RBM) initiative and CBI was initiated to ensure bednet coverage of all populations at risk in areas implementing the basic development needs (BDN) approach. Projects are being implemented in Pakistan and Somalia using Global Fund to Fight AIDS, Tuberculosis and Malaria resources. BDN staff assist in distribution of bednets awareness campaigns, as well as in monitoring and evaluation of the intervention. They also assist in implementation of other vector control interventions, such as indoor residual spraying, by increasing community acceptance and through community involvement in environmental management, such as elimination of breeding places or use of larvicides, including larvivorous fish.

Regarding case management, one of the important strategic approaches to reaching inaccessible populations and those lacking access to health care is to empower the community to identify, recognize and treat or refer malaria cases to minimize the risk of severe malaria by using standard dose treatment in blister packs; this is known as home management of malaria. The RBM unit collaborated with CBI in the national malaria programme managers meeting in 2005, where a presentation was made and then a workshop followed focusing on this. Operational research studies are being supported in Somalia and Sudan to study different modalities of implementation that are culturally sensitive before going to large scale (e.g. training village volunteers, shop keepers or community health workers). RBM has also collaborated with CBI in developing a training manual on malaria recognition, treatment and prevention to be used for training of community representatives.

Our third disease of poverty is tuberculosis, which is closely linked to poverty. Poor nutrition and poor living conditions increase the risk of converting tuberculosis infection into tuberculosis disease. Moreover, poverty adds to delay in diagnosis due to financial difficulties and lack of access to primary health care services.

The CBI programme is supporting poor communities to improve their living conditions and generate better income, and therefore has a role in reducing tuberculosis risk factors. Additionally, CBI, through proper coordination with tuberculosis control programmes in countries, can play a major role in improving access to tuberculosis control services. This can be done through providing health education, supporting tuberculosis patients in the community and building links with health facilities that provide tuberculosis services at the community level.

**2. As part of the Millennium Development Goals, countries have agreed to halting and reversing the spread of HIV/AIDS, malaria and other major diseases by 2015. In our Region it has been agreed to integrate tuberculosis directly observed treatment, short course (DOTS) into all BDN areas by 2007. What is your advice to national communicable disease control programme managers and WHO staff on integration of DOTS into CBI areas, and on linking their efforts with organized and mobilized communities?**

The new global Stop TB strategy has a component to empower tuberculosis patients and communities in their fight against tuberculosis. This cannot be done without using organized communities and local nongovernmental organizations. CBI provides a good opportunity for tuberculosis control programmes to reach communities in a systematic and productive way. The Stop TB unit in the Regional Office has started an effective collaboration with CBI and we encourage all country communicable disease control units to coordinate their efforts at the community level with CBI.

**3. CBI is pleased to see that the Disease Early Warning System (DEWS) is working well in a number of countries of the Region. How can the health system use the presence of the community to upscale DEWS?**

Let me start first with giving a brief background on DEWS. As you know, the status of basic health services in some Member States in the Region, including access and quality, remains inadequate. The few available health facilities are largely unevenly distributed, poorly equipped, under-financed and inadequately staffed. Poverty, some cases of long years of ongoing civil strife and conflict, shortage of adequately trained health workers and lack of effective managerial support system, all contribute to the deplorable situation of health services. Moreover, a low level of health awareness among the general public and seasonal flooding contribute to a high prevalence of infectious diseases, resulting in illness, disability and death.

Aware of these challenges, some countries in the Region initiated a strategy to narrow gaps in alerting, detecting and responding to disease outbreaks. The strategy is to strengthen surveillance and response for epidemic-prone and vaccine-preventable diseases. The experiences of Lebanon, Pakistan, Somalia and Sudan have been milestones in this strategy.

Most disease outbreaks occur in remote areas where basic health services are either very weak or do not exist, and among crowded population groups (such as internally displaced populations), urban ghettos, cattle and fishing camps, and isolated villages, and where communication is difficult. Lack of adequate community awareness, and sometimes lack of awareness among primary health care providers, further contributes to long delays in identifying, reporting and responding to outbreaks. In such situations, outbreaks are either reported late or not reported at all; and when reported late, the response is often late and ineffective.

Thus, there is a need to narrow the gap between the onset of an outbreak, its reporting and an effective response. To this end, improving community level detection and reporting of suspected outbreaks is indispensable. This has to be preceded by the orientation of the community on outbreak surveillance and DEWS, and establishing an early reporting and response network in these communities.

Active involvement of communities in disease surveillance and response contributes to the development of sustainable capacity to improve local response to outbreaks. Experiences from countries provide lessons for further strengthening DEWS and outbreak surveillance and response.

If I want to clarify the roles of the community in DEWS, I can say that as a member of a community, everyone has the responsibility to support health workers in getting timely information and in mobilizing the community to contain disease outbreaks. However, it is important to have a mechanism to coordinate the involvement of the community. This mechanism is formed by focal people in different locations who can collect timely information on suspected outbreaks, alert responsible organizations and support response efforts. This is what we call the Early Warning and Response Network (EWARN). The Network, among other things, can:

- get evidence of suspected outbreaks and new (emerging) diseases.
- immediately pass this information to the appropriate health authorities or organizations.
- mobilize community resources (assign people, seek local materials).
- coordinate construction of temporary shelters for patients where required.
- participate in health education, including selection of a convenient place and time.
- motivate communities to implement messages on vaccinations, treatment, etc.

Overall, the Network can speed up the time required for creating awareness of the problem, thereby contributing to determination of the problem and providing interventions. These efforts are critical to slow or stop the further spread of the disease and prevent further deaths. The Network is a bridge between the community and health institutions. It is an important step towards active

involvement of those at the core of the problem and solution: communities.

**4.Dr Hallaj, you have been an esteemed and renowned pioneer in the area of communicable diseases and as WHO Representative of Egypt have also witnessed the eradication of polio from the country, all of which have taken strong political commitment and community participation. Do you have any advice for CBI in its future endeavours?**

National health-related programmes by their nature should allow all actors to contribute to health development; CBI is not a national initiative where communities remain passive. The Alma Ata declaration stated that health is for all, but it also meant that it is by all. Thus, strong political commitment and active community participation is the basis of any successful development programme, including those that focus on health. It is how polio was eradicated from Egypt. It is also the spirit in which CBI has been formed, and therefore my advice for future endeavours is to follow this spirit and be major advocates for political commitment and active community participation. Once again, I extend my thanks to the CBI unit and wish them success in all their future endeavours.

# Community participation in Roll Back Malaria

To scale up and ensure the sustainability and effectiveness of malaria control interventions, it is necessary to plan, implement and supervise them with those who are most affected. Community participation in malaria control interventions can be designed to complement current malaria programmes to maximize the benefits to the community, especially where a sizable section of the population are widely dispersed across remote areas.

The objectives of community-based interventions for malaria control include:

- to improve malaria diagnosis and provide effective treatment by caregivers within 24 hours of the onset of illness
- to strengthen the capacity of health systems, including access to antimalarial drugs and referral mechanisms
- to improve health-seeking behaviour of caregivers, family and community to enable them to recognize signs of severe illness
- to promote appropriate vector control measures, particularly insecticide-treated nets
- to promote malaria prevention measures during pregnancy.

Community-based initiatives and interventions are an integral part of the regional strategy for malaria control in endemic countries/areas. Lack of access to effective treatment in remote areas, especially in countries with intense malaria transmission (Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen) is still a challenge in the Region. In settings with low health care system coverage, early and appropriate treatment of malaria is mainly possible through the introduction or improvement of home management of malaria. This seeks to improve self-care practices, the care practices of mothers and other caregivers in the home, and those of community health workers, drug vendors and shopkeepers.

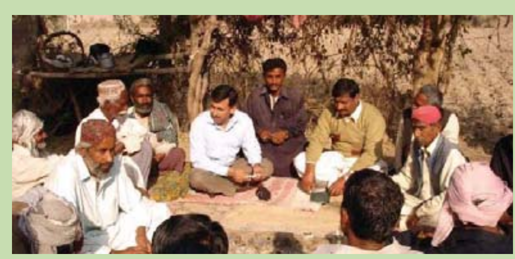
Some examples of community participation in malaria control programmes are given below.

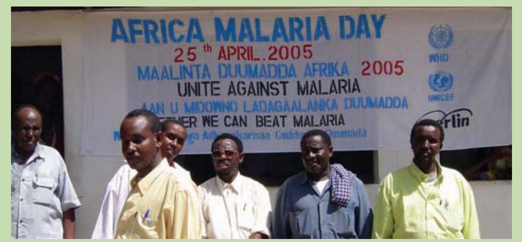
- In Zarabad village, Sistan and Baluchestan province, in the Islamic Republic of Iran, a high transmission area, 5% of malaria cases were detected by trained school teachers/volunteers. In a pilot area, more than 80% of cases were detected by other volunteers.

- In Somalia, insecticide-treated bednets and larvivorous fish (top water minnow or mosquito fish *Gambusia affinis*, a widely-used biological control agent against mosquito larvae) were distributed in BDN villages in North West Zone. Health staff and village health committees were trained in these interventions. In North East Zone in Somalia, long lasting insecticide-treated bednets were distributed to 3020 households in BDN villages through the support of the Global Fund to Fight AIDS, Tuberculosis and Malaria and UNICEF. Further plans include operational research in BDN villages, involving cluster surveys on home management of malaria by local health workers, establishing village health committees and increasing the availability of traditional birth attendants.

- In the village of Jogis, Sindh province, Pakistan, the local community participated in a campaign to encourage early diagnosis and prompt treatment at public health facilities and to discourage self-treatment or treatment by non-qualified persons, and to encourage the use of insecticide-treated bednets for children and pregnant women.

- A community-based malaria control project took place in eastern Afghanistan (2002–2004) in which women and schoolchildren were trained to be involved in bednet re-treatment and focal larviciding. This was a multipartite endeavour to control malaria, that involved WHO, the Ministry of Health and Population, HealthNet International, World Food Programme, German Agro Action, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), United Nations Development Programme, Food and Agriculture Organization of the United Nations (FAO) and Mission d'Aide au Développement des Economies Rurales en Afghanistan (Madera). Thirteen teams (comprised of three men and one woman per team) worked in the villages throughout the transmission season. Bodies of water not suitable for larviciding and/or drainage were targeted with larvivorous fish; 230 farmers were trained and involved in a *Gambusia* fish programme. As malarial mosquitoes feed predominantly on animals, and only secondarily on humans, cattle sponging with insecticide was also carried out. Finally, in addition to conventional health education using mass media at the primary health care level, special sessions were conducted in nine schools and more than 12 000 students received malaria health education.






# The Basic Development Needs initiative in Somalia

The Basic Development Needs (BDN) initiative has made an invaluable contribution to the achievements and progress made in strengthening primary health care in Somalia, especially in improving maternal and child health activities such as immunization, malaria control and antenatal, delivery and post-natal care. The following examples illustrate the key role of the initiative in selected programme areas and villages.

## Enabling access to primary health care services

The BDN initiative has closely integrated its activities with other primary health care programmes, notably routine immunization, measles and malaria control, and basic hygiene and sanitation programmes. As a result, communities in the BDN villages have actively participated in implementation of these programmes and encouraging progress has been seen in improving access to and quality of services.

For example, the coverage rate for a measles catch-up immunization campaign in three visited BDN villages in Hargeisa region was more than 95%. In 2006, a total of 119 newborns received BCG and 111 infants received measles vaccination at nine months of age through the routine EPI programme in two months alone. An assessment team that visited eight BDN villages and settlements in May 2005 concluded that "the general health situation is better [than other villages] and there are no children affected by measles after the measles catch-up immunization campaign in the area".

Likewise, the initiative contributes to improving antenatal, delivery and post-natal services in villages through training supervision and provision of supplies. A supervisory report on three BDN villages documented an increase in antenatal care attendance and deliveries attended by traditional birth attendants.

## Capacity development: investing in training of community leaders and health workers

The BDN initiative participated in training of vaccination teams on injection safety and waste management procedures for both the measles catch-up immunization campaign and delivery of routine immunization at BDN sites. In 2005, a five-day training activity was organized for 15 health workers selected from eight BDN villages in North West Zone, focusing on appropriate selection, use and disposal of injection equipment and waste management. The aim of the workshop was to improve injection safety standards and appropriate disposal techniques.

Similarly, in 2006, an eight-day training activity took place for 54 maternal and child health workers on the interim antimalarial drug policy. The objective of the training was to familiarize participants with the new policy and to improve the skills of health workers in preventive strategies, early detection and diagnosis (including rapid diagnostic testing), case management and referral.

Furthermore, the capacity development effort was expanded to empower village development committees and cluster representatives at community level. Training focused on enhancing community leadership for mobilization and the delivery of basic social services including immunization, water and sanitation, basic education and partnerships.

# Prevention of cardiovascular diseases through active community participation in Egypt

There are several social determinants of health management that impact the well-being of underprivileged communities. A study to investigate the social obstacles to hypertension and cardiovascular disease management was carried out in the Nag Al-Arab community of Alexandria, Egypt. For the study, 499 participants (ages 18–83) were surveyed and screened at random for blood pressure measurements. Results indicated that 18.4% of the population was hypertensive (blood pressure 140/90) at the time of the study. T-test comparisons between hyper- and normotensive participants demonstrated that inadequate visits to the doctor, medication inaccessibility and increased salt intake were not significant causes for this hypertension ($P > 0.72$, 0.79, 0.89, respectively). Rather, the statistically significant causes were decreased physical activity ($P < 0.0001$) and increased saturated fat intake in diet.

Awareness of cardiovascular disease management and hypertension risk factors was found to be extremely limited throughout the population sample. Normotensive participants were unable to demonstrate significantly greater awareness of hypertension risk factors than hypertensive participants ($P > 0.62$). Furthermore, 66.3% of the hypertensive participants in the study stated that they had no history of hypertension prior to the screening, demonstrating very poor awareness of their cardiovascular health. Health differences based on gender were found, with a lower prevalence of hypertension in men (16.5%) compared to women (20.6%); this is partially explained by the significantly higher daily physical activity demonstrated by men in Nag Al-Arab ($P < 0.0001$).

Based on the results of this study, cluster representatives have attempted to educate the Nag Al-Arab community on hypertension management and lifestyle modifications. Alexandria's Office for the Ministry of Health and Population will provide additional support to improve access of the community to primary health care services. The knowledge and skills of the cluster representatives who will be used in community awareness building and screening need to be constantly updated and a sustainable follow-up system needs to be created.

# BDN expansion in Djibouti

The Ministry of Health, Djibouti, in collaboration with WHO, has developed a national strategy and plan of action for expansion of the BDN initiative in the country. WHO assigned Dr Nada Darkaoui, Director of Ambulatory Health Services and focal person for the BDN initiative in Morocco, from 8 June to 1 July 2006, for this task. The national strategy was launched by H.E the Minister of Health in the presence of four other Ministers on 24 June, after consultation with a group of key stakeholders during a two-day workshop held on 21–22 June. The Government of Djibouti demonstrated their high commitment to making BDN a tool for reducing poverty and to integrating it within their Poverty Reduction Strategy Paper. These accomplishments were made possible through the advocacy efforts made by the WHO Deputy Regional Director during his recent visit to Djibouti.

The national strategy for BDN expansion contains three main strategies: partnership, an organizational structure for BDN management, and BDN implementation and expansion to 25 sites by the end of 2007. The partners endorsed the summary of the national strategy document as an act of commitment to the expansion of the BDN programme.

"The launch of the national strategy on 24 June 2006."

# The city of Ariana, Tunisia, becomes a global demonstration site for healthy urbanization

The WHO Kobe Centre (WKC) for health development located in Kobe, Japan, is supporting a global project in Chile, China, India and Japan on healthy urbanization. The main objective of the project is to reduce health inequity in urban settings by addressing the social determinants of health. The Regional Office has joined the global project through the addition of the city of Ariana in Tunisia as the fifth demonstration site. The city of Ariana and the expertise of the National Institute of Public Health in Tunisia both fulfill the eligibility criteria to host the project and have the prerequisites for its success. Furthermore, the new community-based project for combating noncommunicable diseases and lifestyle risks that has recently been launched by the Ministry of Public Health in collaboration with WHO in Ariana is another important reason why this regional demonstration project is likely to succeed.

The development of the project will follow the established set of activities that WKC has developed. Both the Regional Office and WKC will provide, through the WHO Representative's Office in Tunisia, all the necessary technical support for implementation of the project. The Regional Director has approved the allocation of US$ 50 000 by early 2007 and WKC will fund the remaining amount during 2007–2008. The lessons learned from the project will help the countries of the Region to develop workable strategies in this key area of concern and at the same time contribute to the work of the Global Commission on the Social Determinants of Health.

**Steps to implement the healthy urbanization project in Ariana, Tunisia**

| Activity | Responsibilities | Expected output |
|---|---|---|
| 1. Development of scoping paper | Qualified person/institute. | Working paper describing social determinants of health in Ariana. |
| 2. **Module 1** Project planning in an 8-10-day workshop to review social determinants in the city using the scoping paper; planning and management tools and methodology will be used to select 3–4 high priorities, identify root causes and plan to overcome problems. | City management team: city development /health planners representing different development sectors, nongovernmental organizations, key officials, health staff, key national stakeholders. | Feasible plan of action to overcome identified gaps. |
| 3. Implementation of the planned project over 6 months including resource generation and partnership, development of required tools/instruments, staffing, and procurement of supplies and equipment. | City management team. | Regular progress reports. |
| 4. **Module 2** Progress report presented in a 4/5-day workshop. | City management team; facilitated by Regional Office and WKC. | Progress report: achievements, obstacles, comments, suggestions for improvement. |
| 5. Application of required changes based on output of module 2 workshop and evaluation of outputs after 3–4 months. | City management team. | Improved implementation process. |
| 6. **Module 3** Presentation of final report and evaluation in a 2-day workshop. | City management team; facilitated by Regional Office and WKC. | Result of evaluation. |
| 7. National advocacy seminar to present findings. | City management team. | Agreement on expansion of healthy urbanization project to other cites and its institutionalization in national health and development plans and policies. |

# Healthy and Safe School Environment project in Yemen

The Healthy and Safe School Environment for Children (HSEC) project was launched by the WHO Regional Centre for Environmental Health Activities (CEHA) in 2005 in Yemen to raise awareness of the impact of the school physical environment on children's health through community participation and intersectoral action. The environmental health status of 58 schools in the BDN areas of 10 governorates in Yemen has been assessed by a committee composed of the school headmasters and members of village development committees. The committees are preparing action plans to improve the environmental health status of the schools. WHO is assisting the Ministry of Public Health and Population and the Ministry of Education

in advocating the project to generate resources through building partnerships with the World Bank's Social Development Fund, UNICEF, the World Food Programme and other potential partners. The project will be evaluated after a year and the output presented to policy-makers for its institutionalization.

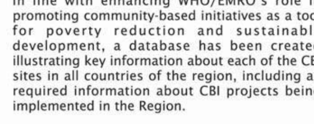
# A new CBI database

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, has expressed his interest in the creation of a database to house the information gathered from the 18 countries of the Region implementing the CBI programme. The database will provide CBI with an opportunity to continually update existing information about CBI-implementing areas, using it for improving the planning and support process at all levels. In addition, the database will enable the sharing of information with potential partners and donors for programme expansion, as well as with all stakeholders, including WHO offices, ministries of health and civil society partners, to facilitate their ability to take informed decisions. CBI hopes that this project will enhance the Regional Office's role in promoting community-based initiatives as a tool for poverty reduction and sustainable development.

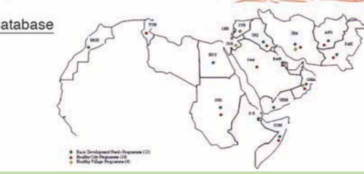
**Main menu**

On EMRO intranet use http://intranet.emro.who.int/CBI/ URL to launch the main menu of the CBI database

**Profiles for countries implementing Community-Based Initiatives (CBI) in the WHO Eastern Mediterranean Region**


In line with enhancing WHO/EMRO's role in promoting community-based initiatives as a tool for poverty reduction and sustainable development, a database has been created illustrating key information about each of the CBI sites in all countries of the region, including all required information about CBI projects being implemented in the Region.

- CBI programmes database



CBI would like to express its appreciation to the HIT Unit, and especially Dr Najeeb El Shorbaji, Mr Mohamed Nour and Mr Khaled Shams for their active participation in this endeavour. In addition, we would like to gratefully acknowledge the efforts being made by our CBI focal points in the WHO country offices in Sudan (Dr Sumaia Alfadil), Yemen (Mr Agha Khan Aseel), Iraq (Dr Iman Shenkati) and Pakistan (Dr Khoshal Khan Zaman) who are in regular contact with the CBI unit. Our appreciation also goes also to Mr Farid Ayoub, a young Egyptian intern who is studying international development and political science at McGill University, Canada, for his concerted efforts as a member of the team during his summer internship.

# Partnership development for CBI

Partnership development in the scaling up of the CBI programme in the demonstration areas is vital for the expansion phase. Many agencies and civil society organizations are already working in the area of community development and poverty reduction. The health sector, in collaboration with WHO, should play a leading role in health and community development at the national level.

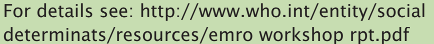
Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, believes that partnership development and resource generation is vital for CBI programme expansion and sustainability as CBI programmes cannot work in isolation. CBI thrives on building partnerships and generating resources from intersectoral cooperation, UN agencies, civil society and potential donors. It is important for national authorities to design a system to map potential partners in health, community development and poverty reduction, in order to create harmony and align partnership efforts in these areas.

CBI is currently in the process of making an inventory of all partners working in health and community development in all countries of the Region. The inventory can be used by the community development committees in CBI implementation areas, and at district, provincial, national and regional levels in community-driven programmes. In addition, it will facilitate efficient utilization of the available resources and harmonize inputs for health and community development.



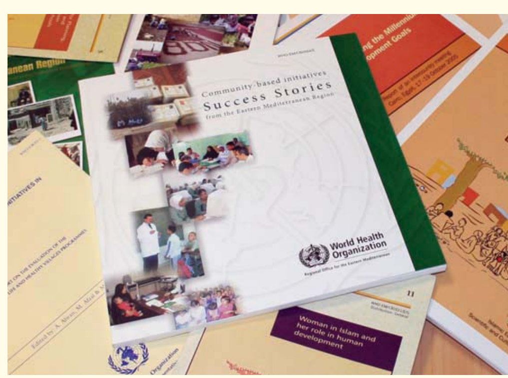
# Social determinants of health and health equity workshop

A workshop on the development of a regional perspective on social determinants of health, health equity issues and their policy implications was held in Cairo, Egypt, on 5–7 June 2006 at the Social Research Center of the American University in Cairo. It was jointly sponsored by the Social Research Center and the Regional Office. Presentations explored the evidence base for best practices in implementing social determinants of health programmes and promoting health equity. Discussions of CBI centered on the institutionalization of programmes at governmental level and the role of civil society organizations in achieving local sustainability.


For details see: http://www.who.int/entity/social determinats/resources/emro workshop rpt.pdf

# CBI success stories

During the 53rd session of the WHO Regional Committee for Eastern Mediterranean, Dr Hussein A. Gezairy, WHO Regional Director, launched a new advocacy document entitled *Community-based initiatives: Success stories from the Eastern Mediterranean Region.* It describes success stories from 10 countries of the Region that demonstrate how community-based initiatives have improved people's health and quality of life. The stories illustrate the achievements and the sustainability of the CBI programme and the crucial role that women play in development. They are intended to demonstrate to policy-makers, professional bodies, local government, international partners and other stakeholders involved in development the efficacy of the CBI programme in reducing poverty and in addressing all social determinants of health. The electronic copy of the material is available at: http://www.emro.who.int/cbi/




# Correction

In the last *Community-based initiatives newsletter*, Vol. 2, Issue 1, January 2006, the website of the Healthy Cities Programme in Saudi Arabia was given incorrectly. The correct website address of the programme is: www.hcp.gov.sa

# Summary in French

Le présent numéro du Bulletin d'information sur les initiatives communautaires propose un entretien avec Dr Zuhair Hallaj, Directeur de la Lutte contre les maladies transmissibles au Bureau régional de l'OMS pour la Méditerranée orientale et Représentant de l'OMS par intérim en Égypte. Dr Hallaj a examiné le rôle joué par le programme des Initiatives communautaires dans la lutte contre le VIH/SIDA, la tuberculose et le paludisme en s'attaquant aux obstacles qui s'opposent à la réussite de la mise en œuvre des initiatives de traitement et de prévention, en les rendant accessibles à la plupart des communautés touchées. Les initiatives communautaires fournissent au programme de lutte antituberculeuse un excellent moyen d'atteindre les communautés. L'Unité Halte à la tuberculose au Bureau régional a entamé une collaboration efficace avec le programme des Initiatives communautaires (CBI) et tous les programmes de lutte contre les maladies transmissibles dans les pays sont encouragés à coordonner leurs efforts au niveau communautaire avec

le programme CBI. Les communautés ont aussi un rôle à jouer dans le système d'alerte précoce pour les maladies en aidant les agents de santé à obtenir des informations rapidement et en mobilisant la communauté pour endiguer les flambées de maladies. Pour coordonner l'implication de la communauté, on a créé le mécanisme du Réseau d'alerte précoce et de riposte. Les programmes nationaux liés à la santé devraient permettre à tous les acteurs de contribuer au développement sanitaire. Un ferme engagement politique et une participation communautaire active sont à la base de la réussite de tout programme de développement, y compris de ceux qui sont axés sur la santé.

Pour intensifier les interventions antipaludiques et pour assurer leur pérennité et leur efficacité, il convient de planifier, de mettre en œuvre et de superviser ces interventions avec ceux qui sont les plus touchés. La participation communautaire aux interventions antipaludiques peut être conçue en tant que complément aux programmes de lutte antipaludique actuels afin de maximiser les bénéfices pour la communauté, en particulier là où une partie non négligeable de la population est très dispersée dans des zones reculées.

L'initiative des Besoins fondamentaux en matière de développement (BDN) en Somalie a intégré ses activités dans d'autres programmes concernant les soins de santé primaires, notamment pour la vaccination systématique, la rougeole et la lutte contre le paludisme, ainsi que l'hygiène et l'assainissement de base. Par conséquent, les communautés appliquant les BDN ont participé activement à la mise en œuvre de ces programmes et des progrès encourageants ont été accomplis en ce qui concerne l'amélioration de l'accès aux services et la qualité de ces services.

Il y a souvent plusieurs déterminants sociaux de la gestion sanitaire qui ont un impact sur le bien-être des communautés défavorisées. Une étude de la communauté de Nag Al-Arab à Alexandrie (Égypte) qui visait à examiner les obstacles sociaux à la prise en charge de l'hypertension et des maladies cardiovasculaires chez 499 participants (âgés de 18 à 83 ans) ayant fait l'objet d'un examen et d'un dépistage aléatoire pour la mesure de la tension artérielle, a permis de constater que 18,4 % de la population était hypertendue, ce qui était significativement associé avec une diminution de l'activité physique et une augmentation de l'apport de graisses saturées dans l'alimentation.

Le ministère djiboutien de la Santé, en collaboration avec l'OMS, a élaboré une stratégie et un plan d'action nationaux pour l'extension du programme des Besoins fondamentaux en matière de développement dans le pays. La stratégie a été lancée par Son Excellence le Ministre de la Santé en présence de quatre autres ministres le 24 juin 2006, après une consultation avec un groupe de partenaires principaux lors d'un séminaire-atelier de deux jours qui s'est tenu les 21 et 22 juin 2006. Le Gouvernement djiboutien a démontré un ferme engagement pour faire du programme des Besoins fondamentaux en matière de développement un outil de réduction de la pauvreté en l'intégrant à son document stratégique de lutte contre la pauvreté.

Le ministère tunisien de la Santé publique, le Bureau régional et le Centre OMS pour le développement sanitaire de Kobe vont se lancer dans un projet de démonstration à Ariana (Tunisie). Le Directeur régional a approuvé l'allocation de USD 50 000 d'ici début 2007 et le Centre de Kobe financera le reste du montant durant la période 2007-2008.

Le projet *Healthy and Safe School Environnement for Children* - HSEC (Environnement scolaire sain et sûr pour les enfants) a été lancé par le Centre régional de l'OMS pour les activités d'hygiène de l'environnement (CEHA) en 2005 afin de mieux faire connaître l'impact que l'environnement physique des écoles peut avoir sur la santé des enfants, au moyen de la participation communautaire et de l'action intersectorielle. La situation concernant la salubrité de l'environnement dans 58 écoles situées dans des zones BDN de 10 gouvernorats a été évaluée par un comité composé de directeurs d'écoles et de membres de comités de développement villageois.

Une base de données doit être créée pour héberger les informations recueillies en provenance de 18 pays de la Région qui mettent en œuvre le programme des Initiatives communautaires. Ceci permettra d'actualiser les informations existantes sur les zones qui mettent en œuvre ces initiatives afin d'améliorer le processus de planification et d'appui à tous les niveaux. De plus, ceci permettra de partager les informations avec des partenaires et des donateurs potentiels pour l'extension du programme.

L'Unité Initiatives communautaires procède actuellement à un inventaire de tous les partenaires intervenant dans le développement sanitaire et communautaire dans l'ensemble des pays de la Région. Il est important pour les autorités nationales de concevoir un système pour recenser les partenaires potentiels dans la santé, le développement communautaire et la réduction de la pauvreté, de créer une harmonie et de mettre en adéquation les efforts de partenariat dans ces domaines.

Le Bureau régional et le Centre de recherche sociale de l'Université américaine du Caire ont organisé un séminaire-atelier sur l'élaboration d'une perspective régionale concernant les déterminants sociaux de la santé, les questions d'équité en santé et leurs implications politiques. Ce séminaire s'est tenu au Caire (Égypte) du 5 au 7 juin 2006.

Un nouveau document de sensibilisation a été lancé ; il est intitulé *Community-based initiatives : Success stories from the Eastern Mediterranean Region.* Il décrit les exemples de réussite dans 10 pays de la Région de la Méditerranée orientale qui montrent comment les initiatives communautaires ont permis d'améliorer la santé des gens et leur qualité de vie. Ce document peut être consulté sur l'Internet à l'adresse suivante : http://www.emro.who.int/cbi/.

Dans le numéro 1, Vol. 2, du Bulletin d'information sur les initiatives communautaires de janvier 2006, le site Web du Programme Villes-santé d'Arabie saoudite a été indiqué de manière incorrecte. L'adresse correcte du site Web est la suivante : www.hcp.gov.sa.

## Summary in Arabic

في هذا العدد من الرسالة الإخبارية لوحدة المبادرات المجتمعية، نجري مقابلة مع الدكتور زهير حلاج، مدير قسم مكافحة الأمراض السارية، بمكتب منظمة الصحة العالمية الإقليمي لشرق المتوسط، والقائم بعمل ممثل المنظمة في مصر. يناقش الدكتور حلاج في هذه المقابلة دور برنامج المبادرات المجتمعية في مكافحة مرض الإيدز والعدوى بفيروسه، والسل، والملاريا، عن طريق التصدّي لعوائق التنفيذ الناجح لمبادرات المعالجة والوقاية، بما يجعل هذه المبادرات في متناول معظم المجتمعات المتضرِّرة. وتمثّل المبادرات المجتمعية فرصة ممتازة تتيح للمجتمعات الاستفادة من برنامج مكافحة السل. ولقد بدأت وحدة مكافحة السل في المكتب الإقليمي تعاوناً فعالاً مع برنامج المبادرات المجتمعية، وتوصى جميع البرامج القطرية المعنية بمكافحة الأمراض السارية بتنسيق جهودها مع المبادرات المجتمعية على مستوى المجتمع. كما أن للمجتمعات دوراً في نظام الإنذار المبكر بالأمراض، وذلك بمساعدة العاملين الصحيين على الحصول على المعلومات في الوقت المناسب، وباستنهاض المجتمع لاحتواء الفاشيات المرضية. ولتنسيق عملية مشاركة المجتمع، تم إنشاء شبكة للإنذار المبكر والاستجابة. وينبغي لجميع البرامج الوطنية ذات العلاقة بالصحة أن تتيح لجميع الأطراف المساهمة في تنمية الصحة. فالالتزام السياسي والمشاركة النشطة للمجتمع هما الأساس لأي نجاح تحققه برامج التنمية، بما في ذلك البرامج التي تركز على الصحة.

وللنهوض بمداخلات مكافحة الملاريا وضمان استمراريتها وفعاليتها، من الضروري تخطيط هذه المبادرات وتنفيذها والإشراف عليها، بالمشاركة مع الفئات السكانية الأشد تضرُّراً. ويمكن تصميم عملية المشاركة المجتمعية في مكافحة الملاريا، بحيث تتكامل مع برامج مكافحة الملاريا الحالية، بُغية تعظيم استفادة المجتمع منها، ولاسيَّما إذا كان قطاع كبير من السكان منتشراً انتشاراً واسعاً في مناطق نائية.

وقد أدمجت مبادرة تلبية الاحتياجات التنموية الأساسية في الصومال أنشطتها في برامج الرعاية الصحية الأولية الأخرى، ولاسيَّما برامج التمنيع الروتيني، ومكافحة الحصبة والملاريا، وبرامج الصرف الصحي والنظافة الشخصية الأساسية. نتيجة لذلك، أسهمت المجتمعات المشاركة في مبادرة تلبية الاحتياجات التنموية الأساسية في القرى، في تنفيذ هذه البرامج وفي تشجيع التقدُّم الذي أحرز في تحسين الحصول على الخدمات وتحسين جودتها.

وعادة ما تكون هنالك عدة محددات اجتماعية للإدارة الصحية، تؤثـِّـر على صحة وعافية المجتمعات المحرومة من الخدمات. وفي دراسة أجريت في منطقة نجع العرب، بمحافظة الإسكندرية، بمصر، لتقصِّي العوائق الاجتماعية أمام معالجة فرط ضغط الدم ومرض القلب الوعائي لـدى ٤٩٩ مشاركاً (في الفئة العمريـة ١٨-٨٣ عامـاً)، تمت دراستهم وتحريهم بشكل عشوائي لقياس ضغط الدم لديهم، تبيَّن أن ١٨,٤٪ من هذه المجموعة السكانية مصابون بفرط ضغط الدم. وترتبط هذه النتيجة ارتباطاً مهماً بانخفاض النشاط الجسماني الرياضي وارتفاع الدهون المشبَّعة في الغذاء المتناول.

وقد وضعت وزارة الصحة في جيبوتي، بالتعاون مع منظمة الصحة العالمية، استراتيجية وطنية وخطة عمل لتوسيع نطاق مبادرة تلبية الاحتياجات التنموية الأساسية في جيبوتي. وقد أطلق هذه الاستراتيجية معالي وزير الصحـة في ٢٤ حزيران/يونيو ٢٠٠٦، في حضور أربعة وزراء آخرين، وذلك بعد التشاور مع مجموعة من أصحاب الشأن المعنيِّين في حلقة عملية عُقدت لمدة يومين، من ٢١-٢٢