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Community-based initiatives

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Contents

Interview with

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1. The community-based initiatives (CBI) programme has been implemented to varying degrees for more than two decades in 17 countries of the Region at different levels. In the Islamic Republic of Iran, Oman, Morocco, Saudi Arabia and Pakistan, the programme is making progress towards integration into national health systems. What are the factors that have contributed to this success and how can other countries learn from these experiences?

In the Region, the CBI programme has been implemented and adapted according to national and local contexts. While CBI implementation and operational processes are often similar in countries, the inputs and outcomes vary in degree and scale. Political support and government commitment are viewed as two of the key factors for the success and sustainability of the programme. The programme's reliance on intersectoral support is in line with individual governmental systems and provides assistance for local development. Other factors for success include the existence of necessary infrastructure and a recognition of the success of the CBI approach by development partners. Community participation and women's involvement in all programme areas are also crucial. The sharing of relevant information, ongoing training programmes, improvements in management and communication skills and advocacy at all levels have also contributed towards the sustainability of the programme's approach over its period of implementation. Emerging approaches such as those undertaken to achieve the targets of the MDGs, or those pursued by the Commission on Macroeconomics and Health (CMH) and the Commission on the Social Determinants of Health (SDH) have further supported the CBI approach and have proven its success. It is also imperative that the efforts and achievements of the CBI programme are documented and evidence of successful experiences disseminated, in addition to recognizing the

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importance of sharing information, exchanging visits and transferring related knowledge and technologies.

2. In the Region, many organizations are becoming involved in development and are encouraging community participation. What are the major strategies that countries and WHO should adopt in order to strengthen partnerships with potential partners in development?

The CBI programme, which relies on a multisectoral approach, requires wider partnerships with relevant stakeholders, civil society organizations, UN agencies and potential donors. In this respect, advocacy and promotion of the approach to decision-makers, the media, donors and stakeholders is the most significant activity, in addition to orientation and demonstration visits to model sites. The continuous exchange of experiences and information with partners, developing coordination networks and capacity-building activities can be described as the best course of action for mobilizing effective partnerships.

To develop sustainable partnerships, particularly with civil societies, WHO needs to earmark adequate funds to serve as seed money. The Organization should focus on marketing the approach and building the capacities of potential partners and organizations in order that they are able to implement the approach on their own. This requires representatives of the CBI programme to proactively approach other stakeholders and enlist them as partners while respecting the mandates of individual organizations.

3. Improving the health status of people in CBI-implementing areas through community leadership and ownership is the ultimate goal of the programme. How can other health-related programmes benefit from the existence of an organized and mobilized community in CBI areas?

Community participation and intersectoral coordination are the key components of the primary health care approach but due to the absence of appropriate processes, the goal of the Strategy of Health for All has not yet been achieved. Supporting the primary health care approach, CBI provide a formal system for community participation and intersectoral support at local levels as communities are empowered to participate at full capacity. Community capacity building enhances local ability to be proactively involved in local development processes, including health services delivery through sensitizing communities to their health needs and mobilizing them to invest in solving their own problems. As a result, the initiatives, within well-organized community settings and intersectoral structures, provide a suitable and convenient environment for all health programmes to implement health actions.

This process of facilitation at grass-roots level can also assist in reducing the duplication of effort and resources and in enhancing health outcomes related to priority health programmes. This can provide an opportunity for integrating planning, implementing and monitoring processes and ensuring comprehensive health care for communities. These objectives are possible through a number of innovative ideas, such as intrasectoral coordination mechanisms at all levels, designing common strategies and monitoring indicators, developing local health care guidelines, making integrated local health plans, bringing together health resources and implementing essential health services in each area.

Partnerships and coordination within the health sector can be facilitated through orientation sessions conducted for programme managers, arranging demonstration visits to model areas, conducting in-house advocacy and information sharing, undertaking joint assessments, and if possible, through piloting common actions in certain areas. The WHO Regional Office should take the lead in this coordination process and design appropriate mechanisms and tools for joint endeavours through the clustering of related health units and programmes.

4. In order to institutionalize the programme, maintain achievements and move towards self sufficiency of the programme, what would you recommend as future directions for the programme?

The programme has gained a reasonable level of maturity and it is time to critically review its processes and to think ahead in order to align it with its actual goals and concepts and to respond to emerging needs. In this regard, a paper: *CBI lessons learned and the way forward* has been developed and was presented during a recent meeting of WHO country representatives at the Regional Office. The paper presents a set of modalities to be adapted and adopted by Member States. These include: (i) institutionalizing the initiatives within health systems and linking them to the primary health care system; (ii) creating intrasectoral mechanisms for comprehensive health care; (iii) formalizing an intersectoral collaboration mechanism which aligns the initiatives with other sectors; (iv) empowering communities and implementing the initiatives in urban and rural settings following common approaches; (v) scaling up programme expansion and forming linkages with ongoing development activities specifying clear roles for its various component areas in the model and expansion phases; (vi) streamlining programme management and monitoring; and (vii) introducing a disaster management component in CBI areas. Complementing these modalities, essential packages for health services, women' s development, skills development and socioeconomic development have been designed to be implemented in all areas.

WHO support for the programme needs to be strengthened, particularly in terms of providing technical assistance, programme advocacy, promoting its incorporation into national strategies or government agendas and enhancing the role of partners during the expansion phase. In this process, emerging approaches such as those adopted to achieve the targets of the MDGs and those adopted by the Commission on Macroeconomics and Health (CMH) and the Commission on the Social Determinants of Health (SDH)

need to be fully incorporated within the approach. The development of training manuals can be instrumental in building local capacity and in conducting refresher training for CBI teams and communities, in addition, training manuals are useful for raising the awareness of stakeholders and partners. Further to this process, academia also needs to be involved in the research and development process. Medical institutions and other universities should be encouraged to include a CBI component in their educational and research programmes through the development of training curriculum and study programmes, initiating research projects on related aspects of the approach and introducing internships for university graduates. The objective is the conceptual growth of the approach with research-based scholastic input and the testing of emerging ideas.

5. This is an excellent opportunity to discuss the success of the CBI programme in the Islamic Republic of Iran, and how this success can be sustained during the expansion phase.

Over the years, the CBI programme has witnessed outstanding achievements in the Islamic Republic of Iran. The Ministry of Health and Medical Education, with the active support and contribution of WHO, is implementing the initiatives in 16 out of 30 provinces in the country. The programme is being implemented in 103 areas, of which 56 are urban and 47 are rural. In addition to these, it is planned that the programme will be implemented in 15 new areas in five provinces in 2007. The national coordination council for the healthy city and healthy village programmes provides leadership at national level, with intersectoral support mechanisms that function in line with the government system and provide assistance to CBI areas through a range of multisectoral activities. Gender mainstreaming and women's development is a cross-cutting activity in all CBI areas, where women are actively participating in programme activities. Partnerships have been developed with the Imam Khomeini Relief Foundation (IKRF) and the Ministry of Welfare and Social Security. WHO has also signed memorandums of understanding with the Kerman University of Medical Sciences and Lorestan University of Medical Sciences, both located in earthquake-affected provinces. Recently, a national training course was conducted for the development of a core team of experts that was attended by various key partners, ministries and civil society organizations. This has paved the way towards formalizing links with other partners, stakeholders and civil society organizations. Over the last year, evaluation of the programme and its validation was carried out to assess its inputs, processes and outputs in order to review implementation strategies for programme expansion. Its findings are of critical value and have become a basis for institutionalizing the programme within health systems.

The following are several examples which highlight the significant achievements in improving health and social conditions in CBI areas. The healthy city programme was implemented in the urban area of Saveh in 1997. In 2003, the community carried out a revised needs assessment and identified the problem of youth involvement in substance use. In order to address the problem, the community, with the active participation of the state welfare organization, established a narcotics anonymous (NA) association to treat addicts and encourage their integration as responsible members of society. In this endeavour, other partners including the education office, the women's affairs commission, *Basij* (volunteer militia), the municipality and physical education office of Saveh also contributed. Initially, the response from addicts was not encouraging. Six months after the formation of the association, its membership was only 20 although this number gradually increased to over 240 by 2005. Supported by the efforts of the NA association, a number of addicts have ceased taking drugs, and intense follow-up including rehabilitation measures are being undertaken for the remaining addicts.

Polan is a poor locality situated in the periphery of Sistan and Baluchistan provinces. Due to a lack of resources and opportunities, the area has remained under developed. The CBI programme was introduced in 2003 and has undertaken a number of activities to address key priorities in the area. Solid waste was a major issue that was creating environmental pollution and damaging the health of the community. With the active support of related departments, the community implemented a project for solid waste management. The Government contributed through the provision of a collection vehicle and the community was proactively involved in operational activities. Periodic sanitation campaigns were also carried out, raising the community's awareness of sanitation, hygienic practices and the safe disposal of solid waste. Soon, this project became the most popular venture in the area as it substantially improved local environmental conditions. Over a short space of time, the positive impact of the project was visible with a reduction in the number of cases of diarrhoea and of other waterborne infections. The community was also motivated to carry out other health and social welfare activities to improve their quality of life.

Before

After

Refuse collection and disposal in Polan, Sistan and Baluchistan province

Djibouti launches a national initiative for social development–a project for a democratic and modern society

During the first session of the Cabinet held on 10 January 2007, H.E. the President of Djibouti, Mr Ismail Omar Guelleh, announced the implementation of the national initiative for social development. The aim of the initiative is to reduce social disparities, fight the exclusion of underserved groups of the population and to reduce levels of poverty. The initiative was created as a result of the fact that large groups of the population were living under very difficult conditions and were experiencing severe poverty and marginalization. The initiative intends to establish a new strategy to confront the political, economic and social challenges facing Djibouti and to establish a democratic and modern society that will live up to the expectations of the nation. The President highlighted the fact that the hard-won autonomy of Djibouti was not only limited to living in a society which guaranteed the physical integrity of its citizens, but that more importantly, ensured equity, tolerance and solidarity.

The project aims to enable the society to respond to the numerous challenges facing Djibouti where basic social services are proving inadequate for the increasing demands of the population. Consequently, large sections of the population remain outside of the development process and live in poverty with few employment opportunities.

The initiative is based on the existence of four conditions which led to its foundation and shaped its philosophy. Firstly, large groups of the Djiboutian population are living under severe conditions. Secondly, a set of long-term integrated public policies have been established in which political, social, economic, educational, cultural and ecological dimensions are all working together to complement each other. Thirdly, openness and participation in the globalization process are being encouraged, and fourthly, social models previously adopted by other countries are being used to fight poverty and exclusion.

Three areas of focus for action were identified within the initiative including:

- promoting access to basic social services through the strengthening of social policies in education, health, energy and housing, in addition to reinforcing the infrastructure serving culture, sport and transportation;
- restructuring national production systems in order to generate greater employment opportunities and to eradicate poverty, particularly among youth;
- providing assistance and support to the most vulnerable groups in order to provide them with the opportunity of satisfying their needs.

For this project to come to fruitition, the Government needs to overcome the challenge of insufficient financial and other resources. Thus, this project needs to be accompanied with objective criteria to determine which beneficiaries are in real need.

The first objective of the project is to improve the quality of life for those in the poorest rural and urban districts where unemployment, social exclusion, delinquency and poverty prevail in their worst forms. Secondly, the project will progressively allow the use and reinforcement of existing structures, in terms of quality and capacity to be able to respond to and assist individuals found in a situation of social misfortune, such as abandoned children, women in financial need, the elderly and orphans who are often left without income or shelter.

The initiative calls for listening to the nation, joining all stakeholders whether political parties, civil society, syndicates, local communities, individuals and even the private sector to become involved in the development process. The plan of action will be based on the principles of good governance, accountability, transparency, community involvement and rationalizing the performance of public entities, in addition to the ensurance of systematic follow-up and the formation of continuous evaluation mechanisms.

In terms of financing, the initiative will be supported from substantial resources already allocated in the Government's budget. The financial mechanisms will be arranged in such a way as to guarantee the sustainability of resources, the simplification of implementing procedures, and at the same time, not cause any increase in taxes or the fiscal burden for individuals or enterprises. The initiative should result in creating a real human capital comprising qualified human resources, in addition to vigilant mechanisms to monitor the progress towards the planned objectives.

The project also highlights the importance of optimal implementation of the reform of the education system as a lever for social integration and as a means of social mobility. It is also important that the country develop a set of long-term strategies that foster the development of rural areas and achieve the optimal utilization of agricultural resources.

Finally, the initiative is a call for everyone to be truly committed to work hard to free underprivileged groups and areas from poverty, exclusion and under development in order to achieve sustainable human development that will remain the main challenge facing Djibouti today and tomorrow.

Progress towards achieving the health-related targets of the MDGs in the 10 priority countries of the Region

World Health Organization
Regional Office for the Eastern Mediterranean

unicef

United Nations Educational, Scientific and Cultural Organization

The annual joint coordination meeting of WHO Regional Office and UNICEF Regional Office for the Middle East and North Africa (MENARO) Regional Directors, in partnership with UNFPA, UNESCO, FAO, WFP and UNAIDS, was held in WHO Regional Office on 20 February 2007. One of the items on the meeting's agenda was progress towards achieving the health-related targets of the MDGs in the 10 priority countries of the Region (Afghanistan, Djibouti, Egypt, Iraq, Morocco, Pakistan, Palestine, Somalia, Sudan and Yemen).

During the meeting, Dr Abdullah Assa'edi, WHO Assistant Regional Director for the Eastern Mediterranean, highlighted the regional strategies that WHO had put into action to support countries in their endeavours towards achieving the targets of the MDGs. These strategies include:

- scaling up health systems;
- implementing community-based initiatives and empowering women in development;
- conducting education for sustainable development;
- controlling and preventing malnutrition including micronutrient deficiencies;
- implementing the reach-every-district approach (for measles immunization);
- introducing new life-saving vaccines;
- implementing the Integrated Management of Child Health and child health policy initiatives;
- Making Pregnancy Safer;
- managing/controlling HIV/AIDS and STIs;
- Roll Back Malaria (RBM);
- Stop TB (DOTS);
- managing health care waste safely;
- implementing the healthy environments for children initiative;
- creating global partnerships for development.

WHO and other UN agencies, particularly UNICEF, UNFPA, UNDP and WFP are already combining efforts in conducting these strategies. However, close collaboration and harmonization is needed to prevent duplication of effort and to improve the efficiency of inputs.

Analysis of current trends indicates that most of the priority countries are far behind the goal of achieving the targets if the current pace of progress is maintained. The following text highlights the current trends towards achieving the health-related targets of the MDGs in the 10 priority countries, as reported or as estimated for 2005.

Although Goal 4 aims to reduce child mortality, the latest figures for under-5 mortality rates show that among the 10 priority countries, Afghanistan, Somalia and Iraq are the three countries with the highest rates. This is mainly due to the fact that the countries are experiencing complex emergencies, lack quality health care services and record low levels of literacy among the population, particularly among females. The highest under-5 mortality rate in 2005 was registered in Afghanistan where it had reached 257 per 1000 live births. This rate is substantially higher than the 83.3 target set for Afghanistan for 2015. The situation is also difficult in Somalia and Iraq. In Somalia, the under-5 mortality rate is set to be reduced by 2015 from 224 to 84, and in Iraq from 130 to 17.3.

Egypt and Morocco are both demonstrating positive progress and these countries are already very close to reaching the set targets; under-5 mortality in Egypt in 2005 was 26.2 per 1000 live births and in Morocco 47 per 1000 live births. The targets for both countries are 18.7 and 23, respectively.

In terms of the percentage of immunization coverage against measles among children under 1 year of age, Palestine, Egypt and Morocco have succeeded in exceeding 95% coverage recording a coverage rate of 100%, 98% and 97%, respectively. In 2005, the lowest immunization coverage rates were reported in Somalia (35%), Afghanistan (64%) and Djibouti (65%). Between 2000 and 2005, Pakistan and Sudan witnessed a remarkable increase in immunization coverage; in Pakistan

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it increased from 56% to 78%, and in Sudan from 47% to 73%. The overall measles mortality rate in the Eastern Mediterranean Region between 1999 and 2006 has decreased from 103 800 to 34 000 deaths.

In relation to the goal of improving maternal health (Goal 5), the 10 priority countries are progressing well towards reaching the targets with the exception of Afghanistan, Djibouti, Somalia and Sudan. The maternal mortality ratio in Somalia and Afghanistan has reached 1600 per 100 000 live births. In view of the current rate, both countries need to deploy greater efforts to reduce this rate by 400% to achieve the set targets. The rate in Djibouti is 546, and in Sudan 509, both figures still relatively high when compared to the 2015 targets of 185 and 165, respectively.

As for the percentage of births attended by skilled personnel, Iraq has achieved the 90% target and Palestine has exceeded it with a percentage of 97%. Afghanistan, Pakistan, Somalia and Yemen are the four countries with the lowest percentages at 14%, 19%, 23% and 28%, respectively.

In relation to Goal 6, the Region is witnessing reductions in tuberculosis prevalence at different rates in almost all countries. Among the 10 priority countries, Djibouti, Iraq and Sudan have been slow in reducing the prevalence of tuberculosis. For malaria, the reported figures are much lower than the estimated figures as a result of weak health information systems. Sudan accounts for 50% of the malaria burden in the Region, however, the country is witnessing a decline in reported cases. There is a need to increase the coverage of main preventive and curative treatments, i.e. the use of insecticide-treated bednets. Efforts to combat HIV/AIDS continue in the Region, although overall, the number of HIV-infected people is increasing. The number of people living with HIV in Iraq and Yemen remains difficult to estimate, however, the estimated number in Sudan was 350 000, and in Pakistan it was 85 000 for 2005.

The meeting presented a good opportunity to also present the feedback received from Jordan, Iraq, Morocco and Sudan on achieving the targets of the MDGs. In Sudan and Iraq, the health information systems were identified as weak although the situation there is improving relatively. In terms of resource mobilization, the trend in Sudan is weak although improving. In Jordan, Iraq and Morocco, resource mobilization is perceived as fair. Strong political commitment to achieve the targets exists in Iraq and Jordan. The need for strengthened intersectoral collaboration has been identified as a priority area for Jordan and Sudan. These four countries reported strong involvement of UN country teams (UNCT) in monitoring the targets and have requested greater support from UN agencies and assistance in partnership development, advocacy, resource mobilization and in-depth assessment of the causes for the slow progress towards attainment of the targets.

In view of the current situation, WHO, UNICEF, FAO and UNESCO have jointly requested the support of Regional Directors in the following areas:

- establishing a regional cross interagency team (including the UN Economic and Social Commission for Western Asia (ESCWA)) to plan the joint operational activities based on local needs and capacities;
- identifying a regional interagency pool of resources to implement collaborative projects;
- arranging joint visits of the Regional Directors to the priority countries to procure high-level political commitment;
- requesting UNCT to report MDGs progress on an annual basis to the regional cross interagency team;
- advocacy to address rapid turnover of trained staff.

Maternal health in the Eastern Mediterranean Region

Maternal health care delivery indicators have shown significant improvement in the Eastern Mediterranean Region. The average maternal mortality rate in the Region was reduced by 18.9% (from 465 to 377 per 100 000 live births) from 1990 to 2006. The trend, however, in Afghanistan, Iraq, Morocco, Pakistan, Somalia, Sudan and Yemen does not indicate that the set targets will be achieved.

Key achievements in improving maternal health in 2006 include the:

- development and introduction of the regional framework "Strategic directions for accelerating the reduction of maternal mortality in the Eastern Mediterranean Region";
- expanding Making Pregnancy Safer (MPS) strategy implementation from Sudan in 2001 to 12 other member countries in 2006;
- implementing strategic partnership programmes on maternal and neonatal health and family planning in selected countries of the Region;

Dr. Ramez Mahaini, Coordinator, Family and Community Healthy

- initiating the introduction of the integrated health technology package (IHTP) to MDG priority countries;

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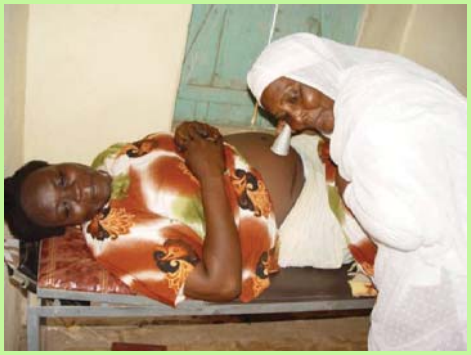
- initiating joint training in essential newborn care;
- strengthening community awareness-raising activities to promote life-saving practices in maternal and neonatal health through working with individuals, families and communities.

The main challenges to improving maternal health include:

- lack of effective national policies that reflect long-term directions and which ensure sustained commitment;
- difficult economic circumstances and competing priorities;
- poor health care delivery systems and barriers which hinder disadvantaged people from utilizing available health services;
- gender-based discrimination which makes women more prone to gender-based violence and a lack of decision-making power in reproduction and health;
- poor availability and under utilization of relevant data.



"This section is dedicated to sharing the experiences of CBI beneficiaries. In their own words they will tell us how the CBI programme has changed their lives. We believe that their stories will inspire us and justify the continuation of efforts to improve their quality of life through the programme."

Voice of the community: BDN success story from Egypt

Walking up to Taheya Melad's small shop, you will find her busy selling light bulbs to a customer. Taheya is a widow and a mother of six children: Rafat, Safwat, Momen, Amal, Mariam and Heba. Taheya's husband worked as an electrician and had opened this small shop to sell electrical supplies. When her husband died a few years ago, Taheya found herself in a situation of receiving no income although facing continuous expenses. She did not have enough money to keep the shop open and was forced to close. Taheya describes how the day-to-day living became very difficult with very little money even for food as her husband's illness had taken a lot of the money she had. Even though four of her children had married, Taheya was faced with big expenses, such as money for food, electricity and medication for her high blood pressure, diabetes and liver problem. Taheya also had to pay for her daughter's school fees and so she found herself in a very difficult situation. She was able to manage as a result of the assistance she received from the church, although as time went by her expenses increased and yet her income did not. Taheya says "I could not have managed without the help of the church, they paid for Heba's secondary education at the time when I could not afford it."

Then, Taheya heard about basic development needs (BDN) income-generating loans from a neighbour who had received a loan herself. Taheya says "many people in my street had received a loan to start a project and so I thought why couldn't I apply for one myself." She talked to a member of the community development committee about it and they submitted a request for a loan for her to the income-generating loans committee which assessed and approved an amount of 1100 Egyptian Pounds (LE) for her to buy electrical supplies and to re-open the shop.

Taheya was able to do so with the help of her daughter, Heba, who was familiar with electrical maintenance, a skill which she had learned from watching her

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father at work. Together, they began to sell electrical supplies and Heba repaired simple electrical appliances which customers brought in.

Re-opening the shop provided the family with a steady income to pay for their daily expenses. Taheya says "I can now buy meat once or twice a month which is something I could never do before". Furthermore, income generated from the shop has enabled Taheya to pay for Heba's education at a vocational institution. "My daughter Heba attends classes two days a week and helps me out during the rest of the week. When she obtains her diploma she will be able to work in a hairdresser's salon and earn additional money to help out" she explained.

Taheya's shop has been doing so well that one of the members of the community made an offer to buy it from her and although she refused, she realized what a great source of income the shop represented.

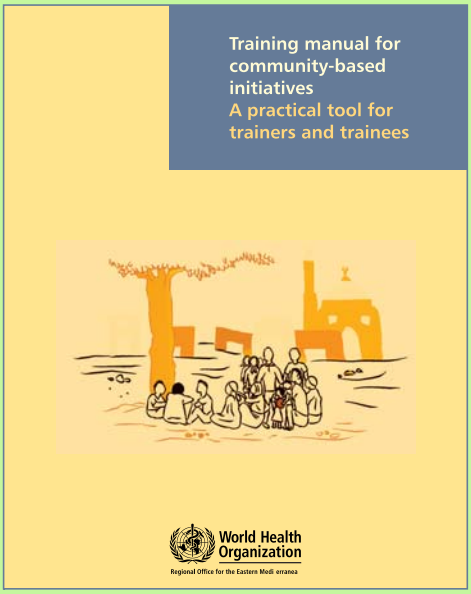
Taheya hopes to expand her project by diversifying and raising goats and is already saving up for this future venture. She added "I want more and more people to benefit from these loans, there are families here in Batn al Baqarah who want to work and who have good ideas but they do not have the money to implement them and so I tell them about the loan I received from the BDN programme."

Community-based initiatives training manual: a practical tool for trainers and trainees

Due to the expansion of community-based initiatives in the Region, it was felt that there was a need to create a standard training manual for community representatives that outlined the programme's approach and methodology. The manual is based on practical experiences gained so far in various countries and follows a participatory approach to training providing a framework for the effective follow-up and monitoring of interventions. The manual comes as a supplement to the *CBI training manual for mid-level managers*, which was produced in 2002 and field-tested during two regional training courses held in Pakistan and Jordan. The community-based initiatives training manual *A practical tool for trainers and trainees* was published in January 2007 and was disseminated to all member countries.

This training manual will improve the process of programme implementation through a scaling-up of communities' capacity. Although the manual serves as a reference for master trainers, they are at liberty to use different teaching and training methods to adapt to the requirements of the target groups. Programme managers at all levels and intersectoral team members from the relevant development sectors are the main target groups for this training manual. The material is flexible enough to be adapted to local needs.

The manual comprises two parts: Part A provides guidelines for the facilitators, which offer an introduction to community-based initiatives approaches, the structure and plan of the course, in addition to a set of guidelines for the planning, organizing, conducting and evaluating of the training course. Part B comprises five modules that are further divided into units which cover basic concepts, public health, social mobilization and development, management of community-based initiatives and leadership skills.



CEHA organizes a workshop on community-based solid waste management in Amman

The Regional Centre for Environmental Health Activities (CEHA) organized a workshop on community-based solid waste management in Amman from 5 to 7 March 2007. The workshop aimed to share, exchange and disseminate experiences and lessons learned from CEHA pilot projects in Lebanon and Yemen. Participants discussed a proposed framework for establishing a sustainable community-based solid waste initiative in CBI-implementing areas and approaches for empowering communities to achieve better health and to increase the quality of people's lives.

The proposed guidelines would strengthen the environmental health component, such as water supply and sanitation, within CBI areas. In addition,

it would help communities to identify problems, needs and solutions that are locally applicable and which takes into consideration socioeconomic, cultural and political conditions at local level, as well as the recommendations of the Commission on Macroeconomics and Health, the regional strategy on sustainable health development and poverty reduction (approved in 2003 by the WHO Regional Committee for the Eastern Mediterranean), as well as concerns raised by the WHO Commission on the Social Determinants of Health.

Participants recommended the need to consider the following strategic issues for planning sustainable community-based solid waste initiatives in the Region.

- health protection to be placed at the centre of the social, political and development agendas;
- investment in environmental services including solid waste for improving people's health;

  community empowerment and the role of women to be promoted;
- a sense of community ownership to be promoted;
- partnerships between people and local authorities, civil society and project stakeholders to be enhanced;
- intersectoral actions/efforts for health protection to be enhanced;
- gender awareness and capacity building for the encouragement of behavioural change;
- communities to be encouraged to implement income-generating projects on solid waste and environmental services;

- community associations, such as women's associations and city committees, to be involved in the process of planning and implementation of community-based solid waste initiatives;
- integration of community-based solid waste actions to be ensured within environmental health activities, such as water supply and sanitation, in CBI activities in the Region.

The healthy village of El Ba'ath in the Syrian Arab Republic

In February 2006, Dr Ibrahim Betelmal, WHO Representative for the Syrian Arab Republic, undertook a field visit to the healthy village of El Baa'th in the Kunaitra governorate.

Dr Hossam Dagooth, the healthy villages coordinator in Kunaitra, the female district representatives and the heads of committees briefed the WHO Representative on the achievements attained since programme implementation began in 1996. In Kunaitra, programme implementation began with three villages and today has been expanded to 11 villages. The programme has yielded a notable increase in the community's awareness of many health and environmental issues. Eight safe children's parks have been established and a further three are under construction. Moreover, in order to socially integrate people with physical disabilities, who have experienced marginalization for a long time, a centre for skills development was established in Khan Arnaba. Through healthy village interventions, 38 wheel chairs, 125 walking sticks and 55 hearing aids have been distributed.

The population of Al Baa'th is 4500. There are 115 smokers in the village, 12 of whom are women. It is estimated that 1 254 600 Syrian Pounds (SYP) are spent annually on tobacco. District representatives explained that a number of meetings were arranged to raise the community's awareness on the hazards of smoking and to encourage smokers to quit. Awareness-raising sessions on the importance of vaccination coverage for mothers and children, gardening and environmental issues were also conducted. The primary school was improved, transportation to the village was secured and a playground and a youth centre were established.

During the visit, the WHO Representative witnessed one of the activities taking place within the healthy eye project in a community school. He also visited the centre in Khan Arnaba, which is equipped with speaking computers for blind people, computers and Internet facilities, musical instruments, chess sets, a gymnasium and a reading hall. Mr Shaman El Mohaya, Head of the Blind Association, explained that there are 151 blind people in the governorate and the total number of visually-impaired people amount to 191. The Association is benefiting from the facilities that the centre is providing, particularly the students who have been provided with access to the centre's audio library.

Dr Mohsin Kanaan, the Director of the healthy village programme in the Ministry of Health, noted that by the end of 2006, the programme had been implemented in 567 villages. The

Ministry hopes to soon expand coverage to reach 1500 villages. It was also highlighted that all villages implementing the programme had witnessed an increase in the child immunization rate from 79% to 98%. The percentage of pregnant women with access to health care and family planning services has increased from 49% to 82%, and 39% to 77.5%, respectively. In terms of the coverage rate of access to sanitation, the rate has doubled from 45% to 90% and access to safe drinking-water has increased from 63% to 92%.

Dr Abdel Aziz El Nahar, the Director of School Health in the Ministry of Education, highlighted that one of the most important components of the healthy village programme is the community school. Through the formation of a community school, the Ministry attempts to encourage students' research skills by focusing on selected health and development challenges and encourages students to devise appropriate solutions.

While in the health centre, the WHO Representative stated that he was proud to be starting his field work with this visit. Al Ba'ath is a village that has achieved major success in achieving the programme's objectives, particularly in raising community health awareness. He expressed his wish that the healthy village programme would be expanded to cover all rural areas and the entire population. He also reiterated that the main goal of WHO was to achieve health for all, and thus, the Organization would continue to provide its full support and technical assistance to the programme in Al Baa'th and in other villages.

Résumé de ce numéro

Dr Mubashar Riaz Sheikh, Représentant de l'OMS en République islamique d'Iran, met en évidence le fait que le succès obtenu par le programme des initiatives communautaires (CBI) dans certains pays de la Région n'aurait pas été possible sans un fort appui politique, une collaboration intersectorielle, des infrastructures solides, une participation communautaire et l'implication des femmes dans le programme. Il souligne également le fait que le partage de l'information, le renforcement des capacités et la sensibilisation adéquate sont non seulement les seuls facteurs garantissant la pérennité du programme, mais aussi, de manière plus importante, des instruments permettant d'élargir les partenariats entre toutes les parties intéressées. À l'avenir, déclare-t-il, le programme devrait s'orienter vers i) l'institutionnalisation des initiatives communautaires dans les systèmes de santé en les liant notamment au système des soins de santé primaires ; ii) la création de mécanismes intrasectoriels pour des soins de santé complets ; iii) la systématisation du mécanisme de collaboration intersectorielle qui permet d'harmoniser les initiatives communautaires avec d'autres secteurs ; iv) l'autonomisation des communautés et la mise en œuvre des initiatives communautaires en milieu urbain et rural en suivant une approche commune ; v) l'accélération de l'extension du programme et l'établissement de liens avec les activités de développement en cours, en spécifiant des rôles clairs pour ses différentes composantes dans les phases pilotes et d'extension ; vi) la rationalisation de la gestion et du suivi du programme ; et vii) l'introduction d'une composante de gestion des catastrophes dans les zones appliquant les initiatives communautaires.

Les pays de la Région de la Méditerranée orientale ont entrepris de nombreuses activités et manifestations liées au développement social. À Djibouti, Son Excellence le Président Ismail Omar Guelleh a annoncé la mise en œuvre de l'Initiative nationale pour le Développement social le 10 janvier 2007. Cette initiative vise à réduire les disparités sociales, à combattre l'exclusion des groupes de population défavorisés et à faire reculer la pauvreté de larges franges de la population. L'initiative est également axée sur la promotion de l'accès aux services sociaux de base, la restructuration des systèmes de production nationaux pour créer de nouvelles perspectives d'emploi, l'éradication de la pauvreté en particulier chez les jeunes, et enfin la fourniture d'une assistance et d'un appui aux groupes les plus vulnérables.

En février 2007, Dr Ibrahim Betelmal, Représentant de l'OMS en République arabe syrienne, a effectué une visite sur le terrain dans le village de El Baa'th dans le gouvernorat de Qunaitra où il a pu observer les différentes activités alors en cours d'exécution dans les domaines de l'éducation, de l'hygiène du milieu, de la sensibilisation communautaire, de l'intégration des handicapés physiques dans la société, et des soins maternels et infantiles.

À Amman (Jordanie), le Centre régional pour les Activités d'Hygiène de l'Environnement (CEHA) a organisé un séminaire-atelier sur la gestion communautaire des déchets solides du 5 au 7 mars 2007. Ce séminaire-atelier visait à partager, échanger et diffuser des données d'expérience et les enseignements tirés des projets pilotes du Centre CEHA au Liban et au Yémen.

Au Caire, la réunion annuelle conjointe de coordination des Directeurs régionaux du Bureau régional de l'OMS et du Bureau régional de l'UNICEF pour le Moyen-Orient et l'Afrique du Nord s'est tenue au Bureau régional de

l'OMS le 20 février 2007, en partenariat avec le FNUAP, l'Organisation des Nations Unies pour l'éducation, la science et la culture (UNESCO), l'Organisation des Nations Unies pour l'alimentation et l'agriculture (FAO), le Programme alimentaire mondial (PAM) et le Programme commun des Nations Unies sur le VIH/SIDA (ONUSIDA). La réunion a constitué une bonne occasion d'examiner, entre autres choses, les progrès effectués par les 10 pays prioritaires vers la réalisation des cibles liées à la santé des objectifs du Millénaire pour le développement (OMD). Pendant la réunion, Dr Abdullah Assa'edi, Sous-Directeur du Bureau régional de l'OMS pour la Méditerranée orientale, a souligné les progrès majeurs réalisés et les défis auxquels les pays prioritaires sont confrontés. Du fait de la situation actuelle, le soutien des Directeurs régionaux est requis pour i) mettre en place une équipe interagence en vue de planifier les activités opérationnelles communes sur la base des capacités et des besoins locaux ; ii) identifier un ensemble régional de ressources pour mettre en œuvre les projets de collaboration ; iii) organiser des visites communes des Directeurs régionaux dans les pays prioritaires afin d'obtenir l'engagement politique à haut niveau ; iv) veiller à ce que les équipes de pays des Nations Unies fournissent un rapport de situation annuel sur les cibles des OMD ; et v) effectuer un plaidoyer pour s'attaquer à la rotation rapide du personnel formé.

L'équipe CBI du Bureau régional a produit un manuel de formation pour les initiatives communautaires (en anglais) intitulé *A practical tool for trainers and trainees*. Ce manuel a été produit suite à l'extension du programme qui a créé la nécessité de disposer d'un document standard pour la formation des représentants communautaires. Il présente l'approche et la méthodologie du programme et permettra d'améliorer la mise en œuvre du programme grâce au développement des capacités communautaires.

ملخص العدد

أوضح الدكتور مبشر رياض شيخ، ممثل المنظمة في جمهورية إيران الإسلامية، أن النجاح الذي حققه برنامج المبادرات المجتمعية في عدد من بلدان الإقليم، ما كان ليتحقّق لولا الدعم السياسي القوي، والتعاون الذي يتم بين القطاعات المختلفة، ووجود البنية الأساسية القوية، والمشاركة المجتمعية، وانخراط المرأة في هذا البرنامج. وأكّد الدكتور شيخ كذلك، أن تشاطر المعلومات، وبناء القدرات، والدعوة الفاعلة للبرنامج ليست هي العوامل الوحيدة التي تضمن استمراره، بل الأهم من ذلك وجود الأدوات التي يمكن من خلالها توسيع الشراكة مع جميع أصحاب الشأن المعنيـّين. وأضاف أن التوجُّه المستقبلي لهذا البرنامج ينبغي أن يمضي صوب: (١) إضفاء الطابع المؤسسي على هذه المبادرات في إطار النظام الصحي، وبخاصة ربطها بنظام الرعاية الصحية الأولية؛ (٢) إنشاء آليات للعمل بين القطاعات لتحقيق الرعاية الصحية الشاملة؛ (٣) إنشاء آلية تكتسب طابعاً رسمياً للتعاون بين القطاعات بما يضع المبادرات المجتمعية في مصاف القطاعات الأخرى؛ (٤) تمكين المجتمعات وتنفيذ هذه المبـــادرات في المحيطـــات الحضرية والريفـــية وفقاً لأساليب مشتركة؛ (٥) التوسُّع في البرنامج وربطه بأنشطة التنمية المتواصلة وتحديد أدوار واضحة في ما يتعلّق بعناصر تكوينه المختلفة، سواء في مراحل وضع النموذج، أو في مراحل التوسُّع فيه؛ (٦) تنسيق إدارة البرنامج وأنشطة رصد مسيرته؛ (٧) إدخال عنصر إدارة الكوارث ضمن مجالات عمل المبادرات المجتمعية.

ولقد شهدت بلدان إقليم شرق المتوسط أنشطة وأحداثاً عديدة في مجال التنمية الاجتماعية. ففي جيبوتي أعلن فخامة الرئيس إسماعيل عمر غيلة، في العاشر من كانون الثاني/يناير ٢٠٠٧، إطلاق المبادرة الوطنية للتنمية الاجتماعية، التي تهدف إلى تقليص الفوارق الاجتماعية، والتصدي لعملية استبعاد الفئات السكانية المحرومة من الخدمات، والتصدّي للفقر الآخذ في الازدياد بين فئات كثيرة من المواطنين. وتـــركز المبادرة أيضاً على تعزيز الحصول على الخدمات الاجتماعية الأساسية، وإعادة هيكلة نُظُم الإنتاج الوطنية لخلق المزيد من فرص العمل واستئصال شأفة الفقر، ولاسيّما بين الشباب، وأخيراً تقديم الدعم والمساندة للمستضعفين.

وفي شباط/فبراير ٢٠٠٧، قام الدكتور إبراهيم بيت المال، ممثل المنظمة في الجمهورية العربية السورية، بزيارة ميدانية إلى قرية البعث الصحية في محافظة القنيطرة، حيث سنحت لـــه الفرصة لمشاهدة مختلف الأنشطة التي تجري في مجالات التعليم، وصحة البيئة، وإذكاء الوعي المجتمعي، وإدماج الأفراد الذين يعانون من عجز بدني ضمن المجتمع، والرعاية الصحية للأمهات والأطفال.

وفي عمّان، بالأردن، نظّم المركز الإقليمي لأنشطة صحة البيئة حلقة عملية حول الإدارة المجتمعية للنفايات الصلبة، في المدة من ٥ إلى ٧ آذار/مارس ٢٠٠٧. وكان الغرض من هذه الحلقة هو تقاسُم المعلومات، وتشاطر وبث الخبرات والدروس المستفادة من المشروع الارتيادي الذي نفّذه المركز في كل من لبنان واليمن.

وفي القاهرة، شهد المكتب الإقليمي، في ٢٠ شباط/فبراير ٢٠٠٧، انعقاد الاجتماع التنسيقي السنوي المشترك للمديرين الإقليميّين في كلٍّ من المكتب الإقليمي لمنظمة الصحة العالمية لشرق المتوسط، واليونيسف، والمكتب الإقليمي للشرق الأوسط وشمال أفريقيا، بالاشتراك مع صندوق الأمم المتحدة للسكان، واليونسكو، ومنظمة الأغذية والزراعة (الفاو)، وبرنامج الأغذية العالمي، وبرنامج الأمم المتحدة المشترك المعني بفيروس نقص المناعة البشرية/الإيدز. وكان هذا الاجتماع بمثابة فرصة طيبة لمناقشة جملة أمور أخرى منها، التقدُّم الذي حقّقته البلدان العشرة ذات الأولوية في إطار سعيها لبلوغ المرامي الإنمائية للألفية في المجال الصحي. وقد أبرز الدكتور عبد الله الصاعدي، مساعد المدير الإقليمي للمنظمة، التقدُّم الكبير الذي تم إحرازه، وكذلك التحدّيات التي تواجهها البلدان ذات الأولوية، في هذا المجال. وقد طُلب من المديرين الإقليميّين، في ضوء الأوضاع الراهنة، تقديم الدعم اللازم من أجل: (١) تشكيل فريق إقليمي للعمل في ما بين الوكالات يتولى التخطيط للأنشطة الميدانية المشتركة التي ترتكز على الاحتياجات والقدرات الوطنية؛ (٢) تحديد جهة إقليمية للعمل في ما بين الوكالات لتجميع الموارد اللازمة لتنفيذ المشروعات التعاونية؛ (٣) الترتيب لزيارة مشتركة، يقوم بها المديرون الإقليميون، للبلدان ذات الأولوية، للحصول على الالتزام السياسي الرفيع المستوى؛ (٤) التحقُّق من قيام الفرق القطرية التابعة للأمم المتحدة بتقديم تقرير مرحلي سنوي عن التقدُّم المحرز نحو بلوغ المرامي الإنمائية للألفية؛ (٥) تقديم برامج للدعوة للتصدّي لعملية التنقل السريع للعاملين المدربين.

هذا، وقد أصدر فريق المبادرات المجتمعية بالمكتب الإقليمي لشرق المتوسط الدليل التدريبي الخاص بالمبادرات المجتمعية، الذي يُعد أداة عملية للمدربين والمتدربين في نفس الوقت. ويأتي صدور هذا الدليل نتيجة للتوسُّع في البرنامج، الأمر الذي دعا لوجود مادة تدريبية معيارية لممثلي المجتمعات لإيضاح أسلوب ومنهجية البرنامج. ومن شأن هذا الدليل أن يحسّن من عملية تنفيذ البرنامج من خلال رفع مستوى القدرات بالمجتمع والارتقاء بها.

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