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Regional Office for the Eastern Mediterranean

Community-based initiatives Newsletter



Interview with Dr Naeema Al-Gasseer, WHO Representative, Iraq

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One of the aims of the national development strategy in Iraq is to improve the quality of life for the Iraqi population. How can CBI be used as a tool to achieve this objective?

CBI is being used as an approach to strengthen the primary health care system to promote a comprehensive holistic approach to health and to place it at the heart of development. There is a belief in the role of individuals, families and communities in health and the importance of their investment in a healthier lifestyle and environment. This entails building the capacity and awareness of the community and enabling them to identify their health and development needs in Iraq. Moreover, it will enable community institutions to address those needs and to find options to respond to various emergency and development interventions, such as:

- reducing morbidity and mortality, especially among women and children;
- improving health status through increased family income and greater self care;
- promoting equity and healthy lifestyles;
- promoting community involvement and ownership;
- encouraging decentralization and self-reliance;

- reducing the financial burden on the Government by contributing to the socioeconomic development of the country;
- alleviating poverty and improving quality of life;
- facilitating peaceful coexistence; and
- encouraging the development of a collective team spirit to build health as a bridge for peace and development.

In Iraq, the Ministry of Health works closely with WHO as the lead agency for the health and nutrition sector. What are the major outcomes of this collaboration?

The major outcomes of this collaboration have been: a 50% reduction in the under-5 mortality rate; a 15% reduction in maternal mortality; increased access to quality health care services, especially for vulnerable groups and unreached communities; enhanced disease prevention and control, including HIV/AIDS; the assurance of an enabling environment for healthy lifestyles; and the preparation of an emergency preparedness and response plan.

What roles would you assign to the community to maintain health-related outcomes?

WHO has been advocating to the Ministry of Health and other key ministries, civil society and parliamentarians that community members need to be at the centre of efforts to achieve the Ministry of Health's aim and to meet the targets of the Millennium Development Goals in Iraq. In addition to sensitizing community leaders in Iraq at selected sites, community volunteers have been trained to support almost all ongoing programmes at the primary health care level. Areas of training have included: the maternal and child health programme, including



Dr Al-Gasseer during the opening ceremony of the rehabilitated National Center for Drug Control and Research

the training of traditional birth attendants, the Expanded Programme on Immunization (EPI), Integrated Management of Childhood Illnesses and interventions to prevent and control communicable and waterborne diseases. The training has also included the promotion of breastfeeding and conducting of nutrition and school health programmes. The selection of community members for training was undertaken using a transparent and participatory approach. WHO in Iraq has ensured that the CBI approach is utilized in the overall implementation of various programmes and activities, such as in mental health and environmental health programmes. For example, access to safe drinking-water is not only addressed in selected CBI areas but also in the overall activities of WHO and under funds relevant to other programmes.

In regard to the much needed emergency preparedness and response plan, the Ministry of Health has approved and has indicated its desire to train the community on emergency and response. However, currently both the Ministry of Health and WHO Regional Office are in the process of planning for such an activity, in which

the community would support the existing system in providing first aid on sight until support arrives. The funding for this training also has been ensured recently.

In a country in a situation such as Iraq, how can we best advocate for community participation in health and social development?

It is imperative to enlist the local community as key players for the success of any health programmes in Iraq, especially given the increasing insecurity and violence. WHO has been actively working in Iraq with partners in supporting the Ministry of Health and implementing the 'health as a bridge for peace' strategy. Evidence shows in Iraq that when local communities are oriented, sensitized, involved and empowered, interventions have been completed successfully. Over the past four years, local communities have successfully supported the completion and rehabilitation of health facilities, for example, in hot spot areas, such as Heet. The Ministry of Health and WHO have relied heavily on the role of community members at local level to ensure the success of the immunization campaign by closely working with the

health team. The commitment to the success of the initiatives is assisting Iraq towards the implementation and readiness of decentralization mechanisms. Empowerment will ensure sustainability and the dedication to meet the needs of local and national development, stability and the goal of safety which, in turn, affects the quality of life of vulnerable groups within the country. WHO perceives that for a country in a situation such as Iraq health and social development can be more sustainable through the initiatives.

How would you evaluate the progress of CBI in a country in complex emergency, such as Iraq?

The progress is seen as successful given that the Ministry of Health has adopted CBI as an approach to support the primary health care system and not as an unintegrated vertical programme. There is commitment and advocacy at the top policy level to continue this approach. Selected communities have identified immediate urgent basic needs to work on, such as: access to safe drinking-water, electricity, public health threats and dealing with continued emergencies and casualties. Communities should be commended for their role in identifying their socioeconomic priorities, addressing those needs based on available resources and applying community-based solutions.

For example, the most evident developmental changes were seen in Al-Dahira, Al-Rumaiha and Al-Samawa. In these villages, several infrastructural projects were completed which, in turn, have improved access to quality care through: strengthening the power network; repairing the water network; repairing roads with a new asbestos cover; repairing schools and building new schools; completing plans to build a new primary health care centre, in close coordination with the Directorate of Health; and creating new initiatives. A member of the village development committee suggested the use of a new technique to overcome irrigation problems and this has been approved by the Ministry of Irrigation.

Another success story has been demonstrated by the healthy city programme in Swaira where sanitation was a major problem. The local community with the support of the Ministry of Health and in coordination with the Ministry of Municipalities, developed a sewage disposal project which is almost complete.





Handicrafts exhibition organized by the women's association of Bait Sayed village

Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, visits a BDN village in Yemen



Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, visited Yemen from 9 to 12 March 2008. In addition to launching the first phase of the bilharzia control campaign, he also paid a visit on 11 March 2008 to the village of Bait Al Sayed in the Sayed Bani Hushaish district, Sana'a. As Dr Gezairy had personally inaugurated implementation of the first round of socioeconomic projects in Bait Al Sayed village in 2001, it was time to observe the progress made thus far in the different aspects of the community development programme.

Dr Gezairy, accompanied by a WHO team and the Deputy Ministers for Health Planning and Development and Primary Health Care, was warmly welcomed by the community upon his arrival to the village. The group visited the school library, which also doubles as the BDN office. Information on BDN activities and achievements were summarized in tables and charts decorating the walls of the library. Mr Abdul Aziz Al Wazir, the chair of the village development committee, described the process of BDN initiation, community organizations

and elaborated on some of the BDN achievements.

Such achievements included: establishment and staffing of the health centre; an improved level of sanitation; an increase in the community's access to safe drinking-water (from 65% in 2000 to 100% in 2007); increased school enrolment (from 80% in 2000 to 95% in 2006); an increase in the women's literacy rate and a reduction in morbidity and mortality. Mr Al Wazir highlighted the progress made from 2000 to 2006 with respect to increases in immunization rates of children under one year of age (from 65% to 97%) and the TT vaccination rate for pregnant women (from 10% to 43%).

Mr Abdul Qader M. Othman, a member of the village development committee and chair of the education subcommittee, presented the achievements of the village in the education sector which resulted in: extension of the school building; establishment of a library and school committee responsible for the cleanliness of schools and monitoring of water and sanitation and plantation

issues. Mr Othman went on to elaborate that the BDN programme had taught them that health was not only about hospitals and doctors, but also about access to safe drinking-water, a clean environment, a good income, proper social status and reliable transportation as essential components of a better quality of life.

Ms Hannah Ali Othman, a member of the village development committee and chair of the women's association of the village, described the role of women in the BDN programme and highlighted the achievements made so far. She explained that women were now part of the decision-making body in the village and contributed to the well-being of the community.

Before leaving, Dr Gezairy and the team visited a small handicrafts' exhibition, organized by the women's association of Bait Sayed village. Dr Gezairy commended the achievements made in the BDN programme thanking them for their excellent presentations and stated that members of the village development committee had defined health better than many health professionals were able to.



Dr Sirous Pileroudi

Interview with Dr Pileroudi, one of the pioneers and founders of the district health system in the Islamic Republic of Iran

Dr Sirous Pileroudi is one of the pioneers in the development of the district health system in the Islamic Republic of Iran based on primary health care. He has invested more than 41 years of his life in assessing the real needs of the community, planning, designing, supporting, implementing and expanding the district health system across the country. Dr Pileroudi contributed much to capacity-building and educating policy-makers and managers at different levels and tried his best to develop evidence that health should be put at the centre of development. Dr Pileroudi, now 70 years old, is actively involved in attending meetings at national level to discuss the district health system with policy-makers and to contribute to health system reform in the country. He has travelled to all parts of the country to assess, monitor and evaluate the effectiveness of the district health system at grass-roots level.

Dr Pileroudi was among the key planners and designers of the district health plan for the country. The plan clearly identifies the location of health facilities (health houses, rural health centres, urban health centres) with their functions, population coverage, the staff needed for each facility based on a defined criteria, distance of the facility from cities, expected key functions from each level and disease morbidity and mortality rates.

Dr Pileroudi is the author of many books, guidelines and articles on primary health care related to design and planning, management, administrative and financial matters in the district health system, planning human resources for health, the logistics of the district health system, integration

of health-related programmes and training of mid-level and central-level managers in the primary health care system.

An interview was conducted with Dr Pileroudi during his participation in the launch of the Urban HEART project in Tehran, April 2008. He said that primary health care in the Islamic Republic of Iran was unique due to the full support of top level policy-makers who provided full financial and policy support, even during times of war. The planning stage of the primary health care network system started in 1978 (the year of the Islamic Revolution) and ended in 1984. Six years of planning for all districts of the country was conducted. In 1984, Parliament agreed to provide the equivalent of US\$ 250 000 to finance the establishment of health houses, rural health centres and urban health centres as the main providers of primary health care services and for the training of native health workers (*behvarz*) and other health technicians who served at rural and urban health facilities.

Dr Pileroudi said that the selection and training of community health workers, known as *behvarz* responsible for the provision of primary health care services to a population of nearly 1500, was key for the success of the health system in the country. *Behvarz* are native literate young females and males with intermediate qualifications, selected and introduced by the community to be trained by the district health authorities for two years and stationed in the health houses that are established in their own villages.

He went on to add that the *behvarz* are the first line of contact between the community and the health system. At present, more than 25 000 *behvarzes*

provide the major bulk of primary health care services in rural areas all over the country. Programme evaluation has shown their effectiveness in the reduction of mortality and morbidity and in improving different health care indicators in the rural areas of the country.

The district health system in the Islamic Republic of Iran has:

- provided all people, especially those living in poor and underprivileged areas, with access to primary health care services. Existing health services have been improved and made available to all through the different levels of the health system. The interesting point is that even if a family does not approach the health centre for a certain and timely health service, such as EPI, *behvarzes* are supposed to visit the family in their home and provide services, so that community members will not miss the dates for their primary health care service appointments;
- improved health indicators, such as the infant mortality rate, maternal mortality ratio, vaccination coverage, reproductive health indicators, including family planning indices; and reduced preventable deaths and morbidities;
- trained native community health workers meeting more than 80% of the health care needs of the community in rural areas, which is a cost-effective strategy, and used their services in rural areas complemented by the supervisory visits of nurses, doctors and technicians placed in the upper level of health care services.

Dr Pileroudi believes that all health-related interventions, such as the Roll-Back Malaria initiative, tuberculosis

directly observed treatment short-course, (DOTS), mother and child health programmes, water and sanitation, food safety and control and even the running of the health centres should be directed towards community-based management and ownership. Policy-makers and managers should plan to build community capacity to hand over all aspects related to the prioritization of health needs, planning, management and evaluation to the local community. He said that governments should encourage communities to organize themselves and that the salaries of health workers should be paid by the *shora* or local health development committees. Government may transfer the salaries of health workers to the *shora*/health development committee bank account. In this way, the community will own the health system, maximize utilization of available services at the local level and generate additional resources to fill in gaps and maintain a

high standard of health care services to constantly improve health and social indicators. Experience in the Islamic Republic of Iran has shown that with little effort the community is able to participate in community-based health system research. A lay woman or man, as volunteers in the community, can act as an agent for local change. He or she can be trained on how to document the research processes, interventions, assess the outcomes, identify achievements, use it for filling in gaps and maintain health at a standard and acceptable level.

With regard to changes or reforms that the health system needs after nearly 30 years of planning, Dr Pileroudi responded that the district health system was still valid in many parts of the country and that they were proud of the workable infrastructure but he said that perhaps the software of this system needed to be adapted based on the needs of the community. He added that the level of education in rural areas had improved substantially compared to 30 years ago. At present, there are many high school diploma and university graduates working or looking for jobs in rural areas. The educated community may expect more from community health workers. In this respect, the Ministry of Health and Medical Education has set the high school diploma as a minimum qualification requirement to join the *behvarzi* school. In short, health planners should identify the needs of the time without touching the strategic lines that are priorities for the poor and underprivileged.

Another point is that the Ministry

of Health and Medical Education should set criteria for the distribution of services and responsibilities to the private sector, nongovernmental organizations and other health care providers and free itself to better concentrate on health policy development, direction, monitoring and evaluation. The Ministry of Health and Medical Education should gradually withdraw itself from service delivery and needs to involve the private sector in providing preventive health services, particularly for those who are unable to afford such services. Dr Pileroudi added that urban and rural health councils or *shora* need to be more involved in health care management and they should be given the ownership of all types of health care services/programmes.

Dr Pileroudi thanked the CBI unit for conducting this interview. The CBI unit wishes Dr Pileroudi health, happiness and a long life and thank him for his valuable contribution to primary health care services in the Islamic Republic of Iran. We are confident that all readers of the newsletter will enjoy and benefit from his lively interview.



Anti-tobacco activities in Oman



Nizwa healthy lifestyle project is an action-oriented community-based intervention programme for noncommunicable disease prevention and health promotion in Oman. The population of the wilaya is 68 785, distributed over approximately 77 villages, including Nizwa city centre. The objectives of the project are to map the emerging epidemics of noncommunicable diseases and to analyse the social, economic, behavioural and political determinants of the disease; to reduce the exposure of individuals and populations to the major determinants of noncommunicable diseases; to prevent the emergence of preventable common risk factors and to strengthen health care for people by supporting effective interventions.

The project promotes healthy lifestyles through three subcommittees: (1) tobacco control and accident prevention; (2) promotion of physical activity; and (3) promotion of healthy nutrition. The project also aims to assess the feasibility and impact of a community-based approach in Oman for the prevention of chronic diseases through multisectoral collaboration and public-private partnership.

Based on the strategic plan, interventions are planned around a subproject to facilitate follow-up using two approaches—the population

approach and the high-risk approach. The population approach includes: school programmes, community empowerment and public education; and the high-risk approach includes: lifestyle clinic, health professionals' education and involvement, obesity screening and management at primary health care centres and a tobacco cessation clinic. Health professionals and volunteers interested in tobacco control and road safety are members of the subcommittee on tobacco control and accident prevention. In 2007, the committee decided to focus on building community awareness of the dangers of tobacco use.

A large variety of activities were carried out, including educational sessions in schools and colleges targeting students and teaching faculty members; posting street signs and bill boards in public roads and in various workplaces and public areas; launching the official web site of the Nizwa healthy lifestyle project (www.nizwahlp.org); using television as a channel for building community awareness; and holding face-to-face educational sessions by the health staff in primary health care centres. Many of these activities were carried out in partnership with the public sector, the private sector, as well as with the Oman Society for Cancer Awareness.

One unique activity was a social worker-

based tobacco cessation project carried out in schools to support students to quit using tobacco. This was conducted mainly through school-based advocacy campaigns with invitations to students interested in quitting to see the social worker to obtain support with the assurance of maintaining their privacy. Social workers were trained in two workshops on counselling methods for tobacco cessation. In the new academic year, the team plans to develop a monitoring system so as to measure the effectiveness of this intervention and identify ways to strengthen it.

Tobacco control activities, conducted by Nizwa healthy lifestyle project in 2007, strengthened the partnership with other sectors, both private and public, and involved a large number of community members. A wide range of activities was carried out, in collaboration with over 10 institutions, including several ministries, private companies, schools and private colleges. Over 3000 people were involved in this initiative.

Visit of
Dr Mohamed A. Jama,
 WHO Deputy Regional Director
 for the Eastern Mediterranean, to healthy
 village sites



On 12 March 2008, Dr Mohammad Abdi Jama, WHO Deputy Regional Director for the Eastern Mediterranean, and Dr Ibrahim Betelmal, WHO Representative, Syrian Arab Republic, accompanied by the WHO country office team visited the two healthy villages of Kafrin and Ahmadiyah in rural Damascus. They met with Dr Mohsen Kanaan, the Director of the healthy village programme and his team, as well as the communities of the two villages. The heads of the village development committees briefed the Deputy Regional Director on the achievements made with regard to the marked improvement in health and social indicators in the two villages, through tobacco control activities, literacy and back-to-education campaigns for those between the ages of 15 and 49 years old, as well as the activities related

to women's empowerment and their positive role in village development. Both communities stressed their fruitful partnership with the Ministry of Health, WHO, related government sectors and other partners, such as the Fund for Integrated Rural Development (FIRDOS).

Both communities presented the community school experience through small projects and live drama performed by the students. The cluster representatives also shared their experience and role in strengthening the community-based information system which is linked to the health information system in the health centre. This system monitors home health care and regular follow-up visits to families and is linked with the activities in the health centre, in addition to promoting health activities.





Voice from the community: Siham M. Khalid

My name is Siham Mohamed Khalid, I am 30 years old and I work as a secondary school teacher. I live in Eldanagla village, Wad Madani locality, Gezira State in Sudan. I came to learn about community-based initiatives through reading the programme material which my elder brother used to bring home from work as a coordinator for the programme in Gezira State. Later, I was chosen as a community development committee member of Eldanagla village and chairperson of the health committee. I was trained on programme management and thereafter became one of the founders.

The community in Eldanagla was motivated by the experience of the initiatives in neighbouring villages. We approached the State and Federal Ministry of Health to include our village under the programme as it was not in the expansion plan. This was in 2005 when the programme was introduced in the village. At the beginning, I did not have any experience in public/development work; just a little experience in management in general but none in the field management of community development. Later, we were trained in programme management and community development.

During my work in the programme, I gained experience in terms of communication with others in spite of the differences in sex, age and interests. I learned a lot on how to plan and improve health, education, income and the environment in our local community. I think the nature of my work as a teacher has given me

a solid knowledge base to build on. The impact of the community-based initiatives programme, especially in health, was positive and clear, during the 4 years—the life time of the programme in the village—more than 80% of the planned activities which targeted improvements in public and environmental health were achieved. Those activities were identified by the community as priorities as a result of the baseline surveys that were conducted. Regarding the future of the programme and its sustainability, we need to improve the health of the family, in general, of mothers and children under five years of age, in particular. In addition, we need to pay more attention to improve the conditions of our schools.

Secondly, I hope that the community development committee pay more attention to poorer families as poverty reduction is a priority now. In this regard we have to strengthen our partnership aimed at poverty reduction that will affect the health of the people. Thirdly, as the programme is built on voluntarism, we should encourage more members of the community to join this programme and contribute to improve the health of needy people in the society.

Finally, I wish all of you the best and I ask God to help every person who contributes to the health and social well-being of the Sudanese.





Sudan: CBI biennial report 2006–2007

Iwish that all the villages in the El-Managil locality were like Kamil Nomak, because it has organized leaders, a community that knows what their problems and needs are, how to prioritize them, who to contact and what they need in order to solve them. I think this is due to the CBI programme."

Governor of El-Managil locality, March 2007

The CBI biennial report for 2006–2007 prepared by the primary health care directorate of the Federal Ministry of Health, Sudan, in collaboration with WHO Sudan country office, is a useful guide in assessing the programme's progress over two years. It highlights achievements, gaps, constraints and possible solutions. This can be used by both programme managers and the community to upscale BDN activities. The document contains an introduction, a summary of the background of community-based initiatives from 1997 to 2005, programme achievements, gaps and a set of recommendations addressing the existing shortcomings within the programme. The document presents some BDN success stories that can be replicated in other BDN sites in Sudan and other countries of the Region. The report is a useful tool for all programme directors at different levels, the BDN community, local intersectoral teams, policy-makers, partners, and even other countries in the Region, implementing CBI. The health system and community development planners can use this document in their future policy directions, strategies and relevant plans of action.

Partnership in BDN expansion was one of the major concerns during 2006–2007. The programme benefited from building partnerships with other

UN agencies in south Kordofan and has generated US\$ 250 000 for BDN expansion to 15 villages in two localities. In addition, collaboration started with the Islamic International Relief Organization, Jeddah, for introduction of the BDN programme to three areas of Gezira State that will result in improved literacy rates among women, the creation of job opportunities, heightened community awareness and practices related to health and the involvement of women and youth in local development planning processes.

In addition, during 2006–2007 the BDN programme partnered with three nongovernmental organizations: River Nile Basin, Eloghthoor and the Arab Corporation for Investment and Agriculture Development of El Gezira State.

Health systems in some BDN-implementing sites have been rehabilitated; EPI coverage has been improved; bednets and other components of malaria control have been better distributed; community ownership for health development has been strengthened; a polio eradication campaign was conducted by the community; a community health insurance scheme was introduced in three BDN sites; a health awareness and cleaning campaign was conducted; access to safe drinking-water and sanitation has been increased, computer literacy training for women and youth was conducted; and handicrafts training and literacy classes for 108 women were provided.

Insufficient political commitment, lack of programme institutionalization, insufficient advocacy kits and activities, shortage of adequate technical staff at local and state level, weak linkages of the programme with primary health

care services, lack of a community-based financial and management tool and a limited budget are among the priorities that the Federal Ministry of Health will need to address in the coming biennium.

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10 Introduction of Urban HEART, Tehran



The Urban HEART (health equity assessment and response tool) tool was developed as a means for mainstreaming the knowledge network and urban settings of the WHO Commission on Social Determinants of Health into the work of the Regions and Member States. It helps countries to systemically generate evidence to assess and respond to unfair health conditions and inequity in urban settings. It will also stimulate city-to-city learning and the sharing of experiences among the countries and across Regions. The tool was introduced by both the WHO Centre for Health Development in Kobe, Japan and the Regional Office in a meeting hosted by the municipality of Tehran, Islamic Republic of Iran, held from 19 to 21 April 2008, attended by representatives from the five pilot countries: Brazil, India, Islamic Republic of Iran, Philippines and Zambia.

The Urban HEART framework was presented by the centre in Kobe followed by country presentations during which the potential of the pilot countries to field-test this tool was discussed. The pilot countries reviewed the core indicators proposed by the centre and adapted them to their culture, health and social system and other environmental factors. Among the five country presentations, it was noted that the Islamic Republic of Iran has already started reviewing

the core indicators related to health equity and has formed different technical committees to assist in the implementation of this project. In this regard, four technical groups were assigned to review the core indicators of each specific domain. The core indicators of the four domains will be finalized by each city/country considering their priorities and existing health and social systems. Participants have initially agreed upon the core indicators which will be finalized by each pilot country after discussions with national technical teams.

Country representatives devised a definition for each of the indicators, their rationale, data collection methodology and assessment intervals. They also drafted a workplan for introduction of Urban HEART to be finalized at the city level by a technical intersectoral team. The WHO centre will coordinate the process with the assistance of the WHO regional project focal point in each Region and will provide technical and financial support to the pilot countries for introduction of the tool in the selected cities. The progress of project implementation in each country will be shared in a joint meeting tentatively scheduled to take place in April 2009 in Brazil. The CBI programme added a link to its website (www.emro.who.int/cbi) where all news and documents related to the Urban HEART project will be posted.

The participants also had the opportunity to visit various healthy city projects in Saveh City that have been ongoing for the last 10 years. Engineer Golestani Far, the Governor of Saveh briefed participants about CBI activities and said that "All governors in the Islamic Republic of Iran should welcome the initiatives and use all possible resources in the government for poverty reduction and health development through the CBI concept and methodology."

Participants expressed their appreciation for the outcome of the healthy city programme, stating that its success could only be achieved through high-level political commitment and intersectoral collaboration for human and socioeconomic development. They also commended the country's primary health care system which relies on effective community participation.

Visit of a Libyan team to the Syrian Arab Republic to learn from the experiences of the healthy village programme



A Libyan team comprising four members from the Ministry of Health and the Ministry of Education visited the Syrian Arab Republic in April 2008 to accustom themselves with the healthy village programme and health-promoting experience in the Syrian Arab Republic. The team was briefed on the concept of community schools by Dr Abdelaziz Nahar, Director of School Health, the Ministry of Education and Dr Mohsen Kanaan, the director of the healthy village programme, Ministry of Health. The team was briefed on the concept of community schools and visited several health-promoting schools in Qunaitera, Homs and Sweida governorates. Pupils presented their projects highlighting community-related problems and proposed solutions on how to overcome these problems.

The team also visited several healthy village sites and were accompanied by the WHO Representative on their visit to Sweida village, where they were interviewed by local television. It is to be noted that this year the WHO Regional Office will assist the Government of the Libyan Arab Jamahiriya to start planning and implementing its own healthy city programme embracing the experience of the Syrian Arab Republic.

Le Dr Naeema Al-Gasseer décrit les initiatives communautaires comme un moyen de renforcer le système de soins de santé primaires en Iraq. Le rôle des individus, des familles et des communautés dans la santé ainsi que l'importance de leur investissement pour un mode de vie et un environnement plus sains sont largement valorisés. Pour cela, il faut renforcer les capacités et la sensibilisation de la communauté et permettre à cette dernière d'identifier ses besoins en matière de santé et de développement. Le Dr Al-Gasseer poursuit en rappelant que l'OMS recommande au ministère de la Santé et aux autres ministères importants, à la société civile et aux parlementaires de faire en sorte que les membres de la communauté soient au centre de l'attention pour atteindre les cibles des objectifs du Millénaire pour le développement en Iraq. Elle ajoute que, selon les données disponibles en Iraq, l'orientation, la sensibilisation, l'implication et l'autonomisation des communautés locales garantissent le succès des interventions. Les changements en matière de développement qui ont eu lieu dans les villages d'Al-Dahira, Al-Rumailtha et Al Samawa constituent un exemple digne d'éloges.

Le 11 mars 2008, le Dr Hussein A. Gezairy, Directeur régional de l'OMS pour la Méditerranée orientale, accompagné d'une équipe d'experts du Bureau régional et du Siège de l'OMS, a visité un village dans le district de Sayed Bani Hushaish, à Sana'a (Yémen) où l'approche des besoins fondamentaux en matière de développement est appliquée. Depuis l'inauguration par le Dr Gezairy en 2001 de projets socioéconomiques dans le village, la communauté a pris d'importantes mesures, notamment la création du centre de santé et la dotation en personnel de ce centre, une amélioration du niveau d'assainissement et un renforcement de l'accès de la communauté à l'eau potable. Le Dr Gezairy a salué les résultats du programme des besoins fondamentaux en matière de développement et a déclaré que les membres du comité de développement villageois ont défini la santé mieux que beaucoup d'autres professionnels de la santé étaient capables de le faire.

Avec plus de 41 ans de sa vie passés à évaluer les besoins réels de la communauté et étendre le système de santé du district dans le pays, le

Dr Pileroudi, aujourd'hui âgé de 70 ans, joue un rôle très actif dans la réforme du système de santé dans son pays. Le succès du système de soins de santé primaires en République islamique d'Iran est dû au soutien sans réserve des hauts responsables de l'élaboration des politiques qui ont soutenu le développement du système de santé même pendant les périodes de guerre. Le Dr Pileroudi poursuit en déclarant que toutes les interventions liées à la santé devraient être orientées vers la gestion et l'adhésion communautaires. Le ministère de la Santé et de l'Enseignement médical devrait se retirer progressivement de la prestation de services et transférer la responsabilité au secteur privé, aux organisations non gouvernementales et autres prestataires de soins de santé afin de pouvoir se concentrer davantage sur l'élaboration, la direction, la surveillance et l'évaluation des politiques de santé.

Le rapport biennuel du Soudan sur les initiatives communautaires pour 2006-2007 établi par la Direction des soins de santé primaires du Ministère fédéral de la santé, en collaboration avec le bureau de pays de l'OMS au Soudan, est un guide utile pour évaluer les progrès du programme au cours des deux dernières années. Parmi les succès du programme, on trouve les partenariats établis avec les autres institutions des Nations Unies au Kordofan du Sud qui ont permis d'obtenir USD 250 000 pour étendre l'approche des besoins fondamentaux en matière de développement à 15 villages dans deux localités. Le rapport présente également, sous forme de tableau, les activités des besoins fondamentaux en matière de développement appliquées conformément aux cibles des objectifs du Millénaire pour le développement. Parmi les problèmes et lacunes soulignés, on trouve un engagement politique insuffisant, l'absence d'outils gestionnaire et financier communautaire et un budget limité pour répondre aux besoins.

Le 12 mars 2008, le Dr Mohammad A. Jama, Directeur régional adjoint de l'OMS pour la Méditerranée orientale et le Dr Ibrahim Betelmal, Représentant de l'OMS en République arabe syrienne, accompagnés de l'équipe du bureau OMS de pays ont visité les deux villages-santé de Kafrin et Ahmadiéh dans la zone rurale de Damas, où ils ont rencontré les responsables des comités de

développement villageois. Le Dr Jama a été informé des nettes améliorations des indicateurs sanitaires et sociaux dans les deux villages grâce aux activités de lutte antitabac et aux campagnes d'alphabétisation et de retour à l'éducation, ainsi que des activités liées à l'autonomisation des femmes et à leur rôle positif dans le développement du village. Ces réalisations ont été rendues possibles grâce au solide partenariat établi entre la communauté, le ministère de la Santé, l'OMS et d'autres partenaires.

L'outil d'évaluation et d'intervention pour l'équité en santé permet aux pays de générer systématiquement des données pour évaluer les conditions sanitaires injustes et l'inégalité dans les milieux urbains et y répondre. Il va également stimuler l'apprentissage de ville à ville et un échange d'expériences entre les pays et les régions. Cet outil a été introduit par le Centre OMS pour le développement sanitaire de Kobe (Japon) et le Bureau régional lors d'une réunion organisée du 19 au 21 avril 2008 par la municipalité de Téhéran, à laquelle ont participé des représentants du Brésil, de l'Inde, de la République islamique d'Iran, des Philippines et de la Zambie. Lors de cette réunion, les cinq pays pilotes ont proposé des indicateurs de base conformes à leur culture, leurs systèmes sanitaires et sociaux et autres facteurs environnementaux ainsi que leurs plans de travail pour tester cet outil dans une localité sélectionnée comme ville pilote. Les indicateurs de base couvraient les quatre domaines d'orientation suivants : environnement physique et infrastructure, développement social et humain, économie et gouvernance.

Une équipe libyenne composée de quatre membres du ministère de la Santé et du ministère de l'Éducation s'est rendue en République arabe syrienne pour se familiariser avec le concept de village-santé ainsi qu'avec les expériences de promotion de la santé dans le pays. L'équipe a été informée sur le concept des écoles communautaires et a visité des écoles-santé dans les gouvernorats de Qunaitera, Homs et Sweida. Les élèves ont présenté leurs projets en soulignant les problèmes liés à la communauté et en proposant des solutions pour les résoudre. Le Bureau régional va aider le gouvernement de la Jamahiriya arabe libyenne à lancer la planification et la mise en œuvre du programme des villes-santé dans le pays.

Le projet à Nizwa est une intervention communautaire pratique visant à promouvoir la lutte contre les maladies non transmissibles. La population bénéficiant de ce projet dans cette wilaya est de 68 785 personnes. Le projet vise à recenser les nouvelles épidémies de maladies non transmissibles et à analyser les déterminants sociaux, économiques, comportementaux et politiques de la maladie ; à réduire l'exposition de la population aux principaux déterminants des maladies non transmissibles ; à prévenir l'émergence des facteurs de risque évitables courants et à renforcer les services de soins de santé. Parmi les principales interventions du projet, on trouve l'information des groupes cibles, des activités de sensibilisation et la formation d'un groupe d'étudiants pour remplir la fonction de travailleurs sociaux qui aident la communauté à arrêter de fumer.

Siham M. Khalid, une enseignante du secondaire âgée de 30 ans qui vit dans le village d'Eldanagla, localité de Wad Madani, État de Gezira au Soudan, a pris connaissance du programme des initiatives communautaires grâce à des brochures apportées à la maison par son frère qui est coordinateur pour le programme dans l'État de Gezira. Après avoir reçu une formation sur les concepts de gestion du programme et développement communautaire, Siham était prête à les mettre en pratique. Siham est maintenant membre du comité de développement communautaire du village d'Eldanagla et présidente du comité de santé. Siham fait le point sur la situation du programme dans son village où ont été réalisées plus de 80 % des activités planifiées (identifiées par la communauté comme des priorités) ciblant des améliorations de la santé publique et la salubrité de l'environnement.

موجز المجلد الرابع. العدد 2

كافرين وأحمدية الواقعتان بالمناطق الريفية لدمشق. والتقاو جميعاً مع رؤساء اللجان التنموية للقرية. ولقد اطلع الدكتور جامع بإيجاز على ما تحقق من إنجازات من خلال التحسّن الملحوظ في المؤشرات الصحية والاجتماعية للقرية، وذلك بفضل أنشطة مكافحة التدخين، وحملات محو الأمية وحملات العودة للتعليم، علاوة على الأنشطة الخاصة بتمكين المرأة ودورها الإيجابي في تنمية القرية. ويعود الفضل في إتمام هذه الإنجازات إلى الشراكة القوية بين المجتمع، ووزارة الصحة، ومنظمة الصحة العالمية، وسائر الشركاء.

وتساعد أداة تقييم العدالة الصحية والاستجابة لها، البلدان في الحصول على البيانات بصورة منتظمة من أجل تقييم الأوضاع الصحية غير المنصفة والتصدّي لها في المواقع الحضرية. كما تحث على تعلم المدن من خبرات بعضها البعض، والتشارك في الخبرات بين البلدان وعبر الأقاليم. وقد تم تقديم هذه الأداة من قبل كل من مركز منظمة الصحة العالمية للتنمية الصحية في مدينة كوبي في اليابان والمكتب الإقليمي لمنظمة الصحة العالمية لشرق المتوسط وذلك في اجتماع عقد تحت رعاية بلدية طهران بجمهورية إيران الإسلامية، في الفترة من 19 إلى 21 نيسان/إبريل 2008، وحضره ممثلون من خمسة بلدان وهي البرازيل، والهند، وجمهورية إيران الإسلامية، والفلبين، وزامبيا. وخلال الاجتماع اقترحت البلدان الرائدة مؤشرات أساسية تتفق ونظمها الثقافية والصحية والاجتماعية إضافة إلى سائر العوامل البيئية. كما عرضت خطط العمل المستخدمة في تجربة هذه الأداة في بلدان معينة على سبيل الارتداد. ولقد غطت المؤشرات أربعة مجالات البيئة العملية والبنية التحتية، والتنمية الاجتماعية وال بشرية، والاقتصاديات والحوكمة.

قام فريق لبسي مكون من أربعة أعضاء من وزارة الصحة ووزارة التعليم بزيارة الجمهورية العربية السورية للتعرف على برنامج القرى الصحية وعلى الخبرة السورية في تعزيز الصحة. وقد اطلع الفريق على مفهوم المدارس المجتمعية، وزار عدداً من المدارس المعززة للصحة في محافظات القنيطرة، وحمص، والسويداء. وعرض التلاميذ مشاريعهم التي تلقي الضوء على المشكلات المجتمعية والحلول المقترحة حول كيفية التغلب على هذه المشكلات. وتجدر الإشارة إلى أن المكتب الإقليمي للمنظمة سوف يساعد حكومة الجهورية العربية السورية للبيئة هذا العام على البدء في تخطيط وتنفيذ برنامج المدن الصحية في الجماهيرية.

إن مشروع نيزوى هو عبارة عن مداخله عملية مجتمعية من أجل الوقاية من الأمراض غير السارية ومكافحتها. ويبلغ عدد سكان «الولايات» المستفيدين من هذه المداخله 68 785 نسمة. ويهدف المشروع إلى رسم الخرائط الصحية للأوبئة المستجدة للأمراض غير السارية، وتحليل المحددات الاجتماعية والاقتصادية والسلوكية والسياسية للأمراض، وخفض تعرّض الأفراد والمجموعات للمحددات الرئيسية للأمراض غير السارية، والوقاية من ظهور عوامل الاختطار الشائعة والتي يمكن توقيها، وتقوية خدمات الرعاية الصحية. ولقد اشتملت المداخلات الرئيسية للمشروع على بناء الوعي بين المجموعات المستهدفة، والترويج للأنشطة وتدريب مجموعة من الطلاب للعمل كإخصائين اجتماعيين لمساندة المجتمع في الإقلاع عن التدخين.

سهم محمد خالد تبلغ من العمر 30 عاماً وتعمل معلمة في مدرسة ثانوية، وتعيش في قرية الدناجلة، منطقة واد مدني بولاية الجزيرة في السودان. ولقد تعرفت على مشروع المبادرات المجتمعية من خلال مطالعتها لمواد البرنامج التي يحضرها أخوها معه إلى المنزل بصفته منسق للبرنامج في ولاية الجزيرة. وقد تلقت تدريباً على إدارة البرنامج، ومفاهيم التنمية المجتمعية. وكانت على أهبة الاستعداد لتنفيذ ما تدربت عليه على أرض الواقع. وهي الآن عضوة في لجنة التنمية المجتمعية بقرية الدناجلة، ورئيسة اللجنة الصحية. ولقد ألقت سهام الضوء على ما أحرز من تقدّم للبرنامج في قريتها حيث نفذ أكثر من 80% من الأنشطة التي خطط لها (والتي حددها المجتمع على أنها من الأولويات) وكانت هذه الأنشطة قد استهدفت تحسين الصحة العمومية والصحة البيئية.

قامت الدكتورة نعيمة بوصف المبادرات المجتمعية على أنها أسلوب لتعزيز نظام الرعاية الصحية الأولية في العراق. وأشادت بالقيمة الكبيرة للدور الذي يقوم به الأفراد والأسر والمجتمعات في المجال الصحي، وأهمية الاستثمار في أنماط الحياة الصحية والبيئة. وأوضحت أن هذا يتطلب بناء قدرات المجتمع وإذكاء وعيه وتمكينه من تحديد احتياجاته الصحية والتنموية. وقد أعربت الدكتورة نعيمة عن الدور الذي قامت به منظمة الصحة العالمية في توجيه وزارة الصحة وسائر الوزارات الرئيسية والمجتمع المدني والبرلماني نحو الحاجة إلى وضع أفراد المجتمع في بؤرة الاهتمام من أجل بلوغ المرامي الإنمائية للألفية في العراق. وأضافت أن البيانات قد دلت على أنه إذا ما تم توجيه المجتمع المحلي في العراق وتوعيته وإشراكه وتمكينه، فإن هذا من شأنه أن يعمل على إتمام المداخلات بنجاح. وأشارت إلى مثال للاحتذاء به يتمثل في التغيرات التنموية التي حدثت في قرى الظهرة، والرميلة والسماوا.

في 11 آذار/مارس 2008، قام الدكتور حسين عبد الرزاق الجزائري، المدير الإقليمي لمنظمة الصحة العالمية لشرق المتوسط بصحبة وفد من الخبراء من المكتب الإقليمي ومن المقر الرئيسي للمنظمة، بزيارة قرية تتبع برنامج الاحتياجات التنموية الأساسية في مقاطعة سيد بني حشيش، في صنعاء بالجمهورية اليمنية. ولقد خطا المجتمع خطى حثيثة منذ أن قام الدكتور الجزائري بافتتاح المشروعات الاجتماعية والاقتصادية في القرية عام 2001. ومن ضمن هذه الإنجازات كان إنشاء المركز الصحي وانتقاء العاملين به، وتحسين مستوى الإصحاح مع زيادة سبل وصول أفراد المجتمع إلى مياه الشرب الآمنة. وقد أثنى الدكتور الجزائري على ما أحرز من إنجازات نتيجة لما قام به برنامج الاحتياجات التنموية الأساسية، وصرّح بأن أعضاء لجنة تنمية القرية قد تفوقوا على الكثير من المهنيين الصحيين في شرح مفهوم الصحة.

قضى الدكتور بيلرودي ما يربو على 41 عاماً في تقييم الاحتياجات الحقيقية للمجتمع والسعي إلى توسيع نطاق نظام صحة المنطقة في البلاد بأكملها، وبشارك الدكتور بيلرودي الذي يناهز السبعين بنشاط في إصلاح النظام الصحي في بلده. ولأمراء في أن النجاح الذي تحقّق في نظام الرعاية الصحية الأولية بجمهورية إيران الإسلامية يعزى إلى الدعم الكامل لراسمي السياسات على أعلى مستوى الذين ساندوا تطوير النظام الصحي حتى خلال أوقات الحرب. وقد أفاض الدكتور بيلرودي في حديثه قائلاً: أن جميع المداخلات المعنية بالصحة يجب أن تتجه إلى الملكية والإدارة المجتمعية، على أن تتسحب وزارة الصحة والتعليم تدريجياً من تقديم الخدمات وتحول مسؤوليتها إلى القطاع الخاص، والمنظمات الاحكومية وسائر مقدّمي الرعاية الصحية بحيث يمكنها التركيز بصورة أفضل على تنمية السياسات الصحية وتوجيهها ورصدها وتقييمها.

أعد تقرير المبادرات المجتمعية للثلاثية 2006-2007 في السودان من قبل مديرية الرعاية الصحية الأولية لوزارة الصحة الاتحادية، بالتعاون مع المكتب القطري لمنظمة الصحة العالمية في السودان. وبعد التقرير بمثابة دليل نافع يستهدى به لتقييم مدى التقدم الذي أحرزته البرنامج على مدى العامين المنصرمين. ومن ضمن قصص نجاح البرنامج كانت تكوين الشراكات مع سائر وكالات الأمم المتحدة في جنوب دارفور، ونجاحه في استجلاب 250 ألف دولار أمريكي من أجل توسيع نطاق برنامج تلبية الاحتياجات التنموية الأساسية ليشمل 15 قرية في محافظتين (محليتين). وقام التقرير بتصنيف الأنشطة التي نفذها برنامج تلبية الاحتياجات التنموية الأساسية وفقاً للأهداف المحددة في المرامي الإنمائية للألفية. ومن الفجوات والتحديات التي ألقى عليها الضوء كان عدم كفاية الالتزام السياسي، وضعف التمويل المجتمعي والافتقار إلى الأداة الإدارية والتنظيمية ومحدودية الميزانية اللازمة لتلبية الاحتياجات.

في 12 آذار/مارس من عام 2008 قام الدكتور محمد عدي جامع، نائب المدير الإقليمي لمنظمة الصحة العالمية لشرق المتوسط، والدكتور إبراهيم بيت المال، ممثل المنظمة في الجمهورية العربية السورية، بمصاحبة فريق من المكتب القطري للمنظمة بزيارة قريتين من القرى الصحية، هما قريتا



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