



**World Health  
Organization**

Regional Office for the Eastern Mediterranean

# Community-based initiatives Newsletter



**Interview with Dr Guido Sabatinelli,**  
Special Representative and Director of Health, United Nations Relief  
and Works Agency for Palestine Refugees in the Near East (UNRWA)

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### **C**an you briefly describe the health care services and the health structure that UNRWA provides.

UNRWA operates in Jordan, Lebanon, Syrian Arab Republic, the occupied Palestinian territory (oPt) and Gaza in a context characterized by upsurges of violence and a worsening socioeconomic situation. UNRWA was established in 1949 to assist individuals and descendants of individuals whose residence was Palestine between June 1946 and May 1948, and who lost both their homes and means of livelihood as a result of the 1948 conflict.

During the early years, emergency aid delivery evolved into a human development approach in the areas of education, health, relief and social services. In recent years a self-supported programme of micro-credit and microfinance became operational to assist the most needy refugees. Currently, 4.6 million Palestinian refugees are eligible for UNRWA services.

The health programme aims to safeguard and promote the health status of Palestinian refugees. Over the years it has adopted a holistic approach to health, encompassing the whole life span of beneficiaries from birth to old age. In 2007, more than 3 million refugees accessed UNRWA's health services.

The programme focuses on comprehensive primary health care delivered by a network of 134 health centres. Services offered include: outpatient and general practice services and dental consultations, specialist consultations, immunization, expanded maternal health and family planning and communicable and noncommunicable diseases prevention and control.

Each health centre is structured to allow for:

- curative health care services (outpatient services, noncommunicable disease clinics and dental clinics)
- preventive services (maternal health,



family planning and healthy baby clinics that also provide immunization services), and

- diagnostic services (laboratory and diagnostic imaging).

A reimbursement scheme is in place to assist patients needing hospitalization and/or advanced diagnostic services not offered by UNRWA clinics.

I would like to add that even though noncommunicable diseases are on the rise in the Region, communicable diseases still represent a threat to public health. For this reason, prevention of communicable diseases remains a cornerstone of the programme. The health programme is in charge of environmental health services in all UNRWA refugee camps, moreover, an effective epidemic surveillance system, including an early warning package is in place in order to rapidly identify and control outbreaks.

**Based on your vast experience in health and community development, how do you see the role of the community in health and social well-being in UNRWA camps?**

I firmly believe that the direct involvement of the community is vital in order to effectively address their needs. Both in my current post in the Middle East and during my experience as WHO Representative in Sudan, I have exerted efforts in promoting a participative approach to health care.

We all know that poverty and ill-health form a vicious cycle. Poverty leads to ill-health through increased personal and environmental risk, increased malnutrition and food insecurity, less access to knowledge and information and a reduced ability to access health care. At the same time, ill-health leads to poverty by reducing a household's

income and lowering people's ability, productivity and quality of life. Therefore, it is not possible to address health without looking at all its social and economic determinants.

It is always crucial to integrate interventions that tackle the various aspects of well-being. In the case of UNRWA, the interaction of health, social and micro-credit programmes at the community level is being strengthened as part of the current WHO/UNRWA community-based initiatives (CBI) partnership.

**What are the challenges you see in the implementation of CBI in UNRWA?**

We need to strengthen community leadership in health and social development with a shift from programme-centred to community-centred approaches. This will require additional resource mobilization and the development of partnerships to promote the health and social well-being of our stakeholders.

The WHO/UNRWA CBI partnership aims to build local capacity in this field, with funds sanctioned by Dr Hussein Gezairy, WHO Regional Director for the Eastern Mediterranean. WHO will assist UNRWA in designing a training package for community representatives, health and social volunteers and field/area officers responsible for health, social and micro-credit programmes. WHO will also provide technical expertise in training and in building the community's capacities in health and social development.

To directly address health and/or its socioeconomic determinants, the health, social, education and micro-credit programmes need to work more closely to complement each other's interventions and to build leadership

capacity in the community if we want to empower our beneficiaries and help them to achieve the highest possible level of health and social development.

I thank the CBI programme for giving me this opportunity to share our experience and introduce UNRWA to your readers.



# LEBANON:

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## an assessment of reproductive health needs in rural Ayta es Sha'ab and Rmeish



The objectives of the assessment conducted by the Imam Sadr Foundation were to assess community reproductive health needs and integrate these needs into primary health care services in Ayta es Sha'ab and Rmeish. Eight participants from the Foundation were trained by the Lebanese Center for Policy Studies on how to conduct a focus group discussion.

Two hundred and seventy-five women aged between 20 and 49 completed a questionnaire during the focus group sessions. They identified a need to address the following issues in order to improve reproductive health in Ayta es Sha'ab and Rmeish.

- the lack of understanding of reproductive health issues, particularly among husbands in matters related to pregnancy and family planning;
- the lack of economic resources;
- the lack of information about reproductive health and sexually transmitted infections;
- the tendency of mothers to put family members first;
- the lack of involvement of medical professionals in informing

adolescents before marriage of reproductive health and sexually transmitted infections;

- the unavailability of regular free of-charge preventive check-up services;
- early marriage and pregnancy;
- illiteracy.

To address these issues the following interventions were proposed.

- Develop Information, Education, Communication (IEC) materials based on the results of the assessment. A brochure on menopause and cervical cancer and two small information booklets on adolescent health (one for boys and one for girls) were developed and are being distributed to target groups at health facilities run by the Imam Sadr Foundation.
- Promote family planning services, and the education of community leaders.
- Involve health staff in activities related to reproductive health, prevention of sexually transmitted infections and adolescent health.
- Strengthen linkages between health facilities and clients about when

and where to benefit from health services.

- Make available a comprehensive package on reproductive health services and related health education at health facilities. The package should contain: adolescent care, family planning, prenatal care, safe delivery, postnatal care, breastfeeding, growth-monitoring, vaccination and child care services and post-menopausal care services.
- Conduct regular awareness-raising sessions at community level.
- Develop a training package to improve communication.
- Encourage greater community participation in the delivery of reproductive health services and the sharing of responsibilities between community members.





## The basic development needs programme in **Pakistan**

The basic development needs (BDN) programme in Pakistan is being implemented in nine districts covering a population of 1.4 million. The programme has resulted in the empowerment of communities and has led to tangible successes in health and other social sectors. This has been achieved through the development of voluntary, participatory and leadership skills. The programme has demonstrated that mobilization of communities, coupled with the creation of a network of community volunteers, can significantly improve health and other socioeconomic indicators.

More than 731 village development committees have been organized, trained and mobilized for health action, with over 150 000 cluster representatives. A total of 1472 local health workers were sensitized on the BDN concept and process. While 768 local health workers were trained and involved in the Expanded Programme on Immunization (EPI), maternal neonatal and child health, malaria and tuberculosis control efforts. 1477 women health volunteers were trained on home health care and growth-monitoring. A total of 64 first-level health care facilities and 19 mother and child health centres have also been strengthened. Twelve community-based maternal and child health centres have been established to improve access in areas where no

facilities previously existed.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) provided funds in its third round. This grant enabled expansion of community organization/mobilization to most parts of the BDN districts, covering a population of 6 million. The communities were involved in

the cure and prevention of malaria and tuberculosis through innovative community-driven strategies. Table 1 shows improvements in key health indicators achieved by the programme between 2000 and 2007. Table 2 shows the impact of the BDN programme on the outcomes of the tuberculosis programme.

Table 1. Health indicators in BDN districts, 2000–2007

Indicator	Baseline 2000	Total BDN districts average 2007
Infant mortality rate per 1000 live births	144	38
EPI coverage (%)	37	86
TT coverage (pregnant women) (%)	19	83
Pregnant women seeking antenatal care (%)	40	82
Deliveries attended by skilled birth attendant (%)	29	83
Use of contraceptives (%)	18	47

Table 2. Impact of the BDN programme on the outcomes of the tuberculosis programme

Tuberculosis indicators	Baseline 2004 (BDN) (%)	National 2006 (%)	BDN districts 2006 (%)
Case detection rate	45	51	80
Cure rate	61	71	91
Default rate	12	10	3



providing adult literacy. Significant improvements have been witnessed in educational outcomes in all BDN areas (see Table 3).

The Government of Sindh has twice provided funds, during 2002–2005 and 2005–2008 for replication of the BDN programme in five subdivisions

Table 3. Percentage of change in educational outcome indicators, 2000–2007

Indicator	Adult literacy (%)		Primary school enrolment (%)			
	Base line	Current	Baseline	Current		
Total BDN districts average	31	44	38	Total	Male	Female
				87	91	82

The BDN programme has contributed significantly towards gender mainstreaming and the empowerment of women through education, capacity-building and income-generating skills, participation in decision-making and development initiatives. A total number of 74 women's vocational training centres were established through community cost-sharing, where skills in sewing, knitting, handicrafts, embroidery and other vocations were imparted along with home health care and basic literacy. So far, 22 632 women have been trained in various skills, while 15 000 illiterate adult women have received basic literacy through these centres. Furthermore, 22 000 students of women's vocational training centres were trained on home health care and participatory skills.

Primary education and adult literacy with a focus on girls is a key area that has been identified by BDN communities. Several community primary schools have been established in rural areas and the community is involved in cost-sharing of construction/rent of buildings, provision of books and school furniture. A total of 130 public sector primary schools have been strengthened, through additional construction and provision of teachers, furniture and books, benefiting 26 000 primary schoolchildren. Furthermore, 56 400 children who defaulted on primary school education were restored and registered by the village development committees and women volunteers through motivation and persuasion of the parents. The programme has also established 37 adult literacy centres, in addition to the 74 women's vocational training centres

A lack of safe drinking-water and sanitation has compounded health problems in most BDN areas. Accordingly, BDN communities have given the highest priority to the provision of clean drinking-water and sanitation. A total number of 402 hand pumps, 20 electric/diesel powered tube wells, 20 water tanks along with supply lines and 22 gravity water supply schemes have been established and sustained in BDN areas, through community co-financing, providing clean water to 440 053 people. Similarly, 605 sanitary soakage pit latrines, 23 wastewater and solid waste disposal projects were completed through community cost-sharing, benefiting almost 200 000 people (see Table 4).

(52 union councils) of the Dadu and Jamshoro districts. The Government of Balochistan has allocated funds for programme expansion in the Mastung district during the financial years 2002–2004. The Government of Northwest Frontier Province has allocated funds for replication of the BDN programme in five districts: Buner, Batagram, Bannu, DI Khan and Upper Dir during 2005–2007. Furthermore, the Global Fund has provided US\$ 2.72 million in its third round for malaria and tuberculosis control efforts and will further provide US\$ 3.4 million for malaria and tuberculosis control for 2008–2012, in the sixth and seventh rounds. A proposal for achievement of

Table 4. Percentage of change in selected water and sanitation indicators, 2000–2007

Indicators water and sanitation (%)	Access to safe water supply (%)		Access to sanitary latrines (%)	
	Baseline	Current	Baseline	Current
Total BDN district average	45	87	10	69

The Government of Pakistan has incorporated BDN in the medium-term development framework as a means of ensuring sustainable health development and poverty reduction. A project document representing a total cost of 1.7 billion Pakistani Rupees provided by the Ministry of Health is pending the approval of the Planning Commission of Pakistan. The proposal seeks to replicate the programme in rural and periurban slums of 24 districts (43 *tehsils*) throughout the country.

the targets of Millennium Development Goals 4 and 5 through community participation has also been shortlisted for GAVI Alliance/civil society organization funding.

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# Community-based malaria control programme: a success story from Sudan



**H**ave community interventions helped in resolving the problem of inaccessibility to health services?

The problem of accessibility to health care services remains a major barrier to achieving the goal of health for all. Obstacles vary between countries but many countries share the issue of the lack of availability of health facilities and trained health personnel. Moreover, the lack of availability of medicines and regulations to assure the quality of services for disadvantaged communities complicates matters. This problem affects all aspects of health, but has a considerable impact in the case of malaria in endemic countries; especially in rural communities.

Sudan has attempted to develop a model for delivering malaria services, including diagnosis and treatment where no health services are available, through community volunteers. The country is now planning to expand the strategy to similar communities. The study identified ways to significantly reduce malaria, and the prevalence of fever from 24% to 8.5%, and to improve accessibility of health services within villages from 25% to 64% and ensure the referral of all other non-malaria and severe cases. The findings showed that the number of deaths was significantly reduced from 61 to only one death, with no mortality recorded for children under-5 years of age.

The model offered non-monetary incentives for volunteers, or malaria control assistants, who were selected by community leaders in the target areas. The pilot project was implemented in the Um Adara area, south Kordofan State, and volunteers were trained on:

- malaria diagnosis using rapid diagnostic tests (RDT) and treating malaria cases with artesunate plus sulfadoxine-pyrimethamine;
- identification of severe malaria and non-malaria cases for referral;
- initiating malaria prevention activities and conducting advocacy for better health through community mobilization.

Despite non-monetary incentives and the limited educational levels of some volunteers the protocols and guidelines of the study were adhered to. Most of the villages selected were more than 5 km away from the nearest health facility, and during the rainy season many of the villages are inaccessible. The study has served 23 733 people and has resulted in a significant reduction in the prevalence of malaria, an increase in the community's access to diagnosis, treatment and improved

referral rates. In addition, it has had a social impact on community partnership for health action by:

- ensuring the satisfaction of patients, communities, volunteers and health care providers;
- convincing patients of the effectiveness of rapid diagnostic tests in diagnosis and in accepting a plan for treatment;
- encouraging the support of the community for volunteers by providing or building a place to be used as a volunteers' clinic;
- facilitating the volunteers' work through supervisory visits by community leaders and conducting advocacy to benefit from the services provided;
- encouraging the spiritual aspect of the volunteers' work.

Although this project has achieved its goal in reducing the burden of malaria through a community volunteers' model, the problem of managing the cases of non-malaria fever was raised, evoking the question of the feasibility of expanding this model to involve other common febrile problems in the area.

<sup>1</sup>This article is based on an interview with Khalid A Elmardi, Elfatih M Malik and Tarig Abdelgadir, National Malaria Control Programme, Federal Ministry of Health, Khartoum, Sudan



# Senegal:

## best practice on a collaborative iodine initiative

In 2006, the World Food Programme (WFP) partnered with the Micronutrient Initiative, funded by the Canadian International Development Agency (CIDA), to support five countries: India (Rajasthan State), Pakistan (northern provinces), Sudan, Ghana and Senegal to increase their production and consumption of iodized salt and bridge the gap of 30% to 40% of poor households without access to iodized salt. The main focus of the initiative was to work with small and very small-scale salt producers, mainly women, in the informal sector.

In partnership with the Micronutrient Initiative, UNICEF and the national committee against malnutrition, WFP Senegal supports government efforts to achieve universal salt iodization objectives by promoting the local production of iodized salt and its consumption within Senegalese households. A total of 14 local salt-producer groups were selected as beneficiaries of the WFP's "Iodization of salt in Senegal" project and received iodization units, an allocation of potassium iodate (KI03) as well as technical training.

The producer Groupe d'Interet Economique of Taanomak-Ndiémou, in the Fatick region, is composed entirely of women, and comprises 664 salt producers from 28 villages, scattered throughout the marshland of this food-insecure region. Thanks to the installation of a six ton per hour iodization unit, the delivery of



potassium iodate allocation and WFP's efforts to build the capacity of women producers, the producer group was selected by a wholesaler short-listed by the WFP to supply it with 22 metric tons of good quality iodized salt.

This locally-produced salt was distributed by the WFP and its partners to 9000 pregnant and lactating women in Kaolack and Fatick, who receive food assistance under the national nutrition programme. This "Food for training" activity was based on awareness-raising and training sessions for pregnant and lactating women on sound dietary, nutritional, hygiene and health practices, and contributes to growth-monitoring of children under-2 years of age, during the most critical months of the lean period (July to September). The aim is to prevent

malnutrition in children under-5 years of age by increasing awareness at the community level. Women participating in the community awareness sessions receive an incentive consisting of a take-home family ration of 5 kgs of pulses, 2 kgs of vitamin A-enriched oil and 400 g of iodized salt.

Not far from the Ndiémou production site, on 24 July 2007, pregnant and lactating women from Koumbal village, Kaolack region, were attending a training session on malaria prevention. Before the distribution of rations, the voluntary community workers tested the salt and the violet colour confirmed the adequate level of iodine essential to prevent goitre and to avoid permanent cognitive defects in those babies soon to be born.

The WFP is hoping to replicate this good practice, with the support of the Micronutrient Initiative, UNICEF and other partners, in other areas where local salt producer groups are able to compete in the local market and manage a food fortification activity for the benefit of neighbouring communities.

# Morocco shares its experience in community mutual insurance



To help resolve the problem of the low utilization of health services as a result of limited income the Moroccan Government is implementing a medical assistance scheme known as Régime d'Assistance Médicale (RAMED) by providing a package of health services which are outside those provided by public health facilities.

In order to cover other health services that are not included in RAMED, the Ministry of Health in Morocco has engaged its partners: WHO, United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF), in pilot-testing of community mutual insurance in 30 communes located in seven provinces.

Community mutual insurance is a mechanism of solidarity and insurance at a local level, which allows individuals to pool the funding of some health care services. Members pay a fixed fee for a package of health services. Individuals from the community are involved in collecting members' contributions and reimbursing health care providers. In this way, the consumption of health care services by households is less dependent on their income. It is expected that this will encourage the community to fully utilize health care services. The mutual insurance package includes reimbursing the cost of medicines which are not available in health centres and referring patients to provincial hospitals and laboratory services.

The WHO Representative's Office in Morocco is supporting the Ministry of Health in four sites by improving implementation methodology. This methodology is inspired by the work of the STEP programme (strategies and tools against social exclusion and poverty) of the International Labour Organization (ILO) which has worked in this field in many countries, and which has developed guidelines for the improvement of community participation.

The implementation methodology involves:

- negotiation with local health authorities and community representatives;
- establishment of a pilot committee at local level;
- compilation of a health package and calculation of the portion of the community's contribution;
- conducting of a feasibility study after reviewing the health registers to identify the frequency of use of health facilities by each person on an average during a year;
- convening of a general assembly and meeting with the community to inform them of the package of services and the community's contribution;
- mobilization of the community and collection of membership fees;

- implementation of the project.

The first site started in 2005 in Tabant. The health care services package included the essential medicines prescribed by the physician and the cost of the ambulance service for referring needy patients to the provincial hospital with a membership fee amounting to 200 Moroccan Dirham (MAD), the equivalent of US\$ 23 per family per year. The Ministry of Health, WHO and UNFPA are all working together to expand this package and to better respond to the communities' expectations.

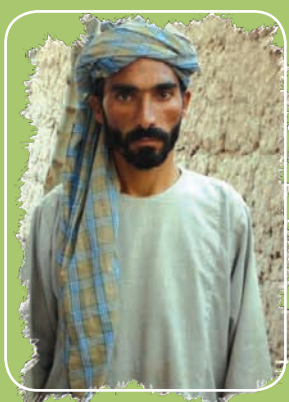
The project has proven itself to be feasible and has resulted in enhancing communities' accessibility to health care services. The ease of project implementation was also raised. The participation of community and the involvement of different partners is encouraging, and the coordination of different actors is vital for its sustainability. More attention should be given to documenting the experiences and expanding the package.

Based on this experience, WHO and the Ministry of Health will develop guidelines that will elaborate on the methodology and strategies used, in addition to outlining of the roles and responsibilities for expanding the social protection scheme through the RAMED scheme.





# Voice of the community: Mr Wakil Ahmad, Afghanistan



**M**y name is Wakil Ahmad and I live in Ghaizan village, Enjeel district, Herat province, Afghanistan.

Before I received a loan from the BDN programme, I worked as a labourer, on a day-to-day basis, but my wages were insufficient to make an adequate living. Most of the time it was hard to find work and sometimes I had no income.

The BDN programme started in our village 10 years ago. I came to know about the programme through the *shora* council. As I did not have enough money to start a project, I asked for a loan from the BDN programme to buy a dairy cow. By selling the milk and yogurt my life has improved and I am no longer jobless. The BDN programme has benefited all the people in my community in different ways, such as improving the literacy of women, vaccinating children and improving hygiene in the community among many other achievements. I am thankful to those who initiated the programme as now my children can go to school instead of working with me as they did in the past. My wife has also received a basic education. Through my dairy project I am able to support my family and our health has improved. The programme has not only provided

income-generating projects and literacy classes but taught the community the importance of hygiene and vaccination of both children and pregnant women.

War and drought have left many people jobless; therefore, it is important to learn a vocational skill in order to earn a living. I believe that the programme should provide more loans, to encourage jobless people, especially youth, to benefit from it. I am keen to assist in the programme's expansion and will continue to participate in community activities, encourage my relatives and neighbours to be active in the implementation of different projects and also in returning their BDN loans on time.



## Acknowledgements

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- Dr Adrien Renaud, former Technical Officer, WHO Representative's Office, Morocco
- Ms Samira Gabal, Community-based Initiatives Focal Point, WHO Representative's Office, Morocco
- Dr Hoda Atta, Regional Adviser, Roll-Back Malaria, WHO Regional Office
- Dr Mohamed Mansour, Technical Officer, Nutrition, WHO Regional Office
- Dr Saifullah Nadeeb, National Professional Officer, WHO Representative's Office, Afghanistan

# Invitation to share

The CBI newsletter is a channel for creating a network for community development issues that:

**C**apture the impact of the programme in the field through:

- tracking the important visits of high-level officials, stakeholders, etc. and following campaigns/ events and activities that involve the community in development;
- publishing the results of research related to community participation in health development;
- sharing the experiences of nongovernmental organizations involved in community development.

**B**ring to light the experiences of the community in:

- Voice of the community—an important column in our newsletter—where a selected member of the community shares the problem(s) they faced in their city/village and how they overcame these problems utilizing available resources and local solutions;
- improving the lifestyle of families, communities and villages as a whole in terms of health, education, solidarity and other development issues, such as income and security.

**I**nspire interventions to resolve day-to-day problems faced by the community through establishment of:

- women’s vocational or youth development centres;

- community centres;
- local transportation systems;
- water and sanitation projects;
- community empowerment in programme management.

In this regard, CBI would like to invite you to share with us your experiences, success stories or lessons learnt, including 2 to 3 high resolution (600 dpi) photos illustrating active community involvement/ownership related to your area of work for publishing in our upcoming issues.

The CBI programme looks forward to receiving your contributions by e-mail: [CBI@emro.who.int](mailto:CBI@emro.who.int)



L'Office de Secours et de Travaux des Nations Unies pour les Réfugiés de Palestine dans le Proche-Orient (UNRWA), qui mène des opérations en Jordanie, au Liban, en République arabe syrienne, dans le Territoire palestinien occupé et dans la Bande de Gaza, non seulement fournit une aide d'urgence mais applique aussi une approche du développement humain dans les domaines de l'éducation, de la santé, des secours et des services sociaux. Le programme de santé a adopté une approche holistique visant à préserver et à améliorer l'état de santé des réfugiés palestiniens en mettant l'accent sur les soins de santé primaires dispensés par le biais d'un réseau de 134 centres de santé. Grâce à un système de surveillance des épidémies extrêmement efficace, notamment un système d'alerte rapide, l'UNRWA est en mesure de détecter et d'endiguer rapidement les flambées de maladies transmissibles. L'actuel partenariat OMS/UNRWA pour des initiatives communautaires reconnaît qu'il est extrêmement important d'intégrer des interventions destinées à traiter les divers aspects de la santé et du bien-être. Ce partenariat vise à renforcer les capacités communautaires pour permettre aux bénéficiaires de se prendre en charge afin d'atteindre les niveaux de santé et de développement social les plus élevés possibles. À cette fin, l'OMS apporte un soutien financier, approuvé par le Dr Hussein A. Gezairy, le Directeur régional pour la Méditerranée orientale, et aide l'UNRWA à mettre au point un programme de formation destiné aux représentants communautaires, aux agents de santé et travailleurs sociaux bénévoles et aux fonctionnaires de terrain chargés des programmes sanitaires et sociaux et des programmes de microcrédit.

L'étude sur la santé génésique menée au Liban par la Fondation de l'Imam Sadr avait pour objectif d'examiner les besoins des communautés et d'inscrire la santé génésique en tant que partie intégrante des services de soins de santé primaires, services qui ont été sérieusement mis à mal durant le conflit de 2006. Huit participants désignés par la Fondation ont été formés à la conduite de groupes de discussion par le Centre libanais d'Études politiques. Durant les sessions des groupes de discussion, il a été demandé à 275 femmes âgées de 20 à 49 ans de remplir un questionnaire. Il est ressorti de cet exercice que le manque

de connaissance des questions de santé génésique était dû à plusieurs facteurs socioéconomiques et culturels tels que, notamment, le défaut de compréhension de ces questions ou l'ignorance en la matière et le manque d'accès au matériel pédagogique adéquat. Parmi les interventions proposées figuraient la mise au point de brochures d'information à distribuer aux centres de santé, la promotion de services de planification familiale et le renforcement des liens entre les centres de santé et les clients afin d'encourager ces derniers à bénéficier le plus possible des services offerts.

Le programme des besoins fondamentaux en matière de développement (BDN) est actuellement mis en œuvre dans neuf districts du Pakistan couvrant une population de 1,4 million d'habitants. Le programme a doté les communautés de moyens d'action et a abouti à des succès tangibles dans le secteur de la santé et dans d'autres secteurs sociaux. La mobilisation des communautés et la création d'un réseau de volontaires communautaires peuvent sensiblement améliorer les indicateurs sanitaires et autres indicateurs socioéconomiques, ainsi que le montrent les améliorations constatées dans les indicateurs concernant l'eau et l'assainissement, l'alphabétisation des adultes, la scolarisation dans le primaire et le taux de mortalité infantile dans les neuf zones qui appliquent le programme BDN.

Afin d'aider à résoudre le problème de la faible utilisation des services sanitaires en raison des revenus limités, le gouvernement marocain met actuellement en œuvre un Régime d'assistance médicale (RAMED) qui propose un ensemble de services de santé différents de ceux qu'offrent les centres de santé publique. Le ministère de la Santé a procédé, en partenariat avec l'OMS, le FNUAP et l'UNICEF, à l'essai pilote d'une mutuelle communautaire dans 30 communes situées dans sept provinces. La première expérience a démarré en 2005 à Tabant, où les prestations offertes consistaient dans des médicaments essentiels prescrits par le médecin et le transfert en ambulance de patients défavorisés à l'hôpital provincial, moyennant une cotisation de MAD 200 (équivalant à USD 23) par famille et par an. Le ministère de la Santé, l'OMS et le FNUAP travaillent ensemble à l'élargissement de cet

ensemble de prestations et en vue de mieux répondre aux attentes des communautés.

Le Soudan a élaboré un programme de lutte antipaludique à base communautaire en recourant à des incitations non financières accordées à des bénévoles choisis par des responsables locaux dans des zones cibles. Le projet pilote, mis en œuvre dans la région d'Um Adara, dans le sud de l'État de Kordofan, a bénéficié à 23 733 personnes. Il a permis de diminuer notablement la prévalence du paludisme, de ramener la prévalence de la fièvre de 24 % à 85 % et de faire passer le taux d'accessibilité aux services de santé dans les villages de 25 % à 64 %. Des résultats d'enquête ont montré d'autre part que le nombre de décès a considérablement diminué, tombant de 61 à 1, tandis qu'aucun décès n'était à signaler chez les enfants de moins de cinq ans.

En 2006, le Programme alimentaire mondial (PAM) a établi un partenariat avec l'Initiative en faveur des micronutriments, fondée par l'Agence canadienne de développement international (ACDI), pour aider cinq pays – l'Inde (État du Rajasthan), le Pakistan (provinces septentrionales), le Soudan, le Ghana et le Sénégal – à augmenter leur production et leur consommation de sel iodé. Au Sénégal, 14 groupes de producteurs de sel locaux au total ont été sélectionnés pour bénéficier du projet d'« iodation du sel » du PAM et ont ainsi reçu des unités d'iodation et de l'iodate de potassium (KI03), et ont suivi une formation technique. Ce sel produit localement a été distribué par le PAM et ses partenaires à 9000 femmes enceintes et allaitantes à Kaolack et à Fatick, où elles reçoivent une aide alimentaire au titre du programme national de nutrition. Le PAM espère, avec l'appui de l'Initiative en faveur des micronutriments, de l'UNICEF et d'autres partenaires, renouveler cette bonne pratique dans d'autres régions où les groupes de producteurs de sel locaux sont capables d'être concurrentiels sur le marché local et de prendre en charge une activité d'enrichissement des aliments au profit des communautés avoisinantes.

Avant de recevoir un prêt du programme BDN en Afghanistan, Wakil Ahmad travaillait en tant qu'ouvrier mais son salaire ne lui permettait pas de vivre décemment. Aujourd'hui, il possède

une vache laitière et gagne sa vie en vendant du lait et du yaourt. Grâce à ses gains, il a pu envoyer ses enfants à l'école et sa femme a reçu une éducation de base. Le programme BDN a bénéficié aux habitants du village de

Wakil en leur dispensant une formation, en améliorant leur hygiène et en assurant la vaccination des enfants et des femmes enceintes.

استخدام الخدمات الصحية نتيجة لقلة الدخل، وذلك عن طريق تقديم حزمة من الخدمات الصحية غير تلك التي تقدمها المرافق الصحية العامة. وقد قامت وزارة الصحة بالشراكة مع منظمة الصحة العالمية وصندوق الأمم المتحدة للسكان ومنظمة اليونيسف باختبار ارتيادي للتأمين المجتمعي المتبادل في 30 وحدة إدارية موجودة في سبع مناطق. وقد بدأ الموقع الأول في عام 2005 في تبانت بالمغرب، وقد ضمت الحزمة كل من الأدوية الأساسية الموصوفة من الأطباء، وتكلفة خدمات الإسعاف لإحالة المرضى المحتاجين إلى مستشفى المنطقة مقابل رسوم عضوية تقدر بحوالي 200 درهم مغربي، أي ما يعادل 23 دولار أمريكي لكل أسرة في العام. وتتعاون وزارة الصحة ومنظمة الصحة العالمية وبرنامج الأمم المتحدة للسكان في تحسين نشر هذه الحزمة وتلبية توقعات المجتمع.

أعدت السودان برنامجاً مجتمعياً لمكافحة الملاريا باستخدام حوافز غير نقدية لمتطوعين قام باختيارهم قادة المجتمع في المناطق المستهدفة. وتم تنفيذ المشروع الارتيادي في منطقة أم دارا في جنوب ولاية كردفان، وتم تقديم الخدمة إلى 23733 شخصاً، وقد أدى ذلك إلى انخفاض كبير في معدلات الإصابة بالملاريا، وانخفاض معدل انتشار الحمى من 24% إلى 85%، وتحسين فرص الحصول على الخدمات الصحية في القرى من 25% إلى 64%. كما أوضحت النتائج أن عدد الوفيات قد انخفض انخفاضاً كبيراً من 61 وفاة إلى وفاة واحدة، ولم تسجل وفيات بين الأطفال أقل من عمر 5 سنوات.

في عام 2006، اشترك برنامج الغذاء العالمي مع مبادرة المغذيات الزهيدة المقدار، وتمويل من وكالة التنمية الدولية الكندية، في دعم خمسة بلدان هي: الهند (ولاية زاجستان)، وباكستان (المناطق الشمالية)، والسودان، وغانا، والسنغال لزيادة إنتاج هذه البلدان واستهلاكها من الملح المعزز باليود. وقد اختبر في السنغال 14 منتجاً محلياً للملح ضمن المستفيدين من مشروع برنامج الغذاء العالمي لتعزيز الملح باليود، وتلقى المستفيدون وحدات تعزيز اليود، ومخصصات من يودات البوتاسيوم بجانب التدريب التقني. وتم توزيع الملح المنتج محلياً من قبل برنامج الغذاء العالمي وشركائه على 9 آلاف امرأة حامل ومرضة في كاولا وفاتيك، اللذين تلقيا مساعدات غذائية ضمن برنامج التغذية الوطني. ويأمل برنامج الغذاء العالمي إلى تكرار هذه الممارسة الجيدة بدعم من مبادرة المغذيات الزهيدة المقدار وهيئة اليونيسف وسائر الشركاء في مناطق أخرى حتى يكون في استطاعة منتجي الملح المحليين المنافسة على السوق المحلي، وإدارة نشاط تعزيز الأغذية لتحقيق النفع للمجتمعات المجاورة.

قبل أن يحصل على قرض من برنامج الاحتياجات التنموية الأساسية، كان "وكيل أحمد" عاملاً ولكن راتبه لم يكن يكفي للعيش عيشة مناسبة. الآن أصبح يمتلك بقرة تدر حليباً، ويكسب دخله من بيع الحليب والزبادي. لقد أتاح المكسب الحالي لوكيل أن يرسل أبناءه إلى المدرسة، وأن تحصل زوجته على تعليم أساسي. إن برنامج الاحتياجات التنموية الأساسية قد أفاد أهالي قرية "وكيل" حيث وفر لهم التدريب، وحسّن مستوى النظافة، وضمن تحصين الأطفال والأمهات. العوامل.

إن وكالة الأمم المتحدة لإغاثة وتشغيل اللاجئين الفلسطينيين في الشرق الأدنى (الأونروا)، بعملياتها القائمة في كل من الأردن، ولبنان، والجمهورية العربية السورية، والمناطق الفلسطينية المحتلة وقطاع غزة، لا يقتصر عملها على تقديم المساعدات الطارئة وحسب، بل تقوم أيضاً بتطبيق أسلوب تنموي بشري في مجالات التعليم، والصحة، والإغاثة، والخدمات الاجتماعية. وقد تبنى البرنامج الصحي نهجاً متكاملاً يهدف إلى حماية وتعزيز الوضع الصحي للاجئين الفلسطينيين مع التركيز على الرعاية الصحية الأولية المقدمة من خلال شبكة تتكون من 134 مركزاً صحياً. ومن خلال وجود نظام ترصد وبائي فعال للغاية يضم نظاماً للإنذار المبكر، استطاعت وكالة إغاثة اللاجئين الفلسطينيين اكتشاف ومكافحة فاشيات الأمراض السارية بسرعة. وتدرج الشراكة الحالية القائمة بين منظمة الصحة العالمية ووكالة الأونروا في مجال المبادرات المجتمعية ضرورة تكامل المداخلات للتصدي لأوجه الصحة والعافية المختلفة. وتهدف الشراكة إلى بناء قدرات المجتمع لتمكين المستفيدين من مساعدة أنفسهم في تحقيق أعلى مستوى ممكن من الصحة والتنمية الاجتماعية. ووفقاً لذلك تقدم منظمة الصحة العالمية الدعم المالي المعتمد من الدكتور حسين الجزائري، المدير الإقليمي لشرق المتوسط، وتساعد وكالة الأونروا في تصميم حزمة تدريبية لممثلي المجتمع والمتطوعين الصحيين والعاملين في المجتمعات والمسؤولين الميدانيين للبرامج الصحية والاجتماعية والائتمان البالغ الصغر.

الهدف من دراسة الصحة الإنجابية التي أجرتها مؤسسة الإمام الصدر في لبنان هو مراجعة احتياجات المجتمع، وإدراج الصحة الإنجابية كجزء مكمل لخدمات الرعاية الصحية الأولية، والتي تضررت تضرراً بالغاً أثناء الصراع المسلح في عام 2006. وقد درس ثمانية مشاركين من المؤسسة كيفية تكوين فرق التركيز من خلال المناقشات والتدريب المقدم من مركز الدراسات السياسية اللبناني. وقد أتمت 275 امرأة في المرحلة العمرية 20-49 استبياناً أثناء جلسات مجموعة التركيز. وأظهرت نتائج هذا التمرين أن النقص في معارف الصحة الإنجابية كان نتيجة لعوامل اجتماعية واقتصادية وثقافية متعددة، مثل قلة المعرفة أو الجهل بمشاكل الصحة الإنجابية، وعدم قدرة الحصول على مواد تثقيفية ملائمة. وتضمنت المداخلات المقترحة إعداد كتيبات معرفية لتوزيعها على المرافق الصحية، والترويج لخدمات تنظيم الأسرة، وتعزيز الروابط بين المرافق الصحية والمراجعين لتشجيعهم على زيادة الاستفادة من الخدمات.

يتم حالياً تنفيذ برنامج الاحتياجات التنموية الأساسية في تسع مناطق في باكستان، ويغطي 14 مليون شخص. وقد أتاح البرنامج الفرصة لتمكين المجتمع مما أدى إلى نجاح ملموس في القطاع الصحي والقطاعات الاجتماعية الأخرى. إن استنهاض المجتمع وتكوين شبكات من المتطوعين الاجتماعيين يمكن أن يحسن كثيراً من الصحة والمؤشرات الاقتصادية والاجتماعية الأخرى، كما حدث في تحسين مؤشرات الماء، والنظافة، وتعليم البالغين، والمواظبة على حضور التلاميذ في المدارس الابتدائية، ومعدلات وفيات الأطفال في المناطق التسع التي تطبق برنامج الاحتياجات التنموية الأساسية.

تقوم الحكومة المغربية بتنفيذ مخطط للمساعدة الطبية لحل مشكلة قلة



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