Volume 6 Issue 1 | 2010

CONTENTS

World Health Organization
Regional Office for the Eastern Mediterranean

Empowering People

Community-based initiatives newsletter

World Health Day
celebration at WHO Regional Office

On 7 April 2010 the inaugural ceremony for World Health Day (WHD) was held at the WHO Regional Office for the Eastern Mediterranean. The ceremony began with a speech from the Regional Director Dr Hussein A. Gezairy, who provided evidence of the major health challenges

faced in five specific urban areas in the Region: Ariana in Tunisia, the Cairo slum area of Baten El Bakra in Egypt, Sale in Morocco, Khartoum in Sudan and Rawalpindi in Pakistan.

He explained that this evidence should serve as an advocacy tool to influence policy-makers and to facilitate positive change in urban health actions, particularly through the implementation of the health city programme. Attention was drawn to the fact that the slum and poor areas of these cities have a higher incidence of infant and maternal mortality, higher rates of depression, higher child malnutrition rates, male gender bias in education and a high level of substance abuse. Health inequity and poor quality of life were also underlined as key concerns. Dr Gezairy ended his speech by urging all stakeholders, city planners, United Nations partners, civil society and community members to work together and to pool resources and efforts to improve urban health and to reduce health inequity in urban slums.

In order to provide further clarification on major issues surrounding "Urbanization and Health" four key topics were selected and presented by influential dignitaries who were invited from Egypt, Islamic Republic of Iran, Morocco and Pakistan.

Dr Sayed Hadi Ayazi, Deputy Mayor of Tehran, on behalf of the mayor HE Mr Ghalibaf, discussed intersectoral collaboration and community empowerment in Tehran. He outlined the key requirements to achieve good health: a good state of physical and mental health, wholesome food, clean drinking-water, unpolluted air, rewarding employment a sense of belonging and self-esteem, and suitable and safe housing. In addition, he said that people must be presented with a variety of choices so as to be involved in the decision-making process. The key role of the Mayor is to facilitate multisectoral action and community involvement; this is one of the most crucial elements for urban health development. He proposed that the Tehran municipality arrange a field visit of key stakeholders, including mayors of mega cities from the Region, to witness and share experiences in the field of health. He also proposed inclusion of "Urban Health" on the next agenda of the Asian Mayors Assembly. He said that Tehran was also ready to share its experiences on implementation of the "Urban Health Equity Assessment and Response Tool" (Urban HEART) with countries of the Region who were interested in implementing Urban HEART to reduce health inequity in urban areas.

Ms Nadia El Guermai, the Governor

of the National Initiative for Human Development in Morocco, discussed political commitment and leadership based on the commitment of high-level authorities in Morocco to achieve the targets of the Millennium Development Goals (MDGs). Ms El Guermai identified the main force behind good governance as strong institutions, a judicious legal framework and the development of consensus. Achieving equity, skilled manpower, community empowerment, allocation and an efficient use of resources requires political commitment at the highest level. In Morocco, the leadership connects all the key and vital ingredients of a joint action programme for health.

Dr Ejaz Rahim, former Minister of Health, Governor of Pakistan and Member of the WHO Kobe Centre advisory committee, raised the issue of health inequity in urban slums. Dr Rahim explained that owing to population growth and increasing migration from rural settings to urban areas, especially slum areas, was a major challenge. Slum areas pose increasing health threats to other city dwellers. They are an "efficient" breeding ground for epidemics, pandemics and noncommunicable diseases; furthermore, crime, use of illicit drugs and other social vices can be nurtured in slums. The slum areas interface between the rural and urban poor. The Pakistan experience demonstrates that in order to address this problem, a balanced approach of attention to both urban and rural development is necessary.

Dr Abelazim Wazir, the Governor of Cairo talked about health equity and social justice. He said that currently the average out-of-pocket health expenditure bordered on catastrophic expenditure for the poor trying to access quality health care services. The challenge lay in governments providing universal coverage that guaranteed equity and social justice.

At the end of the ceremony Dr Gezairy invited dignitaries, guests and the media to the Children's Park where the Egyptian Red Crescent Society, in collaboration with WHO, organized activities for children of all ages from aerobics, running races and karate to arts and crafts, adding a lively spirit to the events of the Day. To encourage a greener environment Dr Gezairy and the dignitaries also planted a tree in the garden in commemoration of the Day.

Voice of the community: Asha, the first female member of the village development committee in Darawein village, Somalia

Asha is a 35-year-old widow with eight children all living under the same roof. To secure any kind of livelihood for her children, under very difficult living conditions and with the constant threat felt by all families in her village, Asha started to raise livestock as the only source of income for her family. As the head of her household, Asha had approached village leaders requesting support for her family, but to no avail. In 1998, a team composed of various government sectors (health, education, livestock and agriculture) paid a two-day visit to the village.

Asha was eager to learn more about the objectives of the mission and decided to participate in the public meeting. During the meeting the team introduced the concept of the basic developments needs programme and stressed the importance of self-reliance/self-management of the priorities of the village and the importance of community organization to lead the process. The team requested that village members select a village development committee, including women, and explained the responsibilities to members. The chairman of the village development committee approached Asha to become a member of the committee and she readily accepted.

"During our first meeting with the BDN team they briefed us on the BDN concept and thereafter I participated in several meetings focusing on planning and how to go about solving community problems. I was actively involved in the baseline survey and later participated in analysing the outcomes of the survey. I also benefited from attending meetings of the technical support team and village development committee, and especially their capacity-building meetings. This component was extremely important in identifying solutions to problems and prioritizing needs.

As the only woman among the committee member elders little attention was given to my suggestions in our initial meetings. However, as a member of the committee I took part in the selection process of community members who would participate in community capacity-building training sessions on community development. Furthermore, I became a beneficiary of the income-generating programme. This programme made me realize that raising animals as the sole source of family income was not enough. As I grew more and more involved in community development activities this left me no time to attend to my animals. Thus, after lengthy discussions with close friends and distant relatives involved in running small-scale businesses, I took the tough decision to transform the source of our family income from being livestock based to business oriented by opening a small shop.

Another changing point in my life was the BDN-organized literacy session which I attended and as a result became able to read and write. Using the skills I have acquired I started to calculate income and expenses. Encouraged by my experience I have organized a women's groups association in the village, of which I am the chairperson, to share with other women the important role they have in village development activities. We maintain the cleanliness of the village through contributions of 0.5 cents of a dollar per month per member of the association.

I will continue to advocate the importance of the concept and lessons learned through women's associations and youth groups and stress the need for activities such as expanding the application of larvivorous fish and insecticide-treated bednets, maintaining immunization of children and women and continuing literacy sessions.

Use of the urban health equity assessment and response tool,

Islamic Republic of Iran

Studies over the past decades have consistently shown inequalities in health status according to socioeconomic group, gender, ethnicity, geographical area and other indicators associated with social determinants which influence health. The WHO Regional Office and the WHO Centre for Health Development in Kobe, Japan, selected Tehran as one of the cities to pilot-test the urban health equity assessment and response tool (urban HEART). An adapted model of the tool for Tehran adopted the six domains of physical infrastructure, human and social development, economic, governance, health and nutrition.

A pilot test was conducted on a random cluster sample of 250 families in five districts of the city to measure how comprehensible the questionnaire was and to

validate the tool and rapidly analyse data. Necessary changes were applied to the tool according to the validation process and sample size calculation for the main survey. Sample findings for the main survey were based on GIS; a review of the maps by methodologists ensured unified sample distribution within each district and also on-site selection to avoid replacements. The tool was then administered to 22 130 households (81 000 people), representing 1000 families (125 clusters) in each of the 22 districts in Tehran to measure 41 indicators, that were categorized within the six domains mentioned earlier.

Data for the remaining indicators (24 indices) were collected from other resources, such as registry systems (some indicators for governance, primary education, air pollution). Nutritional status was assessed among only 10% of the whole target/ sample families. Some specific surveys were also conducted as complementary to the main surveys to detect disparities in safe water supply, air pollution, noise nuisance, solid waste management and utilization of health service by households.

Monitoring and evaluation of the whole process were conducted using tough field supervision by academia, and a computerized evaluation system was applied to reduce errors in data entry and data processing. Monitoring teams were organized into three levels to ensure all data were uniformly collected complying with the written protocols.

Significant inequalities in most of the indicators were found within the 22 districts. Disadvantaged districts in terms of economic status suffered from greater illiteracy, unemployment, less access to higher education, severe mental health problems, less access to living facilities and assets and larger family sizes. Findings were mapped and a clear distinction was noted between the north and south of Tehran in nearly all of the indicators, with those living in the north having greater access to social services.

Table 1. Socioeconomic indicators in selected districts in Tehran, 2009

District No.	Home owner (%)	Size of mean home (metres)	Time taken to reach public transport (in minutes)	Freezer ownership (%)	Cell phone ownership (%)	Car ownership (%)	Access to clean water (%)
3	62	131.1	12.4	90	82	48	100
5	72	86.9	9.8	84	94	64	100
8	60	88.28	12.2	90	74	40	100
12	66	85.02	9.6	78	80	36	100
20	62	90.54	12	54	64	26	100
Average	64.40	96.37	11.2	79.20	78.80	42.80	100

Table 2. Health indicators in selected districts in Tehran, 2009

District No.	Children under 3 years of age (%)	Giving birth in last year (%)	Healthy delivery (%)	Suspected mental disorder (%)	Disability (%)
3	0	0		28	4
5	6	0		37	2
8	10	4	100	36	2
12	6	6	100	46.20	10
20	4	2	100	51.10	8
Average	5.20	2.40	100	40	5.20

Table 3. Unemployment, illiteracy and domestic violence in selected districts in Tehran, 2009

Districts	Unemployment rate (%)	Illiteracy rate (%)	Domestic violence (%)
3	20.69	0.03	0.04
5	11.67	0.03	0.12
8	10.53	0.06	0.1
12	20	0.07	0.12
20	37.08	0.12	0.18
Average	20.94	0.06	0.112

Impact on under-5 child mortality:
a case demonstration from the central highlands of Afghanistan

In two remote Afghan valleys a women's empowerment project reduced under-5 child mortality by 46% in two years. For each village a community health worker was trained to apply a new model of community-based child health care. After the training, unexpectedly, outside funding was diverted but rather than the programme closing, the women decided to continue the programme themselves. The significance of what happened is both that this intervention was able to create a 46% impact,and also that the programme was continued by the women, thereby demonstrating a level of sustainability not previously seen in the Basic Package of Health Services (BPHS) projects.

In rural areas, where 80% of the national population lives, BPHS was not so successful and significant lack of coverage continues. The training of community health workers had been planned to reach village homes working out of the established clinics in a process designed for geographical extension. However, the alternative model developed within this project extended primary and preventative services much more rapidly by building the capacity of the women, rather than just health infrastructure. Extension into the lives of people, using education and behaviour change sustained the impact for the two-year period.

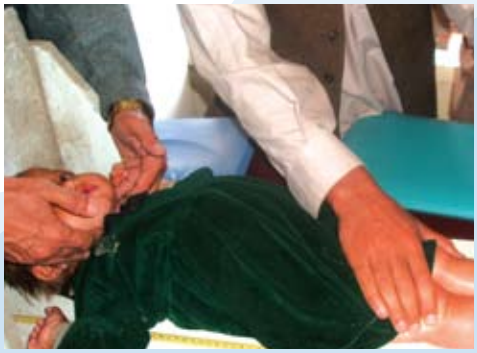
This project crafted itself around trying to investigate how to strengthen the ongoing design of the BPHS. It did so by developing a basic curriculum for training community health workers, one that covered the content of the current system of BPHS. A major component added to this new curriculum was to demonstrate not only the impact, but how social interventions such as organizing mothers into volunteer "women's action groups" it was able to expand very rapidly and cover all village households; their continuing work was supported informally by a local mullah who had been a staff member of a local nongovernmental organization called Future Generations. Because of the reports of continued progress two years later, he led a team back to these villages to investigate results.

Using a new version of retrospective pregnancy history surveys developed by Johns Hopkins Professor Stan Becker a baseline was created for health status prior to the intervention to show that the declines had held during the two-year absence of formal assistance. By assessing gaps in the pregnancy histories reported by mothers it is possible to retrospectively calculate infant and under-5 child mortality rates. Initial studies suggest the trend lines may have accuracy going as far back as seven years.

The empowerment process spread rapidly as the action groups generated a momentum involving nearly all the women with careful attention to keeping decision-making voluntary. Change occurred because health improvements were tangible. The spread of ideas differed; for example the spread of family planning was gradual based on decisions by each couple in contrast to community decisions

about child immunization and cleanliness of water and sanitation, which were adopted almost immediately.

The reduction in mortality among children under the age of 5 showed an overall reduction of 46% (Figure 1). An important observation is that this drop in mortality occurred after the training had stopped, when the formal intervention period by outsiders was over. The women were conducting implementation through their empowered action groups. The projected sustainability of this health intervention may be very cost effective and promote more effective methods of participatory community-based primary health care.



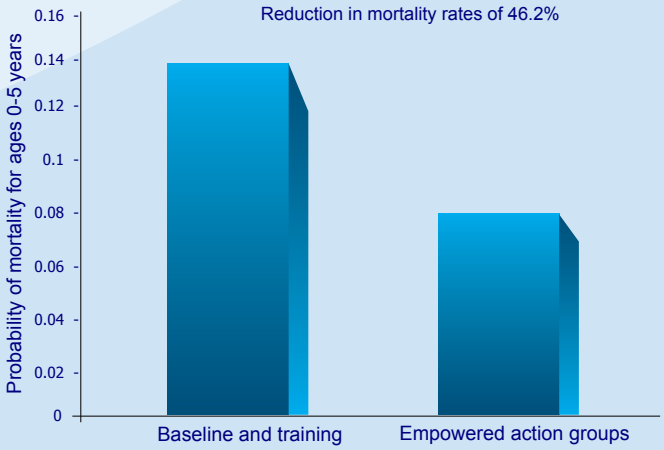


Figure 1. Reduction in under-5 mortality through women's action groups in Afghanistan

Community-based projects competition in OMAN

Since 1990 the Ministry of Health has undertaken immense development efforts with decentralization as a symbol of this development. This began with the decentralization of the regional and *willayat* authorities.

The Ministry has been encouraging the development of a planning culture in the system; the managerial process for national health planning was introduced in the 1980s to develop the national five-year plan. The *willayat* problem-solving approach was also adopted in the early 1990s. The establishment of *willayat* health committees took place in 1999 and these committees were considered a focal point of the programme because its members included government intersectoral representatives, civil societies and the community. What adds to its importance is that it is headed by the *wali* of the province and the committee is assigned by the director or supervisor of health services in the province.

Responsibilities of the health committee include:

• participating in the planning, establishing strategies and assessing five-year health plans at the national and provincial level;

• building health awareness to mobilize community capacity and encouraging their active participation in all stages of project implementation;

• facilitating and coordinating cooperation between the Ministry of Health and other health-related sectors, as well as civil societies and volunteer groups.

The approach of the *willayat* health committees was accompanied by the introduction of the community-based projects competition, which is one of the major

achievements planned and implemented by these health committees. The Ministry of Health took successive steps in the sustainability of these projects through an annual award for the best community-based project. All the *willayat* in the country (61 *willayat*) participated in these projects in the 20072008/ competition; of which 16 projects reached the finals. This was carried out through the formation of an evaluation team which consists of Ministry of Health personnel and technical officers from UNICEF and the United Nations Population Fund (UNFPA); the development of an evaluation tool; field visits and data collection; data analysis and dissemination of results. Some of the projects which have been approved and implemented in the local areas include:

• five healthy lifestyle-related projects;

• six other health-related and health education projects, mostly on prevention of noncommunicable diseases;

• four environmental health projects;

• one basic development needs project.

An award ceremony, organized in collaboration with UNICEF, was held on 30 April 2009 to award the best project. This ceremony was held under the auspices of the Under-Secretary of the Ministry of Interior with the presence of several governmental officials, walis and community members. The awarded projects were as follows: first place to *willayat* al Khaboura's project to combat obesity in the *willayat* (phase one)"; second place to Qurayat's project "Social development of Wissal village"; the third place was awarded to two projects—al Mudhibi's project "The nutrition information centre in Talool village" and Taka's project "Early detection and prevention of high cholesterol, hypertension and obesity".

The Ministry of Health also presented awards for the best project in resource utilization to willayat Liwa's project entitled "The campaign against hepatitis A in harmool village"; for the best sustainable project in Jallan entitled "Healthy environment project in wadi al Laabedaa"; for the best community information centre in al Awabi entitled "The project to reduce cases of protein energy malnutrition in children under-5 years of age";

Other significant finding and results included:

• a reduction in cases of protein energy malnutrition in children under-5 years of age;

• increased community participation and collaboration for health actions;

• awareness campaign on the prevention of noncommunicable diseases;

• promotion of physical activity with a focus on females;

• provision of training holes and equipment for physical activity.

Friendly camp campaign

for people with physical disabilities at UNRWA Suf refugee camp, JORDAN

With the beginning of a new year, a new hope dawned for children with physical disabilities in the Suf refugee camp in Jordan. As a community-based initiative, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), with the support of the WHO Regional Office, introduced an integrated programme «Integrated community-based actions (ICBA)" that is currently being implemented in the camp. Under the programme, a whole month's activities are planned on raising awareness about people with disabilities. A series of 15 awareness-raising workshops will be conducted by specialists for the community on different subjects related to disability, starting from prevention and moving on to treatment, care and rehabilitation.

In addition to the awareness-raising programme, modifications are being made to 12 houses of needy families with children with physical disabilities. To ease the access of disabled persons to their homes, ramps will be installed at the entrances of the 12 houses, and four of these houses will have modified toilet facilities to suit the needs of their users.

As an initial step, an opening ceremony was organized in January 2010 by the ICBA advisory committee, which consists of representatives of various stakeholders concerned with the camp's community. At the beginning of the event the children marched down to the camp distribution centre, which will in the future be used as the ICBA information centre.

Ms Rula Z. Arar, the first female camp services officer, stated that the community was becoming increasingly independent and no longer relied on UNRWA to support its activities. Ms Rula went on to elaborate that in the past the community had depended on the camp's services to fulfil their needs, now however, they were empowered enough to handle their own events and campaigns and their assistance was even sought to implement certain UNRWA programmes.

Thanks to the community's participation and ICBA development in the Suf refugee camp area, six year-old Ubada's life has become easier. Ubada needed to be carried with his wheelchair to get in or out of his home. However, today, a new ramp has been fixed at the foot of his doorstep allowing him to move more easily.

With the change in attitude of the community a new "people-to-people" culture is in place and with time, it is also expected to spread to other camps in the Region making the lives of Palestinian refugees capacitated and empowered.

Community-based malaria control programme, YEMEN

The community-based malaria control programme is a joint collaborative intervention supported by the Ministry of Public Health and Population of Yemen, the Patient Helping Fund (Kuwait) and WHO, and is in line with the regional goal of eradicating malaria from the entire Arabian peninsula by 2019. This comprehensive multipartite malaria control project was launched in the Hajjah governorate and although the project relies on local communities to play the most crucial and decisive role, tools and strategies are available to assist them in reaching the goal of eradication.

The community-based malaria control programme builds on the experiences of the basic development needs programme and the concept of community empowerment. It is strongly believed that through this strategy desired change will be accelerated, ensuring the programme's sustainability and resulting in a more effective impact.

Two districts were selected to pilot-test the programme in the poor and underserved areas of the Hajjah governorate: Mustaba and Bani Qais. The BDN project in the Mustaba district comprises 13 villages with a total population of 6205. The district is located in the low land of the Tihama region, which is characterized by winter transmission of malaria and demographic and health characteristics similar to those of Bani Qais. The BDN project in the Bani Qais district comprises 48 villages with a total population of 20 500. The district stretches along the foothills of the Tihama region that harbours 60% of the malaria burden in Yemen. The area is characterized by a rather long malaria transmission season, inadequate coverage of health services and poor and marginalized communities that are exposed to an unregulated private sector with self-medication a common practice.

The intervention started by conducting a situational analysis by interviewing members of communities, followed by training of volunteers on the prevention of malaria, screening and referral of suspected cases, assistance in collection of blood slides and completion of patients' profiles which were then dispatched with the assistance of the village council to the nearest diagnostic facility within the project area. Volunteers were trained on follow-up of the diagnosed cases and to ensure the proper usage of the treatment advised by health facilities. In addition, the trained volunteers were actively involved in the distribution of 9900 long lasting insecticide-treated nets (LLINs) in June 2009.

Volunteers were trained on how to deal with critical cases, i.e. patients with severe symptoms of malaria, emergent situations or cases which arrived late at night in the absence of health cadres. The volunteer is authorized to access the limited stocks of rapid diagnostic tests and ACTs that are kept in the custody of the village representatives to manage the onset of such emergencies.

All the villages are clustered in groups and are linked to the nearest health facility. The staff in each facility directly supervises the work of the village representatives and volunteers through regular reports from them. The village development committees and the village representatives are required to observe closely and report immediately any malpractices.

Spraying operations (indoor residual spraying and larviciding) depend on the exclusive decision of the national malaria control programme. The staff of the national malaria control programme approached the volunteers at the village level, who are trained to screen suspected malaria cases and ensure their referral to the nearest health facility. Volunteers are able to make blood slides from the suspected cases if needed, complete the patient's information form and dispatch it to the nearest malaria diagnostic facility within the project area.

If malaria is confirmed the health facility will dispense the appropriate treatment to the patient through the volunteer, who should then advise the patient of the regimen and follow up its administration.

The national malaria control programme is responsible for the training and technical supervision of these volunteers. The spraying equipment and supplies provided by the national malaria control programme are kept in the custody of the local health authority and the local development committees. The government authorities and WHO Yemen are confident that active community involvement in this process will be much more effective and sustainable in high-burden countries and the initiative will be easily spread throughout Yemen.

Healthy walk initiative in Jaber healthy village,

Jordan improves health outcomes

Rajeb village in the Ajloun governorate is one of the 42 villages in which the healthy village programme has been implemented since 1998. The eight-member council for development is committed to improving the lives of the villagers through needs assessment, encouraging health volunteers, ensuring equity in access to services

and funding socioeconomic projects to support disadvantaged groups, including the elderly and people with disabilities and encouraging community participation in health-related activities.

The primary health care centre is leading the community into healthier lifestyles through a range of initiatives. Although the centre is understaffed for the delivery of primary health care to 5000 people, it is supported by a number of 15 female health volunteers, providing health education and supporting six health initiatives. The health initiatives include: (1) healthy walk for women; (2) health interventions for older persons; (3) physical exercise for all, including people with physical disabilities; (4) the creation of child-friendly homes; (5) the beautiful smile, anti-smoking initiative; and (6) the pure breeze for early detection of cancers. A song was composed for each theme of the programmes by the Director of the health centre in Rajeb village, Ajloun.

The healthy walking programme started about three years ago and involves about 30 women walking every day for one hour in the afternoon. A young female volunteer specialized in physical fitness trains others on a number of physical activities, in cooperation with the health centre.

The team was very impressed with the reported changes in their lifestyle, in addition to the impact on their psychosocial life. There are 30 ladies participating in the initiative, 13 were overweight or obese and 20 had diabetes or hypertension. The registry logs designed to measure changes showed that all women managed to achieve either weight loss or had at least stabilized their weight during the last three years. This initiative also includes a health education component on healthy diets and habits. All women suffering from hypertension witnessed an improvement in their health and their blood pressure is now stable and based on laboratory analysis the women who suffered from diabetes showed a decrease in blood sugar levels. The healthy villages programme has succeeded in orienting people on health issues as an important variable in economic prosperity.

Acknowledgements

The CBI programme in the Regional Office would like to extend its sincere appreciation for the contributions of the following colleagues to this issue:

Dr Jihane Tawilah, WHO Representative, Oman

Dr Yassir Turki, Medical Officer/ Community-based Initiatives, Health Directorate, UNRWA

Dr Mohsen Asadi, Iran University of Medical Sciences and Health Services, Islamic Republic of Iran

Luke Taylor-Ide, International Programme Coordinator, Future Generations

Dr Halim El Hinawi, CBI Focal Point, Ministry of Health, Oman, Dr Sana Naffa, Health System Focal Point, WHO Representative's Office Jordan

Dr Zaki Habib AlMasoud Zawaida, Director of the Health Centre, Rajeb Village, Ajloun

Dr Mustafa Kamel, Medical Officer/Roll Back Malaria, Yemen

Dr Ghulam Nabi Kazi, WHO Representative's Office, Pakistan

RÉSUMÉ

L'OMS a choisi « l'urbanisation et la santé » comme thème de la Journée mondiale de la Santé 2010, reconnaissant ainsi les conséquences globales et individuelles de l'urbanisation sur notre santé. Le slogan de cette Journée était « la santé urbaine est importante ». D'après une étude réalisée par le Bureau régional à cette occasion, il existe d'importants écarts dans l'accès aux services de santé entre les habitants des zones de logements insalubres et ceux des autres quartiers de la ville.

Le discours inaugural de la Journée mondiale de la Santé a notamment porté sur les conclusions de quatre études de cas fondées sur des bases factuelles, portant sur différentes villes de la Région : Ariana en Tunisie, la zone de bidonvilles de Baten El Bakra, au Caire en Égypte, Salé au Maroc et Rawalpindi au Pakistan. Les principaux enjeux sanitaires auxquels sont confrontées ces villes ont été détaillés. Afin d'apporter des éclaircissements sur les principaux problèmes impliqués par le thème « Urbanisation et santé », quatre sujets clés ont été choisis et présentés par des personnalités influentes originaires d'Égypte, de la République islamique d'Iran, du Maroc et du Pakistan.

À l'issue de la cérémonie, l'ensemble des personnalités, des invités et du personnel de l'OMS s'est joint aux célébrations organisées dans le jardin faisant face au Bureau régional. En collaboration avec la Société égyptienne du Croissant-Rouge, des enfants et des adolescents se sont activement impliqués dans les diverses activités favorisant une bonne santé qui étaient organisées dans ce jardin : danse, sports, activités artistiques et artisanales. Les événements de la Journée comprenaient aussi la plantation d'un arbre par le Directeur régional, pour symboliser l'importance de la promotion d'un environnement plus sain et plus vert dans nos villes.

Cette année a marqué le lancement d'un programme conjoint de l'OMS et de l'UNRWA (Office de secours et de travaux des Nations Unies pour les réfugiés de Palestine dans le Proche-Orient), intitulé « Actions communautaires intégrées ». Celui-ci vise à sensibiliser la communauté au sujet des personnes souffrant d'incapacités physiques. L'une des activités menées dans le cadre de cette initiative consistait à adapter le camp de réfugiés palestiniens Souf aux personnes souffrant d'incapacités physiques. En janvier 2010, les enfants souffrant d'incapacités physiques ont marché dans les rues du camp. Suite à la mise en œuvre du programme, des rampes d'accès ont été installées dans 12 maisons afin que l'entrée de ces enfants soit facilitée.

Téhéran a été sélectionnée pour être l'une des villes pilotes de la Région afin d'expérimenter l'outil d'évaluation et d'intervention pour l'équité en santé urbaine. L'outil a été testé dans les six domaines suivants : infrastructures physiques, développement social et humain, économie, gouvernance, santé et nutrition. L'étude a révélé l'existence d'inégalités importantes en matière de situation économique entre les districts, entraînant des résultats négatifs pour la plupart des indicateurs.

Les districts défavorisés présentaient des niveaux supérieurs d'analphabétisme et de chômage, un accès moindre à l'enseignement supérieur, aux équipements domestiques et aux ressources, ainsi que de graves problèmes de santé mentale. La taille des familles y était également plus élevée. Représentés sur des cartes, ces constats ont fait apparaître une distinction nette entre le nord et le sud de Téhéran pour presque tous les indicateurs, les habitants du nord jouissant d'un meilleur accès aux services sociaux.

Un projet de responsabilisation des femmes dans deux vallées isolées d'Afghanistan a permis de réduire la mortalité des enfants de moins de cinq ans de 46 % en deux ans. Ce projet s'est appuyé sur l'infrastructure et sur le programme d'études de l'ensemble de base des services de santé, et a eu recours aux interventions sociales, en organisant les mères en groupes d'action de femmes volontaires, pour assurer la pérennité du projet. Une base de référence de l'état de santé avant l'intervention a été créée à partir des enquêtes rétrospectives des fiches obstétricales élaborées par le Professeur Stan Becker de l'Université John Hopkins. À l'issue de deux années, en l'absence d'aide formelle, le taux de mortalité des enfants de moins de cinq ans a connu une diminution.

Le ministère de la Santé d'Oman a subi une transformation en 1990 pour réaliser d'immenses efforts de développement. Celle-ci a débuté par la décentralisation du pouvoir régional et de celui des districts. Créés en 1999, les Comités sanitaires de district (willayat) sont devenus les points focaux du programme de développement, car ils étaient notamment composés de représentants gouvernementaux intersectoriels ainsi que de représentants de la société civile et de la communauté. L'une des réalisations majeures du ministère de la Santé a été l'introduction dans ces comités des concours de projets communautaires. Le ministère de la Santé a incité les 61 districts à soutenir leurs projets lors de concours annuels. Les projets en compétition étaient examinés par une équipe d'évaluation composée d'employés du ministère de la Santé et de responsables techniques de l'UNICEF et du Fonds des Nations Unies pour la population (FNUAP). Grâce aux résultats du concours, les comités ont acquis de meilleures capacités à traiter les problèmes sociaux en adoptant les mesures qui s'imposent et en encourageant la communauté à contribuer activement à la santé et à participer au développement au plan local.

Rajeb, dans le gouvernorat d'Ajloun, est l'un des 42 villages qui met en œuvre le programme des villages-santé depuis 1998. C'est un bon exemple de participation communautaire, soutenue par un Conseil pour le développement engagé dans l'amélioration de la vie des villageois. Le centre de soins de santé primaires joue un rôle capital dans la promotion d'un mode de vie sain auprès de la communauté. Parmi les activités figure un programme de marche de santé pour les femmes. Le changement de mode de vie, notamment la perte de poids et une alimentation saine, est aussi encouragé pour réduire la gravité de l'hypertension artérielle et du diabète. Bien que le programme des villages-santé ait réussi à guider les habitants du village vers un mode de vie sain, le Conseil peine à influencer les changements et les décisions majeures, qui nécessitent une volonté politique.

Conformément à l'initiative régionale visant à éradiquer le paludisme de l'ensemble de la péninsule arabique d'ici à 2019, le ministère de la Santé publique et de la Population du Yémen, le *Patients Helping Fund* [Fonds d'aide aux patients] du Koweït et l'OMS ont créé dans le gouvernorat d'Hajjah un programme multipartite complet de lutte contre le paludisme, engageant les communautés locales à tous les niveaux. Celui-ci tire profit de l'expérience acquise au sein du programme des besoins fondamentaux en matière de développement et utilise le concept d'autonomisation communautaire. Deux sites du programme des besoins fondamentaux en matière de développement, Mustaba et Bani Qasi,

ont été choisis pour réaliser ce projet pilote. Les volontaires ont été formés à la prise en charge des cas suspects de paludisme comme des cas chroniques. Ils ont aussi été autorisés à utiliser les stocks limités de tests diagnostiques rapides et d'associations médicamenteuses comportant de l'artémisinine pendant les situations d'urgence en l'absence de cadres de santé. Le programme national de lutte contre le paludisme est responsable des opérations de pulvérisation d'insecticide, de la formation et de la supervision technique des volontaires. Les responsables gouvernementaux et l'OMS ont la certitude que l'implication communautaire active sera efficace et durable, et pourra être étendue à tout le Yémen ainsi que dans tous les pays fortement touchés.

Asha est une jeune veuve de 35 ans vivant avec ses huit enfants sous un même toit, dans le village de Darawien, en Somalie. Fournissant à elle seule l'ensemble des revenus de la famille, Asha lutte pour subvenir aux besoins de tous en élevant du bétail. Comme dans de nombreux villages, les hommes dirigent les activités villageoises, tandis que les femmes restent à la maison pour s'occuper de la famille. Mais Asha désirait vivement connaître le programme des besoins fondamentaux en matière de développement : elle est donc devenue le premier membre féminin du comité de développement du village. Elle est fière d'affirmer que le programme a représenté un tournant dans sa vie, car il lui a permis de comprendre que l'élevage ne suffirait pas à nourrir sa famille. Après de longues discussions avec ses amis et sa famille, elle a pris la difficile décision d'ouvrir un petit commerce. Encouragée par son implication dans le comité de développement du village, Asha a aussi suivi des cours d'alphabétisation et organisé la première association de groupes de femmes dans son village.

الموجـز

اختارت منظمة الصحة العالمية موضوع «التحضر والصحة» للاحتفال بيوم الصحة العالمي، اعترافاً منها بأثر التحضُّر على صحتنا الجماعية على نطاق العالم وعلى صحة كل فرد. ودارت احتفالات يوم الصحة العالمي لعام 2010 حول شعار «لصحة المدن ألف وزن». وقد أشارت دراسة أجراها المكتب الإقليمي بمناسبة الاحتفال بيوم الصحة العالمي، إلى وجود تفاوت كبير في الحصول على الخدمات الصحية بين الأفراد الذين يقطنون في المناطق العشوائية وأولئك الذين يسكنون المدن.

وقد عُرِضَت خلال الكلمة الافتتاحية لاحتفالية يوم الصحة العالمي، نتائج دراسات حالة مُسْنَدَة بالبيِّنات لأربعة من بلدان الإقليم، هي: أريانا في تونس، وبطن البقر بالقاهرة، وسلا بالمغرب، وراولبيندي بباكستان. وتمّ دراسة التحديات الصحية الكبرى التي واجهت مسيرة العمل في المدن الأربعة. ولمزيد من الإيضاح حول المشكلات الرئيسية التي أثيرت عند طرح موضوع «الصحة والتحضُّر»، اختيرت أربع قضايا رئيسية لكي يتحدَّث عنها عدد من كبار المدعوين من باكستان، وجمهورية إيران الإسلامية، ومصر والمغرب.

وعقب الاحتفالية، شارك كبار الحضور والعاملون بمنظمة الصحة العالمية في الاحتفالات التي أقيمت بالحديقة المواجهة للمكتب الإقليمي. وشهدت هذه الاحتفالات، التي أقيمت بالتعاون مع جمعية الهلال الأحمر المصرية، مشاركة فعالة من الأطفال والشباب في مختلف الأنشطة الصحية التي أقيمت في الحديقة، من رقص، وأنشطة رياضية، وأعمال يدوية وفنية. وشهدت الفعاليات كذلك قيام المدير الإقليمي بزراعة شجرة لتجسد أهمية تشجيع بيئة خضراء وأكثر صحة في المدن التي نعيش بها.

شهد هذا العام البدء في تنفيذ برنامج مشترك بين منظمة الصحة العالمية ووكالة الأمم المتحدة لإغاثة وتشغيل اللاجئين الفلسطينيين في الشرق الأدنى (الأونروا) تحت عنوان «الإجراءات المجتمعية المتكاملة». ويهدف البرنامج إلى رفع مستوى الوعي المجتمعي حول المعاقين بدنياً. وتمثل أحد الأنشطة التي أجريت بمعسكر «سوف» في إطار هذه المبادرة في جعل معسكرات اللاجئين الفلسطينيين مراعية للمعاقين. كما نظم الأطفال المعاقون، خلال شهر كانون الثاني/يناير 2010، مسيرة في معسكرات اللاجئين الفلسطينيين. وكان من بين النتائج التي أثمر عنها البرنامج إنشاء منحدرات على مداخل 12 منزلاً من أجل تسهيل حركة الأطفال المعاقين بدنياً من منازلهم وإليها.

اختيرت طهران كواحدة من مدن إقليم شرق المتوسط لتجربة استخدام أداة تقييم العدالة الصحية في الحضر والاستجابة لها (القلب الحضري) على سبيل الارتياد. وقد تبنّت هذه الأداة ستة مجالات هي: البنية الأساسية، والتنمية البشرية والاجتماعية، والاقتصاد، والحَوْكَمَة، والصحة، والتغذية. وأفادت نتائج الدراسة عن وجود عدد من أوجه الـجَوْر وعدم المساواة بين مختلف أحياء المدينة من حيث الوضع الاقتصادي، وهو ما انعكس سلباً على أغلب المؤشِّرات. فقد أظهرت الأحياء المحرومة معدلات أعلى من الأمية، والبطالة، وانخفاض فرص الالتحاق بالتعليم العالي، والمشكلات الصحية النفسية الوخيمة، وقلة فرص استخدام المرافق والممتلكات، فضلاً عن زيادة حجم الأسَر بها. وقد أعدَّت خريطة بنتائج الدراسة، مع رسم توضيحي فاصل بين شمال طهران وجنوبها، من حيث جميع المؤشرات تقريباً، حيث ثبت أن سكان الشمال يتمتعون بفرص أعلى في الحصول على الخدمات الاجتماعية.

نجح أحد مشروعات تمكين المرأة، المنفَّذة في اثنين من الوديان الأفغانية النائية، في تقليص معدَّل وفيات الأطفال تحت سن الخامسة بنسبة 46% خلال عامين. وقد استخدَم المشروع البنية الأساسية والمناهج الدراسية القائمة لحزمة الخدمات الصحية الأساسية، بالإضافة إلى الاستفادة من التدخلات الاجتماعية من خلال استخدام الأمهات في فرَق العمل النسائية التطوعية، ومن ثَمَّ ضمان استمرارية المشروع. واستناداً إلى المسوحات الاسترجاعية بشأن تاريخ الحمل التي أجراها البروفسور ستان بيكر بجامعة جون هوبكينز، تم تحديد خطط الأساس للوضع الصحي قبل التدخل، وفي نهاية العامين اللذين غابت فيهما المساعدة الرسمية اتضح تقلص معدل وفيات الأطفال دون سن الخامسة.

شهدت وزارة الصحة العُمانية تحوُّلاً مهماً في عام 1990 لتنفيذ جهود هائلة ترمي إلى دفع عجلة التنمية، وهي الجهود التي بدأت بعملية لامركزية في سلطات الأقاليم والولايات. وعقب إنشاء لجان الصحة بالولايات في عام 1999، أصبحت هذه اللجان نقاط الاتصال في برنامج التنمية، حيث كان من بين أعضائها ممثلون لمختلف القطاعات الحكومية والمجتمع المدني والمجتمع المحلي. وجاءت على رأس الإنجازات الكبرى التي أدخلتها وزارة الصحة إلى المجتمع، مسابقة المشروعات، حيث قامت وزارة الصحة بتشجيع الإحدى والستين ولاية على ضمان استمرار مشروعاتهم من خلال إقامة مسابقات سنوية، بحيث تخضع المشروعات المتنافسة إلى المراجعة من قِبَل فريق تقييم يتألف من ممثلي وزارة الصحة ومسؤولين تقنيين من اليونيسيف، وصندوق الأمم المتحدة للسكان. وانطلاقاً من النتائج التي أسفرت عنها المسابقة، تمكنت اللجان من مواجهة المشكلات الاجتماعية عن طريق اتخاذ الإجراءات الملائمة وتشجيع المشاركة المجتمعية الفعَّالة في الصحة والتنمية على الصعيد المحلي.

تُعَد قرية راجب في محافظة عجلون من بين القرى الاثنين والأربعين التي نفذت برنامج القرية الصحية منذ عام 1998. وتقدِّم قرية راجب نموذجا جيداً للمشاركة المجتمعية، يدعمها في ذلك مجلس التنمية وقد أخذ على عاتقه الالتزام بتحسين حياة أهالي القرية. وفي هذا الإطار، يلعب مركز الرعاية الصحية الأولية دوراً حيوياً في تشجيع المجتمع على أن يحيا حياة صحية. وقد اشتملت الأنشطة التي جَرَت خلال البرنامج على ما يلي: برنامج المشي الصحي للسيدات وتشجيع التغيير في نمط الحياة من أجل التخفيف من حدة أمراض ارتفاع ضغط الدم والسكري من خلال التشجيع على إنقاص الوزن والتغذية الصحية. وبرغم نجاح تنفيذ برنامج القرى الصحية في توجيه الأفراد نحو نمط حياة صحي، واجهت المجالس عدداً من التحدِّيات في فرض التغييرات الكبرى والقرارات المهمة التي تتطلب توافر الإرادة السياسية.

تماشياً مع المبادرة الإقليمية للقضاء على الملاريا في شبه الجزيرة العربية قاطبة بحلول عام 2019، أطلقت وزارة الصحة والسكان في الجمهورية اليمنية، وصندوق مساعدة المرضى الكويتي، ومنظمة الصحة العالمية، برنامجاً شاملا متعدِّد الأجزاء لمكافحة الملاريا، يتضمَّن مشاركة المجتمعات المحلية على جميع أصعدة المشروع في محافظة حجة. وينطلق برنامج القضاء على الملاريا من التجارب التي شهدها برنامج الاحتياجات الإنمائية الأساسية، ويستخدم مفهوم تمكين المجتمع، حيث اختير اثنان من مواقع برنامج الاحتياجات الإنمائية الأساسية لإجراء هذا المشروع التجريبي، وهما موصطابة وبني قيس. وقد تم تدريب المتطوعين على كيفية التعامل مع حالات الإصابة بالملاريا بدءاً من حالات الاشتباه وحتى الحالات المزمنة. كما سُمح للمتطوعين باستخدام المخزون المحدود من اختبارات التشخيص السريع والمعالجات المُرْتَكزة على الأرتيميسنين خلال حالات الطوارئ في غياب كوادر الرعاية الصحية. ويتحمَّل البرنامج الوطني لمكافحة الملاريا مسؤولية عمليات الرش والتدريب والإشراف التقني على المتطوعين. والسلطات الحكومية ومنظمة الصحة العالمية كلها ثقة بأن المشاركة المجتمعية الفعالة سوف تكون مؤثِّرة ومستمرة وقابلة لأن تُطَبَّق في شتى أنحاء الجمهورية اليمنية وفي جميع البلدان التي ترزح تحت وطأة الأعباء.

آشا، هي أرملة تبلغ من العمر خمسة وثلاثين عاماً ولديها ثمانية أطفال، يعيشون جميعاً تحت سقف بيت واحد صغير في قرية داراوين بالصومال. ولما كانت آشا هي المعيلة الوحيدة لأسرتها، كان عليها أن تكافح من أجل توفير سُبُل العيش لأولادها، وقد اهتدت في سبيل تحقيق ذلك إلى تربية الماشية. ولكن كما هو الحال في الكثير من القرى، يمسك الرجل بزمام الأمور في القرية، في حين إن المرأة مكانها هو البيت لخدمة الأسرة وتلبية احتياجاتها. غير أن آشا كانت تتوق لتعلم المزيد عن المفهوم الذي يقوم عليه برنامج الاحتياجات الإنمائية الأساسية، وأن تصبح أول سيدة بين أعضاء لجنة تنمية القرية. وهو ما جعلها تشعر بالفخر إذْ تقول إن البرنامج كان بمثابة نقطة تحوُّل في حياتها عندما جعلها تدرك أن تربية الحيوانات كمصدر وحيد لدخل الأسرة لم يكن كافياً، وبعد مناقشات طويلة مع أصدقائها وأفراد أسرتها، قرَّرت أن تأخذ القرار الصعب وأن تفتح محلاً صغيراً. ودأبت آشا كذلك، مدفوعة بمشاركتها في لجنة تنمية القرية، على حضور فصول محو الأمية وقامت بتنظيم اتحاد للجماعات النسائية في قريتها.

World Health Organization

Regional Office for the Eastern Mediterranean

For further information contact:

Community-based initiatives
World Health Organization
Regional Office for the Eastern Mediterranean
Abdel Razzak Al Sanhoury Street,
PO 7608 Nasr City,
Cairo, Egypt
Telephone: 00-202-2276-5000
Facsimile: 00-202-2670-2492/4
e-mail:CBI@emro.who.int
web site: http://www.emro.who.int/cbi

“ Write to us at: CBI@emro.who.int”