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Newsletter

Interview with Dr Mohammad Abdurrab, WHO Representative in Sudan

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Based on your vast experience in health system research at the country and regional level and recognizing community-based initiatives (CBI) as a tool for community research, how could CBI have an input into generating knowledge for health system policy improvement?

The goal of health and health-related research is to improve the quality of life of communities. Traditionally, communities help researchers to select subjects for research and facilitate their mission at field level. However, communities have been excluded from being involved as partners in research, in spite of the fact that they have a central role to play in research design, implementation, the dissemination of results and their utilization for interventions. Luckily, the world is now moving towards community-based participatory research. The initiatives demonstrate perfectly the concept of community-based participatory research through baseline surveys.

Baseline surveys are a prerequisite for the initiation of programme interventions in any area as they provide decision-makers with the information needed for future interventions and for the identification of priority needs. Baseline surveys are designed to reflect the main development indicators that assist in the planning, monitoring and evaluation of planned interventions. Examples are indicators on social service provision including health, such as the number of health facilities in the area, the type and quality of service provided and information on human resources for health. In addition, service utilization indicators such as the number of pregnant women visiting facilities for antenatal care, vaccinated children, growth-monitoring, as well as the prevalence of main health problems are also assessed.

The process of conducting baseline surveys demonstrates partnership for research, where cluster representatives and community development committees are trained by a multidisciplinary technical team from the locality (district) and State authorities on the objectives of the survey, data collection, implementation, and analysis and interpretation of results. Through this

Dr Mohammad Abdurrab, WHO Representative in Sudan

systematic process, communities develop what they call an area profile. This profile is the source of many indicators and provides knowledge on the community that will lead to policy improvement. There are good examples in many villages in Sudan implementing the initiatives: Oum Saygaon, Dar Mali, Neiama, etc., where the rehabilitation of health facilities, including equipping them with human resources and supplies, conducting malaria campaigns, distributing bednets, conducting cleaning campaigns and implementing child health communication programmes are carried out by the communities as a result of the small-scale research and investigation undertaken by themselves.

How can CBI in Sudan boost public health programmes?

Two of the main gaps identified in primary health care are the lack of community participation and intersectoral collaboration. Primary health care at the community level must ensure the establishment of an accessible health facility, provide community health promoters, introduce community development structures, such as community development committees and cluster representatives, and initiate intersectoral coordination, especially for water and sanitation, housing, agriculture and economic development projects, etc.

The CBI programme provides a process whereby communities play an active role and multisectoral government provides support for sustainable health development. As one of the tools for sustainable development, the CBI programme improves the quality of life by promoting health, preventing diseases and creating new business to strengthen the economy of communities, which in turn reflects positively on their health.

In Sudan, voluntarism, social solidarity and cohesion, which are embedded in the culture of Sudanese communities, provides a platform for support to public health programmes through collective response and partnership at the community level. Communities are organized by the selection of cluster representatives who are responsible for a given number of houses and are supported by community development committees and the government sectors. The initiatives, in essence, translate into the Alma-Ata principles of primary health care and public health. I would like to add the experience of strengthening the community component of the Integrated Management of Childhood Illnesses (IMCI) programme in CBI areas, the promotion of bednets in south Kordofan and Dar Mali, and the safe water supply in north Kordofan. Social projects implemented by communities with the help of related sectors such as electricity projects in Neima in White Nile and Kamil Nomak in Gezira State are important for public health programmes.

How can the Federal Ministry of Health in Sudan expand the CBI concept and approach through the development of partnerships?

Any Ministry of Health that wants to achieve the ultimate goal of health for all through partnership provided by CBI can achieve that goal. The Comprehensive Peace Agreement signed in 2005 by both the Government of National Unity and the Government of south Sudan provides a unique opportunity for extending partnership to scale-up the initiatives in Sudan. Almost all development sectors United Nations (UN) agencies and community-based organizations are engaged in community development programmes using same modalities for CBI implementation. The Federal Ministry of Health in Sudan can significantly contribute towards community development through developing policies, and enhancing advocacy and coordinated partnership-building. It should focus on developing the capacities of implementing sectors and community-based organizations through training, assistance in planning and through monitoring implementation. This would require that the Ministry of Health at Federal, State and local levels strengthens its programme management and leadership through hiring and placement of qualified and experienced staff. Effective leadership in this area is key for developing productive partnerships. The leadership should also establish a memoranda of understanding with clear plans and projects.

The Federal Ministry of Health in collaboration with WHO is in the process of establishing a training centre in Shendi University for community leadership and reintegration targeting senior and mid-level community development programme managers and coordinators from line ministries, community-based organizations and UN agencies.

Sudan has a long experience of implementing the basic development needs (BDN) programme although facing various health-related problems including emergencies and instability in the south and other areas. How can the initiatives provide support in this challenging environment?

A community is a group of people sharing common values, interests and identity. The same holds true in

emergency situations; people live in communities, for example, in camps for internally-displaced people (IDP) in which they share the same space and the same difficult circumstances. When peace and stability ensue, they are able to return back to their original homes and need assistance in rehabilitation, recovery and development. Community collective work and social capital is key to the reintegration and recovery of such populations.

It may be difficult to implement all CBI processes in the early stages of an emergency, but it is necessary to be creative in order to bring people together to start thinking of their needs, such as food rations or cleaning their camp. Community volunteers could be trained as health promoters on key family practices with emphasis on maternal and child health, HIV/AIDS and STIs as well as on counselling, especially for women having experienced rape and gender-based violence. They can also help in assessing situations in affected communities to allow decision-makers to prioritize urgent needs and undertake appropriate and rapid interventions.

To facilitate this process it is crucial to organize the community in clusters and to create decision-making bodies during the rehabilitation and recovery phases

during which the need for development becomes urgent. Partnership with communities at this phase will build trust and the confidence necessary for social integration following a period of dependency on humanitarian assistance.

In fact, this is exactly what is taking place with sister UN agencies, such as the United Nations Children's Fund (UNICEF), the Food and Agriculture Organization of the United Nations (FAO) and the United Nations Development Programme (UNDP) through the integrated community recovery and development (ICRD) project being implemented in south Kordofan.

Training for BDN teachers of literacy in Egypt

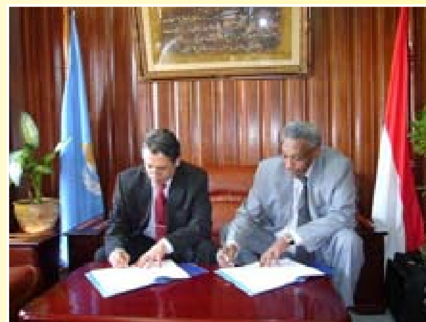
In an effort to enhance the impact of the literacy classes conducted in BDN communities in Old Cairo, El Marg and Nag Al Arab, the Health Information and Telecommunication Unit (HIT) of WHO Regional Office for the Eastern Mediterranean, in collaboration with the WHO Representative's Office, Egypt, initiated the use of computers as a medium for conducting literacy classes. A literacy CD-ROM, developed by the Ministry of Communication and Information Technology in partnership with UNDP, was introduced during a three-day training course which took place in September 2007. Nine of the

BDN literacy teachers (seven of whom were women) participated in this training activity. After an overview of how to use the computer, the teachers were taught how to navigate through the CD-ROM.

At the end of the course, the trainees were at a point whereby they could begin teaching community members this new tool. After completion of the training sessions, each trainee was given a CD-ROM to take back to their communities. Trainees were requested to complete a questionnaire to assess the course, and their feedback and opinions on the sessions were documented. Generally, participants felt positively about the training sessions and were confident that their respective communities would welcome the change. They also requested more training sessions to better master the basics of how to use the computer.

Accordingly a 15-day basic computer training course was organized in September 2007, in order to familiarize them with basic computer applications especially as they would need to be aware of this when documenting their community's achievements and obstacles in order to further empower themselves.

Project collaboration agreement in Yemen



On Wednesday, 21 November 2007, Dr Ghulam Popal, WHO Representative in Yemen, signed a project collaboration agreement with Dr Elkheir K. Khalid, representing the Arab Authority for Agricultural Investment and Development (AAAID). Under this collaborative agreement, the BDN programme will be expanded to Socotra Island.

The total amount obligated under the agreement, for BDN-related activities in Socotra Island, is US$ 167 800, US$ 150 000 of which is AAAID's contribution and the remainder WHO's. Project implementation and supervision will be managed by WHO.

Copies of the mutually-signed project collaboration agreements were exchanged in a friendly atmosphere and both parties anticipate the successful implementation of the project and the continuation of such collaboration in the future.

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Health for All or Hell for All?

The role of leadership in health equity

Recognizing the central role that community members can play in reaching underprivileged populations; WHO Regional Office for South-East Asia arranged a regional meeting on revisiting the roles of community-based health workers and community health volunteers, from 3 to 5 October 2007, in Chiang Mai, Thailand. The meeting was attended by representatives of ministries of health, nongovernmental organizations, UN agencies and academic institutes from Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand. During the meeting, Dr Halfdan T. Mahler, WHO Director-General (Emeritus), gave a speech addressing the role of leadership in health equity, entitled "Health for All or Hell for All?"

"... I am convinced that health is politics and that politics is health as if all people truly mattered. I am, therefore, also convinced that political action for health, locally and globally, requires moral and intellectual stimulation.

I am furthermore morally and intellectually convinced that the health for all vision and primary health care strategy provide significant starting forces and added impetus for health development all over the world. Such development is based on the principle that those who have little in health and wealth will generate much more for themselves, and those who have much will have no less, but will have it with a better social conscience.

I see startling patterns of inequities in the health scores throughout our miserable world. I am not talking about a first, or second, or third, or fourth world—I am talking about ONE WORLD—the only one we have got to share and care for.

I have always maintained that people's own creativity and ingenuity are the keys to their and the world's progress. People's apathy can turn development dreams into stagnating nightmares. The transformation of social apathy into social and economic productivity is the point of embarkation of all sustainable and cumulatively growing human development. And an adequate level of health is a basic ingredient that fuels this transformation. What the billions of people throughout the developing world need and want is what everyone, everywhere needs and wants: the well-being of those they love; a better future for their children; an end to gross injustice; and a beginning of hope. So, development is about the creation and expansion of opportunities for human beings to realize what they consider to be their positive destiny.

Equity, especially in ensuring essential health and socioeconomic care, and particularly as it relates to vulnerable groups such as the poor, children, women, the elderly and people with physical disabilities remain for me a primordial objective of all development. Indeed, I consider equity a moral imperative to which all social and economic activities must be subsumed. I do believe that a greater degree of equity, to assure a more just and reasonable equality of health opportunity, is an absolute necessity for the preservation of a sane local and global humanity. Let us not forget that there are still thousands of millions of humans caught in the absolute poverty trap—a condition of life so characterized by malnutrition, illiteracy and ill-health as to be beneath any definition of human decency.

It has been said that leaders have a significant role in creating the state of mind that is the society. They can express the values that hold the society together. They can bring to consciousness the society's sense of its own needs, values and purposes. And let us not forget that visionaries have always been the true realists of humankind's society.

It is my firm personal conviction that leadership is nothing if it is not linked to the collective purposes of the society. The effectiveness of the leaders must be gauged, not by their charisma, or their visibility, or the so-called power they hold, but by the actual social change they create, measured by the satisfaction of human needs and expectations.

The vision of a commitment to remove social inequities can not be introduced as a one-shot piece of magic. It must be introduced time after time. It must be incorporated into the political system and supported through strategic and decision-making processes. It must be reinforced continuously through the diligent pursuit of facts and the fearless exposure of the facts that cry out for social justice.

The World Health Assembly decided in 1977 that the main social target of governments and WHO in the coming decades should be the attainment of a strategy known locally and globally as Health for All. And the World Health Assembly described that as a level of health that would permit all the people of the world to lead socially and economically satisfying and productive lives. This morally binding contract of health for all was the basis of the primary health care strategy which implied a commitment not only to a reorientation of the conventional health care systems —which rather should be called "medical repair system"—but to a shift towards people's own control over their health and well-being to the extent that they would be willing to handle profound social reforms in health. This implies a continuous empowerment process whereby people acquire the skill and will

to become the social carriers of their own health and well-being.

Therefore, I do believe that the fundamental values of social justice and equity are firmly embedded in the vision of health for all and the strategy of primary health care. And this vision and strategy can indeed be a strong force and leading edge for achieving social justice and equity. Health may not be everything, but without health, there is very little to well-being. The question is often asked, "Can we afford the cost of social justice and equity?" I would propose a counter question, "Can we afford the cost of social and economic destabilization inherent in today's pursuit of profit-maximization?" The costs generated through the creation of a just and equitable health care system may indeed cause some economic turbulence. But equitable cost containment can be introduced and resources can be reallocated. Just and fiscal responsibilities do not have to be incompatible. They will be only so if there is a breakdown of political nerve.

Health for all leadership—locally and globally—is moved by a vision which cannot tolerate the unacceptable inequities of life, and which has faith in the potential of people, in their inherent ability to develop and to take responsibility for their own destiny.

I do believe that leaders are there who are willing to take up these challenges. They are those in leading political positions, who can emphasize social values and be politically sensitive to them, who feel strongly about equity issues, and who can find ways to motivate and mobilize others. They are the leaders in communities able to take up the cause of justice and equity more strongly, prepared to adjust their own traditional values and approaches and willing to take risks. They are the leaders of thousands of civil society organizations at local and global levels already fighting for equity in health. They are the leaders in educational and scientific institutions able to visualize the scope for improving human conditions, and thus willing to focus their intellectual energies accordingly and also willing to motivate future generations towards social values promoting equity. Last, but not least, they are potentially among the leaders of all the world's religions willing to add the spiritual dimension in the fight for justice and equity.

Those who are fighting for social justice and equity must be even more than ready to look, listen, probe and to learn; must be brave enough to fearlessly evaluate progress or lack of progress in abating inequities. Only by highlighting inequities is it possible to redress them. This struggle for equity can often be frustrating since development knows no limits. The more you move along its road the more you want to move. You can not blame people if they strive to join up with those who are further along the road than they are. That is only human nature. Injustices, however, have to be seen through the eyes of those who are farthest behind on that road. But, we must not let the injustices take over."

Voice of the community: The success of community public transportation in Al Mandhar village, Yemen

Hassan Jaber Kamel a 49-year-old mini-bus driver, resides with his wife and two children in Al Mandhar, a coastal village with a population of 2620 located 7 km south of the city of Hodeidah in the Hodeidah governorate. Before implementation of the BDN programme in Al Mandhar village in early 2000, Hassan, as many of his fellow villagers, used to walk to Hodeidah in search of work as a daily wage labourer.

One of the priority needs identified by the community was the lack of public transportation, as no means of public transportation existed between the village and the city. In order to address the transportation needs of the village, Hassan applied for a BDN loan to purchase a mini-bus. His proposal was to establish a mini-bus project to provide commuting services for patients who may need emergency medical attention (i.e. complicated deliveries, burns, fractures, stroke, etc.) to hospitals in Hodeidah. He also agreed to transport, at half cost, health staff and education officials who visited the village from the city.

Hassan received a BDN loan for a mini-bus in November 2000. Through his business Hassan earned a good livelihood and also met the dire needs of his fellow villagers. By November 2003, Hassan had repaid the entire loan over 36 instalments.

Hassan also regularly contributes a small amount of his income (an equivalent of US$ 10 per month) to the village development fund. As a result of this positive initiative other villagers were encouraged to follow his example and now there are 16 vehicles (mini-buses) providing public transportation services running between the village and the city.

Hassan and the entire village are grateful to the BDN project and WHO for its support in the development of the underprivileged areas. He also, jokingly, added "but I am leading the development of the transportation sector".

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The primary health care strategy and lessons learnt

Dr Amorn Nondasuta, President of the Foundation for Quality of Life, Chiang Mai, Thailand, is one of the most experienced public health planners and managers and participated in introducing the basic minimum needs (BMN) programme in Somalia in 1988. In his presentation during the regional meeting on revisiting the roles of community-based health workers and community health volunteers, in Chiang Mai, Thailand, from 3 to 5 October 2007, Dr Nondasuta presented an interesting list of do's and don'ts to be considered while implementing community-based health programmes (Table 1).

The list is based on the vast experience he gained from the village health volunteer initiative in Thailand. The list is extremely useful during planning, implementation and management processes related to community involvement in health development. The CBI Unit in the Regional Office would like to share it in this edition of the newsletter and take the opportunity to thank Dr Nondasuta for his contribution in initiating the BMN programme in Somalia.

Table 1. Do's and don'ts for the implementation of community-based health programmes

Do	Don't
Develop a good understanding of the concept of the community health volunteer system.	Provide salaries to health volunteers.
Base and develop the community health worker programme on local culture and tradition.	Consider community health volunteers as subordinates to government.
Offer non-monetary incentives.	Relieve government workers of all responsibility and expect that health volunteers can do everything.
Be clear on what is to be accomplished by community health workers as they are only part of the strategic management system.	Burden community health volunteers with official reports and records.
Recognise that community health workers are an instrument to change people's attitudes and behaviours and strive for programme innovations.	Develop the village health worker initiative as a stand-alone programme (ensure at least that some sort of financing scheme and community organization are in place).
Encourage comprehensive quality of life development. Community health volunteers may be asked by different development sectors to assist in other fields of development.	Take community health volunteers for granted.
Establish a direct line of communication with community health volunteers.	Rely on a single channel of communication (use all available methods).
Expect to need a critical number of community health volunteers before tangible results can be expected.	Recruit community health volunteers by appointment.
Put more emphasis on process rather than outputs. A set of process indicators for measurement is needed.	Forget the importance of ongoing educational support for community health volunteers.
Develop problem-specific process outlines and indicators to guide programme activities.	Encourage the use of community health volunteers for political gains.

"Stand Up and Speak Out" against poverty

The Millennium Campaign, in collaboration with a range of civil society organizations, faith-based groups and social movements, including the Global Call to Action Against Poverty and the Guinness World Records, organized a global Stand Up and Speak Out campaign on 16 and 17 October 2007, on the occasion of World Food Day and the International Day for the Eradication of Poverty, respectively.

Dr Khalif Bile, the WHO Representative in Pakistan, in the capacity of acting

UN Resident Coordinator, attended an event organized by the UN in Pakistan in collaboration with the Roots School System in Islamabad where hundreds of teachers, students and staff physically stood up to express their solidarity with the poor. On the occasion, Dr Bile reiterated the commitment of the UN to end hunger and poverty.

A similar event was organized in WHO Pakistan country office in Islamabad where a total of 65 staff members stood up against poverty. A WHO staff member on behalf of all the staff pledged to continue their efforts to end poverty and build support for achieving the targets of the Millennium Development Goals (MDGs).

On October 17, 2007, and to celebrate the same occasion in Jordan, WHO staff joined the global effort against hunger. Dr Hashim El-Zein, the WHO Representative in Jordan, delivered the UN Secretary-General, Ban Ki-moon's speech and spoke about the role of WHO in combating world hunger.

Field visit of WHO Directors of Finance to Settat village, Morocco

Upon the request of Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, the WHO Representative in Morocco, the Director of Finance and the Regional Adviser for CBI in the Regional Office, organized a field visit on 2 November 2007 to the village of Settat to share this community development experience. It was also an opportunity for the Directors of Administration and Finance from all Regional Offices and other senior WHO headquarters staff, who were attending the annual meeting of Directors of Finance in Marrakech, to witness at firsthand this success story.

A delegate from the provincial health department in the Ministry of Health shed light on the project's history, 2001–2002 baseline indicators and the achievements made to date.

In the Representative for Morocco's welcome speech he also highlighted the opportunities that had been created by the programme for the poor to have access to primary health care services and how it had improved their quality of life.

A representative of the local community development committee highlighted the achievements made during the past 4 years of BDN implementation in their region. Furthermore, the guests paid visits to the health centre, some of the income-generating projects and met with local community representatives, in addition to women beneficiaries and partners. Projects that have been predominantly successful in the district were road-building, access to a safe drinking-water supply and animal farming.

The visitors were very impressed with the approach. They also acknowledged that the underlying success of the programme was in its very low cost implications for WHO, the Ministry of Health and the community. This methodology resulted in greatly improved health status and community participation.

After the field visit the group attended a presentation on the methodology used for granting loans. The presentation highlighted the fact that eligible individuals were pre-trained prior to being awarded their loans. The loans are kept in a revolving fund to be accessible to the poorer and needier members of the community. As an indicator of success, loans are no longer covered in the WHO country workplan, but are completely borne by the community with loans contributing to capacity-building of the community and expansion of the scheme to other regions. The group also paid a visit to the women's committee to show support for their achievements. CBI would like to congratulate the Ministry of Health and the WHO Representative in Morocco for organizing this field visit. We believe that the programme in Morocco has reached a point where it is able to convince people in administration and finance of its sustainability and cost–effectiveness.

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The healthy village programme in the Syrian Arab Republic

Visit of Mohamed Saeed Aqeel, the Governor of the rural Damascus Governorate to Alsehl healthy village programme

Taking the initiative from WHO, the Ministry of Health in the Syrian Arab Republic adopted the healthy village programme in 1996 and implemented the programme in the three villages of Akraba, Alkafreen and Bir-Ajam in rural Damascus, Daraa and Alqunaitera governorates. After showing demonstrable success in these model areas, the approach was gradually extended to other governorates. Currently, the programme is being implemented in 615 villages in 13 governorates.

The programme is on the Government's agenda both at national and governorate levels and has been widely accredited. In 2001, after visiting several healthy villages, H.E. Asma Assad, First Lady of the Syrian Arab Republic, further valued the concept and established a national nongovernmental organization called the Fund for Integrated Rural Development (FIRDOS) to support rural and underprivileged communities in the country.

The programme is managed by the healthy village directorate under the Ministry of Health. Within the health directorate at governorate level, there is a healthy village department, in addition to an intersectoral technical support team led by the governor composed of representatives from several governmental sectors. Each programme area has a village development committee and various subcommittees, known as specialist committees, who deal with projects related to health, culture, social issues, sanitation, water, income-generating projects, etc. and who work in close collaboration with the village development committees. Cluster representatives are generally female and are the most active component of the programme.

The programme is at different stages of development in different programme areas. Some villages have met most of their basic and priority needs, some are in the process of development, while others face serious problems as a result of their geographical distance from headquarters or due to the lack of community mobilization.

Health development has remained the main focus of the programme in the Syrian Arab Republic. The programme has succeeded in carrying out the following interventions in different areas according to local needs:

- strengthened health facilities and primary health care programme;
- implementation of the Integrated Management of Childhood Illnesses (IMCI) programme;
- support for the immunization programme;
- improved reproductive health;
- promotion of healthy lifestyles, nutrition and breastfeeding practices;
- implementation of health education and no-smoking campaigns.

It is worth mentioning that UNICEF and WHO are supporting the community school programme, early childhood development, child-friendly homes and other community initiatives. Other social development activities were carried out in order to assess community needs and to improve the quality of life of the community, including:

- developing infrastructure for basic amenities as part of the national policy;
- conducting adult literacy classes, supporting basic education and encouraging school enrolment;
- promoting the introduction of appropriate technologies;
- conducting vocational training and skills development;
- promoting cultural activities and youth development;
- conducting women's empowerment activities.

Economic development was carried out through micro-credit schemes as complementary to other social and health interventions. WHO, FIRDOS, the Agha Khan Development Network (AKDN) and other partners provided loans to communities for livestock and dairy development, agriculture and fruit trees, small trades and skilled professions, especially to women to purchase knitting machines for income generation. AKDN provided loans amounting to US$ 7 160 700 for the programme in two governorates, which in turn, created 6689 job opportunities; with a 100% of loans reimbursed. WHO also provided an amount of US$ 370 000 for income-generating projects which

Training of the village development committee and cluster representatives on early childhood development

created 450 job opportunities; and loans were reimbursed at a rate of 98.3%.

The programme has succeeded in building partnerships with international agencies, stationed in the Syrian Arab Republic, namely UNICEF, UNDP, United Nations Population Fund (UNFPA), the European Union (EU), and the AKDN. Similarly at local level, collaboration between national nongovernmental organizations, i.e. FIRDOS and the Women's Union has been significantly strengthened.

The programme has made efforts in holistic development through numerous multisectoral interventions.

Programme-assisted activities have helped to improve social and health indicators. The external evaluation of the programme in 2005 shows certain levels of maturity in some areas: the adult literacy rate has improved from 70% to 93%, access to safe drinking-water has increased from 76% to 98%, and the number of the population with access to adequate excreta disposal facilities from 65% to 92%. The immunization of children under 1 year of age has improved from 79% to 100%, and tetanus toxoid vaccination of mothers has increased from 58% to 92%. There has been a reduction in the incidences of acute respiratory infections, diarrhoeal diseases and cutaneous leishmaniasis from 31%, 19% and 3% to 12%, 6% and 1%, respectively.

Information centres have been established where most healthy villages are equipped with a computer. This represents one of the major strengths of the programme. Baseline information and priority needs, vital event charts and family folders are available in most villages.

In Masoud village, all girls who had dropped out of school returned, and out of the 44 students, 43 earned their high school diploma. In some areas communities used the summer holidays to conduct special English and mathematics courses for students. In Al Ahmadia and Alholl villages, several girls who had dropped out of primary school were inspired by the healthy village programme to continue their education and gained secondary school qualifications. Many now teach computer skills; others serve the community as health volunteers.

The future vision of the programme is to focus more on the social determinants of health, urban development as well as to introduce initiatives on community-based rehabilitation and preparedness for disasters. This calls for greater efforts for resource mobilization and the creation of effective partnerships with relevant donors, civil society and private sector involvement in local development.

The rapid expansion of the programme will be restricted in accordance with the capacity of programme structures and availability of resources, focusing on the comprehensive development of the existing areas as well as strengthening intra-departmental coordination within the Ministry of Health and intersectoral cooperation between different government sectors.

Furthermore, in 2008–2009, the Primary Health Care Directorate will select 50 healthy villages as a platform to introduce all primary health care components, including family medicine, healthy lifestyles and control of tobacco and noncommunicable diseases.

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Integrated community recovery and development in south Kordofan

In October 2006, it was agreed that joint programming and collaboration between UN agencies take place in integrated community recovery and development (ICRD). The idea was conceived when Dr Mohamed Assai, WHO Regional Adviser, Community-based Initiatives in the Regional Office for the Eastern Mediterranean, paid a visit to Sudan and met with the UNICEF country representative in Khartoum. There was a discussion on community-based programmes in both organizations and it was agreed that both the child-friendly community initiative supported by UNICEF, and the BDN programme supported by WHO, are two faces of the same coin.

A series of meetings took place in UNICEF, WHO and World Food Programme (WFP) offices in Khartoum to discuss and agree on how to take this initiative further. This was followed by a meeting and teleconference conducted in October 2006 attended by WHO, UNICEF,

FAO, WFP and UNDP to explore the interest of the field offices in south Kordofan. The participants agreed on the need for comprehensive interventions from UN agencies to address community needs and that through working together in the same locations, and with synergy of efforts, UN agencies would accomplish more than the sum total of the results of each agency.

The UN team decided to start ICRD as a pilot project in 15 villages of Lagawa and Kadugli localities. It was agreed that the pilot project would be supported by the above-mentioned five agencies. The objectives of the programme were to:

- meet the basic social and economic needs of the community;
- enhance participatory and community-based conflict management and peace-building;
- strengthen human and institutional capacity at locality and community levels for 110 000 people in the 45 most vulnerable communities in south Kordofan;
- provide integrated sectoral and cross-sectoral development packages that would take environmental, biophysical, socioeconomic and political factors into account.

These objectives will be achieved through several strategies; community-based institutional development, partnership-building, disparityreduction, advocacy and social mobilization, service delivery and environmental protection.

Programme areas include:

- strengthened governance institutions and community empowerment;
- livelihood development and food security;
- access to improved drinking-water sources;
- greater access to primary health care services;
- access to quality and child-friendly basic education;
- strengthened sustainable protective systems for vulnerable children and women.

Activities and achievements include:

- the formation of a technical working group from related UN agencies in Khartoum. An ICRD coordination committee at state level was formed in Kadugli from the focal points of UN agencies and related ministries, headed by the Director-General of State Ministry of Economy and Investment.
- the drafting and endorsement of a concept paper by UN agencies, ICRD coordination committee and government at state level.
- a proposal with a budget of US$ 4 188 488 submitted to the Common Humanitarian Fund (CHF) through the UN Office for the Coordination of Humanitarian Affairs (UNOCHA) as administrative agent under the UN and partners' work plan for Sudan. The proposal was approved in May 2007 and a grant of US$ 500 000 was allocated (US$ 250 000 for WHO and US$ 250 000 for FAO).
- a preliminary needs assessment conducted in 22 villages in February–March 2007, in Lagawa and in Kadugli localities, in which all agencies have actively participated.
- approval of 15 villages for ICRD piloting by the state ICRD coordination committee: seven in Lagawa and eight in Kadugli localities.
- conducting briefing/orientation on ICRD for key stakeholders in Lagawa and Kadugli localities.
- the sharing of the WHO assessment tool with the working group.
- the sharing the CBI training manual with the technical working group that was drafted to train the representatives from UN agencies in order to harmonize them on approaches of integrated community-based development.

Résumé

Dr Mohammed Abdurrab, Représentant de l'OMS au Soudan, a souligné le rôle important que le programme des initiatives communautaires doit jouer en tant qu'outil, parmi d'autres, du développement durable dans les pays. La participation communautaire et la collaboration intersectorielle qui font défaut constituent deux des principales lacunes identifiées dans les soins de santé primaires. Essentiellement, le programme des initiatives communautaires est destiné à combler ces lacunes en fournissant un processus qui permet de rationaliser les rôles de la communauté et des représentants multisectoriels des pouvoirs publics à l'appui du développement sanitaire durable. Le Représentant de l'OMS au Soudan a brièvement présenté les étapes importantes atteintes dans le programme des initiatives communautaires au Soudan, à savoir l'expérience du renforcement de la composante communautaire de la Prise en charge intégrée de la santé de l'enfant (PCIME) dans les domaines des initiatives communautaires, la promotion de l'initiative Faire reculer le paludisme au Kordofan Sud et à Dar Mali et le projet d'approvisionnement en eau saine au Kordofan Nord. Dr Abdurrab a également mis en évidence les défis rencontrés dans les situations d'urgence où le partenariat avec les communautés permet d'établir la confiance nécessaire à l'intégration sociale.

Le Bureau régional de l'OMS pour l'Asie du Sud-Est a organisé une réunion régionale à Chiang Mai (Thaïlande), du 3 au 5 octobre 2007, sur la révision des rôles des agents de santé communautaires et des volontaires de santé communautaires. Des représentants des ministères de la Santé, d'organisations non gouvernementales, d'institutions des Nations Unies et d'établissements universitaires du Bangladesh, du Bhoutan, d'Inde, d'Indonésie, des Maldives, du Myanmar, du Népal, du Sri Lanka et de Thaïlande ont assisté à cette réunion. Dr M. Assai, Conseiller régional pour les initiatives communautaires au Bureau régional de la Méditerranée orientale, a présenté les expériences du programme des initiatives communautaires, mettant l'accent sur la formation des agents de santé communautaires et des volontaires de santé en République islamique d'Iran et au Pakistan. Parmi les points saillants de cette réunion, il convient de relever le discours du Dr Halfdan T. Mahler, ancien Directeur général de l'OMS, intitulé « *Health for All or Hell for All* » [La santé pour tous ou l'enfer pour tous].

Dans un effort visant à renforcer l'impact des classes d'alphabétisation, un cours de formation de trois jours sur l'utilisation des ordinateurs et du CD-ROM pour l'alphabétisation a été organisé en septembre 2007 dans trois communautés qui appliquent le programme des besoins fondamentaux en matière de développement (BDN) au Caire. Cette initiative a été accueillie favorablement par les neuf enseignants en alphabétisation dans le cadre du programme des BDN qui ont participé à cette activité de formation. Le retour d'information a été positif et un deuxième cours de formation informatique a également été organisé à la demande des participants pour améliorer leurs aptitudes informatiques.

Dr Amorn Nondasuta a présenté les lignes directrices sur les bonnes pratiques dans les processus de planification, de mise en œuvre et de gestion liés à la participation communautaire au développement sanitaire. Dr Nondasuta est non seulement connu pour sa participation à l'introduction du programme des besoins fondamentaux minimums en Somalie en 1988 mais aussi pour l'initiative des volontaires de santé villageois en Thaïlande.

À la demande du Dr Hussein Gezairy, Directeur régional OMS de la Méditerranée orientale, le ministère marocain de la Santé, en collaboration avec l'OMS, a organisé une visite de terrain le 2 novembre 2007 dans le village de Settat pour partager cette expérience de développement communautaire avec les Directeurs de l'Administration et des Finances de tous les bureaux régionaux de l'OMS et des responsables du Siège de l'OMS. Les directeurs se trouvaient déjà au Maroc pour assister à leur réunion annuelle à Marrakech et ils ont pris connaissance directement de cette expérience réussie. Le Programme BDN a trouvé un terrain favorable pour s'épanouir au Maroc du fait de l'engagement politique à haut niveau associé à l'Initiative nationale de développement humain soutenue par Sa Majesté le Roi Mohammed VI. Tous les participants ont été impressionnés par le succès et la rentabilité de l'approche, dont les coûts sont partagés entre la communauté et le ministère de la Santé.

En 1996, le ministère de la Santé de la République arabe syrienne a mis en œuvre le programme des villages-santé dans les zones rurales des gouvernorats de Damas, Daraa, Alqunaitera. Le succès obtenu par le programme dans ces zones pilotes s'est rapidement propagé à 615 autres villages qui mettent en œuvre le programme dans 13 gouvernorats. Le programme a également été accrédité par Son Excellence Asma Assad, Première Dame de la République arabe syrienne, et a réussi à établir des partenariats aux niveaux national et international.

Hassan Jaber Kamel qui vit à Al Mandhar, un village côtier dans le Gouvernorat d'Hodeidah, nous fait connaître l'exemple réussi de son projet pionnier qui a consisté à acheter un minibus à l'aide d'un prêt BDN. Le projet de Hassan a permis de faire face à un manque extrême de transports dans la zone pour aider ses co-villageois, les patients qui nécessitent une aide médicale d'urgence et d'autres personnes qui effectuent des allers-retours au village. D'autres ont suivi son exemple et le village est maintenant desservi par 16 minibus qui font la liaison entre le village et la ville.

Une campagne mondiale de mobilisation a été organisée en collaboration avec diverses organisations de la société civile les 16 et 17 octobre 2007 à l'occasion de la Journée mondiale de l'alimentation et de la Journée internationale de l'éradication de la pauvreté respectivement. Dr K. Bile, Représentant de l'OMS au Pakistan, en sa qualité de Coordonnateur Résident des Nations Unies par intérim, a réitéré l'engagement des Nations Unies à éliminer la faim et la pauvreté. Dr Hashim El-Zein, Représentant de l'OMS en Jordanie, a pour sa part évoqué le rôle de l'OMS dans le combat contre la faim dans le monde.

Le mercredi 21 novembre 2007, Dr Ghulam Popal, Représentant de l'OMS au Yémen, a signé un accord de collaboration pour un projet avec Dr Elkheir K. Khalid, représentant l'Autorité arabe d'investissement et de développement agricole, d'un montant de USD 167 800 pour l'extension du programme des Besoins fondamentaux en matière de développement à l'Île de Socotra au Yémen.

En octobre 2006 ont été formulés un programme commun et une initiative de collaboration sur la reprise et

le développement communautaires intégrés entre cinq institutions des Nations Unies : la FAO, l’OMS, le PAM, le PNUD et l’UNICEF. Dr M. Assai, Conseiller régional pour les initiatives communautaires au Bureau régional, a été inspiré par cette idée lors d’une réunion avec un représentant de l’UNICEF alors qu’il était en visite au Soudan. Devant le fait que l’initiative communautaire favorable aux enfants soutenue par l’UNICEF et que le programme des BDN soutenu par l’OMS sont deux aspects d’une même démarche qui se recoupent, il a été proposé d’expérimenter l’initiative concernant la reprise et le développement communautaires intégrés dans 15 villages des localités de Lagawa et Kadugli dans le cadre d’un projet pilote, avec le soutien complet des cinq institutions.

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الرسالة الإخبارية رقم 11 للمبادرات المجتمعية (المجلد الرابع، العدد الأول)

أكد الدكتور محمد عبد الربّ، ممثل منظمة الصحة العالمية في السودان، على أهمية الدور الذي ينبغي لبرنامج المبادرات المجتمعية الاضطلاع به بوصفه إحدى أدوات التنمية المضمونة الاستمرار في البلدان. ولقد تحددت فجوتان ضمن الفجوات الرئيسية في الرعاية الصحية الأولية، أولاهما قلة مشاركة المجتمعات وثانيهما نقص التعاون بين القطاعات. ولقد قام برنامج المبادرات المجتمعية بسد هاتين الفجوتين من خلال تسهيل دور المجتمعات ودور الحكومة المتعدد القطاعات من أجل دعم التنمية الصحية المضمونة الاستمرار. وقد عرض ممثل المنظمة في السودان ما تم إنجازه في برنامج المبادرات المجتمعية في السودان، مشيراً إلى تجربة تعزيز المكون المجتمعي لبرنامج التدبير المتكامل لصحة الطفل في مناطق عمل المبادرات المجتمعية، وتقوية مبادرة دحر الملاريا في جنوب كردفان ودار مالي، ومشروع الإمداد بالمياه المامونة في شمال كردفان. كما ألقى الدكتور عبد الربّ الضوء على التحديات التي تواجه في أوقات الطوارئ، عندما تنجح الشراكة مع المجتمعات في بناء الثقة اللازمة للاندماج الاجتماعي.

ولقد عقد المكتب الإقليمي لجنوب شرق آسيا اجتماعا إقليميا في الفترة من 3 إلى 5 تشرين الأول/أكتوبر 2007 حول مراجعة دور العاملين والمتطوعين في مجال صحة المجتمع، وذلك في شيانغ ماي، بتايلاند. وحضر الاجتماع ممثلون لوزارات الصحة والمنظمات غير الحكومية، ووكالات الأمم المتحدة والمؤسسات التعليمية من بنغلاديش، وبوتان، والهند، وإندونيسيا، والملديف، وميانمار، وسري لانكا، وتايلاند. وقام الدكتور محمد أساي، المستشار الإقليمي المعني بالمبادرات المجتمعية في المكتب الإقليمي لشرق المتوسط، بعرض التجارب التي خاضها برنامج المبادرات المجتمعية، كما ركز على التدريب الذي تلقاه العاملون في صحة المجتمع والمتطوعون، في كل من جمهورية إيران الإسلامية وفلسطين. وكانت كلمة الدكتور هافدان ماهلر، المدير العام الأسبق لمنظمة الصحة العالمية، والمعنونة « الصحة للجميع أو الجحيم للجميع» ضمن الوثائق التي تمت الإشارة إليها في الاجتماع.

وفي إطار الجهود المبذولة لتحسين تاثير فصول محو الأمية، نُظِّمَت، في القاهرة، دورة تدريبية مدتها ثلاثة أيام في أيلول/سبتمبر من عام 2007 في ثلاثة مجتمعات تُنفَّذ فيها مبادرة تلبية الاحتياجات التنموية الأساسية، وكان موضوع التدريب هو التعليم عن طريق الحواسيب والأقراص المكتنزة CD . ولقد رحب المعلمون التسعة الذين اشتركوا في الدورة التدريبية بهذه المبادرة وكانت التعليقات التي دارت حول الدورة إيجابية، وقد عُقِدَت حلقة تدريبية ثانية على الحاسوب بناء على طلب المشاركين لتحسين مهاراتهم في استخدامه.

وقد قام الدكتور أمورن نونداسوتا، بتقديم دلائل إرشادية حول ما ينبغي عمله وما لا ينبغي عمله في عمليات التخطيط والتنفيذ والإدارة المتعلقة بإشراك المجتمعات في التنمية الصحية. ولا ترجع شهرة الدكتور نونداسوتا إلى مشاركته في إدخال برنامج تلبية الاحتياجات التنموية الأساسية في الصومال في عام 1988 فحسب، بل أيضا لدوره في تنفيذ مبادرة المتطوعين الصحيين في القرى، في تايلاند.

وعملا بتوجيهات الدكتور حسين الجزائري، المدير الإقليمي للمكتب الإقليمي لمنظمة الصحة العالمية لشرق المتوسط، قامت وزارة الصحة في المغرب، بالتعاون مع المنظمة، بترتيب زيارة ميدانية في 2 تشرين الثاني/نوفمبر 2007 إلى قرية ستات، من أجل التشارك في تجربة التنمية المجتمعية مع مديري الإدارات الإدارية والمالية من جميع المكاتب الإقليمية للمنظمة، ومع كبار العاملين بالمقر الرئيسي للمنظمة. وكان هؤلاء المديرون موجودين بالفعل في المغرب لحضور اجتماعهم السنوي في مراكش، وشهدوا ما حققه المشروع من نجاح. ولقد وجد برنامج تلبية الاحتياجات التنموية الأساسية في المغرب بيئة جيدة ترعرع فيها نتيجة للالتزام السياسي الرفيع المستوى والذي تزامن مع المبادرة الوطنية للتنمية البشرية التي يرعاها جلالة الملك محمد السادس. وقد أعرب المشاركون عن إعجابهم بما حققه هذا الأسلوب من نجاح ومردود، والذي شارك المجتمع في تحمل تكاليفه مع وزارة الصحة.

وفي 1996، نفَّذَت وزارة الصحة السورية برنامج القرى الصحية في المناطق الريفية التابعة لمحافظات دمشق، ودرعا، والقنيطرة. وكان النجاح الذي تحقق في هذه المناطق النموذجية دافعاً لامتداد التجربة إلى 615 قرية أخرى في 13 محافظة قامت بتنفيذ البرنامج. وقد اعتُمد البرنامج من قبل سيدة سورية الأولى، السيدة أسماء الأسد، ونجح البرنامج في بناء شراكة على الصعيدين الوطني والدولي.

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,وتم تنظيم حملة عالمية بارزة ومؤثرة بالتعاون مع عدد من منظمات المجتمع المدني خلال اليومين 16 و17 تشرين الأول/أكتوبر 2007، اللذين يوافقان الاحتفال باليوم العالمي للغذاء، واليوم الدولي للقضاء على الفقر، على التوالي. وقد أعاد الدكتور بيل، ممثل منظمة الصحة العالمية في باكستان، وبالنيابة عن المنسق المقيم للأمم المتحدة، تاكيد التزام الأمم المتحدة بالقضاء على الجوع والفقر. كما تحدث الدكتور هاشم الزين، ممثل منظمة الصحة العالمية في الأردن، حول دور المنظمة في مكافحة الجوع في العالم.

وفي يوم الأربعاء 21 تشرين الثاني/ نوفمبر 2007، قام الدكتور غلام بوبال، ممثل المنظمة في اليمن، بالتوقيع على اتفاق للتعاون في مجال المشاريع مع الدكتور الخير الخالد، ممثل الهيئة العربية للاستثمار والتنمية في المجال الزراعي، بمخصصات مالية تبلغ 167800 دولار، بغرض التوسع في برنامج تلبية الاحتياجات التنموية الأساسية ليشمل أيضاً جزيرة سوقطرة باليمن.

وشَهِدَ شهر تشرين الأول/أكتوبر من عام 2006 صياغة البرنامج المشترك والمبادرة التعاونية حول الإنعاش المتكامل للمجتمع وتنميته وذلك بين خمس من وكالات الأمم المتحدة، هي منظمة الصحة العالمية، واليونيسف، ومنظمة الأمم المتحدة للأغذية والزراعة، وبرنامج الأغذية العالمي، وبرنامج الأمم المتحدة الإنمائي. وقد تحمَّس الدكتور محمد أساي للفكرة خلال اجتماعه مع ممثل اليونيسف إبان زيارته للسودان. ونظرا لأن مبادرة المجتمع المصادق للطفل التي يدعمها اليونيسف، وبرنامج تلبية الاحتياجات التنموية الأساسية المدعوم من منظمة الصحة العالمية، هما وجهان لعملة واحدة، فقد اقتُرح تجربة المبادرة التعاونية حول الإنعاش المتكامل للمجتمع وتنميته في 15 قرية تقع في منطقتي لاغاوا وكادوغلي كمشروع ريادي يلقى الدعم الكامل من الوكالات الخمس.

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