Community-Based Initiatives Series 13

Community-Based Initiatives in the Eastern Mediterranean Region
Status Report May 2003

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Preface

The countries of the World Health Organization Eastern Mediterranean Region have adopted community-based initiatives (CBI) to address all the determinants of health collectively through community empowerment with the aim of transforming social lifestyles and enhancing human development. The Regional Office has played an active role in supporting and promoting CBI among the countries of the Region.

This report presents the contribution made by CBI in empowering local communities and vulnerable groups to acquire their essential needs through the efficient use of available resources. Reports from a number of countries have demonstrated significant reduction in poverty levels and improvement in quality of life indices. In some countries, CBI has been the basis of national development policy and plans to reduce poverty, promote equity and achieve better quality of life.

The extent of CBI coverage in various countries of the Eastern Mediterranean Region has been influenced by the corresponding political situation. Nonetheless, the initiative has proved its effectiveness and sustainability because of its flexibility and locally sensitive operational tools and mechanisms.

1. Introduction

Health for all by the year 2000 was an objective set by the World Health Assembly in 1979 following the International Conference on Primary Health Care held in Alma-Ata in 1978. Over the past few years it has been recognized that the primary health care approach could not be realized in full because the strategy was primarily focused on the delivery of health services and on the role of the health sector in improving health outcomes. Subsequently, WHO and its Member States acknowledged that the reasons for persisting inequalities in health in certain segments of society are largely poverty, limited national resources, lack of education, increase in population, poor sanitation, and lack of awareness of the importance of health and other basic needs. There is now abundant evidence showing that certain major determinants of health lie outside the health sector; consequently, health cannot be achieved in isolation from other sectors. The right approach, therefore, to achieving health for all should include the full spectrum of human needs, taking into account social, political and environmental influences. This holistic view provides a broader spectrum to collectively address all relevant issues, determinants and factors. The community-based initiatives (CBI) approach advocates this view, that human health and well-being are the ultimate goals of development; health services should no longer be considered as a complex of solely medical measures. In fact, health contributes to, and results from, social and economic development.

2. The programmes

2.1 Basic development needs (BDN)

The concept of basic development needs was introduced in the Eastern Mediterranean Region of WHO in 1987. It is an integrated socioeconomic development approach that aims at achieving health for all through improving quality of life and reducing poverty, with consequent reduction in health inequalities. It is based on the principles of self-reliance, self-financing and self-management by organized, empowered and actively participating communities, supported through coordinated intersectoral actions. The rationale stems from recent evidence which suggests that someone with a given income would have better health if he or she lived in a society where income was distributed more equally than in a society where the rich are richer and the poor are poorer.

This initiative has attained remarkable success and is now considered an effective strategy for improving socioeconomic and health indicators. It has also provided a common and attractive base for collaborative, intersectoral actions, strong community partnerships and sustainable integrated development.

2.2 Healthy villages programme (HVP)

Globally, it has been demonstrated that political, social, cultural, economic and geographic changes have promoted rapid urbanization and altered the traditional rural set-up. This change in the sociocultural milieu created serious threats to the health and well-being of the rural population, multiplying health and environmental challenges and aggravating the problems of water supply, sanitation, housing and personal hygiene. As a result, rural inhabitants have to suffer from a greater burden of diseases, especially communicable diseases. The increasing index of poverty is further aggravating the problems of the underprivileged rural communities.

In order to effectively cope with these challenges, in 1989 WHO's Regional Office for the Eastern Mediterranean introduced the healthy villages approach, which has subsequently been adopted by a number of countries. This approach addresses the needs of social and human development in a rural setting in which health is the primary entry point. Provision of potable water and management of solid waste and sanitation are major components of environmental actions. Other specific measures include encouraging government sectors to promote community and individual health; create a physical, social, cultural, institutional and economic environment supportive to health; coordinate village plans with the master development plan of the district; strengthen the capabilities of the offices concerned at local level; and provide essential health care and environmental services.

2.3 Healthy cities programme (HCP)

A healthy city is a clean urban locality, having good health care services and cultural opportunities and providing a physically safe environment where people can live comfortably with their own ethnic bonds, beliefs, customs and lifestyles. The cities in the Region are currently experiencing rapid urbanization and population growth, putting pressure on already overstretched and insufficient or limited services. Therefore, cities struggle with a myriad of physical and institutional problems. The concept of healthy cities has evolved with the aim of improving the social and physical environment of urban localities and neighbourhoods, ultimately improving living conditions and achieving the goal of "health for all."

The Regional Office has supported the countries of the Region to introduce healthy cities programmes since 1988, and these are being implemented in a number of countries. The basic objective is to improve the health of urban dwellers, especially those residing in the underprivileged areas (urban slums), giving priority to the upgrading of environmental health services and living conditions. Other specific objectives include increasing awareness about health and environment issues, political mobilization and community participation and increasing the capacity of municipal government to manage urban problems using participatory approaches. This programme generates local and community support, facilitating practical coordination and initiating dialogue between all partners for the development of a strong promotional

process resulting in social justice and equity in the health and environment sectors.

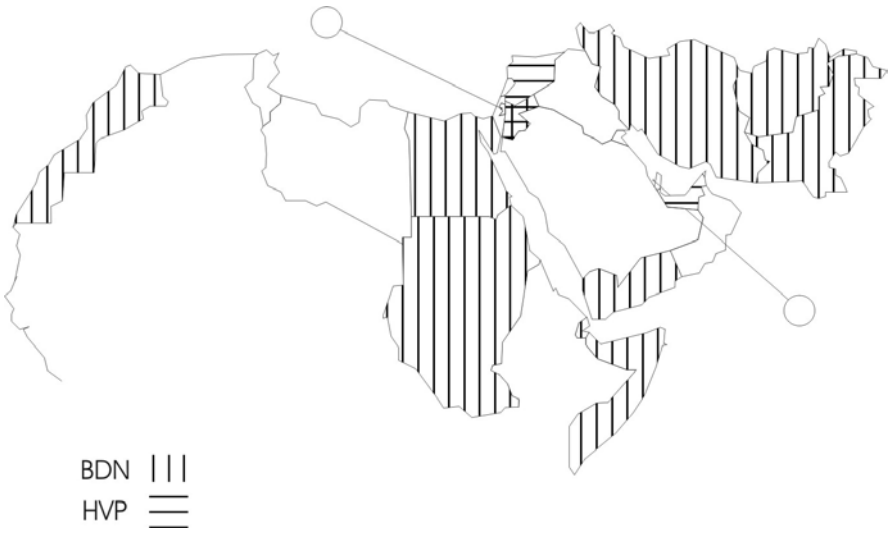
2.4 Women in health and development (WHD)

The countries of the Eastern Mediterranean Region are promoting the proactive role of women in health and development issues. The Regional Office facilitates the development of gender sensitive policies and programmes in a multisectoral framework in order to improve the socioeconomic status of women. This approach focuses on the empowerment of women as central to all efforts for reaching sustainable development including the economic, social and environmental dimensions. It supports gender analysis, encourages gender awareness, meets the special needs of women and supports their rights, dignity, self-respect and abilities by creating opportunities for the active participation of women in the decision-making process at all levels.

3. Status of community-based initiatives

This report presents the implementation status of BDN and HVP in the Region; HCP activities are not reflected in detail, considering its slightly different focus. From this point onward in the report the term CBI, therefore, refers mostly to BDN and HVP. Although WHD does not appear as a separate entity in the map below, part of its activities are integrated in other CBI in most of the countries. The report is based on information received from 13 countries of the Region, namely Afghanistan, Djibouti, Egypt, Islamic Republic of Iran, Jordan, Lebanon, Morocco, Oman, Pakistan, Somalia, Sudan, Syrian Arab Republic and Republic of Yemen. Figure 1 indicates the coverage of CBI (BDN and HVP) in the Eastern Mediterranean Region.

Figure 1. CBI (BDN and HVP) coverage in the countries of the Eastern Mediterranean Region



4. Processes, outputs and outcomes of CBI

4.1 Organization

Managerial arrangement

The CBI programmes in most of the countries have national, district and community structures except for Lebanon (newly introduced), Somalia and Afghanistan (no national structure). Some countries also have structures at state/provincial level (Afghanistan, Egypt, Oman, Sudan, Syrian Arab Republic and Republic of Yemen). These structures range from a focal person at national level within the Ministry of Health (Djibouti and Morocco) to multisectoral national coordinating bodies (Islamic Republic of Iran, Jordan, Oman, Pakistan, Sudan, Syrian Arab Republic, and Republic of Yemen). The structures are almost identical in all countries at district and community levels (principal investigator/programme manager, technical support team, village development committees and cluster representatives). All CBI initiatives are embodied within the Ministry of Health. Quality of life/BDN programmes in Jordan are being implemented by the Noor El Hussein Foundation, a national nongovernmental organization, in addition to HVP by the Ministry of Health, whereas the BDN programme in Egypt is implemented through a team of experts facilitated by the Ministry of Health. Table 1 shows how CBI is organized in the countries of the Region.

Table 1. Organizational structure of CBI in the countries of the Region

	National level			State/ provincial/ governorate level		District/ sub-district level	Community level		
Country	Focal person	Team	Committee	Committee	Team	TST/ PI	VDC	Sub-committees	CR
Afghanistan	MoH	√			√	√	√	√	√
Djibouti	MoH	√				√	√		√
Egypt	WHO experts						√		√
Iran, Islamic Republic of	MoH	√	√	√		√	√		√
Jordan	MoH/ NHF	√	√			√	√	√	√
Lebanon	WHO								
Morocco	MoH	√		√		√	√		√
Oman	MoH	√	√		√	√	√	√	√
Pakistan	MoH	√	√	√		√	√	√	√
Somalia	WHO					√	√		√
Sudan	MoH	√	√	√	√	√	√	√	√
Syrian Arab Republic	MoH	√	√	√	√	√	√	√	√
Yemen, Republic of	MoH	√	√	√	√	√	√		√

VDC = village development committee
TST = technical support team
NHF = Noor El Hussein Foundation
CR = cluster representative
MoH = Ministry of Health
PI = principal investigator

Political commitment

Governments in most countries are committed to CBI. This ranges from a high degree of commitment through political support, e.g. providing leadership and active participation in different CBI activities (field visits, workshops), financial support and legislative cover (Islamic Republic of Iran, Oman, Syrian Arab Republic, and Republic of Yemen), through a moderate degree of commitment (Djibouti, Jordan, Pakistan, Sudan) to a lower degree of commitment (Afghanistan, Egypt). In Morocco, political commitment is available indirectly through national nongovernmental organizations having strong links with the government.

Partnership

CBI provides a unique opportunity for developing partnerships between government and civil society and national/international organizations or agencies. Through joint endeavours, all partners can work together striving for local development in order to attain multi-dimensional achievements. Most CBIs have succeeded in developing strong partnerships with the government sectors concerned, United Nations agencies, nongovernmental organizations and community-based organizations. The best example is Noor El Hussein Foundation in Jordan which has established partnerships with more than 25 organizations and donors. WHO is a common partner for all countries, providing technical and financial support for the implementation of model phases of these programmes.

Advocacy and promotional strategies

Promotion and advocacy are the main instruments for the successful implementation of CBI with the aim of introducing social change as a first step towards sustainable development. Effective advocacy strategies are being implemented in Jordan, Pakistan, Sudan, Syrian Arab Republic and Republic of Yemen. Some advocacy activities are going on in Afghanistan, Djibouti, Islamic Republic of Iran, Morocco and Somalia, while Egypt and Lebanon are currently in the process of developing advocacy strategies and activities.

4.2 Implementation

Total population covered

A gradual but steady increase the population covered has been witnessed since this initiative was first launched. Table 2 shows the total population covered by CBI.

Training activities

The training activities in most of the countries are structured and well organized with clearly outlined specific learning objectives and target groups. These are summarized as follows, and elaborated in Table 3:

- capacity-building of national teams, technical support teams, village development committees and cluster representatives in CBI concepts and approach;

Table 2. Population covered by CBI in the countries of the Region

Country	Programme inception	Population covered	
		Initial	Present (2002)
Afghanistan	–	*	90 138
Djibouti	2001	12 041	12 041
Egypt	1999	20 000	25 000
Iran, Islamic Republic of	–	*	15 568
Jordan	1989	1 667	95 897
Lebanon	–	**	**
Morocco	2001	5 541	12 856
Oman	1994	11 200	113 000
Pakistan	1995	15 000	188 500
Somalia	–	*	67 325
Sudan	–	7 230	77 860
Syrian Arab Republic	1996	10 000	700 000
Yemen, Republic of	–	24 272	48 354
Total		106 721	1 446 539

* no data available ** newly introduced

- vocational training for community members with special focus on women (handicrafts, sewing, food processing, etc);
- financial management of projects;
- health promotion (home health care, health education, disease control and prevention, healthy lifestyles, immunization, etc.) for community and health workers (community health workers, traditional birth attendants and school teachers in Djibouti, Jordan, Pakistan and the Syrian Arab Republic);
- establishment of regional training centres in some countries (Jordan, Pakistan and Sudan); most of the countries have adapted training materials and guidelines.

Community mobilization and organization

Implementation of CBI in most countries of the Eastern Mediterranean Region was initiated with mobilization and organization of the community. In order to do this, a series of community orientation workshops was conducted by the national and district teams in each country. These were followed by various processes aimed at organizing the community at the grass roots level, taking into account gender equality and the involvement of all social and ethnic groups.

Table 3. Training activities in the Region

Country	Training* in CBI concept and approach	Vocational training	Advanced training in finance	Health promotion	Regional training centre
Afghanistan	√	√			
Djibouti	√	√		√	
Egypt	√	√		√	
Iran, Islamic Republic of	√	√			
Jordan	√	√	√	√	√
Lebanon					
Morocco	√	√			
Oman	√	√		√	
Pakistan	√	√	√	√	√
Somalia	√	√			
Sudan	√	√		√	√
Syrian Arab Republic					
Yemen, Republic of	√	√		√	

* For national teams, technical support teams, village development committees, community representatives

This led to the formation of various community organizations having the following structure in most countries except for Lebanon where the process is in the initial stages:

- village development committees
- specialized sub-committees (in Sudan, Pakistan, Jordan and Syrian Arab Republic)
- cluster representatives

These community organizations play a major role in:

- needs assessment surveys, identification of problems, priority setting and designing of projects
- project planning and implementation
- monitoring and supervision
- community/resource mobilization
- establishing community development funds and information centres
- programme promotion and expansion.

Intersectoral collaboration

Intersectoral collaboration is an essential feature of CBI. It exists at national level in the form of a national board/council and task force or at district level (district committee, technical support team) where most of the line departments (health, education, agriculture, livestock, municipality, social welfare, environment/public health engineering etc.) are represented and involved in the development process. The representatives of these departments participate in regular meetings, orientation workshops, decision-making, development of strategies, generation of resources and technical support.

Supervision and monitoring

Supervision and monitoring is an inbuilt mechanism for all CBI. Supportive and planned monitoring and supervision is practised in most of the countries except those newly introducing CBI (Lebanon and Egypt). Supervision and monitoring are carried out in different ways in different countries, for example:

- regular visits from the national level to the district and community levels and also from the district to the community level. In Sudan, monitoring officers have been appointed and stationed in the field to strengthen the monitoring mechanisms;
- standardized monitoring and supervisory checklists;
- regular reports;
- periodic meetings.

Financial management

Major components of financial management include the provision of loans and grants for social and income-generation projects and operational expenditure incurred in the implementation of these projects. Accounts registers, vouchers, receipts and quotations are the financial instruments used in Djibouti, Islamic Republic of Iran, Jordan, Morocco, Pakistan, Somalia, Syrian Arab Republic, Sudan and Republic of Yemen. In most of these countries a principal account is operated where all loans and grants are deposited while reimbursement is deposited in a revolving fund account. Some communities in Djibouti, Egypt, Jordan, Pakistan

and Sudan have established a community development fund from profit-sharing by the beneficiaries of income-generation projects. In Sudan there is an agreement with the Sudanese Savings and Social Development Bank to assist in the financial arrangement of the projects, while in a healthy village programme in Jordan there is a contract with the Agricultural Credit Corporation to deal with loans. All financial procedures at the community level are carried out by village development committees supported by the technical support team. The cluster representatives are responsible for collecting loan repayments from the beneficiaries. Training and refresher courses for the community on accounts maintenance and record keeping are carried out in Djibouti, Jordan and Pakistan. Loan recovery is satisfactory as reported in Djibouti, Jordan, Pakistan and Syrian Arab Republic.

Appropriate technologies introduced

This is one of the pioneering aspects of CBI in most countries. Empowered communities have been able to introduce innovative technologies in their areas, e.g.

- carpet weaving, women's vocational handicrafts centre, energy-saving ovens, sanitation tools and TV/radio repairs in Pakistan;
- new plantations, irrigation and agricultural techniques, new ways of fertilization, pesticide application, small-based industries (handmade paper), computer technologies and interactive theatres in Jordan;
- solar energy water pumps, lights and refrigerators, food processing technologies, gas cylinders and cookers, and improving the quality of herds in Sudan;
- fisheries, textiles, sewing and bee-keeping in Morocco;
- sewing, textiles, handicrafts, improving the quality of goats, internet and computer skills, cheese and dairy products, in the Syrian Arab Republic;
- handicrafts, sewing for women, glass-making, honeybee farms, electronics repairs, fishing, motorbikes for transportation in the Republic of Yemen;
- teaching literacy and numeracy in Somali to adults,

establishment of malaria diagnosing centres, garbage collection, developing football playgrounds and provision of sporting goods, establishment of clean drinking water, and poultry farms in Somalia;

- carpet weaving, women's vocational handicraft centre and adult literacy centres in Egypt.

Documents produced

The different types of CBI-related documents produced by countries of the Region are shown in Table 4. It is clear from the table that Jordan, Pakistan and the Syrian Arab Republic have a good documentation system while other countries are also striving hard within their limited resources to improve the documentation process. WHO's Regional Office for the Eastern Mediterranean has been assisting the project teams and the Ministries of Health to implement formal mechanisms of documentation by building up their capacities.

Table 4. Documents produced by the countries of the Region

Types of documents produced	Countries
Training manuals for technical support teams, village development committees and cluster representatives	Afghanistan, Djibouti, Islamic Republic of Iran, Jordan, Morocco, Pakistan, Somalia, Sudan, Syrian Arab Republic, Republic of Yemen
Manuals for illiterate/informal education	Djibouti, Pakistan
Manuals for community health workers	Djibouti, Pakistan
Home health care manuals	Pakistan
Health and environmental training manual	Egypt
Manuals for school health	Djibouti
Family file	Jordan, Syrian Arab Republic
Brochures	Islamic Republic of Iran, Jordan, Oman, Pakistan, Sudan, Syrian Arab Republic
Newsletters	Jordan, Oman, Pakistan
Bulletins	Islamic Republic of Iran, Pakistan
Posters	Oman, Pakistan, Syrian Arab Republic
Leaflets	Jordan, Oman, Pakistan, Sudan
Annual reports	Djibouti, Islamic Republic of Iran, Jordan, Morocco, Pakistan, Sudan, Syrian Arab Republic, Republic of Yemen
Films and movies	Oman, Republic of Yemen,
Web-based database	Islamic Republic of Iran, Republic of Yemen

4.3 Formal evaluation

Formal evaluations of the programmes have been conducted in Sudan (February 2001) and Jordan (December 2001) jointly by WHO and national experts. Rapid assessment, however, has been carried out in one BDN area in Pakistan and Morocco by national programmes. The results of these evaluations have revealed the following strengths and weaknesses at different levels, enabling both WHO and the Ministries of Health to modify policies accordingly and study the impact of CBI:

Strengths

- All communities are enthusiastic and empowered to manage the programme activities.
- Village development committees and cluster representatives have been selected by the community.
- Village development committees and cluster representatives have been trained at least once and are involved in conducting a baseline survey.
- In some programme areas new, complementary initiatives have been carried out in parallel to CBI.
- Cost-effective new technologies have been introduced such as solar energy, fish farming, home gardens, cheese-making, brick-making, etc.
- Successes in the project areas are inspiring neighbouring communities to become organized, generate monetary resources within the community and implement welfare and development projects on a self-help basis.
- Communities are carrying out cooperative projects and repaying the loans as planned and scheduled.
- Village development committees have become confident in approaching government and other agencies and marketing the approach for implementation at a wider level.

Constraints

- Proper training leading to the transfer of technical

knowledge, awareness and social services is the backbone of the CBI approach. The review found that a maximum of only two training sessions have taken place in the majority of the programme areas. Lack of continuing education can adversely affect the progress of the programme.

- Communities have not been sufficiently trained in financial management, including collection of loan instalments, bookkeeping and future investments.
- The national team does not include specialists in management, community organization, gender issues, microcrediting, marketing etc.
- There is a lack of logistic support, especially transport and resources for training and monitoring.
- There is a lack of ownership by other sectors. This is also true for the various departments/components within the Ministry of Health.
- There is insufficient interaction with other UN agencies, bilateral and international agencies and nongovernmental organizations.

4.4 Improvement in health and socioeconomic indicators

The gradual and steady increase in the coverage of CBI has had a positive impact on various social indicators in different countries in the Region. Improvement in these indicators in some countries is remarkable, whereas in others it tends to be slow. However, two positive aspects have prevailed in all those countries where CBIs have been implemented. First, there has been a steady increase in the coverage, showing its effectiveness and relevance to both the governments/partners and the community and stimulating their subsequent interest in expanding the initiatives. Second, almost all social indicators reflected in Table 5 and the graphs which follow it (Figures 2 to 7) show positive progress. The fact that in some countries the rate of improvement is relatively slower than others is due to a variety of reasons which have been outlined above in the constraints. Countries and communities in the Region who tend to be responsive to the need to minimize these constraints have shown better results than those who are yet to take these into account. Detailed progress regarding CBI in different countries is shown in Annex 1.

Table 5. Improvement in health and socioeconomic indicators

Component	Variables	Country	At beginning	Latest recorded
Health	% of children <1 year receiving vaccination	Pakistan	42%(1995)	80% (2001)
		Jordan	93.2% (1997)	94.7% (2001)
		Syrian Arab Republic	64.7% (1996)	86.6% (2002)
		Sudan	54% (1998)	98% (2002)
		Djibouti	65.2% (2002)	–
	% of pregnant women vaccinated against tetanus	Pakistan	22%(1995)	70% (2001)
		Jordan	58% (1997)	75% (2001)
		Syrian Arab Republic	51% (1996)	76.6% (2002)
		Sudan	84.8% (1999)	100% (2002)
		Djibouti	48.7% (2002)	–
	% of pregnant women checked by trained health worker at regular intervals	Pakistan	22%(1995)	70% (2001)
		Jordan	91% (1997)	95% (2001)
		Syrian Arab Republic	51% (1996)	76.6% (2002)
		Sudan	79.5% (1999)	99% (2002)
		Djibouti	48.7% (2002)	–
	Number of children <1 year died during past year per 1000 live births	Pakistan	153 (1995)	50 (2001)
		Jordan	8 (1997)	7 (2001)
		Syrian Arab Republic	–	434 (2002)
		Sudan	18 (2000)	11 (2002)
		Djibouti	–	–
	% of eligible couples using birth spacing methods	Pakistan	17.5%(1995)	36% (2001)
		Jordan	50% (1997)	54% (2001)
		Syrian Arab Republic	34.6% (1996)	55.4% (2002)
		Sudan	13.7% (1999)	9.1% (2002)
		Djibouti	–-	–-
Nutrition	% of infants born with weight <2.5 kg	Pakistan	16% (1995)	6% (2001)
		Jordan	6% (1997)	5% (2001)
		Syrian Arab Republic	–	–
		Sudan	–	–-
		Djibouti	5% (2002)	–
	% of children <5 years malnourished	Pakistan	26% (1995)	11% (2001)
		Jordan	–	–
		Syrian Arab Republic	–	–
		Sudan	5.7% (1999)	1% (2001)
		Djibouti	15.5% (2002)	–

Table 5. Improvement in health and socioeconomic indicators (cont.)

Component	Variables	Country	At beginning	Latest recorded
Education	% of children 5–12 years enrolled in schools	Pakistan	5.4% (1995)	81% (2001)
		Jordan	99.6% (1997)	99.8% (2001)
		Syrian Arab Republic	–	–
		Sudan	93.5% (1999)	93.8% (2002)
		Djibouti	68% (2002)	–
		Egypt	–	138
	% of children dropped out of school after enrolment during the last year	Pakistan	25% (1995)	10% (2001)
		Jordan	0.5% (1997)	0.4% (2001)
		Syrian Arab Republic	–	–
		Sudan	–	–
		Djibouti	53.5% (2002)	–
	Number and % of adults attending literacy classes	Pakistan	-	–
		Jordan	13% (1997)	19% (2001)
		Syrian Arab Republic	–	1525 (2002)
		Sudan	zero (1998)	125 (2001)
		Djibouti	–	308 (2002)
Women's development	Number of projects aimed at women's development	Pakistan	zero(1995)	221 (2001)
		Jordan	zero (1997)	774 (2001)
		Syrian Arab Republic	–	–
		Sudan	zero (1998)	399 (2002)
		Djibouti	–	3 (2002)
Water	% of families having access to safe water	Pakistan	50% (1995)	78% (2001)
		Jordan	–	–
		Syrian Arab Republic	57.4% (1996)	68.3% (2002)
		Sudan	48.1% (1999)	89.8% (2002)
		Djibouti	–	44.46% (2002
Sanitation	% of families using sanitary latrines in their houses	Pakistan	10%(1995)	23% (2001)
		Jordan	4153 (1997)	9202 (2001)
		Syrian Arab Republic	41% (1996)	61.2% (2002)
		Sudan	54.7% (1999)	62% (2002)
		Djibouti	30.9% 92002)	–
	Number of villages that introduced garbage disposal measures	Pakistan	–	–
		Jordan	16 (1997)	21 (2001)
		Syrian Arab Republic	–	148 (2002)
		Sudan	zero (1998)	9 (2002)
		Djibouti	–	3 (2002)

Table 5. Improvement in health and socioeconomic indicators (conc.)

Component	Variables	Country	At beginning	Latest recorded
Means of livelihood	Number of families involved in income-generating schemes	Pakistan	395 (1995)	13,824 (2001)
		Jordan	351 (1997)	1412 (2001)
		Syrian Arab Republic	–	1733 (2002)
		Sudan	zero (1998)	892 (2002)
		Djibouti	–	25 (2002)
	% of unemployed individuals	Pakistan	–	–
		Jordan	22% (1997)	16% (2001)
		Syrian Arab Republic	–	–
		Sudan	14.1% (1999)	15.9% (2002)
		Djibouti	18.7% (2002	–
	Average household income	Pakistan	–	–
		Jordan	–	–
		Syrian Arab Republic	–	–
		Sudan	–	–
		Djibouti	–	–

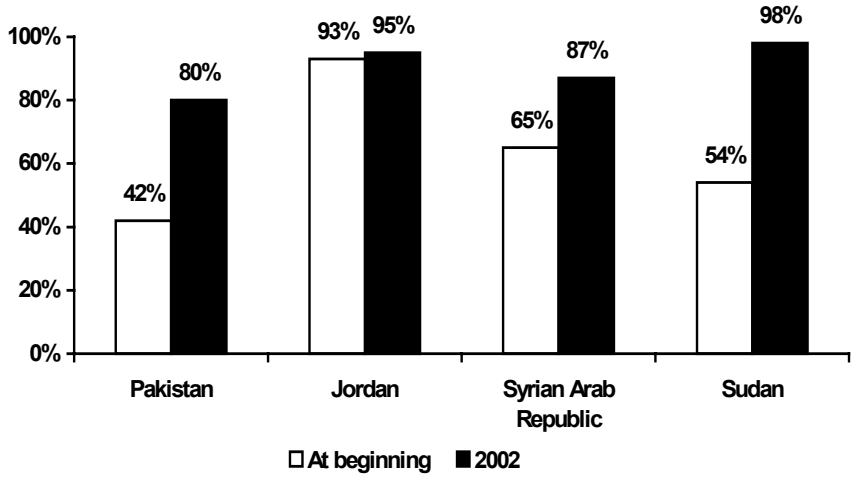


Figure 2. Children <1 year receiving vaccination

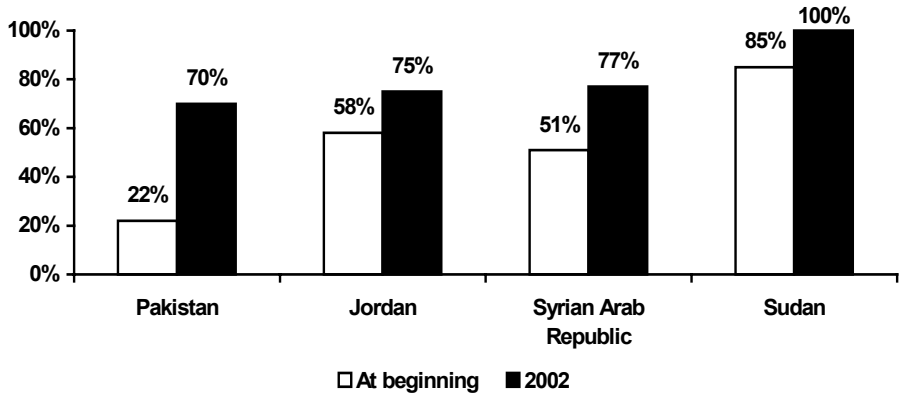


Figure 3. Pregnant women vaccinated against tetanus

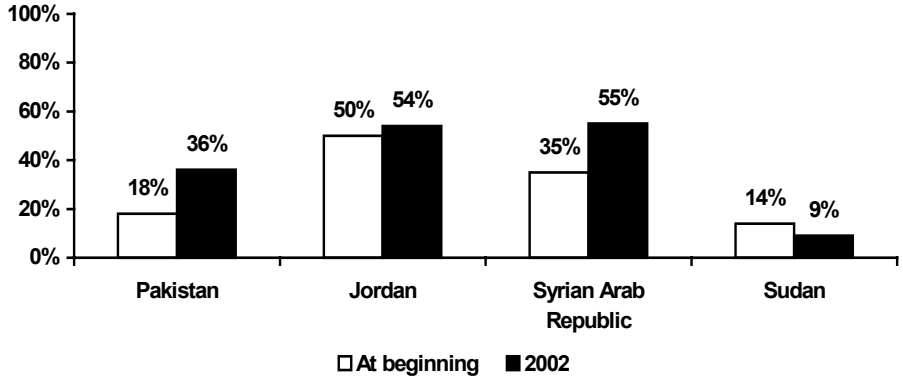


Figure 4. Eligible couples using birth spacing methods

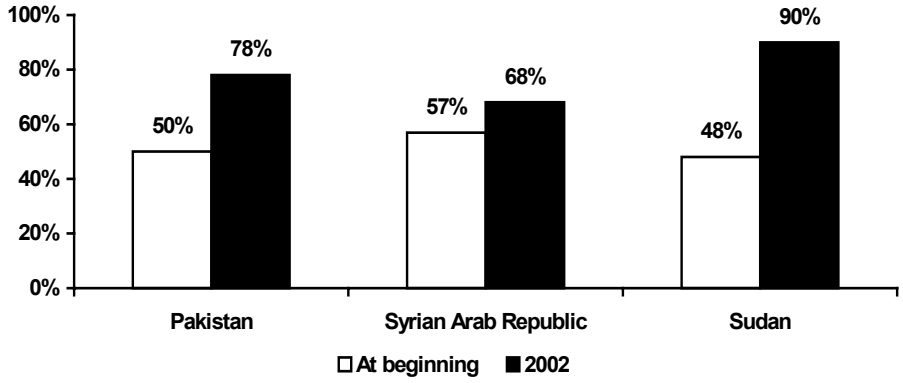


Figure 5. Families having access to safe water

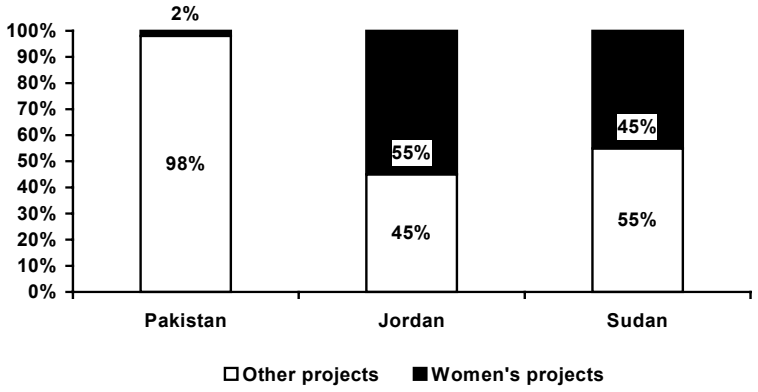


Figure 6. Projects aimed at women's development 2002

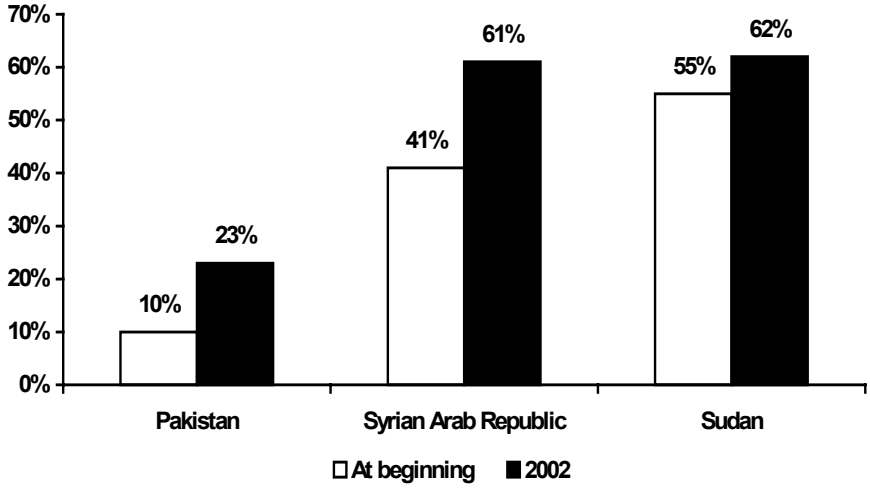


Figure 7. Families using sanitary latrines

4.5 Areas and issues that would assist in regular monitoring and documentation of the CBI in the Region

Strengths of CBI

- Improvement in health and socioeconomic indicators, especially those of women and children;
- Political commitment; however, more efforts should be exerted through continuous advocacy campaigns to enhance this commitment;
- Intersectoral collaboration and creation of partnerships with other stakeholders;
- Community empowerment and leadership: communities have shown strong willingness and commitment and participate effectively in CBI. This has been reflected in the increase in the community share in development projects (reaching more than 25% in some countries), establishing community development funds and increased sense of ownership;
- Involvement of women in the development process (education, training and participation in decision-making), a feature of most of the projects;
- Sharing of experience between different countries in the Region;
- Adoption of easy scientific methodologies at community level;
- Introduction of appropriate technologies, promoting new skills.

Future directions

- Firm government commitment and allocation of resources
- Encourage collaboration and coordination with other partners
- Enhance advocacy
- Exchange of visits and sharing of experience within and between countries

- Sharing of data between the countries of the Region (database centre)
- Promotion of healthy lifestyles
- Moving from area development to district development
- More effort on women's development.

5. Conclusion

Social conditions are major determinants of health. Social forces acting at a collective level shape individual biology, individual risk behaviour, environmental exposure, and access to resources that promote health. There is a graded relationship between social position and health status that affects people at all levels of the social hierarchy. While public health programmes alone cannot ameliorate the social forces that are associated with poor health outcomes, developing a better understanding of the social determinants of health is critical to reducing health disparities among residents of differing socioeconomic status in the Region.

In the light of the facts and figures discussed, the health and development approach has been considered an effective strategy for achieving the goal of health for all, working through coordinated intersectoral efforts, reducing human and economic poverty and the resulting inequities and improving quality of life. This has created a greater sense of ownership, solidarity, trust and confidence among the communities. Community-based initiatives accommodate local situations and effectively respond to the emerging and priority needs, enriching the community with modest methodology as well as creating harmony and balance in social and economic development.

Experience indicates that the social and cultural uplift of society proportionally improves the opportunities to attain better health and reduce health imbalances. Health as an entry point for social uplift is increasingly being recognized as the saner approach, the benefits of which are multi-focal. The empowerment of communities to respond to the changing social dynamics and the resultant benefits to their physical and environmental surroundings are among the successes of CBI in the Eastern Mediterranean Region. Now that this process has been translated from theory into practice, opportunities are ripe for countries and donors to reap the benefits. CBI provides an effective platform for all organizations to link health with development, thereby reducing not only the widening social gap between the rich and the poor, but preventing death and disability to a greater extent.

Annex 1

Summary of country progress

Afghanistan

Basic development needs

Organization	**Managerial arrangement**	National, provincial, local and village level (technical support team, village development committee and cluster representatives)
	Political commitment	Local level
	Partners	WHO, World Food Programme, UNICEF, Health Net International, Danish Committee for Aid of Afghan Refugees, Swedish Committee for Afghanistan, Hewad Reconstruction Services, Kuwaiti Fund for Orphanages, Ockenden International and International Assistance Mission
	Advocacy	Advocacy tools under process
Implementation	**Total population covered**	
	Training activities	Training for technical support team, village development committee and cluster representatives
	Intersectoral collaboration	Line departments
	Community mobilization	Community mobilized and organized
	Supervision and monitoring	Regular at community level
	Documentation and documents produced	Annual reports, training manuals
	Financial management	Financial system is managed according to the WHO BDN guidelines and tools
	Appropriate technologies	Handicrafts
	Formal evaluation	Not yet

Djibouti

Basic development needs

Organization	**Managerial arrangement**	Coordination office (focal point, technical officer, administrative assistant) at central level, intersectoral council level (line departments, supervised by district commissioner assisted by principal investigator) at district level and BDN team, technical support team village/community development committee, zone/cluster representative at local level
	Political commitment	Is available
	Partners	WHO
	Advocacy	Orientation meetings with government ministries, UN agencies and national level nongovernmental organizations
Implementation	**Total population covered**	12 041 (1.9% of total population) in areas in three districts
	Training activities	• Principal investigator, technical support team, village development committee, zone representatives at district and local levels • Training of school teachers on primary health care and school health • Training of traditional birth attendants and community health workers
	Intersectoral collaboration	Intersectoral council
	Community mobilization	Community organizations in all programme areas
	Supervision and monitoring	Regular field visits
	Documentation and documents produced	Manual for informal education, training of school teachers and community health workers
	Financial management	Loan reimbursement is satisfactory
	Appropriate technologies	
	Formal evaluation	Not yet, programme in initial stage

Egypt

Basic development needs

Organization	**Managerial arrangement**	National (WHO experts), local and village level (technical support team, village development committee and cluster representatives)
	Political commitment	Ministry of Health, municipality and related departments
	Partners	Nongovernmental organizations
	Advocacy	
Implementation	**Total population covered**	25 000
	Training activities	• Training for technical support team, village development committee and cluster representatives • Skills development in vocational training centres for women
	Intersectoral collaboration	Line departments represented in technical support team
	Community mobilization	Community mobilized and organized
	Supervision and monitoring	Regular at community level
	Documentation and documents produced	Annual reports, training manuals
	Financial management	The financial system is managed according to the BDN tools
	Appropriate technologies	Handicrafts and food industry
	Formal evaluation	Not yet

Islamic Republic of Iran

Basic development needs

Organization	**Managerial arrangement**	Three levels (national, governorate, district and village level)
	Political commitment	BDN is placed among top priorities to accelerate the community development process. the President strongly emphasized the implementation of BDN in the rural areas
	Partners	WHO, UNICEF
	Advocacy	Clear advocacy strategy
Implementation	**Total population covered**	15 568
	Training activities	• Training for technical support team, village development committee and cluster representatives • Vocational training
	Intersectoral collaboration	All line departments involved
	Community mobilization	Community is organized and mobilized
	Supervision and monitoring	At local level by village development committee, district and provincial level by programme manager, national level by BDN secretariat
	Documentation and documents produced	Training manuals, annual reports
	Financial management	The financial system is managed according to the BDN guidelines and tools
	Appropriate technologies	Sewing and embroidery for women, mushroom and fish farming, handicrafts and carpet weaving
	Formal evaluation	Not yet

Jordan

a) Basic development needs

Organization	**Managerial arrangement**	National level (Noor Al Hussein Foundation, executive director, project coordinator with the higher technical support committee and executive committee formed for line ministries). The programme has three units (technical, monitoring and evaluation, and administrative) Local level (technical support team from line departments village development committees, cluster representatives)
	Political commitment	Government is committed
	Partners	WHO, United Nations Population Fund, World Food Programme, United Nations Development Fund for Women, United Nations Educational, Scientific and Cultural Organization, United Nations Relief and Works Agency, Friedrich Ebert Stiftung, The Italian Association for Women in Development, Global Environment Facility, Afro-Asian Rural Development Organization, Citibank, National Population Commission, Jordan National Women's Commission, Sisterhood Jordan Branch, Ecumenical Popular Education Programme
	Advocacy	Well defined advocacy strategy and tools. Use of satellite and electronic media, TV films, newsletters at village level, national and international forums, inviting decision-makers and media specialists, brochures, leaflets, pamphlets, exhibitions, slogans, exchange of visits
Implementation	**Total population covered**	Total population covered: 1667 in one village in 1989 increased to 50 897 in 20 villages in 2001 (12 provinces)
	Training activities	• Capacity-building. • Vocational training. • Regional training centre • Have manual and guidebooks
	Intersectoral collaboration	Board from line departments
	Community mobilization	Community is organized (cluster representatives, village development committee, sub-committees) and technical support team

	Supervision and monitoring	Inbuilt mechanism, close planned supervision and monitoring from technical support team and national level. Standardized checklist, semi-annual meetings
	Documentation and documents produced	Reports, newsletters and brochures, training guidelines and leaflets
	Financial management	Well organized financial procedures
	Appropriate technologies	New plantations, irrigation and agricultural techniques, new ways of fertilization, pesticide application, small-based industries (handmade papers), computer technologies, interactive theatres
	Formal evaluation	December 2001 by international experts

b) Healthy villages programme

Organization	**Managerial arrangement**	Ministry of Health/primary health care at national level, technical support team at district level, village development committee at village level
	Political commitment	Ministry of Health/primary health care and government
	Partners	UNICEF, local nongovernmental organizations (Jordan Ricer Foundation, Prince Basma Centre, women's societies, Jordan Hashimi Fund)
	Advocacy	National days, exchange of visits, local mass media
Implementation	**Total population covered**	45 000 in 30 villages
	Training activities	• Training of technical support team, village development committees and cluster representatives • Community schools (teachers) • Vocational training • Home health care
	Intersectoral collaboration	Intersectoral collaboration (Ministries of Education, Agriculture, Social Affairs, Municipality Affairs)
	Community mobilization	• Community organizations and committees • Gender balance in community organizations
	Supervision and monitoring	• Supervision from national level • Reports
	Documentation and documents produced	• Reports • Community information database • Family file
	Financial management	Contract with Agricultural Credit Corporation to deal with loans

	Appropriate technologies	Food technology, carpets, handicrafts
	Formal evaluation	Done

Morocco

Basic development needs

Organization	**Managerial arrangement**	At national level, Ministry of Health and national intersectoral team At provincial level, provincial intersectoral coordination committee At district level, district intersectoral implementation committee At local level, social coordinators and village development committees
	Political commitment	Government adopted decentralization and local government policy which addresses integrated community development and poverty alleviation, especially for rural communities
	Partners	Civil society associations, UN agencies and nongovernmental organizations
	Advocacy	Orientation at different levels
Implementation	**Total population covered**	6807
	Training activities	• Vocational training • Specific training
	Intersectoral collaboration	National intersectoral committee, provincial, district and local committees
	Community mobilization	• Regular meetings • Community is organized
	Supervision and monitoring	Supportive supervision from central level to all other levels, the district intersectoral implementation committee to the local level, regular reporting
	Documentation and documents produced	Needs assessment surveys, situational analysis studies, evaluation study, BDN implementation guide
	Financial management	Principal and revolving fund accounts
	Appropriate technologies	Training on rescue techniques for members of fishery association, textile and sewing techniques, bee keeping techniques
	Formal evaluation	2001, evaluation of the impact of the programme in the implementation area Evaluation of the impact of the programme in El Gadida region

Oman

Healthy villages programme

Organization	**Managerial arrangement**	Ministry of Health/primary health care at national level, wilayat (district) health committee at wilayat level, village development committee at village level
	Political commitment	Head of the wilayat (Wali)
	Partners	WHO
	Advocacy	Leaflets, exhibitions, exchange of visits
Implementation	**Total population covered**	11 200
	Training activities	• Capacity-building of community volunteers • Vocational training
	Intersectoral collaboration	Intersectoral wilayat health committee
	Community mobilization	Community is motivated and organized (sub-committees)
	Supervision and monitoring	Monthly visits, planned supervision and monitoring from regional and national levels
	Documentation and documents produced	Reports, newsletters, leaflets and brochures
	Financial management	By financial committee at local level
	Appropriate technologies	New water supply and sewage disposal techniques
	Formal evaluation	Done

Pakistan

Basic development needs

Organization	**Managerial arrangement**	National and local level. 47 male and 12 female village development committees, 840 males and 79 female cluster representatives. Youth and local community-based organizations are represented. Technical support teams from line departments
	Political commitment	National BDN board chaired by Minister of Health and provincial health secretaries for policy guidelines, district steering committee). Poverty reduction strategy paper and establishment of Pakistan Poverty Alleviation Fund, Khoshali Bank for Poverty Alleviation, National Commission for Human Development
	Partners	WHO (technical and administrative support), United Nations Development Programme, Kashmir International Relief Fund trustees.
	Advocacy	Clear advocacy strategy and tools. Print and electronic media (TV), exchange of visits
Implementation	**Total population covered**	150 000 in 55 villages in seven districts
	Training activities	• Seven training courses on home health care • Training and retraining of technical support team, village development committees and cluster representatives
	Intersectoral collaboration	Board from line departments
	Community mobilization	Community is organized and mobilized
	Supervision and monitoring	Inbuilt mechanism, close supervision from village development committee, technical support team and national level
	Documentation and documents produced	Reports, newsletter, brochures, training guidelines, bulletins, home health care manuals, reports, newsletters, leaflets, handbills, and posters.
	Financial management	Well organized financial procedures • Social and income-generating activities • Revolving fund and community development fund • Three training courses on maintaining accounts and record keeping
	Appropriate technologies	Carpet weaving, women's vocational handicrafts centre, energy-saving ovens, TV/radio repairs

	Formal evaluation	Not yet (only rapid assessment in one area)

Somalia

Basic development needs

Organization	**Managerial arrangement**	No central government. two levels (district and village level
	Political commitment	Local level
	Partners	WHO; UNICEF; International Fund for Agricultural Development; Committee for the Coordination of Volunteering Organizations; Somalia Red Crescent; Food and Agriculture Organization; United Nations Educational, Scientific and Cultural Organization
	Advocacy	Designed for communities and partners
Implementation	**Total population covered**	
	Training activities	Training for technical support team, village development committee and cluster representatives. Also women's committee
	Intersectoral collaboration	Only represented in technical support team
	Community mobilization	Community is organized and mobilized
	Supervision and monitoring	At village level
	Documentation and documents produced	Training manuals, annual reports
	Financial management	The financial system is managed according to the WHO-BDN tools
	Appropriate technologies	• Teaching adults literacy and numeracy in Somali • Establishment of malaria diagnosing centres • Garbage collection • Developing football playgrounds and provision of sporting goods • Provision of clean drinking water • Poultry farms
	Formal evaluation	Not yet

Sudan

Basic development needs

Organization	**Managerial arrangement**	Three levels (national, state and local); higher committee for sustainable development, national task force for sustainable development, national programme within primary health care
	Political commitment	Government is committed
	Partners	WHO, UNICEF, World Food Programme, Plan Sudan International, Intermediate Technology Development Group, Azza Foundation, Women's Union
	Advocacy	Clear strategy (workshops, exchange of visits, promotional materials e.g. brochures, posters, video tapes, pamphlets)
Implementation	**Total population covered**	Two villages in 1997 increased to 15 villages in 2002 (eight states)
	Training activities	• Capacity-building (master trainers, technical support team, village development committee, cluster representatives) • Vocational training • Home health care • National training centre
	Intersectoral collaboration	Board from line departments, WHO, UN agencies, national and international nongovernmental organizations at national level
	Community mobilization	Community is organized and mobilized (cluster representatives, village development committee, sub-committees). technical support team
	Supervision and monitoring	Inbuilt mechanism, close planned supervision and monitoring from technical support team and national level. Experience of monitoring officers. Standardized checklist, quarterly meetings with monitoring officer and semi-annual meetings with technical support team, village development committees and cluster representatives
	Documentation and documents produced	Reports, newsletters and brochures, manual and guidebooks, leaflets, a story of a successful village
	Financial management	Under supervision of Sudan Savings and Social Development Bank. Principal and revolving fund accounts, community development fund

	Appropriate technologies	• Solar energy water pumps, lights and refrigerators • Food processing technologies • Gas cylinder and cookers • Improving quality of herds
	Formal evaluation	Carried out in February 2001 by international experts

Syrian Arab Republic

Healthy villages programme

Organization	**Managerial arrangement**	National, provincial, district, and local village levels
	Political commitment	National, provincial, district, and local government. In the form of financial, legislation, adoption, supervisory visits, link with national development plans; incorporated in the structure of Ministry of Health; formation of national intersectoral committee headed by Minister of Health and advocacy by government mass media
	Partners	UN agencies and nongovernmental organizations
	Advocacy	Clear advocacy strategy and tools
Implementation	**Total population covered**	700 000
	Training activities	• Training of national teams, technical support teams, village development committees and cluster representatives in CBI concept and approach • Vocational training
	Intersectoral collaboration	National intersectoral committee, provincial, district and local
	Community mobilization	Regular meetings Community is organized
	Supervision and monitoring	At all levels
	Documentation and documents produced	Clear documentation system at all levels Family forms, reports, posters and brochures
	Financial management	By national manager and an accountant at central level By financial committee at local level
	Appropriate technologies	Sewing, textiles, handicrafts, improving quality of goats, internet and computer skills, cheese and dairy products
	Formal evaluation	Not yet, planned during 2003

Republic of Yemen

Basic development needs

Organization	**Managerial arrangement**	Under the overall auspices of WHO and the Ministry of Public Health and Population, managed through multisectoral teams formed at the national, governorate, district and village level
	Political commitment	The Government has reflected its commitment to CBI for sustainable development through the introduction of several CBI programmes in different sectors addressing poverty alleviation through community development and self-help. The National Poverty Reduction Strategy Paper for the Republic of Yemen has been approved by the government and parliament of the Republic of Yemen
	Partners	The Social Fund for Development and the Public Works Project funded by the World Bank, the Hodeidah Primary Health System Support Project funded by the government of the Netherlands, the Demographic and Health Survey project funded by the government of Germany, the Yemeni Red Crescent, the Charitable Society for social Welfare, the Association for Disabled in Hajjah governorate, the nongovernmental organizations for water and environmental sanitation and Oxfam
	Advocacy	Well defined advocacy and promotional strategies
Implementation	**Total population covered**	48 354 in 16 villages
	Training activities	Training for technical support team, village development committee and cluster representatives
	Intersectoral collaboration	All related departments are involved.
	Community mobilization	Community is organized and mobilized (cluster representatives, village development committee, sub-committees), technical support team
	Supervision and monitoring	Monitoring and supervision are taking place on regular basis, at the national and governorate level (technical support teams and principal investigator)
	Documentation and documents produced	Arabic version of the BDN kit, BDN guidelines and tools, seven minute BDN documentary movie, web-based database

	Financial management	Financial system is managed according to the BDN tools
	Appropriate technologies	Handicrafts, sewing for women, glass making, honeybee farming, electronics repair, fishing, motorbike for transportation
	Formal evaluation	Planned for 2003