Community-Based Initiatives Series 1

Training manual for community-based initiatives

A practical tool for trainers and trainees

World Health Organization
Regional Office for the Eastern Mediterranean

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WHO Library Cataloguing in Publication Data

WHO Regional Office for the Eastern Mediterranean

Training manual for community-based initiatives: a practical tool for trainers and trainees / WHO Regional Office for the Eastern Mediterranean.

p. .- (Community-Based Initiative Series; 1)

ISBN 978-92-9021-578-3

ISSN 1811-2943

1. Community Medicine 2. Community Health Services 3. Regional Health Planning 4. Health Care Economics and Organizations

5.Health Policy 6. Health Promotion I. Title II. Regional Office for the Eastern Mediterranean III. Series

(NLM Classification: WA 546)

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Cover design by Suhaib Al Asbahi
Layout by John Shimwell
Printed by Toshka, Egypt

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PREFACE

This training manual has been prepared for the communities involved in the implementation of community-based initiatives (CBI) in the member countries of the WHO Eastern Mediterranean Region. More than 15.5 million people in this Region are covered by one of the community-based initiatives in the form of the basic development needs programme, the healthy cities and healthy villages programmes and the women in health and development programme. As a result of programme expansion, it was felt there was a need to create a standard training manual for community representatives which outlines the approach and methodology of the programme and which is based on the practical experiences of communities. The manual follows a participatory training approach and provides support for the implementation of an effective follow-up and monitoring system.

This training manual will assist in programme implementation and in capacity-building of communities. It will enable communities to identify and prioritize their needs and will help partners to develop more effective interaction and coordination by facilitating effective implementation of various development activities. This approach relies on the use of local resources to provide solutions to local problems to ensure programme sustainability.

Supplementing this manual, the guidelines for master trainers have been prepared with the intention of assisting the facilitators in designing the programme for capacity-building of communities and imparting them training in a systematic manner that follow the process and steps of the community-based initiatives implementation. The training manual for communities serves as a reference for master trainers; however they are at liberty to use different teaching and training methods to cope with the requirements of the target groups. Keeping the training of communities more useful and practical, the master trainers also can get guidance from the community-based initiatives training manual for mid-level managers.

This manual is a supplement to the *CBI training manual for mid-level managers*, which was produced in 2002 and tested in two international training courses held in Pakistan and Jordan. It is expected that this training manual will also serve as a reference for master trainers and as an advocacy tool for the promotion of health and development initiatives in the Region. It is user-friendly and can be adapted to provide guidance in a wide variety of situations.

Part A

Guidelines for facilitators

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1. INTRODUCTION TO COMMUNITY-BASED INITIATIVES

The concept of health for all was adopted by the World Health Assembly in the late 1970s, and primary health care was adopted as the right approach for achieving the optimum level of health for each individual. The target of health for all by the year 2000, however, could not be achieved due to strategic deficiencies—mainly a weak community role, poor intersectoral actions, a top–down approach to development, and focusing investment on physical infrastructure while neglecting the human dimensions of development.

It has been acknowledged that health cannot be achieved in isolation; it requires an integrated multisectoral development approach, establishing active partnerships between communities and other stakeholders. Major determinants of ill health such as illiteracy, overpopulation, poor food and nutrition, poor sanitation, lack of developmental opportunities, rising scales of poverty and inadequate awareness lie outside the scope of the health sector and are mainly related to socioeconomic and cultural aspects of civil society. Among the underprivileged populations, in addition to ill health, there exists a persistent combination of unemployment and underemployment, economic poverty, low levels of education, poor housing, malnutrition, gender insensitivity and social apathy. It would therefore be unfair to expect any substantial health improvements without removing these constraining conditions.

It has also been observed that health and quality of life are closely interlinked and mutually dependent. Improvement of quality of life depends on families having better health status, literacy, living conditions and income resources. On the other hand, by promoting better quality of life, we can encourage human development and subsequently can improve the health situation.

In the light of the above, WHO's Regional Office for the Eastern Mediterranean introduced the following community-based initiatives (CBI):

- basic development needs approach
- health villages programme
- healthy cities programme
- women in health and development.

The basic development needs (BDN) approach is an integrated socioeconomic development aiming to achieve health for all by enhancing the quality of life of the members of a community and reducing poverty. It is based upon self-reliance, self-financing and self-management by organized, empowered and actively participating communities, supported through coordinated intersectoral actions.

Healthy villages programmes (HVP) address the requirements of social and human development in rural communities considering health as the primary entry point. This approach has been built on the objectives of access and coverage of health services, improving basic environmental conditions and satisfying basic development needs, thus creating awareness in the population and building up village structures.

Healthy cities programmes (HCP) aim at improving the health status of the urban population, especially those residing in underprivileged areas, emphasizing the upgrading of environmental health services and living conditions. Other specific objectives include increasing awareness about health and environmental issues, political mobilization and community participation, and increasing the capacity of municipal government to manage urban problems using the participatory approach.

In addition to the above, WHO is supporting member countries to the promote proactive role of women in health and development issues in order to facilitate the expansion of gender sensitive policies and programmes in a multisectoral framework and improving the socioeconomic status of the women.

These community based initiatives provide a new stimulus for health and human development, and have initiated a transformation process whereby communities are playing a active role and multisectoral government functionaries are providing support for sustainable local development in order to improve the quality of life and health of the people.

2. TRAINING MANUAL

2.1 Objectives

The manual intends to provide comprehensive and informative training materials on community-based initiatives. The specific objectives are:

- developing in Member States trainers who are capable of orienting and training the authorities, technical teams, programme managers, communities and other stakeholders
- updating the knowledge of the field management and teams regarding the various aspects of the programme
- reinforcing leadership and management skills for effective and efficient implementation of the programme.

2.2 Target groups

This manual is designed to cope with the training needs of the following main target groups:

- programme management at all levels
- technical teams from the concerned sectors.

These materials can be adapted to local needs for conducting training on all community based initiatives in different settings and conditions, especially for partner agencies and organization as well as the communities.

2.3 Structure

The training manual comprises two parts. Part A is guidelines for the facilitators. It presents introduction of community-based initiatives approaches, structure and lesson plan of the course in addition to a set of guidelines for planning, organization, conduction and evaluation of the training course.

Structure of CBI training manual

Part A: Guidelines for facilitators

Part-B: Training modules:

- Module 1: Basic concepts
- Module 2: Public health
- Module 3: Social mobilization and development
- Module 4: Management of community-based initiatives
- Module 5: Leadership skills

Part B comprises five training modules which focus on the main issues essential for effective management of community-based initiatives. These modules are further divided into units which furnish particular themes, as detailed in Table 1. The contents of these units are designed maintaining their relevance to the field operations. Each unit contains the text portion and the standardized presentation slides for the convenience of the trainers. These materials can be adapted according to local needs and further developments in the study areas.

2.4 Duration of course

The duration of the course may vary depending on the technical levels and experiences of the participants in community-based initiatives management. The modules in the present form can be imparted in a 10-day period, including one day for field study.

2.5 Expected outcome

At the end of the course, the participants should be well informed on:

- the community-based initiatives concept and philosophy
- the concept of health, its promotion and protection
- developmental packages and indicators to measure progress
- the community-based initiatives process and its implementation procedures
- leadership skills required for successful operation of programme.

Table 1. Structure of community-based initiatives training manual part B

Module 1	**Basic concepts**	
	Unit 1.1	Sustainable development for health
	Unit 1.2	Community-based initiatives in the Eastern Mediterranean Region
Module 2	**Public health**	
	Unit 2.1	Health, health for all and primary health care
	Unit 2.2	Health protection and promotion
	Unit 2.3	Disease prevention and management
Module 3	**Social mobilization and development**	
	Unit 3.1	Community mobilization and social contract
	Unit 3.2	Health development
	Unit 3.3	Social development
	Unit 3.4	Economic development
	Unit 3.5	Health and development indicators
Module 4	**Management of community-based initiatives**	
	Unit 4.1	Planning
	Unit 4.2	Organization
	Unit 4.3	Human resources development
	Unit 4.4	Community surveys and prioritization of needs
	Unit 4.5	Projects preparation and implementation
	Unit 4.6	Supervision and monitoring
	Unit 4.7	Financial management
	Unit 4.8	Documentation and reporting
	Unit 4.9	Promotion and advocacy
	Unit 4.10	Programme assessment
Module 5	**Leadership skills**	
	Unit 5.1	Management techniques
	Unit 5.2	Operational research and development

3. TRAINING COURSE

The training course should be arranged according to the steps given in this document. The checklist given as Annex 1 can be used for confirming all arrangements in sequence.

3.1 Lesson plan

The lesson plan for the training course is flexible and can be adapted for local needs; however, facilitators must allow enough time to teach each unit well. The presentations should be followed by discussion to ensure better learning and full understanding of the subject. Enough time should also be allowed for demonstration and practical work as well as the field visit. The lesson plan for the training course is shown in Table 2.

TABLE 2. Sequence and modules of the training course

Unit	Subject	Activity	Estimated time (minutes)
	Inauguration	Registration and inauguration	45
		Brief on training programme	15
		Pre-assessment	30
Module 1 (basic concepts)			
Unit 1.1	Sustainable development for health	Presentation	45
		Discussion	15
Unit 1.2	Community-based initiatives in the Eastern Mediterranean Region	Presentation	45
		Discussion	15
Module 2 (public health)			
Unit 2.2	Health, health for all and primary health care	Presentation	30
		Discussion	15
Unit 2.2	Health protection and promotion	Presentation	45
		Discussion	15
Unit 2.3	Disease prevention and management	Presentation	30
		Discussion	15
Module 3 (social mobilization and development)			
Unit 3.1	Community mobilization and social contract	Presentation	30
		Discussion	15
		Group work	120
		Plenary	30
Unit 3.2	Heath development	Presentation	45
		Discussion	15
Unit 3.3	Social development	Presentation	45
		Discussion	15
Unit 3.4	Economic development	Presentation	30
		Discussion	15
Unit 3.5	Health and development indicators	Presentation	60
		Discussion	30
Module 4 (management of CBI)			
Unit 4.1	Planning	Presentation	45
		Discussion	15
		Group work	120
		Plenary	30
Unit 4.2	Organization	Presentation	30
		Discussion	15
		Group work	120
		Plenary	30

TABLE 2. Sequence and modules of the training course

Unit 4.3	Human resources development	Presentation	30
		Discussion	15
		Group work	150
		Plenary	30
Unit 4.4	Community survey and needs prioritization	Presentation	60
		Discussion	15
		Group work	150
		Plenary	30
Unit 4.5	Project preparation and implementation	Presentation	45
		Discussion	15
		Group work	150
		Plenary	30
Unit 4.6	Supervision and monitoring	Presentation	30
		Discussion	15
		Group work	90
		Plenary	30
Unit 4.7	Financial management	Presentation	60
		Discussion	30
		Group work	150
		Plenary	30
Unit 4.7	Documentation and reporting	Presentation	45
		Discussion	15
		Group work	150
		Plenary	30
Unit 4.9	Promotion and advocacy	Presentation	30
		Discussion	15
		Group work	120
		Plenary	30
Unit 4.10	Programme assessment	Presentation	45
		Discussion	15
		Group work	120
		Plenary	30
Module 5 (Leadership skills			
Unit 5.1	Management techniques	Presentation	60
		Discussion	15
		Group work	120
		Plenary	30
Unit 5.2	Operational research and development	Presentation	45
		Discussion	15

TABLE 2. Sequence and modules of the training course

Field study			
	Objectives, methodology and plan for field visit		15
	Field visit, briefing on project, demonstration of projects and interaction with the community		1 day
	Feedback on field visit		60
Concluding session			
	Post-training evaluation		30
	Feedback and comments on the training course and its components		60
	Certification and concluding remarks		30

3.2 Effective facilitation

Profile of facilitators

A team of facilitators from major sectors (primarily from health and those involved in programme activities demonstrating high output) should be assigned this task.

The facilitators (trainers or resource persons) should be professionals, having sufficient communication skills and fully acquainted with the training methodologies, capable of adopting participatory facilitation techniques rather than conventional methods. Cohesion among the facilitators and their friendly interaction with the participants is always an asset for successful training. The facilitators must be fully conversant with new developments in the field and emerging approaches in programme implementation. Experts from different sectors with relevant experience and who are acquainted with the programme approach can be invited as resource persons.

Orientation of the facilitators

All facilitators involved in the training process should be familiar with the training materials, training plans and relevant developments. The coordinator of the training course should brief the facilitators well in advance and make them clear their individual assignments and role. The trainers should go through the guidelines for facilitators and practise the essential skills referred to in the document. In order to accomplish successful training, facilitators should undergo intensive training on all parts of the community-based initiatives training manual. In this respect, they should join at least two days before the training course, and the course coordinator should confirm that all of the facilitators fully understand the training methodology, have acquired the necessary communication skills and are well versed with the training manual.

The facilitators should be given sufficient liberty to adapt the training materials in line with the programme approach. During the training course, harmony and coordination between all sessions and the facilitators should be maintained. Every presentation should be shared and discussed with others, in particular with the course coordinator. The objective is that the facilitators should work as a team, fully aware of their individual roles and well versed in the relevant subjects and the approach.

Role of training coordinator

The training is to be coordinated by a senior person possessing sufficient authority to deal with the relevant issues. The responsibilities of the coordinator may include:

- planning for the training course
- correspondence for approval and budgetary allocations
- preparing the agenda with mutual consultation
- disseminating information to those concerned
- arranging the requisite accommodation, logistics, accessories, training and support materials and other services
- facilitating the participants in their lodging arrangements
- communicating with the authorities concerning their participation in the inaugural and concluding sessions
- contacting the facilitators and resources persons, assigning them teaching/training subjects and tasks, and orienting them on the plans
- harmonizing the training activities according to the planned agenda and sequence and helping other facilitators in the accomplishment of their tasks
- solving day-to-day problems in order to ensure the smooth conduction of the training course
- coordinating with the field staff and authorities for arranging a field visit.

Role of facilitator

The role of the trainers will be facilitation rather than conventional teaching; therefore, it is expected that they will demonstrate a high degree of professional skills in order to accomplish the assigned tasks. The trainers will:

- assist in planning, organization and management of the training course

- facilitate the process of learning and transmitting knowledge through a sharing approach
- assist in the practical exercises and individual/group assignments
- conduct and coordinate demonstrations and study visits
- communicate with the community and other partners during field visits
- act as mediators for translation where there is a language difference between the participants and the community facilitators
- demonstrate a high degree of moral and social values as well as leadership abilities to be a role model for others
- mobilize the participants in order to transform their attitudes and behaviour in support of the approach
- monitor the progress and outcome of the training process
- provide the opportunity for each person to study the theme till each concept is clear
- evaluate the participants and execute appropriate feedback measures
- explore the dynamics in the training group, promoting innovative ideas and creative visions
- respond appropriately to the questions and queries of the participants
- maintain discipline among the training group and assist in the solution of their individual/group problems.

3.3 Preparation and organization

Planning

Planning intends to ensure necessary arrangements before the start of the training course.

Costing, approval and funding. The costing of the training course should be feasible and in accordance with the rules and regulations of the sponsoring organization. The approval process usually takes a lot of time and involves various line offices; therefore, the proposal should be initiated at least three months before the expected training date. Administrative approval along with the financial settlements should be ensured before initiating the organization process.

Tentative agenda/plan. The training period should be determined with the mutual consent of participants and all others involved, taking into consideration the season, public holidays and other important events.

Inviting the participants and facilitators. Invitations for prospective participants should be issued well in advance through the appropriate channels of the concerned organizations. This invitation should contain all necessary information in order to fulfil the formalities and prerequisites for approval and travel authorization. The invitations must clearly indicate the travel arrangements, accommodation, transport, per diem involved or the cost to pay, insurance and medical coverage, etc., in addition to containing a clear statement of the training objectives, its structure and duration. The invitation is usually attached with a form to be filled in by the candidates, seeking information on personal data, education, present and past professional positions with job description, and financial arrangements, supported by the curriculum vitae of the candidate. At the same time, availability of the facilitators should also be confirmed through similar process.

Organization

Lodging. Arrangements are essential for the placement of participants coming from other cities or countries, ensuring their comfortable stay and quality meals, according to the budgetary limits.

Resources. Funds should be available well in time for making necessary arrangements and payments to those involved in the training process.

Location. The training room should be sufficiently spacious to accommodate the participants and meet the training requirements. Rooms for group work and for serving refreshments during break times should be available in close proximity. The location should be free from noise or disturbance and be comfortable and appropriate for teaching. It should be well ventilated with the temperature adjusted according to the season. In addition to adequate lighting, the seats should be arranged in a way to ensure access of all participants to the screen and allowing each participant to take part in discussions. The arrangements should be suitable in accordance with the type of training, number of participants and use of training aids. Adequate electrical connections should be readily available for audiovisual and other accessories.

Logistics. All necessary equipment, accessories and teaching/training aids should be available in working order. It should be ensured that these are accessible throughout the session, ensuring that the training programme is not disturbed for want of accessories. In most cases, the following items will be required for conducting a training course:

- white board and markers of multiple colours
- stand board with flip charts and marker pens
- overhead projector for transparencies along with a screen
- computer and multimedia projector if required
- camera for photography (if available)
- photocopier.

Secretarial support. Sufficient and trained manpower should be available to assist in conducting the training course. Secretarial support is usually required to assist in the planning, implementation and documentation process. Assistance will be required for communications, administrative arrangements, photocopying, and computer work in addition to operation and maintenance of equipment like projectors, cameras and audiovisual aids during presentations and group work.

Stationery. The following stationery items are usually required in a training programme:

- transparencies
- papers and flip charts
- pencils and marker pens
- writing pads
- folders.

The quantity of these items should be estimated according to the number of participants.

Training materials and folders. The training materials should be ready before initiating the training course. In addition to this, transparencies or soft copies of presentations should be prepared beforehand, keeping photocopies of each training material in a master file.

Training materials such as handouts, technical papers, supporting documents required for distribution to the participants should be arranged in folders in a sequential order according to the training agenda. These folders should also contain the agenda, a brief introduction concerning the objectives and process of the training, supporting materials, notebooks and pencils.

Photocopying. There is always a large amount of work for photocopying; therefore, this service should be readily available and efficient enough to cope with the day-to-day needs of the training session.

Transport. Mobility is usually essential, not only for the administrative arrangements but also for assisting the participants and carrying them for the field visit. The number and type of vehicles should be in accordance with the actual requirements and they must be comfortable.

Registration and attendance sheets. The participants should be registered at the start of the session. Registration sheets or forms should contain all basic information including name, address and contact numbers. The registration forms should be attached to the training and financial report after completion of the course.

In order to ensure regular participation of all members and to fulfil the administrative and financial prerequisites, an attendance sheet, preferably separate for each session, should be signed by the participants. The record of attendance is preserved in the training file and may help in the assessment of the participants and training course.

Certificates of training. At the end of the training course, certificates should be delivered to all of the participants and facilitators. The certificate should be in a presentable form, printed on durable paper or card, the choice of colours depends upon the availability of funds and printing facility. Certificates usually bear the signature of some key authority/authorities and must be ready before the concluding session.

3.4 Conducting the training course

Registration and seating

The participants should report on time. Since they will be visiting for first time, they need help to guide them towards the training room. This is possible through display of direction cards or banners. One person should also be available at the main entrance to receive and guide the participants. Ideally, name cards should be pasted on each chair or table in an orderly manner. Every participant should be given a folder containing all relevant materials. They should be asked to fill in the registration forms providing them guidance through a small briefing. The course coordinator/facilitator should start the session with the opening remarks, after which participants should be invited to introduce themselves.

Inauguration

Usually, the main guest is an authority closely related to the programme. The guest is briefed in advance about the training course and the programme with special reference to the latest developments in the field. Sometimes, the course coordinator introduces him/her formally to the participants. The chief guest in his/her address gives remarks about the programme, the role of the training in programme promotion and expectations from the participants. It is always advantageous if all of the facilitators and relevant staff are available in this session. One of the facilitators describes the agenda, objectives and contents of the training course. The methodology and rules of business are explained, and feasible time limits for each segment determined. Participants are also informed on what is expected from them at the end of the session. If viable proposals are made by the participants, the agenda may be modified remaining within the limits of course objectives and time span. After adopting the agenda, the revised version should be immediately prepared, copied and distributed to the participants, facilitators and all others concerned.

Technical sessions

Technical sessions will be carried out by the individual facilitators. To strengthen the training and support specific themes, other facilitators or resource persons may be available in certain sessions; however, there should be complete agreement in advance concerning the flow or sequence of training activities and role of each person. The principal facilitator should play the lead role in the presentation and is responsible for the success of the session. Interaction between the facilitators and the participants is essential. The facilitators should be punctual and well disciplined, expecting the same from the participants. Each session should be concluded after a brief question and answer session and discussion of the key issues. Participatory learning will be the main feature of the training. Ideally, every new day should begin with a review of the previous day’s work. The facilitator should assess the outcome of

the previous day and modify the strategies accordingly. The facilitator should also explain the link between the previous and the new topics.

Training tools and methodologies

Presentation or lecture. The presentation or lecture can be given with the aid of a range of audiovisual materials to introduce the theme. Visual images used alongside verbal illustrations strengthen and support the understanding of the participants. The lecture or presentation should be according to an agreed framework, and the sequence of topics should flow with developments in the classroom. Leading questions can be asked of the participants to encourage innovative ideas and exploring potential. The facilitator should apply various methods to retain the attention and maintain the interest of the audience. The main objective should be the transferral and sharing of knowledge.

Discussion. The discussion is an important part of the participatory learning process. The role of the facilitator is crucial in generating discussion, maintaining discipline and achieving the desired outcome.

The theme or topic and reason of the discussion should be clear to all. The group should be informed about the training procedure, how it will take place and what the time limit will be.

Facilitators should initiate discussion and stimulate the participants to be actively involved in the process. They may use questions in order to generate new ideas and clarify relevant concepts. It is worthwhile preparing some key questions in advance which will help to structure the discussion process.

The flow of the discussion should be maintained, and the discussion should remain focused on the subject matter or relevant issues. It should also be in line with the objectives of the training and draw on the relevant experience of the participants. Facilitators should remain vigilant about the environment in the discussion group and use tactics like humour to break the cycle of tension or boredom.

Time management is essential to keep the proceedings on track and according to plan. Time wasting should be politely discouraged, ensuring completion of the discussion within the specified period.

Effective participation of all participants should be ensured, bearing in mind that there are some vocal people who try to take excessive time. The facilitator should encourage the quieter participants and try to explore their ideas.

The ideas coming out of the discussion should be listed on the board and summarized in logical order. Copies of this summary should be circulated to the participants and other facilitators.

Group work. The participants may be divided into groups to exchange views, submit proposals or suggest reforms. They are asked to examine the issue in light of their own situation and integrate what they have learned with the real situation. This exercise helps in improving the analytical skills of the trainees and brings out new ideas. The participants should be divided into equal groups, their number depending on the themes or topics. Each group should be assigned one task at a time which must be realistic and relevant to the

training. Usually, group leaders are nominated to maintain the proceedings. Each group chooses one member to take notes and compile the group report. Facilitators are available as resource persons and to keep an eye on the smooth working of the groups. After the group work, the presenters of groups put forward their findings and conclusions. Ideally the group reports should be copied and circulated to all groups and concerned, and incorporated into the training report for future use.

Brainstorming. This session is conducted on a specific idea or subject and facilitates exploring innovative thoughts. It is the task of the facilitators to stimulate the participants to bring out new ideas and maintain their quality. All ideas should be written on a board and then streamlined to formulate an orderly summary. Participants can be encouraged to contribute by questions or suggesting topics to stimulate creativity. This session is crucial to developing imagination and discussing explanations and interpretations.

Case study. A case study is used to help practise analytical skills. Real problems from true situations are identified and explained to the group, who then discuss the problem and work on alternative solutions before reaching a collective conclusion. This helps in learning to work in coordination in a practical situation.

Reading and assignment. Technical papers, handouts and write-ups are distributed to the participants to further their understanding of the concept. These are usually support material for the subjects discussed in the classroom; however, the participants, individually or in groups, can be given assignments to study additional material and make summaries, answer questions, discuss the information in class or produce a small study on the available materials or books.

Practical exercises. The participants may be given practical training for future application of the knowledge they have gained during the training. The practical exercises may be carried out as individuals or in groups depending upon the nature of work. It will be explained what to do, how to do it and what is expected from them after the exercise. The practical exercises will help to learn form-filling skills, making project proposals, preparing plans of action, documenting information, etc. This part of the training is crucial and will give the trainees confidence in the field work and develop the appropriate skills required for programme implementation. Facilitators should be available to guide the participants in performing these practical exercises.

Field visit. A field visit is the most effective method for transferring knowledge about certain skills within a short period of time. The participants gain practical experience of the processes, products or services and compare them with their own knowledge and experience. The demonstration, such as an exhibition of products or photos or of some machine, can be in the classroom but for community-based initiatives, demonstrations will be mostly in model areas. The trainees will be taken out to a real situation giving them the opportunity to personally observe the operation of a community-based initiative and its outcome. The local team should be made responsible for organization of the visit, with the programme planned in advance. The community should be informed and briefed in detail; their cooperation is essential to this activity. In addition, the local authorities should be informed. Arrangements for transport, food, drink and meeting places should be made in consultation with the local team and community organization. The visit schedule should take into consideration the season, distance and travelling time as well as convenience to the community and the arrangement and timing of activities planned during the visit. Ideally, the visit should be

scheduled for the morning hours, to suit the convenience of both the community and government officials.

The size of the visiting team should be manageable. Large groups can be divided into smaller groups and assigned different tasks. A translator should accompany each group. Local teams should be available to help and answer relevant queries. Participants should be briefed about the study visit, linking its purpose, what to see or study and how to assess the outcome and inputs and make it applicable to their own situation. The visiting group should be encouraged to have an analytic assessment and try to go in depth in all relevant issues and learn the planning, implementation, operation and management, monitoring and supervision, information flow and documentation as well as the evaluation process. In particular, they should view the outcomes in the light of the project objectives and the targets fixed in the proposal as well as the programme goals. At the end of the visit, a session with the community will help in positive feedback and discussion on the possible improvements.

Review and feedback. On return from the field visit, a session should be organized for critical analysis of the visit. The groups may write a brief note on the observations and suggestions. The group should be briefed that this is a study visit, neither an investigation of weaknesses nor an occasion for criticizing. If they find any inconsistency, they should discuss it in the feedback session and not in front of the community. In addition, trainees must be given feedback on their group or individual work presentations, practical exercises, and pre- and post-training assessment. This will help create better understanding and provide the chance to correct erroneous ideas.

Break and refreshments

The interruption of the training session for leisure time, refreshment or prayer is essential to break the cycle of boredom. It should be planned and included in advance in the training schedule, taking into consideration the hours of training. During breaks, participants can relax and interact with each other. Refreshments are also served during this time. If the training schedule is extended to a whole day, a participatory lunch may also be served.

Extra hours

It is important not to overburden the participants with homework and let them relax in the evenings. Social evenings, excursions or sightseeing are always helpful in maintaining the interest of the participants.

Concluding session

The concluding session is intended to wind up the training course. Usually, the session is chaired by a dignitary. The participants, individually or in groups, express their views and comment on the training and the facilitators involved can respond to key questions. The comments of the participants regarding training arrangements, teaching materials and methodologies, attitude of the facilitators and other relevant issues are in fact tools to improve future trainings. The distribution of certificates and settlement of accounts are the main components of this session. The training normally ends with a vote of thanks.

3.5 Pre- and post-training assessments

Pre-training assessment

A pre-training assessment helps in determining the professional knowledge of the participants and their level of understanding about the programme and relevant concepts. It also helps to evaluate their educational status, and facilitators may modify their training strategies in light of the results. It is executed through a questionnaire given in Annex 2.

Post training assessment

A post-training assessment is carried out to evaluate what the participants have achieved during the training course. It is to be conducted before the concluding session, by using the same questionnaire and key as of pre-assessment. It will help in examining the abilities and skills obtained by the participants and will also reflect the success of the training course. This is in fact a direct evaluation of the participants and an indirect evaluation of the facilitators.

Evaluation of the training course by participants

Participants will evaluate the training course by using Annex 3 regarding:

- administrative issues
- technical sessions
- facilitators' support
- field visits.

They will also make suggestions for improving future training courses.

4. FACILITATION TECHNIQUES

The facilitators should be knowledgeable about the technical materials and must possess relevant skills required for effective facilitation.

4.1 Communication skills

Effective training depends upon effective communication among the training partners. It is an integral part of the learning process and should be given due consideration during all sort of training activities.

Factors which may help in better communication are as follows.

- **Language** used during communication should be suited to the target groups and should be easy understandable by all participants. New terminology should be properly explained. It is better to avoid abbreviations but, if used, they should first be explained.

- **Body language** and style are essential components of communication. Dress and make-up should be presentable and suitable for the environment. Body postures including

facial expressions, gestures and movements should coincide with what you want to say or express.

- **Listening** patiently to others not only helps in learning their views and requirements but also generates a friendly environment and help in developing interest among the participants.

- **Responding** promptly to queries and effective feedback discussion, exercises or assignments will enhance the participatory nature of the training and make it more effective. It will advance the quest for knowledge and encourage the exploration of new issues for discussion.

4.2 Motivation skills

Encourage interaction

- During the first day, facilitators should talk individually several times with the participants (for example, during individual discussions). Friendly and helpful behaviour of the facilitators during these initial interactions will overcome the shyness of participants, and let them know that facilitators want to talk and help them. This will facilitate in making the participants to start interacting, becoming more open and productive during the training course.

- Facilitators should look carefully at each participant's work. They should take care of the problems of the participants, even if they do not ask for help. If facilitators show interest and give each participant undivided attention, the participants will feel more compelled to do hard work. Also, if the participants know that someone is interested in what they are doing, they will be more likely to ask for help when they need it.

- Facilitators should be available to the participants at all time during the training course and should be ready to assist them in matters concerning their lodging, meals, transportation and reservations in addition to the training.

Keeping participants involved in discussions

- The facilitators should frequently ask questions of the participants to check their understanding level and keeping them actively thinking and participating through out the session. Questions that begin with "what", "why" or "how" require more than just a few words to answer. Questions that can be answered with a simple "yes" or "no" should be avoided. After asking a question, there should be a small pause, giving participants sufficient time to think and volunteer for response. A common mistake is to ask a question and then answer it yourself. If there is no one reply from the participants, the question should be rephrased that will help in breaking the tension of silence.

- Facilitators should acknowledge participants' responses with a comment, "thank you" or a definite nod. This will make the participants feel valued and encourage further contribution. If a participant has missed some point, ask for clarification, or invite

suggestions from other participants. Facilitators should take care that if any participant feels his comment is ridiculed or ignored, he may withdraw from the discussion entirely or not speak voluntarily again.

- Facilitators should answer participants' questions willingly and encourage them to ask questions when they want rather than to hold the questions until they forget them or become irrelevant to the subject under discussion.

- Facilitators should not feel compelled to answer every question themselves. Depending on the situation, they may turn the question back to the participant in a tactful way or invite other participants to respond. Facilitators may discuss the question with each other before answering. They should have the courage to say "I don't know but I'll try to find out".

- The names the participants should be used while calling them to speak, and while giving them credit or thanks. Similarly the speaker's name should be used when facilitator refers back to a previous comment.

- Facilitators should always maintain eye contact with the participants so that they feel included. He should not to always look at the same participants.

Keeping the session focused and lively

Facilitators should keep their presentation lively through:

- presenting information conversationally rather than reading it

- speaking clearly with varied pitch and pace of voice

- using examples from past experience and asking the participants for the same

- writing key ideas on a flip chart as they are offered. This is a good way to acknowledge the responses and appreciate the ideas of the participants. While recording the ideas on a flip chart, the participant's own words should be used if possible, briefly paraphrasing and recording the idea accurately. Presenters should not turn their back to the group for long periods while writing on the flip chart.

At the beginning of a discussion or group work, the main questions or tasks should be written on the flip chart. This will help participants stay on the subject. When needed, the facilitator should walk to the flip chart and point to the questions or tasks. He should also paraphrase and summarize frequently to keep participants focused. If the discussion in the group strays off topic, the group's attention should be got by telling them they have gone astray, and then original question should be restated to make them focus on the main issues. Several participants should not be allowed to talk at once by assigning an order for speaking and giving everybody a turn to talk.

The quieter participants should be encouraged to talk, by asking their viewpoint and focusing their attention to a particular issue.

Managing overly talkative and disruptive participants

Some participants may talk too much or may unduly disrupt the proceeding. Following are some suggestions to handle such situations.

- Do not ask the talkative participant any more questions. If he answers all the questions directed to the others, ask for an answer from another individual specifically or from a specific subgroup. (For example, ask "Does anyone on this side of the table have any ideas?")

- After a participant has gone on for some time, say "You have had an opportunity to express your views. Let's hear what some of the other participants have to say on this point." Then rephrase the question and invite other participants to respond, or call on someone else immediately by saying "Ms. X, you had your hand up a few minutes ago."

- When the participant pauses, break in quickly and ask to hear from another member of the group or ask a question of the group, such as "What do the rest of you think about this point?"

- Record the participant's main idea on the flip chart. As he continues to talk about the idea, point to it on the flip chart and say "Thank you, we have already covered your suggestion." Then ask the group for other ideas.

- Try to identify participants who have difficulty understanding or speaking the course language. Speak slowly and distinctly so participants can more easily understand. Encourage the participants in their efforts to communicate.

- Discuss with the facilitators any language problems which seriously impair the ability of participants to understand the written materials or the discussions and arrange appropriate help.

- Discuss about the disruptive participants with other facilitators or with the course coordinator. (The course coordinator may be able to discuss matters privately with the disruptive individual.)

Reinforce participants' efforts

The facilitators may have their own style of interacting with participants; however, a few techniques may help in reinforcing participants' efforts:

- avoiding the use of facial expressions or comments which could cause participants feel embarrassed

- sitting or bending down to be on the same level as the participants when talking to them

- answering questions thoughtfully, rather than hurriedly
- encouraging participants to speak to allowing them sufficient time
- demonstrating interest by saying “that’s a good question/suggestion.”

The facilitators should reinforce participants who:

- try hard
- ask for an explanation of a confusing point
- do a good job on an exercise
- participate in group discussions
- help other participants (without distracting them by talking at length about irrelevant matters).

4.3 Facilitation skills

- Spend some time with other facilitators when assignments are first made. Exchange information about prior teaching experiences and individual strengths, weaknesses and preferences. Agree on roles and responsibilities working together as a team.
- Assist one another in providing individual feedback and conducting group discussions. For example, one facilitator may lead a group discussion, and the other may record the important ideas. The second facilitator can check the training modules and add any points that have been omitted or need revision.
- Each day, review the training activities planned to occur the next day and agree on the role of each facilitator.
- Work together on each module rather than taking turns having sole responsibility of one facilitator for a module.

When participants are working

- Remain available, interested and ready to help.
- Watch the participants as they work and offer individual help if a participant seems in trouble, staring into space, not writing answers or not turning pages. These are clues that the participant may need help.
- Encourage participants to ask you questions whenever they need some help.

- If important issues or questions arise when you are talking with an individual, make note of them to discuss later with the entire group.

- If a question arises which a facilitator feels he cannot answer adequately, he should obtain assistance as soon as possible from other facilitators or the course coordinator.

When leading a group discussion

- Plan to conduct the group discussion after all participants have completed the preceding work. Allow ample time for the group work so that participants do not hurry.

- Before beginning the discussion, make appropriate notes to remind the major points for discussion.

- Always begin the group discussion by telling the participants the purpose of the discussion.

- Often there is no single correct answer that needs to be agreed on in a discussion. Just be sure the conclusions of the group are reasonable and that all participants understand how the conclusions were reached.

- Try to get most of the group members involved in the discussion. Record key ideas on a flip chart as they are offered. Keep your participation to a minimum, but ask questions to keep the discussion active and on track.

- Always summarize, or ask a participant to summarize, what was discussed in the exercise. Give participants a copy of the summary.

- Reinforce the participants for their good work:
  - praising them for the list they compiled
  - commenting on their understanding of the exercise
  - commenting on their creative or useful suggestions for using the skills on the job
  - appreciating their ability to work together as a group.

Annex 1

CHECKLIST FOR ORGANIZING TRAINING COURSE

	Activity	**Compliance report**		**Remarks**
		Yes	**No**	
1	Proposal prepared and approved: including the following: • participants list • facilitators list • venue • time schedule • tentative lesson plan • funds and other resources			
2	Approved facilitators confirmed and their profiles obtained			
3	Invitations to the approved participants send, their confirmation and particulars/ documents obtained			
4	Funds and other resources secured			
5	Lodging for the participants arranged			
6	Location/venue confirmed			
7	Logistics arranged, including: • white board and markers • stand board with flip charts • overhead projector and screen • computer and multimedia projector • camera • photocopier machine			
7	Stationery procured, including: • transparencies • papers and flip charts • pencils and marker pens • writing pads • folders			
9	Photocopying facility arranged			
10	Training materials copying/printing and folders for distribution prepared			
11	Secretarial support arranged			
12	Transport for participants and administrative tasks arranged			
13	Registration and attendance sheets printed			
14	Certificates of training prepared and signed (by relevant authority)			
15	Facilitators orientated about the course contents, administrative issue and role of each is earmarked/ defined			

16	Seating arranged, including • seating for presentations • seating for group work • installation of training equipment like projector, screen, sound system • name cards • putting out folders			
17	Refreshments and meals arranged			
18	Chief guest and details of inaugural session arranged			
19	Participants registered and name tags issued			
20	Pre-training assessment and results compiled			
21	Lesson plan adapted and implemented			
22	Field visit arranged, including informing the communities, vehicles, refreshment arrangements and photography			
23	Entertainment/refreshment activities for extra hours arranged			
24	Arrangements for concluding session, including confirmation of chief guest			
25	Post-training assessment and results compiled			
26	Training course evaluated by participants and recommendations consolidated			
27	Results presented in the concluding session			
28	Certification by chief guest and remarks by participants arranged			
29	List of contact numbers/addresses of participants prepared, printed and distributed			
30	Report of the training course prepared			

Annex 2

PRE- AND POST-TRAINING ASSESSMENT

*(Kindly select **one** correct statement for each question)*

QUESTIONS AND STATEMENTS	Tick (√) the appropriate boxes			
	A	**B**	**C**	**D**
1. In your opinion, which of the following sentences is correct? A) Poverty reduction is an essential component of health and human development B) The health sector alone can improve all determinants of health C) Development can be achieved even without community participation D) Development projects may not be based upon country's needs assessment				
2. The major objective of CBI is: A) Generating income B) Promoting literacy C) Improving health D) Creating a parallel system for development				
3. The critical partners for supporting community development are: A) Public sector departments B) NGOs, private sector and international agencies, including WHO C) Community D) All of the above				
4. What kind of mechanism is needed for defining roles and setting the targets at the time of programme initiation? A) Formal contract between the community and supporting partners B) Verbal understanding with the community C) Arrangements with individual beneficiaries only D) B+C				
5. The role of a village development committee is: A) Community mobilization B) Programme management C) Promotion and advocacy D) All of the above				
6. The role of the intersectoral technical support team is: A) Decision making B) Technical support C) Providing loans D) Implementation of the projects				
7. The major role of WHO is: A) Advocacy and technical support B) Providing funds				

QUESTIONS AND STATEMENTS	Tick (√) the appropriate boxes			
	A	**B**	**C**	**D**
C) Managing programme D) None of the above				
8. The priority target group for income-generating projects should be: A) The poorest of the poor B) Members of the community organization C) Technical support team D) All the above				
9. Who should guarantee the return of loans? A) Programme manager B) Government C) Community development committee/other members of the community D) No need for a guarantee				
10. Supervision and monitoring for CBI should assess: A) Technical capacity at all levels B) Sustained improvement of socio-economic indicators C) Documentation and dissemination of programme activities D) All of the above				

Annex 3

EVALUATION OF TRAINING COURSE BY PARTICIPANTS

Components	Grading					Suggestions for improvement
	1 Poor	2 Not Satisfactory	3 Satisfactory	4 Good	5 Excellent	
Administrative						
Arrival arrangements at airport						
Accommodation						
Food						
Secretarial support						
Technical						
Venue						
Duration						
Comprehension						
Quality and relevance of training modules						
Quality of presentations						
Quality of group works						
Quality of plenary discussion						
Facilitator support						
Attitudes						
Knowledge						
Field visit						
Transport						
Clarity of objectives						
Usefulness/relevance						
Quality of time spent in the field						
Feedback and discussions						

How would this training help in your work?

...……

Suggestions for improving future training courses?

……

Part B
Module 1
Unit 1.1

Sustainable development for health

Learning objectives

To gain a better understanding of:

- sustainable development
- quality of life, its model and index
- poverty, its types and causes
- analysing poverty, determining poverty line and identification of poor and vulnerable
- links between sustainable development and health
- strategies for sustainable development for health

Expected outcome

Participants will have a comprehensive understanding of various dimensions of sustainable development in the context of health and application of innovative development approaches in community-based initiatives areas

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1. SUSTAINABLE DEVELOPMENT

Development is a dynamic and cumulative process where all aspects of life come together, affecting the total well-being of the people. Sustainable development meets the needs of the present without compromising the ability to meet those of the future. It is a strategy by which communities seek socioeconomic development approaches which also benefit the local environment and improve quality of life. It is a result of continuity and viability of the development process, which includes the development of human resources, economic infrastructure, natural resources and public service institutions.

Sustainable development with its social and economic dimensions is considered at various levels, such as personal, family, community, national, regional, and global. A country cannot be called developed merely on the basis of high per capita income if most of the people are illiterate, of poor health status and there are no necessary infrastructures required for a healthy living. Accordingly, a community programme or service can be graded as sustainable only if it is able to deliver an appropriate level of benefits and continues over a prolonged period of time.

Sustainable development at local level provides a framework under which communities can use resources efficiently, create efficient infrastructures, protect and enhance quality of life and create new businesses to strengthen their economies

Factors essential for sustainable local development

- Demand and ownership within the community
- Feasible needs-based planning
- Decentralization and transfer of responsibilities and resources
- Capacity building at local level and promotion of technical skills
- Political commitment and administrative support
- Conducive environment and sociocultural factors
- Use of appropriate technologies suitable at local level
- Efficient and transparent financial management
- Effective monitoring and periodic evaluation

2. QUALITY OF LIFE

Quality of life indicates a range of human situations permitting individuals to live socially, spiritually and physically healthy lives, while providing equitable opportunities and accessibility to basic human needs and concurrently restricting key risk factors.

Quality of life is the product of the interplay among social, health, economic and environmental conditions which affect human and social development. It results from a combination of the effects of factors such as those determining health and happiness (including comfort in the physical environment and a satisfactory occupation), education, social and intellectual attainment, freedom of action, justice and freedom from oppression. Therefore, it must be considered in the broader context of local development and human needs, leading individuals to live a productive and healthy life

Quality of life may be subjective or objective. Subjective quality of life is about feeling good and being satisfied with things in general. Objective quality of life is about fulfilling the societal and cultural demands for material wealth, social status and physical well-being. The best way of assessing quality of life is to measure the extents to which people's happiness requirements are met.

Improvement in quality of life depends on better health status, literacy, living conditions and income resources of the family. On the other hand, promotion of better quality of life can promise human development and subsequently improvement of the health situation.

2.1 Quality of life model

Since good quality of life is considered central to human and social development, and its determinants are interdependent, a combination of multidisciplinary actions at community and individual levels is essential for making quality of life model a practical reality. The following are considered the most significant components of quality of life model.

- Health
- Food and nutrition
- Family planning
- Water and sanitation
- Better housing conditions
- Environment
- Education
- Means of livelihood
- Physical and social security
- Communication facilities

2.2 Quality of life index

Quality of life index provides a tool for assessing the community development and monitors the key indicators which encompass the social, health, environmental and economic

dimensions. It intends to monitor the factors which affect the living and working conditions of the people and focus on community actions to improve health.

Quality of life being subjective, outcome of multiple interventions can be indirectly perceived through health and social indicators. The physical index of quality of life[1] consolidates following four indicators which measure results rather than impact:

QOL indicators

- Infant mortality rate
- Life expectancy
- Literacy rate
- GDP per capita

- **Infant mortality rate (IMR)** indicates the availability and use of health services;
- **Life expectancy (LE)** shows overall economic and social development;
- **Literacy rate (LR)** reflects the development of human resources;
- **Gross domestic product (GDP) per capita** (based on purchasing power parity (PPP) exchange rates) interprets the level of economic growth.[2]

In addition to the above, other indicators, such as growth rate, healthy lifestyles or those used for measuring the potential risk factors, may be included.

3. POVERTY

Poverty is a multidimensional issue and affects all walks of life. According to Amartya Sen's analysis,[3] poverty is "capability deprivation", where a person lacks the "substantive freedoms" to live the "kind of life he or she has reason to live". Along with other deprivations, it creates social and emotional needs and relative powerlessness.

Understanding poverty depends upon the historical, cultural and socioeconomic contexts. It can be defined from the perspective of the individual, considering exclusion, lack of resources and deprivation, or from a national perspective, which links poverty to the stages of economic development and existence of socioeconomic disequilibrium.

"Absolute poverty" under WHO's international classification of diseases, is "categorized as a disease"

1 UNDP. *Human development report*, 1990–2001.

2 *Ibid*.

3 Sen A. *Development as freedom. Oxford, Oxford University Press.*

Poverty has been considered the main cause restricting all human development efforts. Economic dispossession is the major factor, causing many social evils and hampering health promotion efforts.

Families are graded as poor when their income is insufficient to obtain the minimum necessities for the maintenance of physical efficiency. In other words, people are poor, when they:

- cannot afford to fulfil their basic needs, such as food, clothing
- do not have housing
- have unsatisfied social needs—the opposite of health

3.1 Extent of poverty

Unfortunately, at the beginning of the 21st century, the number of people living in absolute poverty continues to rise, with grim health consequences. Those living in absolute poverty are five times more likely to die before reaching their fifth birthday, and two-and-half times more likely to die between the ages of 15 and 59 than those in higher income groups. Differences in maternal mortality are even more dramatic. The lifetime risk of dying in pregnancy in parts of sub-Saharan Africa is 1 in 12, compared to 1 in 4000 in Europe. Poverty reduction is a critical development challenge for many member states in the Eastern Mediterranean Region as nine of its countries and areas have annual per capita incomes of less than US$ 1000.

At present, about 20% of the world's population or 1.3 billion people live in absolute poverty, with an income of less than US$ 1 per day. Surviving on less than US$ 2 per day is a reality for almost half the people on the planet

3.2 Types of poverty

Poverty comes in many forms, such as being deprived of education or health, low income, poor access to resources and skills, vulnerability, insecurity, voicelessness and disempowerment. Moreover, poverty can be distinguished from other forms of deprivation, such as physical weakness, isolation, vulnerability and powerlessness, with which it interacts.

Poverty may be human or economic in nature. Human poverty relates to the social aspects of life such as depreciation of health, food and nutrition, education, safe water, whereas economic poverty is scarcity of resources and regular income to maintain livelihood.

Poverty can also be classified as absolute and relative, based on the human needs and development context. Absolute poverty is based on the idea of minimum standards for physical

survival. It is related to a minimum consumption basket containing the basic food necessary for the nationally recommended calorie intake, as well as some non-food items such as housing, water and health facilities. Relative poverty, on the other hand, is state of deprivation resulting from having less than what the majority of the people have. It is deprivation of the opportunities, material assets and self respect regarded as normal in the community to which an individual belongs.

3.3 Causes of poverty

- Economic maldistribution, leading to concentration of resources in few hands, leaving the poor devastated.

- Unemployment and underemployment as a result of economic recession, rapid mechanisation and lack of skills among the risk groups.

- Limited credit facilities with complicated systems and high interest rates keep the poor away from benefiting.

- Poor occupational conditions aggregate the miseries of the poor by causing trauma, occupational health hazards and deformities.

- Chronic debilitating disease or disabilities do not allow living a productive life, but rather reduce or deplete the family assets and savings due to continuous expenditure on medical care.

- Unhealthy life styles and substance abuse are injurious to human health and well being, and aggravate the problem of poverty.

- Large family size is associated with increased financial and material requirements as well as enhanced needs for public services.

- Low education and lack of technical skills prevents the poor to avail good job opportunities to come out of poverty trap .

- Gender deprivation and social demarcation restrict economic and development opportunities, and keep them voiceless and powerless.

3.4 Analysing poverty

Analysing poverty and developing adequate parameters to measure it is a complex process. Poverty measurements have often been restricted to the analysis of income or consumption. There are many aspects of poverty that cannot be measured, such as inadequate participation in decision-making or in community life, lack of security, vulnerability, and social discriminations.

Recognition of the limitations for measuring the economic dimensions of poverty alone, UNDP has developed its Human Poverty Index, which includes:

- longevity (percentage of newborns expected to die before the age of 40)
- education (percentage of adults who are illiterate)
- better standards of living (percentage of people without access to health services and to safe water; percentage of malnourished children below 5 years of age).

Analysis of poverty seeks to understand the dimensions, causes and manifestations of poverty; therefore, the defining line needs to be considered in the context of local situations. Economic poverty may be measured through defining a poverty line, which is a tool for distinguishing the poor from the non-poor.

The poverty line is constructed according to the value of income or consumption necessary to maintain a minimum standard of human nutrition and other basic necessities. The minimum level below which society believes income should not fall can be taken as the scale or line for determining poverty. People living below the poverty line might then be those whose diet falls consistently below the nationally recommended daily calorie intake needed to sustain human life. The poverty line does not generally include other factors which determine quality of life, such as access to safe water and basic public services. The poverty line should reflect differences in the cost of living across time and place. It may also be different in rural and urban areas of the same country.

3.5 Identifying the poor and vulnerable

Vulnerable people and those living in absolute poverty in a society can be identified by a number of characteristics which should always be considered in relation to each other. These include:

- family income below the official poverty line
- consensus by community leaders about family poverty status
- children under three years and moderately or severely malnourished women
- family obliged to resort to child labour because of lack of income
- children not sent to school due to lack of resources
- parents elderly, unemployed, sick or handicapped
- lone-parent families or orphan children
- widows with no regular financial support as heads of the family
- families having no electricity, when the majority have this facility
- families having no personal source of water, when the majority have this facility
- families residing in a one-room house when the majority have two or more room houses

- landless or small landowners
- nomads, refugees and displaced persons
- victims of race inequality suffering employment discrimination.

4. LINKS BETWEEN SUSTAINABLE DEVELOPMENT AND HEALTH

It has been extensively recognized that economic development alone cannot solve the major problems of poverty, hunger, malnutrition and disease. This can only be fruitful with social goals and enhanced human well-being. Experience has illustrated that sustainable development and enhanced quality of life promote health and prevent a range of ills, including diseases and deformities. On the other hand, underdevelopment and poor living conditions add to the miseries and enhance the burden of disease. Simultaneously, the detrimental effects of diseases and deformities on the physical, mental and social capacities of individuals are associated with the loss of productivity and creative opportunities as well as increased vulnerability to further illnesses.

The poor and susceptible groups are at higher risk due to their deprivation and limitation of resources. Once they are trapped in the vicious cycle of poverty, they cannot come out of it without substantial support. Therefore, emphasis should be on developing situations, establishing social infrastructure and ensuring effective use of services to assist communities in improving their quality of life and promoting health.

Health, being an integral part of development, cannot be gained in isolation. Health services are no longer considered merely a complex of solely medical measures, but a subsystem of an extensive socioeconomic system. The human health being the ultimate goals of development requires support and coordination of all stakeholders and those connected with the major determinants of ill health

5. MILLENNIUM DEVELOPMENT GOALS FOR SUSTAINABLE DEVELOPMENT AND HEALTH

The international community has agreed to give health a central position in the development and poverty reduction agenda by establishing the millennium development goals (MDGs).

Millennium development goals related to health	
Eradicate extreme poverty and hunger	• **Halve, between 1990 and 2015, the proportion of people whose income is less than US$ 1 a day and who suffer from hunger**
Reduce child mortality	• **Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate**
Improve maternal health	• **Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio**
Combat HIV/AIDS, malaria and other diseases	• **Have halted by 2015, and begun to reverse, the spread of HIV/AIDS and the incidence of malaria and other major diseases**
Ensure environmental sustainability	• **Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources**
	• **Halve, by 2015, the proportion of people without sustainable access to safe drinking water**

The millennium development goals are an expression of humanitarian concern and call for investment in human well-being; therefore, WHO has focused on fostering its efforts towards joint actions for health and development through:

- intensifying efforts to control and prevent widespread diseases and conditions associated with poverty, such as tuberculosis and malnutrition

- targeting the poor in the areas such as reproductive health, child health, nutrition and malaria

- dealing with the systemic factors that sometimes hamper the access by the poor to the health and development programmes

- promoting awareness regarding the importance of poverty and health-related issues

- addressing the financial barriers to ensuring access of the underprivileged to equitable health opportunities by introducing sustainable health care financing options such as a social safety net and income generation schemes

- collaborating with partners on poverty reduction measures and related strategies.

Strategies for sustainable development for health

Health	- Providing primary health care services at grass roots level - Reducing high rates of mortality and morbidity due to preventable high-risk diseases like malaria, tuberculosis AIDS - Greater investment in reducing maternal and infant mortality - Revitalizing and extending the coverage of immunization programmes - Provision of efficient family planning services - Promotion of healthy and nutritious foods and introducing appropriate measures for food hygiene and safety - Promotion of healthy lifestyles, health awareness, encouraging physical exercise - Introducing school health programmes - Building the capacity of health systems to proactively counter the potential threats to health - Preparing for effective response to the emerging community health needs
Housing, environment and water supply	- Improving housing conditions: - Provision of safe water supply - Promotion of healthy environments and effective sanitation systems
Education	- Enhancing opportunities for education, literacy and awareness, especially among the most vulnerable groups
Economic sector	- Supporting communities to attain optimum income resources, developing employment opportunities, and ensuring job security and satisfaction - Promoting the technical and vocational skills to improve employment opportunities
Local government	- Ensuring intersectoral input and support for sustained local development - Mobilization of resources by both government and the community for focused interventions to achieve social gains

Part B
Module 1
Unit 1.2

Community-based initiatives in the Eastern Mediterranean Region

Learning objectives

To gain a better understanding of:

- concepts, objectives and strategies of community-based initiatives (BDN, HVP, HCP, WHD)
- implementation of community-based initiatives in the Eastern Mediterranean Region
- guidelines and tools for community-based initiatives
- role of WHO in implementation of community-based initiatives
- how community-based initiatives can bring about change

Expected outcome

The participants will understand concepts of community-based initiatives and know the methodology to implement these within the local context

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1. INTRODUCTION

During the past few decades, fundamental changes have been witnessed in the economic, political, social, technological and environmental areas of development. These changes have resulted in a continuous redefinition of the processes and goals of development. There is growing recognition that development should go beyond economic growth and ensure social equity, ecological stability, community participation and intersectoral coordination. Also, it has been acknowledged that major determinants of ill health, such as illiteracy, overpopulation, deficiencies in food and nutrition, poor sanitation, unsafe water supply, lack of development opportunities, rising scales of poverty, and deficient awareness regarding health and life issues, lie outside the domain of the health sector and are mainly related to socioeconomic factors. In order to cope these changing situations, WHO's Regional Office for the Eastern Mediterranean has developed an innovative strategy of community-based initiatives for health and development, in which simultaneous emphasis is put on economic growth, improvement in standards of living, health status and quality of life. These approaches provide a new orientation for multisectoral efforts to ensure that health considerations are core of all development and environmental activities.

The following community based initiatives for health and development have been introduced in the Region.

- basic development needs (BDN)
- health villages programme (HVP)
- healthy cities programme (HCP)
- women in health and development (WHD).

2. OBJECTIVES

The main objective of community-based initiatives is to facilitate the integration of health policies and programmes into national strategic development agendas. These aim at improving health and environmental conditions, reducing poverty and achieving a better quality of life through the attainment of the millennium development goals. The work is focused on promoting equity, especially from a human rights perspective, gender mainstreaming and enhancing the role of women in health and sustainable development.

Community-based initiatives

- put health at the centre of the social and political agendas
- make people partners
- promote healthy lifestyles
- improve environmental services
- reduce poverty

3. STRATEGIES

- To generate and disseminate information on the role and centrality of health in sustainable development, highlighting the socioeconomic and environmental determinants of health.

- To support the countries of the Region in developing a shared vision for health and development and in formulating national strategies focusing on health of the poor based on poverty analysis and measurement.

- To assist national authorities and civil society in reducing health inequalities and poverty through dynamic, intersectoral collaboration and to tackle challenges pertaining to globalisation, human rights and emerging technologies.

- To help in empowering communities and vulnerable groups, particularly women to play the leading role in health and development.

- To build and expand partnerships within and outside the Region in support of WHO policies and programmes for resource mobilization and joint advocacy and actions.

- To assist member countries in incorporating community development approaches in national poverty reduction policies and programmes.

4. BASIC DEVELOPMENT NEEDS PROGRAMME

Acknowledging the need for a broader action to achieve the goal of health for all, WHO's Regional Office for the Eastern Mediterranean introduced the concept of basic development needs (BDN) in 1987 and supported the countries of the Region in its implementation in partnership with the developing communities. After remarkable successes, this approach is now considered an effective instrument for improving socioeconomic and health indicators, providing a valuable basis for intersectoral activities, strong community partnerships and sustainable, integrated development. The approach is particularly significant vis-à-vis the changing social, political, economic, demographic and epidemiological patterns in the Region. This approach also represents a shift from conventional, isolated, sectoral activities towards more holistic development where the community itself assesses and prioritise their needs and plans feasible solutions, supported ands assisted by government departments. Priority is given to those activities which will further improve the health of the people.

The basic development needs programme is an integrated socioeconomic development approach to achieve the goal of health for all through improving quality of life and reducing poverty. It is based on the principles of self-reliance, self-financing and self-management by the organized, empowered and actively participating communities, supported through coordinated intersectoral actions.

4.1 Objectives

- Mobilizing and organizing communities; promoting self-management, self-reliance and self-dependence.

- Encouraging communities to work as partners in the planning, implementation and monitoring of the development process.

- Supporting communities for leadership roles and enhancing their capabilities in this respect.

- Encouraging governments to develop effective collaboration between the departments involved in the programme, partnerships with civil society and other stakeholders and coordination of intersectoral actions in support of the communities.

- Upgrading the managerial and technical capacities of government functionaries.

- Mobilizing communities and government resources in a single direction towards integrated socioeconomic development.

- Enhancing the educational status, literacy and awareness of the people, making them responsible partners in society.

- Identification and promotion of appropriate, health-friendly technologies for community development and encouragement of healthy lifestyles within the community .

- Introducing socioeconomic interventions and supporting the mobilization of community resources and technical, physical and financial inputs by both government and international agencies.

- Operational research for designing developmental models to facilitate replication of programmes in other communities.

- Reducing poverty—the root cause of social evils and ill health.

- Improving health indicators through comprehensive health services and improved quality of life as an outcome of socioeconomic development.

5. HEALTHY VILLAGES PROGRAMMES

The rural communities in the Eastern Mediterranean Region face a number of unique challenges. Migration from rural to urban areas has created a scarcity of trained human resources in the rural areas. The changed structures and circumstances have posed serious threats to the health and well-being of the rural population. Health and environmental challenges have multiplied, aggravating the problems of water supply, sanitation, housing and personal hygiene, resulting in a greater burden of disease. An increasing index of poverty has further deteriorated the underprivileged communities. In order to cope effectively with these

challenges, the Regional Office for the Eastern Mediterranean introduced the healthy villages approach in member countries.

Healthy villages programmes (HVP) are a tool for enhancing and accelerating the process of achieving health for all through improving the quality of life of the people. This approach uses health as the primary entry point in addressing the requirements of social and human development in rural communities. In order to achieve the targets, the organized participation of the communities and strong intersectoral collaboration at all levels are considered essential. These programmes offers health professionals and community leaders a unique opportunity to adapt health activities to local requirements.

5.1 Objectives

- Promoting and mobilizing health and environmental measures.
- Facilitating collaboration between health and related sectors at the local level.
- Raising community awareness and standards of health and hygiene education.
- Placing a high priority on improving environmental services (water supply, sanitation, village cleanliness).
- Stimulating and strengthening local-level decision-making and empowerment.
- Encouraging and promoting mobilization of resources and economic development.
- Creating physical, social, cultural, institutional and economic environments that support health and sustainable development.
- Building capacities and encouraging government sectors to integrate the local plans within the master development plans of districts.

Characteristics of a healthy village

- Clean and safe physical environment
- Social harmony and solidarity
- Promotion of education and awareness
- Accessibility of all to quality health services
- Sustainable use of available resources
- Diverse and innovative economy
- Protection of historical and cultural heritage
- Community access to varied experiences and interactions

6. HEALTHY CITIES PROGRAMMES

The Eastern Mediterranean Region has one of the world's fastest rates of population growth in urban areas. This rapid growth has caused a multitude of political, social, financial, environmental and health problems. Many major cities suffer from congestion, air pollution, industrial pollution, and inadequate sewage and solid waste management systems. Shortage of drinking water is a major issue in the rapidly growing cities. Many cities suffer from housing shortages. Green areas around the cities are being eroded or destroyed. In some countries there is often no town planning, resulting in chaotic development. Physical and social factors such as health services, environment, economy, population growth, social factors, education and awareness directly or indirectly affect the health of urban dwellers. Additionally, rapid urbanization has affected traditional social bonds and cultural affinities. The urban poor, especially in the low- and middle-income countries of the Region, are at the interface between underdevelopment and industrialization, and their lifestyle and disease patterns reflect the problems of both. They are affected by improper diets and a sedentary lifestyle. As a result, they suffer high maternal, infant, and child mortality as well as a high incidence of communicable and noncommunicable diseases. In order to collectively address health determinants, WHO has been supporting the introduction of healthy cities programmes (HCP) in a number of countries and cities in the Region.

A healthy city is a clean urban locality, with a healthy population and good cultural services. It provides a physically safe environment where people can live comfortably with their own cultural bonds, beliefs, customs and lifestyles.

Healthy cities programmes work on the principle that health and quality of life can be improved by the modification of living conditions—home, school, workplace, city—the places or settings where people live and work. It addresses issues such as strengthening health services, water supply, sanitation, pollution and housing, focusing on the promotion of healthy lifestyles and activities that can generate income, improves education and women's development. Healthy cities programmes generate local and community support facilitating coordination by all stakeholders involved and initiates the dialogue between partners for common strategies and actions.

6.1 Objectives

- Upgrading of environmental and health services in urban settings and neighbourhoods, especially underprivileged areas.
- Increasing awareness of health and environmental issues.
- Mobilizing communities and government sectors for political commitment and support.
- Building capacities of municipal authorities to manage urban problems and putting health at the central position in municipal agendas.
- Providing leadership and inspiring partnerships for mobilizing potential resources.

7. WOMEN IN HEALTH AND DEVELOPMENT

The improved status of women is essential to the economic, social and environmental dimensions of sustainable development. Women, especially in developing countries, lack empowerment in matters of daily life and health opportunities. Women are half of the world's population but their income is far less compared to that of males—they receive only 1/10 of total income. They comprise 70% of the poor in the world but still have limited access to the labour market. They account for two-thirds of hours worked but own 1/100 of property. This situation is aggravated when they receive inadequate sectoral support. Women are more prone to household accidents and face a high risk of violence. Social discrimination and powerlessness have aggravated mental health problems among women, in particular depressive neurosis. The health situation of females becomes worse when coupled with poverty. They suffer different patterns of mortality and morbidity, not only due to biological reasons but also due to inequality and lack of awareness. Although life expectancy is slightly higher in women, they suffer more from chronic and acute illnesses that are mainly preventable.

The Regional Office for the Eastern Mediterranean has integrated gender considerations in all facets of its work, and is supporting member countries to promote a proactive role for women in health and development issues. This approach focuses on the empowerment of women as central to all efforts for reaching sustainable development with its economic, social and environmental dimensions. The concept is that women's education, training, empowerment and participation in decision-making positions can transform their place in health and development and harness their role as equal partners in society.

The main objective of the women in health and development approach is to enhance the role of women and mainstream gender as an essential component of community-based initiatives and other WHO programmes.

Women in health and development

- Encourage gender awareness and capacity-building
- Support human rights, dignity, self-worth and abilities of girls and women
- Ensure women participation in decision-making at all levels
- Promote equitable opportunities for health and socio-economic development
- Develop gender-based health information systems and gender analysis
- Give special attention to health related needs of women

8. IMPLEMENTATION OF COMMUNITY-BASED INITIATIVES IN THE EASTERN MEDITERRANEAN REGION

While initiating community-based initiatives in a country, the ministry of health usually takes the lead role with the active support of WHO and carries out following steps:

- preparation and orientation
- organizational set-up
- situational analysis and area development profile
- needs-based interventions and resources mobilization
- financial management
- information and monitoring
- local expansion
- evaluation.

Implementation of community-based initiatives is accomplished in two phases:

- model area development and local expansion
- large-scale expansion.

Phase 1 Model area development and local expansion

Community-based initiatives start with a small-scale research and development project in one or more selected areas. This involves limited risk and feasible cost. After successful implementation, the programme areas demonstrate the results of the community development project to the government and other stakeholders, exploring potential partnerships. It promotes consensus among various sectors in order to work jointly for the attainment of integrated goals. The model areas are gradually expanded into the surrounding areas, a strategy which promotes technical cooperation among developing communities.

Phase 2 Large scale expansion

The expected outcome of the first phase is the large-scale expansion of community-based initiatives activities and their incorporation into the national plan as a strategy for achieving integrated community development. The rational use of existing resources and organizational infrastructures facilitated by devolution of authority assists in bottom up planning and management. Additional resources for expansion are required to be mobilized mainly from the national, regional and local levels, and from partnerships developed with national and international agencies.

9. COMMUNITY-BASED INITIATIVES MANAGEMENT GUIDELINES AND TOOLS

Community-based initiatives, until recently, have been implemented without any uniformity. In order to introduce a common and feasible methodology, the Regional Office for the Eastern Mediterranean has designed a set of management guidelines and tools with the active involvement of member countries. These guidelines can be used as reference for the implementation and management of all community based initiatives, after adaptation according to the local situation and needs in each country.

The major objectives of the management guidelines are to:

- describe the necessary set of activities and milestones for community-based initiatives planning, promotion and evaluation in the various phases of its development at different levels of government
- provide a framework for undertaking and implementing these activities in a systematic manner
- identify potential partners and their roles and resources within the government sector and among nongovernmental organizations, international agencies and the community.

Management guidelines provide the following comprehensive tools:

- planning
- organization
- human resource development
- community survey and prioritization
- project preparation and implementation
- supervision and monitoring
- financial management
- documentation and reporting
- promotion and advocacy
- programme evaluation

10. BUILDING PARTNERSHIPS

Community-based initiatives, being multidisciplinary, and intersectoral development approaches require active partnerships between the health sector and the community as well as other sectors, donor agencies and other stakeholders. The potential partners for community-based initiatives besides government, WHO and the community, include:

- United Nations agencies such as the United Nations Development Programme (UNDP), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the Food and Agriculture Organization of the United Nations (FAO), the International Labour Organization (ILO) and the Arab Gulf Fund for United Nations (AGFUND)

- development banks such as the World Bank, Asian Development Bank, Islamic Development Bank, African Development Bank

- bilateral donor agencies such as the UK Department for International Development (DFID), the Canadian International Development Agency (CIDA), the International

Fund for Agricultural Development (IFAD), and the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)

- nongovernmental organizations (national and international)
- academic and research institutions.

The role of these agencies includes:

- assisting the preparation of national policies and plans
- building the capacity of the national authorities and the communities
- undertaking joint actions for technical assistance and financial support
- fostering the flow of information, exchange of experiences and technical cooperation
- marketing community-based initiatives approaches, creating linkages with similar approaches
- Supporting research and development of appropriate technologies.

While advocating for community-based initiatives to attract new partners, adequate care should be taken to avoid conflicts of interest or resistance to change.

11. THE ROLE OF WHO IN THE IMPLEMENTATION OF COMMUNITY-BASED INITIATIVES

The principal role of WHO in the community-based initiatives programme implementation is catalytic in nature by providing assistance to governments to:

- develop models of sustainable health as part of overall national development
- support the building up of national capacities through orientation and training activities
- prepare, in collaboration with national organizations, plans for launching the CBI approach in model areas, incorporating technical, financial, logistical and evaluation components
- encourage the development of strong intersectoral collaboration with communities, nongovernmental organizations and the private sector to promote the concepts of health and equity as fundamental principles of development
- promote community-based initiatives to other international organizations as well as national decision-makers

- support research and development projects in the countries of the region, with particular emphasis on economic profiles and sustainability

- enable national authorities to integrate and sustain community-based initiatives in national development plans through gradual transformation of the role of WHO. This involves moving from active participation and financial contribution during the first phase of CBI to mainly providing technical support to the government and others during the expansion phase.

12. HOW COMMUNITY-BASED INITIATIVES BRING ABOUT CHANGE

Changes take place through the following:

- encouraging change in self and society

- introducing intersectoral coordination and partnerships

- breaking the vicious cycle of dependency through active community participation (community development for the people, by the people)

- developing awareness among the masses concerning their needs and rights, coping with problems, practising healthy lifestyles and health care measures

- encouraging decentralization and local empowerment for bottom-up planning and self management

- mobilizing local and public resources

- transforming the attitude of government functionaries to be more supportive of the community

- improving health status through increased family income and self-care

- reducing poverty and improving quality of life and health.

Part B
Module 1
Unit 1.2

Community-based initiatives in the Eastern Mediterranean Region

Learning objectives

To gain a better understanding of:

- concepts, objectives and strategies of community-based initiatives (BDN, HVP, HCP, WHD)
- implementation of community-based initiatives in the Eastern Mediterranean Region
- guidelines and tools for community-based initiatives
- role of WHO in implementation of community-based initiatives
- how community-based initiatives can bring about change

Expected outcome

The participants will understand concepts of community-based initiatives and know the methodology to implement these within the local context

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1. INTRODUCTION

During the past few decades, fundamental changes have been witnessed in the economic, political, social, technological and environmental areas of development. These changes have resulted in a continuous redefinition of the processes and goals of development. There is growing recognition that development should go beyond economic growth and ensure social equity, ecological stability, community participation and intersectoral coordination. Also, it has been acknowledged that major determinants of ill health, such as illiteracy, overpopulation, deficiencies in food and nutrition, poor sanitation, unsafe water supply, lack of development opportunities, rising scales of poverty, and deficient awareness regarding health and life issues, lie outside the domain of the health sector and are mainly related to socioeconomic factors. In order to cope these changing situations, WHO's Regional Office for the Eastern Mediterranean has developed an innovative strategy of community-based initiatives for health and development, in which simultaneous emphasis is put on economic growth, improvement in standards of living, health status and quality of life. These approaches provide a new orientation for multisectoral efforts to ensure that health considerations are core of all development and environmental activities.

The following community based initiatives for health and development have been introduced in the Region.

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- women in health and development (WHD).

2. OBJECTIVES

The main objective of community-based initiatives is to facilitate the integration of health policies and programmes into national strategic development agendas. These aim at improving health and environmental conditions, reducing poverty and achieving a better quality of life through the attainment of the millennium development goals. The work is focused on promoting equity, especially from a human rights perspective, gender mainstreaming and enhancing the role of women in health and sustainable development.

Community-based initiatives

- put health at the centre of the social and political agendas
- make people partners
- promote healthy lifestyles
- improve environmental services
- reduce poverty

3. STRATEGIES

- To generate and disseminate information on the role and centrality of health in sustainable development, highlighting the socioeconomic and environmental determinants of health.

- To support the countries of the Region in developing a shared vision for health and development and in formulating national strategies focusing on health of the poor based on poverty analysis and measurement.

- To assist national authorities and civil society in reducing health inequalities and poverty through dynamic, intersectoral collaboration and to tackle challenges pertaining to globalisation, human rights and emerging technologies.

- To help in empowering communities and vulnerable groups, particularly women to play the leading role in health and development.

- To build and expand partnerships within and outside the Region in support of WHO policies and programmes for resource mobilization and joint advocacy and actions.

- To assist member countries in incorporating community development approaches in national poverty reduction policies and programmes.

4. BASIC DEVELOPMENT NEEDS PROGRAMME

Acknowledging the need for a broader action to achieve the goal of health for all, WHO's Regional Office for the Eastern Mediterranean introduced the concept of basic development needs (BDN) in 1987 and supported the countries of the Region in its implementation in partnership with the developing communities. After remarkable successes, this approach is now considered an effective instrument for improving socioeconomic and health indicators, providing a valuable basis for intersectoral activities, strong community partnerships and sustainable, integrated development. The approach is particularly significant vis-à-vis the changing social, political, economic, demographic and epidemiological patterns in the Region. This approach also represents a shift from conventional, isolated, sectoral activities towards more holistic development where the community itself assesses and prioritise their needs and plans feasible solutions, supported ands assisted by government departments. Priority is given to those activities which will further improve the health of the people.

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4.1 Objectives

- Mobilizing and organizing communities; promoting self-management, self-reliance and self-dependence.

- Encouraging communities to work as partners in the planning, implementation and monitoring of the development process.

- Supporting communities for leadership roles and enhancing their capabilities in this respect.

- Encouraging governments to develop effective collaboration between the departments involved in the programme, partnerships with civil society and other stakeholders and coordination of intersectoral actions in support of the communities.

- Upgrading the managerial and technical capacities of government functionaries.

- Mobilizing communities and government resources in a single direction towards integrated socioeconomic development.

- Enhancing the educational status, literacy and awareness of the people, making them responsible partners in society.

- Identification and promotion of appropriate, health-friendly technologies for community development and encouragement of healthy lifestyles within the community .

- Introducing socioeconomic interventions and supporting the mobilization of community resources and technical, physical and financial inputs by both government and international agencies.

- Operational research for designing developmental models to facilitate replication of programmes in other communities.

- Reducing poverty—the root cause of social evils and ill health.

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5. HEALTHY VILLAGES PROGRAMMES

The rural communities in the Eastern Mediterranean Region face a number of unique challenges. Migration from rural to urban areas has created a scarcity of trained human resources in the rural areas. The changed structures and circumstances have posed serious threats to the health and well-being of the rural population. Health and environmental challenges have multiplied, aggravating the problems of water supply, sanitation, housing and personal hygiene, resulting in a greater burden of disease. An increasing index of poverty has further deteriorated the underprivileged communities. In order to cope effectively with these

challenges, the Regional Office for the Eastern Mediterranean introduced the healthy villages approach in member countries.

Healthy villages programmes (HVP) are a tool for enhancing and accelerating the process of achieving health for all through improving the quality of life of the people. This approach uses health as the primary entry point in addressing the requirements of social and human development in rural communities. In order to achieve the targets, the organized participation of the communities and strong intersectoral collaboration at all levels are considered essential. These programmes offers health professionals and community leaders a unique opportunity to adapt health activities to local requirements.

5.1 Objectives

- Promoting and mobilizing health and environmental measures.
- Facilitating collaboration between health and related sectors at the local level.
- Raising community awareness and standards of health and hygiene education.
- Placing a high priority on improving environmental services (water supply, sanitation, village cleanliness).
- Stimulating and strengthening local-level decision-making and empowerment.
- Encouraging and promoting mobilization of resources and economic development.
- Creating physical, social, cultural, institutional and economic environments that support health and sustainable development.
- Building capacities and encouraging government sectors to integrate the local plans within the master development plans of districts.

Characteristics of a healthy village

- Clean and safe physical environment
- Social harmony and solidarity
- Promotion of education and awareness
- Accessibility of all to quality health services
- Sustainable use of available resources
- Diverse and innovative economy
- Protection of historical and cultural heritage
- Community access to varied experiences and interactions

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The Eastern Mediterranean Region has one of the world's fastest rates of population growth in urban areas. This rapid growth has caused a multitude of political, social, financial, environmental and health problems. Many major cities suffer from congestion, air pollution, industrial pollution, and inadequate sewage and solid waste management systems. Shortage of drinking water is a major issue in the rapidly growing cities. Many cities suffer from housing shortages. Green areas around the cities are being eroded or destroyed. In some countries there is often no town planning, resulting in chaotic development. Physical and social factors such as health services, environment, economy, population growth, social factors, education and awareness directly or indirectly affect the health of urban dwellers. Additionally, rapid urbanization has affected traditional social bonds and cultural affinities. The urban poor, especially in the low- and middle-income countries of the Region, are at the interface between underdevelopment and industrialization, and their lifestyle and disease patterns reflect the problems of both. They are affected by improper diets and a sedentary lifestyle. As a result, they suffer high maternal, infant, and child mortality as well as a high incidence of communicable and noncommunicable diseases. In order to collectively address health determinants, WHO has been supporting the introduction of healthy cities programmes (HCP) in a number of countries and cities in the Region.

A healthy city is a clean urban locality, with a healthy population and good cultural services. It provides a physically safe environment where people can live comfortably with their own cultural bonds, beliefs, customs and lifestyles.

Healthy cities programmes work on the principle that health and quality of life can be improved by the modification of living conditions—home, school, workplace, city—the places or settings where people live and work. It addresses issues such as strengthening health services, water supply, sanitation, pollution and housing, focusing on the promotion of healthy lifestyles and activities that can generate income, improves education and women's development. Healthy cities programmes generate local and community support facilitating coordination by all stakeholders involved and initiates the dialogue between partners for common strategies and actions.

6.1 Objectives

- Upgrading of environmental and health services in urban settings and neighbourhoods, especially underprivileged areas.
- Increasing awareness of health and environmental issues.
- Mobilizing communities and government sectors for political commitment and support.
- Building capacities of municipal authorities to manage urban problems and putting health at the central position in municipal agendas.
- Providing leadership and inspiring partnerships for mobilizing potential resources.

7. WOMEN IN HEALTH AND DEVELOPMENT

The improved status of women is essential to the economic, social and environmental dimensions of sustainable development. Women, especially in developing countries, lack empowerment in matters of daily life and health opportunities. Women are half of the world's population but their income is far less compared to that of males—they receive only 1/10 of total income. They comprise 70% of the poor in the world but still have limited access to the labour market. They account for two-thirds of hours worked but own 1/100 of property. This situation is aggravated when they receive inadequate sectoral support. Women are more prone to household accidents and face a high risk of violence. Social discrimination and powerlessness have aggravated mental health problems among women, in particular depressive neurosis. The health situation of females becomes worse when coupled with poverty. They suffer different patterns of mortality and morbidity, not only due to biological reasons but also due to inequality and lack of awareness. Although life expectancy is slightly higher in women, they suffer more from chronic and acute illnesses that are mainly preventable.

The Regional Office for the Eastern Mediterranean has integrated gender considerations in all facets of its work, and is supporting member countries to promote a proactive role for women in health and development issues. This approach focuses on the empowerment of women as central to all efforts for reaching sustainable development with its economic, social and environmental dimensions. The concept is that women's education, training, empowerment and participation in decision-making positions can transform their place in health and development and harness their role as equal partners in society.

The main objective of the women in health and development approach is to enhance the role of women and mainstream gender as an essential component of community-based initiatives and other WHO programmes.

Women in health and development

- Encourage gender awareness and capacity-building
- Support human rights, dignity, self-worth and abilities of girls and women
- Ensure women participation in decision-making at all levels
- Promote equitable opportunities for health and socio-economic development
- Develop gender-based health information systems and gender analysis
- Give special attention to health related needs of women

8. IMPLEMENTATION OF COMMUNITY-BASED INITIATIVES IN THE EASTERN MEDITERRANEAN REGION

While initiating community-based initiatives in a country, the ministry of health usually takes the lead role with the active support of WHO and carries out following steps:

- preparation and orientation
- organizational set-up
- situational analysis and area development profile
- needs-based interventions and resources mobilization
- financial management
- information and monitoring
- local expansion
- evaluation.

Implementation of community-based initiatives is accomplished in two phases:

- model area development and local expansion
- large-scale expansion.

Phase 1 Model area development and local expansion

Community-based initiatives start with a small-scale research and development project in one or more selected areas. This involves limited risk and feasible cost. After successful implementation, the programme areas demonstrate the results of the community development project to the government and other stakeholders, exploring potential partnerships. It promotes consensus among various sectors in order to work jointly for the attainment of integrated goals. The model areas are gradually expanded into the surrounding areas, a strategy which promotes technical cooperation among developing communities.

Phase 2 Large scale expansion

The expected outcome of the first phase is the large-scale expansion of community-based initiatives activities and their incorporation into the national plan as a strategy for achieving integrated community development. The rational use of existing resources and organizational infrastructures facilitated by devolution of authority assists in bottom up planning and management. Additional resources for expansion are required to be mobilized mainly from the national, regional and local levels, and from partnerships developed with national and international agencies.

9. COMMUNITY-BASED INITIATIVES MANAGEMENT GUIDELINES AND TOOLS

Community-based initiatives, until recently, have been implemented without any uniformity. In order to introduce a common and feasible methodology, the Regional Office for the Eastern Mediterranean has designed a set of management guidelines and tools with the active involvement of member countries. These guidelines can be used as reference for the implementation and management of all community based initiatives, after adaptation according to the local situation and needs in each country.

The major objectives of the management guidelines are to:

- describe the necessary set of activities and milestones for community-based initiatives planning, promotion and evaluation in the various phases of its development at different levels of government
- provide a framework for undertaking and implementing these activities in a systematic manner
- identify potential partners and their roles and resources within the government sector and among nongovernmental organizations, international agencies and the community.

Management guidelines provide the following comprehensive tools:

- planning
- organization
- human resource development
- community survey and prioritization
- project preparation and implementation
- supervision and monitoring
- financial management
- documentation and reporting
- promotion and advocacy
- programme evaluation

10. BUILDING PARTNERSHIPS

Community-based initiatives, being multidisciplinary, and intersectoral development approaches require active partnerships between the health sector and the community as well as other sectors, donor agencies and other stakeholders. The potential partners for community-based initiatives besides government, WHO and the community, include:

- United Nations agencies such as the United Nations Development Programme (UNDP), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the Food and Agriculture Organization of the United Nations (FAO), the International Labour Organization (ILO) and the Arab Gulf Fund for United Nations (AGFUND)

- development banks such as the World Bank, Asian Development Bank, Islamic Development Bank, African Development Bank

- bilateral donor agencies such as the UK Department for International Development (DFID), the Canadian International Development Agency (CIDA), the International

Fund for Agricultural Development (IFAD), and the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)

- nongovernmental organizations (national and international)
- academic and research institutions.

The role of these agencies includes:

- assisting the preparation of national policies and plans
- building the capacity of the national authorities and the communities
- undertaking joint actions for technical assistance and financial support
- fostering the flow of information, exchange of experiences and technical cooperation
- marketing community-based initiatives approaches, creating linkages with similar approaches
- Supporting research and development of appropriate technologies.

While advocating for community-based initiatives to attract new partners, adequate care should be taken to avoid conflicts of interest or resistance to change.

11. THE ROLE OF WHO IN THE IMPLEMENTATION OF COMMUNITY-BASED INITIATIVES

The principal role of WHO in the community-based initiatives programme implementation is catalytic in nature by providing assistance to governments to:

- develop models of sustainable health as part of overall national development
- support the building up of national capacities through orientation and training activities
- prepare, in collaboration with national organizations, plans for launching the CBI approach in model areas, incorporating technical, financial, logistical and evaluation components
- encourage the development of strong intersectoral collaboration with communities, nongovernmental organizations and the private sector to promote the concepts of health and equity as fundamental principles of development
- promote community-based initiatives to other international organizations as well as national decision-makers

- support research and development projects in the countries of the region, with particular emphasis on economic profiles and sustainability

- enable national authorities to integrate and sustain community-based initiatives in national development plans through gradual transformation of the role of WHO. This involves moving from active participation and financial contribution during the first phase of CBI to mainly providing technical support to the government and others during the expansion phase.

12. HOW COMMUNITY-BASED INITIATIVES BRING ABOUT CHANGE

Changes take place through the following:

- encouraging change in self and society

- introducing intersectoral coordination and partnerships

- breaking the vicious cycle of dependency through active community participation (community development for the people, by the people)

- developing awareness among the masses concerning their needs and rights, coping with problems, practising healthy lifestyles and health care measures

- encouraging decentralization and local empowerment for bottom-up planning and self management

- mobilizing local and public resources

- transforming the attitude of government functionaries to be more supportive of the community

- improving health status through increased family income and self-care

- reducing poverty and improving quality of life and health.

Part B
Module 2
Unit 2.1

Health, health for all and primary health care

Learning objectives

To gain a better understanding of:

- the concept of health, its dimensions and determinants
- the concepts of health for all and primary health care
- the community health system
- the roles of different stakeholders for health

Expected outcome

Participants will have understanding of concept of health and community based health approaches and able to implement multisectoral interventions for achieving improved health outcomes

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1. HEALTH

In 1947, the World Health Organization adopted a broad definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

This definition takes a holistic view of health and deals with all factors which affect the health of an individual for optimal physical, psychological and social development. It equates health with a productive and creative existence, and focuses on the living state, rather than on categories of diseases causing an illness or death.

Health is a multidimensional process that involves well-being of a person as a whole in relation to the social, political and environmental influences on health

1.1 The significance of health

Health is holistic and is linked with the broader issues of human development, where it plays a vital role in the cohesion, progress, prosperity and development of a society. The following are the major principles of health.

- Health is a fundamental human right.
- Attainment and maintenance of health are a major social investment and a worldwide social goal.
- Health is central to the concept of quality of life and human development.
- Health is the essence of a productive life and not the result of ever increasing expenditure on medical care.
- Health is an intersectoral issue and an integral part of the socioeconomic system where the connection is reciprocal.
- Health involves individuals, community, state and international responsibilities.

1.2 Dimensions of health

There are three dimensions under which health can be classified—physical, mental and social.

Physical

The physical dimension of health implies perfect functioning of the body organs at optimum capacity and in harmony with the rest of the body. It involves the ability to carry out daily tasks, and achieve fitness. A person is normal without any evident disease, and growth is comparable to that of others of similar age.

Mental

The mental dimension of health is not merely the absence of mental illness but the ability to respond to the various experiences of life with flexibility and a sense of purpose. Mental health is a state of balance or harmony between the individual and others as well as the environment. The individual is free from internal conflicts, well adjusted, has high self-esteem, demonstrates good self-control and addresses problems through designing intelligent solutions. Also included here is the emotional dimension of health, which involves the ability to recognize, accept and express feelings and to accept one's limitations. It includes temperament, the ability to manage stress, react to a variety of situations and express emotions appropriately and in a socially acceptable manner.

Social

The social dimension implies harmony and integration of the individual with the world he lives in. It covers interpersonal ties and extent of involvement with society. It includes social skills, social functioning and the ability to see oneself as a member of a larger society, considering the whole person in the context of his social network. It is the ability to interact successfully with people within the environment, maintaining intimacy with others and demonstrating respect and tolerance for those with different opinions and beliefs.

1.3 Health determinants

Multiple variables determine the health status of a person. Some of these factors are internal to the person; others are external. People can usually control their behaviour and choose healthy or unhealthy behaviour. In contrast, they have little or no choice over their genetic make-up, age, sex, physical environment, culture or areas where they are born and grow up.

Health determinants	
Internal	**Biological and cognitive factors** include hereditary factors (such as race, sex, age and development level) or genetic make-up (such as diabetes and breast cancer)
	Psychological and spiritual factors (stress and anxiety, which aggravate health problems, e.g. hypertension, heart attacks, diabetes and gastric ulcer)
External	**Environment factors** (such as climate, shelter, air, water, pollution of water and soil, radiation, pesticides and chemicals)
	Socioeconomic factors (such as means of livelihood, standards of living and investment in health
	Occupation factors (such as working conditions and insurance policies)
	Welfare services (such as social support networks)
	Food (such as adequate and balanced diet, food hygiene and safety)
	Culture (such as living conditions, traditions, values and beliefs)
	Education (such as illiteracy/lack of education)

1.4 Health for all

Gross disparities exist in health status between the rich and the poor communities of the world, both urban and rural. WHO, therefore, adopted an innovative approach to ensure that every human being has equal access to health care and maintenance.

The 30th World Health Assembly in 1977 agreed that "a main social target…should be the attainment by all peoples of the world…of a level of health that can permit them to lead a socially and economically productive life".

The essential principal of health for all is the concept of equity in health—all people should have the opportunity to enjoy good health. This does not mean that doctors and nurses will provide every person with medical care or nobody will be sick or disabled. It simply means even distribution of available health resources among the population so that people have access and can use the available services for better

health. Health for all implies improvements not only in access to health services, but parallel social and economic opportunities.

The target of health for all by the year 2000 could not be achieved due to strategic deficiencies. It was soon realized that this paradigm suffered from a weak community role, poor intersectoral action, a top–down approach for development and the focus of investment on physical infrastructure while neglecting the human dimensions of development. It was acknowledged that health for all cannot be achieved in isolation and requires an integrated multisectoral development approach, developing active partnerships with the communities and other stakeholders. These facts called for a review of policies, redirecting the available resources and conceiving mechanisms ensuring equity of health services.

2. PRIMARY HEALTH CARE

The concept of primary health care was adopted at an international conference held in Alma-Ata, Kazakhstan, in 1978 and it was accepted by WHO Member States as a key methodology for achieving the target of health for all. World health leaders agreed that primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals, families and the community through their full participation and at a cost the community and country can afford. It forms an integral part both of a country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

The primary health care (PHC) approach is based upon the principles of:

- equity, ensuring universal accessibility, irrespective of social and geographical divisions
- socially, culturally and scientifically accepted appropriate methodologies
- nationwide coverage and system development at a cost a country can afford
- self-reliance, using cost-effective methodologies
- intersectoral coordination at all levels
- the involvement and full participation of the people in planning and implementation.

Essential components of primary health care

- Health education about prevailing priority health problems and methods preventing and controlling them
- Promotion of food supply and proper nutrition
- An adequate supply of safe drinking water and basic sanitation
- Maternal and child health care, including family planning
- Immunization against the major infectious diseases
- Prevention and control of endemic diseases
- Appropriate treatment of common diseases, injuries and accidents
- Provision of essential drugs

2.1 Community health care

According to the primary health care approach, the health care system at the community level must be able to introduce the following main interventions:

- developing primary level health facilities, accessible to all, especially vulnerable groups, such as women of childbearing age and children under 5 years
- a community health workers' network, providing linkage between the community and the health facility
- health promotion groups, such as women's clubs, NGO s and volunteers
- community organizations such as community development committees, cluster representatives and health committees in the community-based initiatives areas
- intersectoral coordination, particularly for safe drinking water supply, sanitation, housing, food production, economic development, etc.
- community involvement in identification and prioritization of health needs, as well as implementation and management of health services
- clearly determined roles of all stakeholders.

3. HEALTH: RIGHTS AND RESPONSIBILITIES

Right to health

The universal declaration of human rights in 1948 affirmed that "everyone has the right to a standard of living adequate for the health and well-being of himself and his family".

The constitution of WHO also affirms that "health is one of the fundamental rights of every human being to enjoy the highest attainable standard of health".

Responsibilities for health

Health is not a commodity or product that can be provided by anybody nor can it be obtained or purchased by an individual. In fact, it is an outcome of many interrelated actions undertaken by all concerned and involves efforts by individuals, families, the community and the state as well as international organizations.

Individual responsibilities

Health is a basic human right, but it is also the responsibility of each individual. No government or organization can provide good health if a person does not maintain himself. Self-care promotes health, prevents disease and limits illness. Many activities can be undertaken without professional assistance if a person has the technical knowledge and skills required. Due to changes in all sectors of life and changing disease patterns, there is a demand for greater efforts at the individual and family levels.

Individual responsibilities

- attention to personal hygiene and body care
- adoption of healthy habits and healthy lifestyles by observation of simple rules of healthy behaviour relating to diet, sleep, exercise, weight, smoking, alcohol and drugs
- carrying out specific disease prevention measures, including immunization
- consulting a physician for periodic medical examination and screening
- reporting early in case of sickness and accepting treatment
- undertaking measures to prevent spread of disease to others
- using safe water and healthy food, including all nutrients and promoting breastfeeding of children
- improving housing and environmental conditions:
- practising family planning for spacing of children and population management
- taking precautionary measures for all potential risk factors

Community responsibilities

Health services can never function efficiently and the health of the people can never be adequately protected without the active participation of the community. Therefore in order to shift the emphasis from "health care of the people" to "health care by the people", the active involvement of families and communities in health matters like planning, implementation, use, operation and evaluation of health services is essential.

Community responsibilities

- providing facilities, human resources, logistic support and possibly funds to the local health systems
- using the available health services and monitoring their performance
- developing trained community health workers to ensure primary health care services at each doorstep
- assisting in provision of health care services like growth monitoring, follow-up of tuberculosis cases and implementation of the DOTS tuberculosis treatment strategy
- maintaining environmental health, for example management of stagnant water and solid waste
- removing disease-causing factors such as poverty, poor housing, drug abuse
- promoting the healthy lifestyles, breastfeeding and supplementary feeding
- ensuring safety of food and water, with adequate food for the poor
- adopting family planning practices for population management
- attaining necessary skills and knowledge for health promotion and protection
- reviewing cultural, political and socioeconomic policies and strategies related to health

State responsibilities

Individual and community efforts can only be fruitful if the state also undertakes its responsibilities and provide physical, technical and intellectual support, and efficient leadership.

State responsibilities

- designing needs-oriented health policies and strategies and providing the necessary legislative cover
- planning services, seeking partnerships, mobilizing resources and implementing health programmes
- establishing health facilities, ensuring equitable deployment of staff and the availability of essential services, especially for emergencies and poor patients
- promotion of health education and awareness and provision of technical and intellectual support to communities for their health promotion and protection
- developing human resources, ensuring opportunities for access to the latest technical and professional knowledge and skills
- effective monitoring and evaluation of delivery of health care services, giving special emphasis to risk groups, in particular the poor and underprivileged communities
- identifying major health problems and appropriate action for disease control, especially implementing intense measures against communicable diseases
- organizing communities to carry out health and development programmes
- adopting measures for poverty reduction and economic growth for improving the quality of life of the people
- sharing experiences with other countries and collaborating with international organizations/agencies to develop mutual understanding and partnerships for health

International responsibilities

In order to attain health goals, close cooperation and collaboration are required between countries, particularly neighbouring ones and those facing similar health problems. Similarly, international organizations should support countries, collaborating within the United Nations system and with other peer organizations.

International responsibilities

- exchange of experiences and deployment of experts
- training and development of human resources
- facilitate technical cooperation between developing countries
- development of wider understanding between countries and agencies on matters related to health and human development
- fostering the flow of information
- financial support and material assistance
- joint endeavours to develop models and designing feasible solution for health problems.
- facilitating linkage between different stakeholders and building partnerships in support of the communities and countries

Part B
Module 2
Unit 2.2

Health promotion and protection

Learning objectives

To gain a better understanding of:

- health promotion
- promotion of healthy lifestyles
- health protection

Expected outcome

Participants will have understanding of the mechanism of health promotion, healthy lifestyles and health protection, and capable for designing appropriate interventions

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1. HEALTH PROMOTION

According to WHO, health promotion is the process that offers both to the individual and to communities the possibility of better controlling health factors and improving their health.[1]

It is directed towards improving well-being and actualizing the health potentials of individuals, families, groups, and communities regardless of their health status or age. It is the aggregate of all purposeful activities designed to improve personal and public health through a combination of strategies, including:

- health education and awareness
- environmental modification
- healthy lifestyles and behavioural changes
- nutrition.

1.1 Health education and awareness

This is the most cost-effective mean of promoting health and preventing a large number of diseases. It has been universally acknowledged that adequately informed people take care of their health, adopt necessary precautions and avoid practices which may lead to a health problem. Relevant health knowledge and skills are extended to the people in a simple and understandable way through motivating them to carry out appropriate measures in order to achieve good health. Usually, the health education messages and materials are prepared for the target groups bearing in mind their educational level, cultural and social norms, age and potential health problems. There are many methods for the dissemination of health information, including:

- individual discussion
- group discussion
- lectures or seminars
- printouts/pamphlets/booklets/stories
- displays of banners, charts or boards with health messages, slogans or pictures
- audiovisual aids
- role-play and demonstrations.

1.2 Environmental modifications

Environmental factors are of key importance in the health process. Rapid population growth and industrialization process have caused multitude of environmental health problems. In addition to ecological changes, the growing threats of congestion, air and water pollution, inadequate sewage and solid waste management are hampering the efforts for better health. Therefore, following interventions assist in improving environmental conditions:

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[1] *WHO Ottawa Charter, 1986*

- provision of safe drinking water
- promotion of sanitary latrines
- safe disposal of solid waste and used water
- pollution control measures
- improved housing conditions
- control of insects and rodents.

1.3 Healthy lifestyles and behavioural changes

Practising a healthy lifestyles and positive behaviour towards health are essential for attaining better health status of both individuals and the community. Therefore, it is of paramount importance to educate and motivate the people for changing their views, behaviour and habits. It is achieved through following areas:

- personal hygiene
- healthy food and diet
- smoking control
- physical activities.

1. Personal hygiene

Cleanliness is the most basic health habit. All religions treat it as an essential part of faith and life practices. Lack of hygiene and cleanliness puts a person at risk of a number of diseases, which are mostly communicable and can become public health problems. These include diarrhoea, dysentery, worm infestation, cholera, skin infections, ear infections, conjunctivitis, dental caries, gingivitis and acute respiratory infection. In addition, there are many social problems, such as difficulties in social interactions and loss of respect and dignity. In contrast, maintaining hygiene and cleanliness prevents much suffering and leads to a number of socioeconomic benefits.

How community-based initiatives can assist in promoting personal hygiene

Personal hygiene can be promoted through disseminating the health messages to the community through community representatives and health workers. The messages should focus on the following:

- keeping the body clean
- wearing clean and seasonable clothes and comfortable shoes
- washing hands before and after meals, before handling food and after defecation
- trimming fingernails and keeping them clean
- taking frequent baths with clean water and soap
- cleaning or brushing the teeth at least twice daily, especially after meals
- not passing urine or defecating anywhere on the ground or in water
- not spitting on the ground
- taking care of the eyes and ears

1.4 Healthy food and diet

A healthy diet is one of the key components of a healthy lifestyle. In order to prevent food-related health risks and build a lifestyle based on healthy food and diet, the following three strategies are essential:

- intake of balanced food
- healthy eating habits
- food hygiene.

A balanced meal should be taken at regular intervals. It should contain essential nutrients required to meet the body's needs according to age. Food should be selected from available resources, respecting local traditions.

Healthy eating habits should be promoted from early childhood and continue throughout life.

Food hygiene should be maintained while storing foodstuffs, preparing and handling food, preserving cooked food and eating.

How community-based initiatives can assist in promoting healthy food and diet

- providing relevant information through printouts and audiovisuals regarding cooking and preserving foods, and healthy eating habits
- imparting awareness and orientation to the families through seminars and demonstrations
- facilitating community groups and schools to promote healthy eating habits
- supporting families in construction of proper food stores and kitchens

1.5 Smoking

Many people smoke and are at risk of developing tobacco-related disorders; many others are non-smokers but suffer from involuntary exposure to tobacco smoke (passive smoking) and are also at risk of tobacco-related disorders. Such a broad-based problem requires broad-based solutions, involving many sectors of society.

Extent of the smoking problem

- There are approximately 1.1 billion smokers in the world, about one-third of the global population aged 15 years and over.
- Worldwide consumption of manufactured cigarettes more than doubled from 1967 to 1992, with per capita cigarette consumption increasing by 25% during the same period. There is no count of the tobacco being used through other means.
- A long-term tobacco user has a 50% chance of dying prematurely from tobacco-related disorders. Half of these smokers will die during middle age.
- Each year, tobacco causes four million premature deaths, with one million of these occurring in countries that can least afford the health-care burden.
- Based on current trends, the death toll will rise to 10 million per year by the 2020s or 2030s, with 70% of those deaths occurring in developing countries. In this way, by 2030, tobacco is likely to be the world's leading cause of death and disability, killing more than 10 million people annually and claiming more lives than HIV, tuberculosis, maternal mortality, motor vehicle accidents, suicide and homicide combined.

Tobacco-related disorders

Tobacco is a risk factor for some 25 diseases at least. Studies have revealed the following.

- Smoking is a known or probable cause of death from cancers of the oral cavity, larynx, lung, oesophagus, bladder, pancreas, renal pelvis, stomach and cervix.

- It is also a cause of heart disease, strokes, peripheral vascular diseases, chronic obstructive lung disease and other respiratory diseases, and low-birth weight babies.

- It is a probable cause of peptic ulcers, unsuccessful pregnancies and increased infant mortality, including sudden infant death syndrome.

- The children of parents who smoke have an increased frequency of respiratory and middle-ear infections and are at risk of impaired lung function. Environmental tobacco smoke is also a cause of additional episodes and increased severity of symptoms in asthmatic children. Babies born to women who smoke during pregnancy, as well as those infants exposed to environmental tobacco smoke, have a much greater risk of dying of sudden infant death syndrome.

- Women who smoke are at increased risk of cervical cancer. Smoking during pregnancy increases the risk of miscarriage and has damaging effects on the fetus.

Benefits of quitting smoking

Stopping smoking has immediate and substantial health benefits and dramatically reduces the risk of most smoking-related disorders. One year after quitting, the risk of coronary heart disease decreases by 50%. Within 15 years, the relative risk of dying from coronary heart disease for an ex-smoker approaches that of a lifetime non-smoker. Ten to fourteen years after smoking cessation, the risk of mortality from cancer decreases to nearly that of those who have never smoked. Stopping smoking has a beneficial effect on pulmonary function, particularly in younger subjects, and the rate of decline among former smokers returns to that of those who have never smoked. Stopping before the age of 35 is of greater benefit than ceasing at a later time, but there are still substantial benefits, no matter at what age one quits tobacco use.

How community-based initiatives can assist in tobacco control

- preparation of the social environment for transformation of community behaviour
- mobilizing the community to develop local strategies to discourage the sale and use of tobacco
- implementing health promotion, health education and stop smoking programmes
- orientation of families to prevent children becoming addicted to tobacco
- training of the community on protection from involuntary exposure to environmental tobacco smoke
- assistance in the elimination of socioeconomic factors that encourage the use of tobacco
- discouraging tobacco advertising, promotion and sponsorship in CBI areas
- promoting economic alternatives for tobacco growers and marketers
- approaching government authorities to restrict smoking in health facilities, schools, workplaces, offices and other public places, and prohibit its sale in health facilities and school premises as well as CBI sponsored projects
- advocacy campaigns for tobacco free initiatives through traditional means such as tournaments with anti-smoking themes
- incentives to smokers to quit smoking such as prizes, medals and loans

1.6 Physical activity

Physical activity is body movement which results in an expenditure of energy (burning calories). When a person walks briskly, plays, cleans house or climbs stairs, he or she is consuming calories and moving for health. Physical activity is essential when lifestyles are changing rapidly, and noncommunicable diseases are emerging as a result of inactivity.

Extent of the problem

It is estimated that over 60% of the world's population is not physically active enough to gain health benefits; this is especially true for girls and women.

Most of the countries of the Eastern Mediterranean Region are undergoing rapid changes in lifestyles and social conditions which can be attributed to the consequences of rapid socioeconomic changes, and a sedentary life is becoming an unavoidable way of living in the cities of many countries of the Region.

Obesity and becoming overweight are growing concerns. Most countries in the Region have rates for adults overweight or obese greater than 30%. The rate of obesity in adult females approaches 40% in some countries of the Region.

Diabetes affects more than 70 million women in the world. This figure is projected to double by 2025. In addition to being a cause of cardiovascular disease, diabetes can lead to blindness, nerve damage, kidney failure, foot ulceration and amputation.

Lack of physical activity in combination with improper diet and smoking is responsible for the majority of cases of premature coronary heart disease, several cancers, diabetes, high blood pressure, blood lipid disorders, osteoporosis, depression and anxiety.

Children spend excessive amounts of time watching television, playing computer games and using computers, very often instead of physical activity and sports. Unhealthy lifestyles, including sedentary lifestyles, poor diet and substance abuse, adopted at a young age are likely to persist into adulthood.

What types of activities are recommended?

- Walking, swimming, stretching, gardening, hiking and cycling are all excellent activities for older and middle-aged people.
- Walking or cycling to school is good for children and young people in addition to play, games and exercise.
- Weight-bearing activities and aggressive exercise are excellent for adults.

Benefits of regular physical activity

- Reduces the risk of dying prematurely
- Reduces the risk of dying from heart disease or stroke, which are responsible for one-third of all deaths, and hypertension, which affects one fifth of the world adult population.
- Reduces the risk of developing type 2 diabetes by 50 %.
- Helps to prevent/reduce hypertension, which affects one-fifth of the world’s adult population.
- Helps to prevent/reduce development of lower back pain and osteoporosis, reducing the risk of hip fracture by up to 50% in women.
- Promotes psychological well-being and reduces stress, anxiety and feelings of depression and loneliness.

- Helps prevent or control risky behaviour, especially among children and young people, such as use of tobacco, alcohol or other substances, unhealthy diet or violence.

- Helps control weight and lowers the risk of becoming obese by 50% compared to people with sedentary lifestyles.

How community-based initiatives can assist in promotion of physical activities

- awareness of the community and families regarding benefits of physical activity
- providing evidence-based advocacy on the health, social and economic benefits of physical activity
- developing action-oriented networks and organizations at community level
- promoting integrated, multisectoral plans and actions
- training young volunteers on physical activity counselling and programme development
- organizing specific physical activity programmes like tournaments
- providing seed money for sports/health clubs and gymnasiums

1.7 Nutrition

Nutrition is vital for determining good health. Lack of food or essential nutrients always results in adverse effects on health, especially in the most vulnerable groups such as children and pregnant mothers. Appropriate measures for improving food and nutrition can secure good health and prevent nutritional deficiencies.

Malnutrition is a condition caused by inadequate intake or inadequate digestion of nutrients. It may results from eating an inadequate or unbalanced diet, digestive problems, absorption problems or other medical conditions such as abnormal systemic loss of nutrients due to diarrhoea, haemorrhage, renal failure, excessive sweating, infection or addiction to drugs.

Because of their high demand for energy and essential nutrients, infants and children are more at risk of malnutrition. Protein-energy malnutrition in children consuming inadequate amounts of protein, calories and other nutrients is a particularly severe form of undernutrition that retards growth and development.

Extent of the problem

The health consequences of inadequate nutrition are enormous. According to one estimate, 174 million children under five in the developing world are malnourished as indicated by low weight for age, and 230 million are stunted. Malnutrition results in poor physical and cognitive development as well as lower resistance to illness. It is estimated that

more than half of the young children in south-east Asia suffer from protein-energy malnutrition, which is about five times the prevalence in the Western hemisphere, at least three times the prevalence in the Middle East and more than twice that of east Asia. Estimates for sub-Saharan Africa indicate that the prevalence is approximately 30%.

It is now recognized that 6.6 million out of 12.2 million deaths among children under five years age, or 54% of infant mortality in the developing countries, is associated with malnutrition. In addition to the human suffering, the loss in human potential translates into social and economic costs not affordable by any country.

Causes of malnutrition

Poor nutrition leads to poor health. The three leading causes of malnutrition are:

- poverty and lack of food
- ignorance or indifference
- disease or substance abuse.

Poverty and insufficient global food production are the root cause of malnutrition. Poor families lack the economic, environmental or social resources to purchase or produce enough food. In rural areas, land scarcity and degradation, water salinity due to over irrigation, soil erosion, droughts, and flooding can all undermine a family's ability to grow enough food. In urban areas, low wages, lack of work and underemployment, and rapid changes in food prices often place food supplies out of the reach of poor households. Worldwide, malnutrition continues to be a significant public health problem, especially among children.

Micronutrient deficiencies

Iodine deficiency disorder

Iodine deficiency disorder constitutes the greatest cause of preventable brain damage in the fetus and infant, and of retarded psychomotor development in young children. It remains a major threat to the health and development of the population the world over, but particularly among pre-school children and pregnant women in low-income countries. During pregnancy and lactation, requirements for all nutrients are increased. Iodine deficiency disorder may results in goitre, stillbirth and miscarriages, but its most devastating toll is mental retardation and impaired learning ability. Poor school performance, reduced intellectual ability and impaired work capacity are common with iodine deficiency disorder.

Extent of the iodine deficiency disorder problem

Iodine deficiency disorder is now identified as a significant public health problem in 130 countries, affecting a total of 740 million people, or 13% of the world’s population. In the Eastern Mediterranean Region the prevalence of iodine deficiency disorder is around 21%.

Strategies for management of iodine deficiency disorder

The main WHO intervention strategy for iodine deficiency disorder control is universal salt iodization. In high-risk areas, where population cannot get access to iodized salt, the alternative is to administer iodine directly either as iodide or iodized oil with the focus particularly on women and children.

Iron deficiency anaemia

Iron deficiency anaemia is a serious public health problem in most of countries of the Eastern Mediterranean Region. Iron is a key micronutrient of the body as it is essential for growth, brain development and physical activity. It is a vital for strength, energy and work capacity. In the blood, iron is transported through haemoglobin. When iron-deficiency becomes serious, there is less haemoglobin, a condition that is called anaemia. There are other causes of anaemia, but iron deficiency is the most common.

Extent of the iron deficiency anaemia problem

This nutritional disorder has profound effects on psychological and physical development, behaviour, performance at work and eventually on productivity. It affects mainly women of childbearing age, young children, school-age children and adolescents. Anaemia due to folic acid deficiency is also common in pregnant women, especially those who have taken oral contraceptives.

Strategies for management of iron deficiency anaemia

The strategies for improve iron deficiency anaemia are explained below.

- Child spacing assist in reducing the frequent losses of iron and blood.

- Improving environment and reducing parasite-load through de-worming.

- Anaemia due to dietary causes can be reduced through following approaches:
  - including more iron in the diet and increasing the bioavailability of the iron
  - provision of education to promote increase in the consumption of iron-rich foods
  - distribution of iron supplements while ensuring compliance, especially in high-risk groups
  - fortification or enrichment of a commonly eaten food with iron.

Vitamin A deficiency

Vitamin A deficiency is a major public health problem, and the most vulnerable are pre-school children and pregnant women in low-income countries. In children, vitamin A deficiency is the leading cause of preventable severe visual impairment and blindness. In women, in addition to ocular lesion, vitamin A deficiency may be an important factor contributing to maternal mortality and poor pregnancy and lactation outcomes. Vitamin A

deficiency is also likely to increase vulnerability to other disorders, such as iron deficiency anaemia, for both women and children, and growth deficit in children.

Extent of the vitamin A deficiency problem

About 250 000 to 500 000 vitamin A deficient children become blind every year and about half of these die within a year of becoming blind.

In addition, vitamin A deficiency significantly increases the risk of severe illness and death from common childhood infections, particularly diarrhoeal disease and measles.

In communities where vitamin A deficiency exists, children are, on average, 23% more likely to die and 50% more likely to suffer acute measles.

Strategies for management of vitamin A deficiency

- Protection, promotion and support of breastfeeding are essential components in vitamin A deficiency reduction programmes.
- Dietary improvement is an important complement to supplementation and fortification.
- Promotion of home gardens for particularly vulnerable families, growing vitamin A–rich fruits and vegetables.
- Supplementation with both routine and campaign-based immunization.
- Food fortification with vitamin A as a central strategy for vitamin A deficiency reduction.
- Periodic use of high-dose vitamin A capsules is a low-cost and highly effective means of improving vitamin intake.

How community-based initiatives can assist for improving nutrition

The following set of actions can assist in promotion of nutrition and reduction the related health problems:

- awareness of the community regarding the problems
- provision of logistics and technical support
- training of community health workers and volunteers for monitoring the growth of children and assessment of anaemia
- provision of relevant information through printouts and audiovisual materials for advocacy and orientation
- introduction of programmes for the control and follow-up of related problems

2. HEALTH PROTECTION

Health protection is the provision of conditions for normal mental and physical functioning of the human being, individually and in the group. It includes prevention of sickness as well as curative and restorative medicine in all its aspects. It describes interventions aimed to:

- reduce the incidence of diseases
- restore health, when it is impaired
- limit the duration of a disease and risk of its transmission
- restrict the potential consequences or effects, including physiological, psychological and social effects
- limit the financial burden on families and population.

Health protection prevents individuals, families and communities from acquiring a disease or group of diseases and refers to the actions which protect people against health and safety risks by intercepting the causes of diseases before they can strike.

The following kind of intervention can assist in protecting the health against specific diseases:

- immunization
- use of specific nutrients
- chemoprophylaxis
- protection again occupational hazards
- protection against accidents
- protection form carcinogens
- avoidance of allergens
- control of specific hazards in the environment.

How community-based initiatives can assist in health protection

The following set of actions can assist in promotion of nutrition and reduction the related health problems:

- community orientation about health protection measures
- training of community health workers and volunteers
- introduction of specific programmes for health protection such as occupational health and accidents protection
- provision of logistics and technical support
- provision of relevant information through printouts and audiovisual materials

Part B
Module 2
Unit 2.3

Disease prevention and management

Learning objectives

To gain better understanding of:

- disease prevention at primary, secondary and tertiary levels
- major health problems encountered at community level and the related preventive measures

Expected outcome

Participants will understand the mechanism for restricting the course of diseases and will be able to provide awareness to communities on preventing common health problems

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1. DISEASE PREVENTION

Prevention consists of interventions that have been shown to reduce significantly the likelihood that a disease, injury or disorder will affect an individual or those that interrupt or slow their progression. Preventive measures intend to limit the number of people who can develop a disease by controlling the related causes and risk factors. Efforts are directed towards improving the general well-being of the individual in addition to specific action against the selected diseases.

1.1 Types of prevention

Primary prevention

Primary prevention is action taken prior to the onset of disease. It precedes disease or dysfunction and is applied to generally healthy individuals or groups. Appropriate interventions before the onset of health problems are intended to protect individuals from the risk of disease. These measures ensure health protection against specific disease agents or hazards in the environment. Examples are vaccination, sanitation measures and prophylactic treatment.

Secondary prevention

Secondary prevention includes action to halt the progress of disease at its initial stage and prevent possible complications. Secondary prevention emphasizes the early detection of disease, prompt intervention and health maintenance for individuals suffering form health problems. It reduces disease severity and incidence, complications and disabilities. It also prevents transmission of infection to other community members. Therefore, this process is simultaneously secondary prevention (for patients) and primary prevention (for potential contacts). The main examples of secondary prevention are screening and detection of diseases such as malaria, cataracts, diabetes mellitus, hypertension, breast cancer; assessing the growth and development of children; and referral of suspect cases to a heath facility for diagnosis and management.

Tertiary prevention

Tertiary prevention begins after an illness occurs or when a defect or disability is fixed, stabilized or becomes irreversible. It focuses on the rehabilitation of disabled individuals and restoring them to an optimum level of functioning within the constraints of their disability. Examples are rehabilitation after fractures or paralysis. The community can play a key role in social and financial rehabilitation. In order to maximize any remaining ability, the community can also assist in physical and mental rehabilitation of a patient in line with medical advice and under expert guidance.

At the community level, disease control activities should focus on primary and secondary prevention

2. EARLY DIAGNOSIS AND PROMPT TREATMENT

Whenever an occurrence of disease is discovered or suspected, the objective should be to identify the case as soon as possible and refer it to the relevant health facility. Possible actions may be:

- screening surveys and case-finding measures
- selective examination and diagnosis of the health problem
- treatment of minor ailments at community level
- referral of cases to the relevant health facility and following up.

3. DISEASE ELIMINATION AND ERADICATION

Disease elimination describes the interruption of transmission of disease, whereas eradication implies termination of transmission of infection by extermination of infectious agent. It is an absolute process and is characterized by the disappearance of the disease or infection from the whole world, such as the eradication of smallpox. Currently, WHO is supporting the member countries to eradicate poliomyelitis.

4. COMMON HEALTH PROBLEMS

4.1 Malaria

Malaria is one of the main health problems in many countries of the Region and is considered one of major killer diseases in poor communities.

Causative factors and identification

Malaria is caused by the malarial parasite, which is transferred from a diseased to a healthy person through the bite of the anopheles mosquito, which breeds on stagnant water. After a bite by an infected mosquito, symptoms may appear within 15 days. The disease usually presents as intermittent fever with rigors. Other symptoms may be reduced appetite, headache, weakness, nausea, vomiting, pain in the joints; the fever rises suddenly and remains high for few hours with heavy sweating. Diagnosis of malaria is carried out through microscopic examination of the blood slide for identification of the malarial parasite.

Follow-up of cases

All positive cases of malaria should be followed up to ensure that after completing the basic course of treatment, blood is retested for the malarial parasite.

Strategies for control, prevention and health protection

- Awareness and orientation of the community on malaria and related factors.

- Early diagnosis and treatment.

- Active and passive case detection and prophylactic management of suspected cases.
- Control of vectors through sanitary measures, destroying mosquito breeding places.
- Putting kerosene on wastewater ponds.
- Spraying pesticides in suspected places.
- Using impregnated mosquito bednets, especially in malarial zones.

How community-based initiatives can assist in malaria control

- Assessing the extent of the problem and identifying breeding places
- Mobilizing the community to play an active role in the control of malaria and destroying mosquito breeding places
- Developing community awareness regarding the disease and introducing preventive measures
- Supporting and guiding for developing effective sanitation system
- Coordinating health staff for active and passive case detection, and other relevant measures
- Promoting the use of mosquito bed nets and mobilizing resources to provide impregnated nets to the people at subsidized rates

4.2 Vaccine preventable diseases

Immunization of children

The objective of the Expanded Programme on Immunization (EPI), set up by WHO in 1974, is to protect children against the deadly diseases mentioned below in order to reduce morbidity, disability and mortality from these causes.

- poliomyelitis
- diphtheria
- tetanus
- measles
- pertussis (whooping cough)
- tuberculosis.

Some countries of the Region have immunization programmes against additional preventable diseases such as hepatitis, mumps and rubella.

Why these diseases are dangerous for children

Diseases are of two types: noncommunicable, which cannot spread to others (for example, diabetes and cancer) and communicable, which can spread from one person to another (such as tuberculosis or measles).

The above-mentioned diseases can spread easily from infected to healthy children. Since children have little capacity to defend themselves against these diseases, they acquire the infection easily and become ill.

A vaccine raises the body's immunity against a particular disease; however, immunity against one disease cannot protect the body from others. Therefore, separate immunization is required against all the above-mentioned diseases.

How community-based initiatives can assist in vaccination of children and mothers

- Community mobilization and development of awareness
- Advocacy to mother's groups
- Identification and documentation of target groups
- Coordination of vaccination campaigns
- Active participation of community organizations
- Assistance to health staff in planning and implementation of vaccination campaigns
- Assessment and evaluation of vaccination status
- Encouraging vaccination while providing loans for income generation projects
- Offering incentives like preference for vaccinated children in school admissions

4.3 Diarrhoea

In case of diarrhoea, the child passes loose, watery motions three or more time a day. When there is blood mixed with stool, it is called dysentery.

Why diarrhoea is dangerous

- In the case of severe diarrhoea, death may occur because of excessive loss of water and salts. This is called dehydration. Dysentery is also a significant cause of death among children.

- Diarrhoeal diseases are more common among children who are weak and suffer from nutritional deficiency. Diarrhoea causes further malnutrition.

- Every year many children die due to diarrhoea that could be prevented with simple measures.

Causative factors

The main causes of diarrhoea are unhygienic conditions, contamination of water and food and bottle-feeding of children.

Management of diarrhoea

To reduce unnecessary deaths in children, the most cost-effective treatment method is oral rehydration therapy (ORT) which involves administering oral rehydration salt (ORS) along with the continuation of diet during the episode of diarrhoea.

Thus, management of diarrhoea has three important components:

- preventing dehydration

- urgent and effective treatment if there is dehydration

- continuation of food, plus more water and breast milk.

How community-based initiatives can assist in diarrhoea control

- Imparting health awareness of the community on the problem and related issues
- Promoting healthy lifestyles and personal hygiene
- Mobilizing and organizing the community to maintain sanitary conditions
- Coordinating health staff for training community health workers and establishment of oral rehydration therapy units
- Training of mothers on identification of dehydration and preparation of oral rehydration salt
- Distributing oral rehydration salt through community organizations in all houses having children less than five years

4.4 Tuberculosis

Tuberculosis is a communicable disease which progresses slowly and may take a long time to become active. Because of this, a lot of cases may exist in the community without being diagnosed. Bacteria called *Mycobacterium tuberculosis* present in the sputum of the patient cause this disease. Unprotected coughing, sneezing, laughing, speaking or spitting by a patient with active tuberculosis can transmit the bacteria to others. Poverty, congested housing, poor awareness regarding protective measures and malnutrition aggravate the problem.

Extent of the problem

Tuberculosis continues to be the world's leading infectious killer of young people and adults, claiming two to three million lives each year. In fact, the worldwide prevalence of tuberculosis is growing, particularly in developing countries, because of a number of factors, including poor treatment practices, an increase in tuberculosis/HIV co-infection, the spread of multidrug-resistant tuberculosis and the collapse of public health systems.

Identification

Suspected cases are diagnosed on the basis of clinical and laboratory examination. The diagnosis must be made by trained health personnel.

Strategies for control, prevention and protection

- Screening of suspected cases and referral to health facility.

- Early diagnosis and management of the case through the treatment strategy called DOTS (directly observed treatment short course).

What is DOTS?

In the DOTS strategy, the tuberculosis patient takes drugs under the close supervision of a health worker or a responsible person from the community/household, who gives the medicines to the patient and maintains records. This person receives the medicines from the health centre, keeps records and regularly submits reports to the nearest health facility.

Prevention of tuberculosis

- Patients should take regular treatment and should be closely monitored till the disease is cured and they become healthy.

- Children who are yet not affected by the disease and have not had the BCG vaccination should be vaccinated.

- Patients having cough for more than three weeks should be referred to the hospital for tuberculosis screening.

- Family members and other contacts of the patients should be screened and should be informed about preventive measures.

- The community should be educated about tuberculosis and its prevention.

- Patients should be trained to take care of others, not to spit openly and keep a handkerchief in front of the mouth when speaking.

How community-based initiatives can assist in tuberculosis control

- Imparting health education to the community
- Mobilizing communities for identification and management of cases
- Assistance for screening of suspects
- Facilitation of treatment of cases by following DOTS
- Evaluation of the problem and information sharing

4.5 Acquired immunodeficiency syndrome (AIDS)

The human body has very effective defences. However, any disturbance of the system makes the body vulnerable to different diseases. A virus called human immunodeficiency virus (HIV), when it enters the body, destroys the defence system and causes acquired immunodeficiency syndrome (AIDS). The virus is usually present in the blood and sexual secretions, which can spread the disease. The virus is also found in other body secretions such as sputum, tears, urine and sweat but these cannot spread the disease.

At present, HIV/AIDS is a major global health problem and has created a state of emergency, especially in poor communities and developing countries.

How AIDS spreads

The infection is spread by:

- sexual transmission

- transfusion of infected blood or blood products

- sharing syringes or sharp items

- from infected mother to neonates.

Poverty and deprivation aggravate the problem because of a scarcity of resources for control and management.

How the AIDS virus does not spread

- Social contact, working together, going to school together, living together.
- Sitting together or being in the same room.
- Shaking hands, embracing.
- Eating with the patient and using the same utensils.
- Using the same latrine.
- Using the same bath or swimming pool.
- Using other people's clothes.
- Giving blood (it is necessary to have an AIDS test before giving blood).
- Patient care or nursing (if standard precautions are adopted).

Who should have an AIDS test?

- Those having sexual relations outside of marriage or with multiple partners.
- Homosexuals.
- Someone who has received a blood transfusion.
- People sharing syringes or needles.
- People suffering from other sexually transmitted diseases.
- Children born to infected mothers.
- Anyone who has been pricked or injured during the process of giving an injection to an AIDS patient.

Identification

Diagnosis is done through laboratory testing in special centres by qualified staff. There are no specific symptoms of the disease.

Strategies for control and prevention

Specific measures include:

- Always restrict sexual relations to a life partner.
- If either of the sex partners is infected with the AIDS virus, condoms should be used during the sexual act.
- Injections should be given with disposable or properly sterilized syringes.
- Avoid sharing syringes or needles used by addicts.
- Blood transfusion should only be carried out when absolutely necessary.
- If blood is necessary for saving life, make sure that it is screened for AIDS and hepatitis virus.
- If blood products are to be transfused, make sure that they are free from AIDS and hepatitis virus.

How community-based initiatives can assist in AIDS control?

- Increasing community awareness about the AIDS problem, its consequences and its prevention
- Motivating community groups towards social actions for reducing the spread of AIDS.
- Facilitate health staff in specific activities related to AIDS prevention

Part B
Module 3
Unit 3.1

Community mobilization and social contract

Learning objectives

To gain a better understanding of:

- the concept and objectives of social mobilization
- the framework for social mobilization with a community perspective
- the social contract between the community and other stakeholders

Expected outcome

The participants will be acquainted with social mobilization processes and the contents of a social contract. They will be able to mobilize communities by using this approach and introduce social contract while initiating community-based initiatives

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1. SOCIAL MOBILIZATION

The concept of social mobilization emerged from the recognition that genuine participation of the community is essential for its development. Civil society, the actual beneficiary of the whole development process, has therefore to take a proactive role in its own development and welfare activities. This requires continuous efforts and facilitating mechanisms to empower the people, enabling them to initiate and control personal and communal development, as opposed to merely participating in any initiative.

Social mobilization is a tool that enables people to organize themselves to act collectively to achieve the desired goals

It is well understood that no matter how valid or worthy a cause may be, little progress can be made until wider public support is gained and diverse sectors of society become actively involved in the process of change. Social mobilization goes beyond mere dialogue or interaction with selected groups, involving all people, particularly the poor, deprived and disadvantaged members of society. In this way, it works in a highly participatory environment. Community-based initiatives provide structures and mechanisms to effectively implement social mobilization strategies for reaching the goal of comprehensive development.

Objectives of social mobilization of communities

- Sensitising the community about their needs, rights, and prevailing development status
- Facilitating the transition of community behaviour from the passive to a proactive role
- Developing awareness regarding health and development for improving quality of life
- Building the capacities of community to demonstrate leadership roles in decision-making and self management of the developmental activities
- Identifying recognized and unrecognized needs, and exploring their resources
- Strengthening community participation and maintaining progress towards the goal of sustainable development

1.1 Framework for social mobilization

Social mobilization involves a number of steps. In most cases, it is essential to carry them out in the order described below.

Key steps for social mobilization

- Sensitization, orientation and awareness development
- Motivation and social preparation
- Organizational development
- Capacity-building
- Bringing allies together
- Sharing information and communication
- Support and incentives
- Generation of resources
- Maintaining morale and pace to achieve goals
- Community empowerment and self sufficiency

Sensitization, orientation and awareness development

In community-based initiatives, it is always essential to sensitize the community and orient them appropriately on the objectives, concept, philosophy and process of the approach. These should be expressed in the context of their needs. The community should be informed about the local situation and how the community-based initiatives approach can assist them in solving their problems. Awareness should also be raised regarding their needs, rights, potential and resources as well as their roles in the social set-up where they live and function. Repeated interaction and communication with community members will sensitize them. They will start listening with interest and will be gradually mobilized.

Motivation and social preparation

Motivation is a process of "stimulus and response". It is inducement of people to contribute effectively and efficiently towards the goals. Motivation aims to socially prepare the people for new roles and implementing an unconventional approach. Different community groups and their leaders are approached and motivated for the change.

Motivation intends to socially prepare the people for new roles and implementing an unconventional approach

Organizational development

The community is helped to become organized and develop a network system to carry out collective and coordinated actions. In a community-based initiatives area, through this process, the community members, especially the poor, form their organizations (community development committee, cluster representatives and technical committees). These organizations work on democratic principles, based on the roles agreed by all members.

Capacity-building

Community organization is incomplete without enabling community members to accomplish their changed roles. The capacity-building and training of the community leadership is an essential element for their empowerment and allows them to take up their new roles by self managing the programme activities. The community should be encouraged to maximize their potential and upgrade their existing skills and knowledge.

Bringing allies together

People from different sectors and at various levels of society should be engaged in dialogue for collective and collaborative action. In addition to intersectoral departments, the organizations, stakeholders, opinion-makers and political leadership should be mobilized for developing partnerships and carrying out collaborative action for community development.

Sharing information and communication

Continuous communication and sharing of vital information about the developments in the community-based initiatives areas are vital for programme advocacy and the social mobilization process. There should be clearly defined strategies and a communication system for sharing information with the community and stakeholders.

Support and incentives

In the early stages of development, motivational incentives and material support may be essential for creating interest among community members. However, technical support works throughout the programme to make the change effective and sustainable.

Generation of resources

Creation of capital through the mobilization of community savings, profit-sharing and contributions (like the community development fund) will facilitate the function of community organization and enhance its ability to realize its full potential. These resources will be common assets of the community and the first step towards self-reliance.

Maintaining morale and pace to achieve goals

Social mobilization is intimately connected with morale, which in turn is linked to the successes and achievements of the community. The technical support team in community-

based initiatives areas should continuously encourage the communities for maintaining their morale and continuity of actions. This will keep the social mobilization process vital for programme sustainability.

Community empowerment and self sufficiency

The ultimate result of the social mobilization process is community empowerment and attaining a level of self-sufficiency. The communities should be empowered in their efforts towards becoming more self-sufficient in decision-making and designing strategies for their own future. This should be considered in the context of the community, the family and even the individual. In addition to a stable income, the elements of self-sufficiency include education and skills, housing and nutritional stability, safety and environmental stability, the availability and accessibility of services, relationships and social services.

In community-based initiatives, communities are mobilized and empowered to undertake their own development with the technical and material support of other stakeholders and partners. Being the primary participants of the whole process, communities are obliged to determine terms of reference for their own development, outlining short-term and long-term targets and earmarking role of each partner through the social contract, discussed below.

2. SOCIAL CONTRACT

At the time of introducing the community-based initiatives (basic development needs, healthy villages programmes, healthy cities programmes and women in health and development) in an area, all the development partners and the stakeholders should sign the social contract as a moral obligation to play their role as specified in the contract.

2.1 Objectives

The social contract is intended to promote joint action among the partners with well defined roles and responsibilities for:

- achieving health for all by ensuring equity in health opportunities and improving the health outcomes through health awareness, healthy lifestyles and disease prevention

- facilitating integrated socioeconomic development for social uplift, limiting social disabilities, reducing poverty and improving the quality of life of the people.

2.2 Roles and responsibilities

Since community-based initiatives are a collaborative endeavour, the partners (community, government, WHO and other stakeholders) are required to perform the following roles to achieve the programme targets.

Community

The community of the project area will be obliged to undertake the following measures on the principles of self-help, self-financing, self-reliance and self-management for sustainable community development in collaboration with the ministry of health/government programme management/intersectoral team, WHO and other partners.

The community will mobilize and organize itself as follows.

- A community development committee will be selected by the people representing the whole community. The selected committee will be duly notified by the programme management and/or local administration. Any change in the organization will be subject to approval/notification by these authorities.

- The locality implementing community-based initiatives will be subdivided into clusters, each consisting of a feasible number of houses. The families will nominate their cluster representatives from the residents.

- The women's and youth groups will be mobilized and organized, in addition to technical committees nominated to perform specific tasks such as health, education, sanitation, income-generation activities and financial management.

- The community representatives will work voluntarily without any expectation of payment or any financial rewards/incentives.

- The head of the community development committee or any other member nominated by the community development committee will be the signatory on behalf of the community for programme-related documents, reports, project proposals and agreements.

- Members of community organizations will build up their capacities to act as promoters of the programme through active participation in different training courses. They will be well acquainted with community-based initiatives management guidelines and tools for their regular use in various programme activities.

- The community development committee, cluster representatives and technical committees will meet regularly to share information, and make recommendations/ proposals with wider consensus.

- The community development committee/cluster representatives will assist and facilitate families for solution of their problems, disseminating technical information and collecting requisite information. The community development committee will be obliged to take the families in confidence and keep well informed about the programme developments.

- The community will assist and facilitate the intersectoral team and other partners in carrying out the operational research and will provide relevant information as and when required.

- The community will act as an advocate for the programme by promoting the community-based initiatives approach for health and development and its achievements to other communities/visitors for sharing experiences and the expansion of programme activities.

- The community development committee will be responsible for regular supervision and monitoring of the projects and maintaining their records as prescribed in the community-based initiatives guidelines and tools.

- All activities and decisions of the community development committee will be documented and regularly shared with other partners especially the intersectoral team.

The community, with the support of the intersectoral team, will voluntarily conduct baseline household and community surveys, and needs assessment to collect information on community-based initiatives elements and indicators; compile and analyse the survey results; prioritize identified needs; and prepare an area development plan.

The community will plan and implement the projects/activities for the area as follows.

- Projects will be pro-poor, feasible, responsive to basic priority needs, in line with social norms and within the limits of available resources. All projects must produce a positive impact on the health status of individuals, families and communities.

- The community will mobilize all possible resources, identify skilled human resources and explore options for marketable projects.

- The community development committee will screen and recommend applications for income-generation projects according to the programme criteria and will prepare project proposals on the prescribed formats, providing guarantees for recovery of the loans.

- The community will contribute in all social interventions in addition to at least a 25% share in the income-generation activities.

- The community will ensure that only the underprivileged/poor families benefit from the loans, reducing the overall prevalence of poverty by at least 25% within a period of three years.

- The community, through the community development committee, will manage the programme activities with technical assistance and consultation from the intersectoral team and according to the approved proposals and programme criteria.

The community will ensure the implementation of essential elements of the health and social development packages after their adaptation to the local burden of disease pattern and

socioeconomic priorities. The intersectoral team and WHO will build up the capacity of the community for obtaining necessary skills and knowledge to implement the health and social development packages. Subsequently, the community, with the assistance of the health staff, will introduce all necessary interventions to achieve the agreed health targets within a given period (e.g. three or more years) in comparison with the baseline indicators established at the initiation of programme activities. The targets will be decided through a consultative process using the undermentioned figures. It is critical that agreed targets are achievable, practical and measurable. The list of targets given below and the time frame for achieving these is only a suggestion and can be modified in each area depending on the presenting situation and considering the national parameters for health and development.

- Vaccination of children and mothers ≥ 90%.
- Provision of antenatal and postnatal care to pregnant women and new mothers ≥ 90%.
- Access to safe delivery and maternity care through community-based, trained health workers and referral of high-risk cases to the nearest health facility ≥ 70%
- Promotion of family planning through provision of technical counselling and family planning methods ≥ 50% of eligible couples.
- Reduction in morbidity and mortality among children under five years of age due to diarrhoea by ≥ 75% through training of all mothers in the preparation of oral rehydration salts and management of mild cases.
- Reduction in the mortality and morbidity of children under five years of age due to pneumonia by 50% through appropriate measures.
- Reduction in malnutrition in children by 50% and in mothers by 65% through adequate nutrition, regular monitoring and other corrective measures.
- Promotion of exclusive breastfeeding for at least six months by 75% of all newborns.
- Reduction in morbidity and mortality from tuberculosis by 70% through the introduction of DOTS.
- Reduction in malaria cases by 90% by improving the sanitary conditions of the locality and provision of impregnated bed nets.
- Organization of health awareness sessions for disseminating health information to all families for the promotion of healthy lifestyles and reduction in smoking and substance abuse.
- Provision of safe drinking water to 70% of families.
- Introduction of school health initiatives for the promotion of physical exercise, regular medical check-up of students and better oral health.

- Ensuring training of trained birth attendants and educated youth (especially females) as community health workers on components of primary health care to assist in delivering the components of health packages and developing a linkage with health facilities.

- Generating and maintaining a record of vital events which have a direct impact on the health of the local population.

The community will manage the programme finances in accordance with community-based initiatives guidelines and tools as described below.

- Accounts for principal and revolving funds will be opened at the nearest bank, to be operated with dual signatures of the community representatives and programme manger.

- The community will guarantee the return of all loans according to an agreed schedule, and the community development committee/cluster representatives will carry out effective follow-up of delayed and defaulted loans.

- The community will nominate a finance committee to be responsible for loan disbursement and recovery, managing the bank accounts, maintaining records and preparing monthly reports, ensuring transparent financial management and keeping the community informed.

- The beneficiaries of income-generation will contribute a part of their profit towards community development fund as a mechanism of sharing benefits with other members of the community. The community development committee will collect this, deposit it in a bank account, maintain its records and will consume it partially for operational costs and further development of the community through new projects and welfare schemes, particularly for the poorest and sick segments of the local community.

- The ministry of health and WHO will conduct a yearly assessment of the financial records. The community will facilitate this process.

Intersectoral team

The intersectoral team, under the supervision of the programme manager, will assist the community in undertaking the identified tasks to achieve the desired objectives of the programme. This includes the following.

- Mobilization and organization of the community in order to address their problems and enable sectoral development.

- Training and capacity building of the community in community-based initiatives methodologies and upgrading existing local skills.

- Preparation and approval of the programme area and district development plans based on the identified need and priorities.

- Preparation and appraisal of the project proposals for technical viability and financial sustainability.

- Coordination and collaboration with health staff, voluntary health workers and other functionaries for the successful implementation of the essential health package.

- Providing sectoral inputs from public sectors departments and mobilizing local and external resources for effective implementation of the planned activities..

- Research and promotion of appropriate technologies relevant to programme activities.

- Coordination and collaboration with all stakeholders and exploring new partnerships.

- Documentation and reporting of the programme activities and building evidences towards the efficacy of community-based initiatives inputs, process, outputs and outcomes.

- Advocacy, promotion, marketing and expansion of community-based initiatives within and outside the district.

National and provincial/ governorate authorities

- Appointing focal persons at national and provincial/governorate levels for programme management and coordination.

- Establishing provincial/governorate and national committees for ensuring political commitment, setting policy guidelines and principles, designing standards and procedures for programme implementation, and mobilization of the required resources.

- Developing an effective intersectoral collaboration system.

- Orientation, promotion and advocacy of the approach to gain the support of public sector and other potential partners/agencies.

- Preparation and approval of the national and regional plans and their incorporation in the national development agenda and policies for facilitating the attainment of millennium development goals.

- Monitoring the implementation process and progress of the programme and conducting periodic evaluation of the programme.

WHO and other donor agencies

- Assisting the preparation of related national policies and plans to promote equitable development and achievement of millennium development goals.

- Undertaking advocacy and promotion of community-based initiatives with all potential partners for joint action and reasonable mobilization.

- Providing technical assistance for successful management as a model of sustainable development.

- Extending financial support as seed money for socioeconomic development in model areas.

- Fostering the flow of information, exchange of experiences and technical cooperation between different developing communities on matters related to health and human development.

- Supporting research and development of appropriate technologies, using locally available knowledge and skills.

- Marketing community-based initiatives approaches and creating linkages between different developmental partners and stakeholders.

- Building the capacity of the national authorities and the communities for successful, management of the programme in accordance with the WHO guidelines and tools for community-based initiatives.

Signatories

The social contract will be signed in a joint meeting comprising representatives from WHO, the ministry of health, the government, the community and other stakeholders. The community representatives, programme manager, relevant government authorities and WHO country representative will be the signatories of the social contract.

3. GROUP WORK

Process

On the evening preceding the respective working session, participants should read the materials required for the respective group work. The group work should be conducted as follows.

- Participants should be divided into equal groups, each not exceeding eight members.

- Each group should select its own chairperson and presenter. (These responsibilities should be rotated during each group work assignment.)

- The chairperson should watch the time and encourage every group member to participate.

- The presenter should present the findings/report of the working group in the plenary session.

- Facilitators should help the participants as resource persons and give feedback on the group presentations.

Assignment

During working session, each group will discuss one of the situations presented in Annex 3.1.1 and will give their views in the plenary session on the following question.

"What are the appropriate strategies to mobilize the local community by breaking prevailing sociopolitical barriers and for ensuring collective efforts towards programme implementation?"

Annex 3.1.1

CASE STUDY

Comparison of organizational issues of three villages in the programme area

Factor	Village 1	Village 2	Village 3
Selection of area	On political basis, native village of wealthy landlord who is a political and government authority	Adjoining first village	Adjoining second village
Village size	About 3000 population, divided into three (almost equal) parts situated at walking distance from each other.	Village of about 4000 population, with two small suburbs.	Big village having above 10 000 population, divided into five parts (one main locality and other small parts)
Education and awareness level	The majority o f the people are illiterate and unaware	Literacy rate is low	Literacy rate is not too low compared to other villages, and people are aware of common issues
Facilities	Male and female primary schools, office of union council and basic health unit for the area	Middle schools for male and female children	High school for boys and middle school for girls. No health facility. One administrative office of irrigation department
Sources of income	Agriculture (mostly landless people, tenants or agricultural labourers). All land belongs to three or four families	Agriculture is the main source and the majority of families are smallholders	Agriculture is the major source, as many families own land. Other main sources are trading, shops and technical jobs
Community leadership	One landlord has complete hold on the village	Two rival groups. One is led by a political person who is disliked by the majority	Big community but divided into small groups and no central leadership

Comparison of organizational issues of three villages in the programme area

Factor	Village 1	Village 2	Village 3
Political Influence	People are under the intense influence of one person and do not care about party	One ethnic and political leader tries to influence all community activities	No clear influence of one party or person, but small groups try to influence
Social grouping	No grouping in the community	Two main ethnic and political groups, but community is also divided into religious groups	Community has small political and ethnic groups but no rivalries
Community organization trends	No nongovernmental organizations	One group has created a nongovernmental organization but not representative of whole community	Young people have some support organizations; a few religious organizations also exist
Community entry point	Political figure is very supportive and provides facilities, but does not allow independent action	No clear entry point; both groups want their hold on programme activities	School, mosques, shops (being a big village, difficulty to reach all groups and communities)
Community attitude	People are of dependent nature	People think in the light of ethnic or political basis	People are not dependent on any person or issue
Community empowerment	The community is not allowed to make any independent decisions	One political leader of one group wants to keep hold on local decisions	General community does not actively participate in decision-making
Community decisions	Community decisions are made by one person or his key employees who wait to get his approval for everything	Both political groups make the decisions and try to impose on others	Different people have their own jobs, and are seldom interested in joint activities

Comparison of organizational issues of three villages in the programme area

Factor	Village 1	Village 2	Village 3
Women's empowerment	Women participate in agricultural labour, but not empowered to participate in social work	Women are better educated but do not have opportunities for community or development work.	Women are better educated, help in economic activities, but limited social work.
Main issues	Centralized community leadership, all others dependent on a family; the majority of families are homeless and landless, work as labourers or tenants Dependent community development committee and landlord's manager is chairman of the committee and seldom gives time and always seeks landlord's approval for the action	Political and ethnic rivalry of two groups who are not ready to work together. Each group wants to keep hold on community development committee The community is unreliable and the financial investment may be at risk	Very big village, with diverse leadership; difficult to approach all. Community groups have made a joint committee at village level The number of houses is too large, and 40–50 cluster representatives are not manageable; poverty level is less than that of villages 1 and 2

Part B
Module 3
Unit 3.2

Health development

Learning objectives

To gain a better understanding of the basic elements, proposed interventions and measuring tools in the following main areas of health:

- availability of health services
- health promotion and protection
- integrated management of child health
- making pregnancy safer
- control and prevention of communicable and noncommunicable diseases

Expected outcome

The participants will acquire knowledge of essential components of health and will be able to design feasible projects and activities in community-based initiatives areas

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2.1 Availability of health services 130

2.2 Health promotion and protection 131

2.3 Integrated management of child health 133

2.4 Making pregnancy safer 135

2.5 Control and prevention of communicable and noncommunicable diseases 136

1. INTRODUCTION

Health is central to development and is the priority for every individual. An individual, family or community cannot live a productive life if not healthy. Health is not merely management of diseases, but the total well-being of a person. It is the outcome of composite socioeconomic actions with more focused measures at individual and community levels for preventing diseases, protection from the causative factors of ill-health and promoting healthy lifestyles. The following elements and proposed interventions are intended to promote innovative ideas to foster comprehensive development and promote appropriate actions for improving the health situation. These should be adapted in relation to the country situation and local needs, and must be implemented as an essential strategy under the social contract in CBI areas.

HEALTH SECTOR COMPONENTS AND ELEMENTS

Component	Elements
Availability of health services	Functional health facility Availability of essential drugs Functional referral system
Health promotion and protection	Health education and promotion of healthy lifestyles Tobacco-free initiatives and control of substance abuse School health
Integrated management of child health	Management of diarrhoea and acute respiratory infection Vaccination against preventable diseases Malaria prevention Nutrition
Making pregnancy safer	Safe motherhood Vaccination of pregnant mothers against tetanus Food and nutrition Family planning services
Control and prevention of communicable and noncommunicable diseases	Malaria control Tuberculosis control through DOTS Prevention of AIDS and sexually transmitted diseases Common ailments Noncommunicable diseases

2. PROPOSED INTERVENTIONS AND OUTCOME MEASUREMENT

2.1 Availability of health services

Element	Specific objectives	Possible intervention	Outcome measurement (against baseline)
Functional health facility	Ensuring access of the community to health facility for the promotion, prevention, treatment and rehabilitation of common ailments	Making the health facility nearest to the community functional Ensuring essential equipment in the health facility Ensuring availability of trained staff in the health facility	Health facility is functional and within easy access Trained staff and necessary equipment are available Number of monthly outdoor cases during the past 12 months
Availability of essential drugs	Access of patients to essential drugs required for common health problems	Provision of essential drugs throughout the year Establishment of self-sustained fair-price community pharmacy for sale of essential drugs	Availability of the essential drugs list in conformity with the locally prevalent common illnesses Monthly comparison of availability of essential drugs in the past 12 months, according to the burden of diseases and number of reported patients
Functional referral system	Ensuring a sustainable first level referral system, especially for emergency obstetric and child care	Training of health staff, community workers and traditional birth attendants on early identification and referral of high risk cases, especially among children and pregnant women Provision of transport facilities for the first-level referral facility	Percentage of health staff and community workers trained in early detection and referral of high-risk cases Availability and access to transport facilities for women, children and emergency cases

2.2 Health promotion and protection

Element	Specific objectives	Possible interventions	Outcome measurement (against baseline)
Health education and promotion of healthy lifestyles	Prevention of diseases and promotion of healthy lifestyles to protect and improve health of the people	Provision of health education and counselling of the community through interpersonal communication using health staff and community workers Health promotion activities such as seminars, audiovisual materials, community theatre, shows and mass media Encouraging physical and better dietary habits	Percentage of health staff and community workers trained in interpersonal communication skills Availability of health education and advocacy materials at health facility and community levels Availability of and access to physical activities e.g. gymnasiums and green areas Number of health education activities carried out during the past 12 months and the main health messages delivered
Tobacco-free initiative and control of substance abuse	Reducing the prevalence of smoking and addiction to harmful substances	Community awareness of socioeconomic and health hazards of smoking and substance abuse No smoking campaigns and provision of incentives to quit smoking Restricting the sale of cigarettes/tobacco, alcohol, heroin and other harmful substances	Percentage reduction in the number of smokers during the past 12 months Percentage reduction in the number of addicts during the past 12 months Availability of community-based rehabilitation services

School health	Introducing a school health programme for disease prevention and health promotion among school children	Training of health staff and teachers in school health and developing linkages between school and health facility Imparting health education to students and disseminating health messages to families Improving school hygiene/environment including safe drinking water, sanitary latrines and food safety Identification of health problems and referral of positive cases Prevention of trauma and training on first-aid techniques	Percentage of school teachers trained in identification of main health problems and their referral Number of sessions organized to convey health education messages to students Percentage of schools having safe drinking water, access to safe food and sanitary latrines Percentage of students undergoing periodic medical examination

2.3 Integrated management of child health

Element	Specific objectives	Possible intervention	Outcome measurement (against baseline)
Management of illnesses	Reduction in infant and child morbidity and mortality through prevention, early diagnosis, management and referral of common childhood illnesses	Training of health staff and community workers in integrated management of child health Training of mothers for management of children with malaria, diarrhoea and acute respiratory infections Providing child health services in the affiliated health facility Ensuring availability of essential drugs and oral rehydration salts	Percentage f health staff and community workers trained in integrated management of child health Percentage reduction in the prevalence of malaria, diarrhoea, acute respiratory infections and immunizable diseases Number of deaths in children under 1 year of age during the past 12 months Number of deaths in children up to 5 years age during the past 12 months
Vaccination against preventable diseases	Reduction in the morbidity, mortality and disability due to childhood illnesses through immunization	Provision of immunization services for the health facility and outreach teams Active participation of community organizations and community workers in vaccination activities	Percentage of children with complete vaccination

Nutrition	Reducing incidence of malnutrition and ensuring proper growth of children	Counselling of pregnant mothers during antenatal care Promotion of breastfeeding through orientation and training of mothers' groups on benefits of breastfeeding Training of the health staff and community workers in growth monitoring Monitoring the weight of children under 3 years of age and maintaining their growth charts Referral and follow-up of malnourished children Providing iodine supplements in iodine deficient areas	Number of children under 2 years of age exclusively breastfed for initial 6 months Percentage reduction in the number of severe, moderate and mildly malnourished children during the past 12 months

2.4 Making pregnancy safer

Element	Specific objectives	Possible intervention	Outcome measurement (against baseline)
Safe motherhood	Ensuring community access to safe motherhood services	Training of health staff and community workers in safe motherhood practices such as antenatal and postnatal care, and referral of risk cases Training of traditional birth attendants in safe delivery Establishment of maternity services in the affiliated health facility Health education and counselling of mothers' groups on vaccination, antenatal and postnatal care, safe delivery and identification and referral of high risk cases	Percentage of health staff and community workers trained in safe motherhood Percentage of traditional birth attendants trained in and practising safe deliveries Percentage reduction in maternal mortality
Vaccination of pregnant mothers against tetanus	Reduction in morbidity and mortality in women due to tetanus	Provision of immunization services from the health facility and outreach teams Active participation of community organization and community workers in vaccination of mothers	Percentage reduction of tetanus in newborn children Percentage of pregnant mothers vaccinated against tetanus
Food and nutrition	Reduction in prevalence of anaemia and food deficiencies in mothers	Health education and counselling of married women and pregnant mothers on food and nutrition Screening of women for anaemia and provision of food supplements	Number of activities for health education on food and nutrition

Family planning services	Promotion of family planning practices for effective population management	Advocacy and promotion of family planning through motivation and awareness campaigns Ensuring availability of family planning supplies Adopting alternate strategies such as enhancing literacy rate through institutions and mosques	Percentage of eligible couples with access to family planning services Percentage increase in number of couples practising family planning methods Percentage reduction in growth rate Percentage reduction in fertility rate

2.5 Control and prevention of communicable and noncommunicable diseases

Element	**Specific objectives**	**Possible interventions**	**Outcome measurement (against baseline)**
Malaria control	Reducing morbidity and mortality due to malaria	Awareness of the community regarding causes, prevention, precautions and management of malaria Control of breeding places Identification of malaria suspected cases through blood slides, diagnosis and case management Prophylactic treatment of suspected cases Promotion of insecticide impregnated mosquito bed nets	Percentage of health facilities with diagnostic services Percentage of houses using insecticide impregnated mosquito bed nets Percentage reduction in the number of malaria cases during the past 12 months

Tuberculosis control through DOTS	Reducing the prevalence of tuberculosis and providing treatment to active cases through directly observed treatment short course (DOTS)	Health education of patients, their contacts and the community for prevention of tuberculosis Identification of suspected cases and their referral for diagnosis and management Treatment of confirmed cases through DOTS with the assistance of community organizations and health workers	Percentage of health facilities with diagnostic services Percentage reduction in the number of active tuberculosis cases Availability of and access to tuberculosis drugs
Prevention of HIV/AIDS and sexually transmitted diseases	Reducing the prevalence and spread of HIV/AIDS and sexually transmitted infections	Community awareness regarding causes, spread and prevention of HIV/AIDS and sexually transmitted diseases Ensuring access of target groups to condoms	Percentage of community members having a good awareness of the sources of spread and methods for prevention of HIV/AIDS and sexually transmitted diseases Level of access to condoms of the community
Common ailments (anaemia, cataract, scabies, others)	Reducing the incidence of common ailments and their resultant complications	Mass awareness about prevention of common ailments Screening of the common ailments and taking appropriate measures for early diagnosis and management	Percentage of people aware of the causes of common diseases and methods of their prevention Number of health programmes in place for the management of common ailments
Noncommunicable diseases (cancer, cardiovascular problems, diabetes, others)	Reducing prevalence of and disability from noncommunicable diseases	Community awareness regarding causes, prevention and management of noncommunicable diseases Promotion of healthy lifestyles and physical activity, especially among high risk groups Establishment of community support groups	Number of health awareness sessions organized during the past year on noncommunicable diseases Availability of community based rehabilitation services Reduction in the number of new cases of main noncommunicable diseases, e.g. hypertension, diabetes and cancer

Part B
Module 3
Unit 3.3

Social development

Learning objectives

To gain a better understanding of the main elements, possible interventions and outcome measurement tools in the social components of:

- education
- adequate housing conditions
- environmental health
- social welfare actions
- empowerment of women
- youth development

Expected outcome

The participants will have knowledge of the essential components of social development and will be able to design feasible interventions in the project areas

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   - 2.6 Youth development 148

1. INTRODUCTION

Social development is not only essential for improving living conditions and the quality of life; it is also a pre-requisite for improved health status. Social development is always a priority for the communities, as people want to be respected and able to go about in the society with dignity and pride. In its humanitarian context, social well-being is an essential human right. Social development cannot be achieved through a single activity; in fact, it is a dependent on a group of activities carried out over time according to the priority needs and availability of resources.

The following elements and proposed interventions are intended to promote innovative ideas in order to foster comprehensive development. These should be adapted in relation to the country situation and local needs.

Social sector components and elements

Component	Elements
Education	Adult literacy School education Promotion of life skills and extracurricular activities Development of educational institutions
Adequate housing conditions	Adequate and ventilated living places Separate ventilated kitchen and food safety Separate and safe sanitary latrines Accidents prevention and fire safety measures Healthy neighbourhoods
Environmental health	Safe drinking water Sanitation and hygiene
Social welfare actions	Resources for pro-poor actions and social welfare services
Empowerment of women	Mobilization and organization of women Women as agents of change and promoters of the environment Schemes for skills development and income generation
Youth development	Mobilization and organization of youth Youth development initiatives Reduction of unemployment Recreational activities, including sports and cultural promotion

2. PROPOSED INTERVENTIONS AND OUTCOME MEASUREMENT

2.1 Education

Element	Specific objectives	Possible interventions	Outcome measurement (against baseline)
Adult literacy	Enhancing the literacy rate among the community	Informal education/adult literacy programmes/ centres for those who have missed school opportunities	Number of community members (male/female) attended literacy classes during the past 12 months
School education	Enhancing school education for children	Listing of school defaulters/drop outs for each cluster, identifying the causes and follow-up by the community organizations Establishment of coaching centres or study clubs facilitating improvement of educational status	Number of new admissions of boys and girls in school during past 12 months Number of school-age children not registered in school Reduction in number of school dropouts in the past 12 months compared to previous years Number and category of opportunities available for promotion and improvement of education for males and females
Life skills and extracurricular activities	Promoting life skills, knowledge and intellectual growth through literacy activities	Developing a manual and providing training, particularly for students, on ethics, good manners, and practical life skills Establishing community libraries containing materials on practical issues, including health education Publishing a local gazette/newsletter Developing study forums and circles for exchange of views and brainstorming on community related issues Promotion of cultural and recreational activities such as sports, stage shows, etc.	Life skills development is a regular feature of schools and literacy centres Community has opportunities to improve their knowledge and enhance intellects Community participates in recreational and sociocultural activities

Development of educational institutions	Assisting the private sector and nongovernmental organizations to contribute in the development of educational institutions, especially in the underserved areas	Assistance to the community for establishing schools Encouraging nongovernmental organizations and the private sector to be involved in the development of educational institutions	The private sector and nongovernmental organizations that are taking part in the education development activities

2.2 Adequate housing conditions

Element	**Specific objectives**	**Possible interventions**	**Outcome measurement (against baseline)**
Adequate and ventilated living places	Promotion of healthy living conditions and reduction of chances for cross infection	Informing the community about the hazards of congested houses Promotion of standard rooms (one for four persons)	Majority of the families have well ventilated bedrooms, each for maximum of four persons
Separate ventilated kitchen and food safety	Prevention of hazards of smoke pollution and food contamination	Imparting education to community members regarding significance of ventilation of kitchen and hazards of smoke on the health of family members Training of families for adopting appropriate techniques such as solar energy and modern methods of food safety	Majority of the houses have separate ventilated kitchen Community is aware of and practises food safety measures
Separate and safe sanitary latrines	Promotion of the use of sanitary latrines to prevent diseases caused by unhygienic conditions	Awareness of the community concerning use of sanitary latrines Producing model latrines in locality for demonstration and promotion purpose Financial and technical assistance to the families for construction of sanitary latrines	The majority of houses have sanitary latrines

Accident prevention and fire safety measures	Prevention of accidents, injuries and burns	Training of community members on prevention of common household accidents and burns	The incidence of household accidents including burns is rare
Healthy neighbourhoods	Promotion of a healthy environment in and around residential areas	Community awareness of the significance of clean neighbourhoods Assistance in the development of a cooperative sanitation system for the locality Cleanliness campaigns on regular basis	Streets and neighbourhoods of the locality clean with no breeding places for mosquitoes or flies

2.3 Environmental health

Element	**Specific objectives**	**Possible interventions**	**Outcome measurement (against baseline)**
Safe drinking water	Reducing the prevalence of waterborne diseases	Public awareness of the benefits of drinking safe water Coordination in other sectors for ensuring access to safe drinking water for the whole community Promoting the use of boiled water and other methods such as water purifying tablets	Percentage of households with access to safe drinking water (from any source)
Sanitation and hygiene	Promotion of a healthy environment and sanitation in order to prevent diseases and improve living conditions	Awareness of community on the benefits of good sanitation and hygiene Promotion of healthy neighbourhoods through safe disposal of waste water, excreta and solid waste	Number of cleanliness campaigns during the past 12 months Availability of a community system for waste disposal

2.4 Social welfare action

Element	Specific objectives	Possible interventions	Outcome measurement (against baseline)
Resources for pro-poor action and social welfare services	Developing financial assets for sustainable community development	Contributions from various sources for welfare activities	A community development fund is established and being used for social welfare of the poorest and most vulnerable groups, as well as community development and operational costs of the programme

2.5 Empowerment of women

Element	Specific objectives	Possible interventions	Outcome measurement (against baseline)
Awareness of gender issues	Creating awareness among women on gender issues and their solutions	Training and education of women on common and health-related issues	Women are informed about their particular problems and have the skills to solve them
Mobilization and organization of women	Mobilizing women group in society for organized participation in development process	Mobilization, organization and capacity-building of women	Women's organization is established and functional Percentage of women involved in community development and other committees
Women as agents of change and environment promoters	Promoting proactive role of women for transforming communities and creating awareness regarding mother and child health and environmental health	Training of female volunteers for promotion of healthy lifestyles and a healthy environment Organizing mothers' groups Health education sessions by health staff	A network of women volunteers is working for environmental health and healthy lifestyles Mothers are aware of the relevant health issues and carry out appropriate measures
Schemes for skills development and income generation	Promoting vocational skills for manufacturing traditional items along with provision of loans for income-generation	Establishment of women's development centres for different types of vocational training Provision of loans for income-generation schemes managed by women	Women's development centre is established and women have the opportunity to acquire training in multiple skills Special allocation is established for loans to women

2.6 Youth development

Element	Specific objectives	Possible interventions	Outcome measurement (against baseline)
Youth mobilization and organization	Mobilizing and capacity-building of the youth for developing their potentials and preparing for future leadership	Mobilization and organization of youth Capacity-building of youth and skill development Exploring and mobilizing the youth potentials for community development	Youth of the area (both boys and girls) are organized and actively participating in the community-based initiatives process
Youth development initiatives	Developing the capacity of youth for practical life and better livelihood	Training in modern technologies though technical training centres Conducting short courses such as career development, management, business, entrepreneurship and marketing	The young are mobilized towards improving their skills There are specific interventions for youth development
Reduction of unemployment	Reducing unemployment in youth and providing opportunities for self-employment	Increasing the professional skills of the youth Providing technical and financial assistance for self-employment. Making career development forums for the guidance and help of the unemployed youth	Percentage reduction in unemployment and underemployment rate in educated youth (boys and girls)
Recreational activities and promotion of sports and cultural activities	Engaging the youth in healthy activities to divert them away from unsocial activities	Promotion of youth clubs for sports and cultural activities	Youth have recreational facilities and are actively participating in such activities

Part B
Module 3
Unit 3.4

Economic development

Learning objectives

To gain a better understanding of the main elements of, and possible interventions and outcome measurement in economic sectors such as:

- agriculture and irrigation
- livestock, dairy farming and fisheries
- income generation and microcredit

Expected outcome

The participants will acquire knowledge of essential components of economic development and will be able to help people in designing feasible interventions in community-based initiatives areas.

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2. Proposed interventions and outcome measurement 154

2.1 Agriculture and irrigation 154

2.2 Livestock, dairy farming and fisheries 155

2.3 Income generation and microcredit 156

1. INTRODUCTION

The aspiration of equitable health and social well-being cannot come true if the people of the community are not able to earn enough to meet their basic needs. A human being cannot live without sufficient monetary resources to fulfil the basic needs and requirements and still be a productive member of society. Families need money for their food, living, clothes and utilities, as well as paying the cost of social services. As a basic human right, every family needs to be enabled by society to strive for all reasonable and lawful opportunities to earn money. It is also the obligation of the community as a whole, and the state in particular, to provide assistance, technical or financial, to all needy people in order to raise their economic status and enable them to break out of the poverty trap.

The undermentioned elements and proposed interventions are intended to promote innovative ideas to foster comprehensive development. These should be modified in relation to the country situation and local needs.

Economic sector components and elements

Component	Elements
Agriculture and irrigation	Technical capacity of the community in modern farming and agriculture techniques New foods and cash crops for higher yield Safe and effective use of pesticides Reliable means of irrigation Forestry, tree plantation and gardening
Livestock, dairy farming and fisheries	Modern livestock farming Production, preservation and use of dairy products Commercial and family poultry production Fisheries and bird farming
Income generation and microcredit	Production and marketing skills Income generation for poor families

2. PROPOSED INTERVENTIONS AND OUTCOME MEASUREMENT

2.1 Agriculture and irrigation

Element	Specific objectives	Possible interventions	Outcome measurement (against baseline)
Technical capacity of the community in modern farming and agriculture techniques	Building up the capacity of farmers in modern agricultural techniques	Orientation and training sessions for farmers Promotion of modern agriculture techniques through audiovisual aids	The community is informed about modern techniques used in agriculture
New foods and cash crops for higher yield	Enhancing yield of cash crops to promote self-reliance in food and increased income using quality seeds, necessary pesticides and fertilizers	Introducing new food and cash crops which are more beneficial in terms of use and income Promotion of use of quality seeds, pesticides and fertilizers	The community is self-sufficient in production of food crops and earns better income from increased yield of cash crops
Safe and effective use of fertilizers and pesticides	Preventing health hazards due to the use of pesticides and chemicals	Training of community for proper storing and use of fertilizers and pesticides Informing farmers of the health hazards of the unsafe use of pesticides Prevention of homicidal or accidental poisoning	The community is well informed about the proper use of fertilizers and pesticides There are no accidental poisoning cases in the community
Reliable means of irrigation	Securing crops and increasing their yield through proper irrigation techniques and a sufficient supply of water	Technical assistance to the community in organizing water channels Financial assistance for installation of tube wells and motor pumps. Introducing the drip system for irrigation of plants.	The community has established reliable irrigation system and sufficient water is available for the crops throughout the year

Forestry, tree plantation and gardening	Promoting environmental protection through tree plantation, and food and nutrition through the production of fruit and vegetable	Technical assistance for developing forestry and tree plantation in barren lands and near the locality Promotion of plant nurseries as income-generation activities Promotion and assistance in maintaining orchards and kitchen gardens	Community informed and undertaking plantation and forestry projects The community has plants nursery projects The community has implemented projects for fruit orchards Families have projects for kitchen gardening

2.2 Livestock, dairy farming and fisheries

Element	**Specific objectives**	**Possible interventions**	**Outcome measurement (against baseline)**
Modern livestock farming	Promoting modern techniques in livestock farming and dairy development in order to increase income and yields	Giving training to the community regarding modern livestock and dairy development Financial assistance for the purchase of quality animals Establishment of facilities for artificial insemination Training of young people on vaccination of animals Facilitation for regular vaccination campaigns Promotion of hygiene in animal sheds Training of farmers in improving nutritional value of animal feed	Farmers have knowledge on modern techniques in livestock management People keep quality animals with greater milk and meat yields Mortality and morbidity in animals is negligible and there is no outbreak of disease
Production, preservation and use of dairy products	Improving the nutritional status and income of the families	Training of the farming families in preparing dairy products and preserving/packing for commercial sale	The community has dairy products projects utilizing modern techniques

Commercial and family poultry	Increasing the nutrition and income of the families through poultry farming	Technical and financial assistance to the community for commercial and family poultry	The community has poultry farming projects Families in the community are keeping poultry
Fisheries and birds farming	Increasing the nutrition and income of families through fisheries and bird farming	Technical and financial assistance for fish farming and family fisheries Promotion of birds farming through financial and technical assistance	The community has implemented fisheries projects The community has successfully implemented bird farming projects on commercial basis

2.3 Income generation and microcredit

Element	**Specific objectives**	**Possible interventions**	**Outcome measurement (against baseline)**
Production and marketing skills	Making the community capable of producing quality goods and marketing them competitively to earn a better income	Training courses for men and women on small business organization and management, quality production and marketing skills	Number of community members (men and women) trained in modern business techniques Increased income levels in the community involved in income-generation activities
Income-generation projects for poor families	Increasing the economic status of poor families and developing self sufficiency in earning their livelihood and reducing poverty	Microcredit schemes for income-generation projects to poor families according to their needs and capacities Establishment of revolving fund from returned loans to be used for further projects in the same area and expansion to new areas	Reduction in the prevalence of absolute poverty CBI revolving fund is established Level of use of revolving fund for reinvestment providing loans to other poor families and programme expansion.

Part B
Module 3
Unit 3.5

Health and development indicators

Learning objectives

To gain a better understanding of:

- the concept and objectives of social mobilization
- the framework for social mobilization with a community perspective
- the social contract between the community and other stakeholders

Expected outcome

The participants will be acquainted with social mobilization processes and the contents of a social contract. They will be able to mobilize communities by using this approach and introduce social contract while initiating community-based initiatives

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2. Indicators 163

3. Health indicators 166

4. Environmental indicators 171

5. Socioeconomic indicators 172

1. RELEVANT TERMINOLOGY

Epidemiology
Epidemiology is the study of disease frequency, distribution and determinants of health and health related events occurring in human populations[*].

Morbidity
Morbidity refers to the occurrence of a disease or impairment of health such as malaria or diarrhoea.

Mortality
Mortality indicates the death of the human being. It may be considered in relation to some causative factor like deaths due to tetanus. Mortality may be age specific, sex specific, or cause specific

Deformity
Deformity is physical or psychological impairment of some vital parts of the body such as paralysis of limb or mental retardation.

Rate
A rate measures the occurrence of some particular event (e.g. disease, deformity or death) in a population during a given time period. It is a statement of the risk of developing a condition or problem. It indicates the change in an event that takes place in a population over a specified period of time.

Example:

$$\text{Death rate} = \frac{\text{Number of deaths in one year}}{\text{Mid year population}} \times 100$$

The rate comprises the following elements:

Numerator: the number of times an event has occurred in a population during a specified time. The numerator is the component (part) of the denominator in case of rate but not in the ratio.

Denominator: this is the total population in which that event occurs.

Time specification: period that is specified or considered for the study

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[*] Park JE, Park K. *Textbook of preventive and social medicine*, 13th ed. M/c Banarsidas Bhanot, India, 1991.

Multiplier: the number taken as the standard to be multiplied, such as 100 or 1000

Ratio

Ratio expresses a relation in size between two independent variables. The numerator is not a component of the denominator. The numerator and denominator may involve an interval of time or may be instantaneous in time. Broadly, ratio is a result of dividing one quantity by another.

The difference between rate and ratio can be understood by following examples:

Example of rate:

$$\text{Case fatality rate} = \frac{\text{Number of deaths from the disease (this is part of the denominator)}}{\text{Number of cases of the disease}}$$

Example of ratio:

$$\text{Maternal mortality ratio} = \frac{\text{Number of maternal deaths (this is not part of the denominator)}}{\text{Number of infants born alive}}$$

The numerator is component of denominator in case but not in the ratio

Formula:

$$\text{X:Y or } \frac{X}{Y}$$

Examples are sex ratio, ratio of males to females.

Proportion

A proportion is a ratio which indicates the relation in magnitude of a part to the whole. In this case, the numerator is always included in the denominator. A proportion is usually expressed in percentage.

Example:

$$\frac{\text{Number of children having skin infection at a certain time}}{\text{The total number of children (of same age group) in the village at same time}} \times 100$$

Incidence

Incidence rates measure the probability of healthy people developing a disease during a specified period of time. It is the number of new cases of a disease arising in a given period in a specified population[*]. It shows the rate at which new cases those occur in a defined group of people.

Example:

$$\frac{\text{Number of new disease cases in a population in a specified time}}{\text{Number of people in the population at risk in the specified time}} \times 100$$

Prevalence

Prevalence measures the number of cases of a disease in a given population at a specified time. It includes new and old cases and measures the probability of people having a disease at a time. It is used to help determine health care needs of the community

Example:

$$\frac{\text{Number of people with a disease or condition at a specified time}}{\text{Number of people in the population at risk at the specified time}} \times 100$$

Prevalence = incidence rate × average duration of disease.

2. INDICATORS

The term indicator is derived from the Latin word *indicare* which means to announce, point out or indicate. An indicator is therefore something that provides an indication or points out to exhibit the condition in a specified time frame. It signifies a given situation or provides reflection of the situation. In other words, it is a variable with characteristics of quality, quantity and time used to measure, directly or indirectly, changes in a situation and to appreciate the progress made for addressing the problem.

Types of indicator

Indicators can be classified in many ways according to whether they are concerned with direct or indirect measurement; whether they are measuring quantities or qualities; or whether they are related to inputs, process, outputs and outcome.

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[*] Beaglehole R, Bonita R, Kjellstrom T. *Basic epidemiology*. WHO, Geneva, 1993.

Direct and indirect indicators

Indicators help to measure changes in a related situation directly or indirectly and assist to assess the extent to which the objectives and targets are being attained.

Direct indicators are the variables used for direct measurement of the change or progress, e.g. infant mortality rate.

Indirect indicators are assumed to be associated with a state that cannot be measured directly, e.g. better quality of life, which is measured indirectly through health and socioeconomic indicators.

Quantitative and qualitative indicators

Quantitative indicators involve numerical measurements and are concerned with quantities, not quality. Example: the number of participants attending the training course.

Qualitative indicators are based upon people's opinions or perceptions and therefore measure quality, not the quantity. Example: level of patient satisfaction with treatment at district hospitals.

Input, process, output and outcome indicators

Input indicators are related to the quantified amount of a resource put in a process. These are concerning deployment of resources for some project or activity. Example: budget allocated for a programme.

Process indicators describe the activities resulting from the use and management of those resources. Process indicators inform what is the programme or system, and how it works? Example: number of training session conducted.

Output indicators are used to measure the immediate results of a process. They indicate what changes have occurred resulting from the interventions. Example: the number of jobs created by social and income-generating activities.

Outcome indicators reflect the change to a situation resulting from an action. They are linked to the reference value or policy targets and demonstrate the degree to which the objectives have been achieved. Example: improvement in nutritional status of children following community-based initiatives intervention.

[†] Park JE, Park K. *Textbook of preventive and social medicine*, 13th ed. M/c Banarsidas Bhanot, India, 1991.

Uses of indicators

Indicators are valuable in many ways and help in determining future goals and actions. Indicators are used:

- to measure the health and development status of a community
- to compare the health and development status with other areas and countries
- to assess local developmental needs
- to allocate the required resources
- to monitor and evaluate public services, activities and programmes
- to measure the progress and impact of interventions (current status is compared against baselines)
- to measure the extent to which the objectives and targets of the programme have been attained.

Characteristics of indicators

Indicators should be:

- **valid**. They should actually measure what they are supposed to measure and this should be related to the objects
- **sensitive**. They should be sensitive to variations and changes in the situation concerned
- **specific**. They measure only the phenomenon they are intended to measure
- **reliable**. The answer should be the same if measured by different people in similar circumstances. They produce the same results when used more than once to measure the same phenomenon
- **simple**. They should be easy to understand and to measure by all concerned
- **feasible**. It should be physically possible to collect the information or act upon it at reasonable cost (within the budget).

Example of a good indicator: coverage of children less than one year of age with three doses of diphtheria-tetanus-pertussis vaccine.

Indicators should provide:

- definition of quality (what?)
- definition of a measurement (how much?)
- definition of a target group (who?)
- definition of a time horizon (when?)
- definition of a place (where?).

Health and development are multidimensional and are influenced by numerous factors, some known and many unknown. Therefore, we must measure them in a multidimensional way, conceived in terms of profile, employing many indicators. The undermentioned indicators are most applicable in community-based initiatives. Programme managers and intersectoral teams should be well acquainted with them and use them for monitoring the performance and outcome of programme activities.

3. HEALTH INDICATORS

Life expectancy at birth
Life expectancy at birth is the average number of years that will be lived by those born alive into a population if the current age-specific mortality rate persists.

Crude birth rate
Crude birth rate is the number of births in a defined population during a given time period, irrespective of their fate.†

Formula:

$$\frac{\text{Total number of births recorded in an area during a specified time period}}{\text{Average total population during that period}} \times 1000$$

Crude death rate
Crude death rate is the number of deaths in a given population during a given time period.

Formula:

$$\frac{\text{Number of deaths recorded in an area during a specified time period}}{\text{Average total area population during that period}} \times 1000$$

Infant mortality rate

Infant mortality rate is the number of deaths of infants under one year of age in a given period of time per 1000 live births in the same period.*

Formula:

$$\frac{\text{Number of deaths of infants recorded in an area or community during a year}}{\text{Total number of live births during the same period of time}} \times 1000$$

Note: in both the numerator and denominator, the number of stillbirths is not counted.

Under-five mortality rate

This is the probability of children dying between birth and their fifth birthday in a given year, expressed per 1000 children born alive.

Formula:

$$\frac{\text{Number of deaths of children between birth and fifth birthday recorded in an area or community during a year}}{\text{Total number of live births in the year}} \times 1000$$

Maternal mortality rate

Maternal mortality rate reflects number of deaths of the women of reproductive age caused due to pregnancy during a year, expressed per 100 000 live births.

Formula:

$$\frac{\text{Number of deaths of women due to childbearing and puerperal causes in a year}}{\text{Total number of live births in the year}} \times 100\,000$$

Note: maternal death is a death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

* Park JE, Park K. *Textbook of preventive and social medicine*, 13th ed. M/c Banarsidas Bhanot, India, 1991.

Disease-specific mortality rate

Mortality rate is computed for specific diseases, such as diarrhoea and anaemia, among the community in a specified time period.

Formula:

$$\frac{\text{Number of cases suffering from the disease in a specific community in a one - year period}}{\text{Total population of that age group in mid year of study period}} \times 100$$

Exclusive breastfeeding of infants

This is the population of infants less than 6 months of age who are exclusively breastfed in an area during specific time period.*

Formula:

$$\frac{\text{Number of infants less than six months of age who are exclusively breastfed}}{\text{Total number of infants less than six months of age}} \times 100$$

Prevalence of low birth weight children

This is the proportion of live births where birth weight (birth weight known) is less than 2.5 kg to the total number of live births in a community during q specified time period.

Formula:

$$\frac{\begin{array}{c}\text{Number of live births with birth weight} < 2.5\,\text{kg} \\ \text{in a community during a specified time period}\end{array}}{\begin{array}{c}\text{Total number of live births (weighed at time of birth)} \\ \text{in the same community during the specified time period}\end{array}} \times 100$$

Prevalence of malnourished children

This is the percentage of the children under five years of age living in a population during the study period and having weight for age and/or height for age below acceptable international standards:

Mild: Below 1 standard deviation from reference value
Moderate: Below 2 standard deviations from reference value
Severe: Below 3 standard deviations from reference value

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* *Catalogue of health indicators. A selection of important health indicators recommended by WHO programmes*. World Health Organization, Geneva, 1996.

Formula:

$$\frac{\text{Number of children under five years below 1, 2 or 3 standard deviations from medium weight for age of reference population}}{\text{Total number of children under five years weighed}} \times 100$$

Annual incidence of diarrhoea among children
The annual incidence of diarrhoea in children under five years of age may be expressed as annual number of cases (episodes) of diarrhoea per child under five years of age:

Formula:

$$\frac{\text{Total number of episodes of diarrhoea among children under five years of age during a one - year period}}{\text{Total number of children under five years of age}} \times 100$$

Immunization coverage of children
This is the number or children in the population immunized against specific vaccine-preventable diseases (specific to the country programme) at point in time.

Formula:

$$\frac{\text{Number of children fully immunized under one year of age}}{\text{Population of surviving infants}} \times 100$$

Tetanus immunization among pregnant women
This gives the proportion of pregnant women immunized against tetanus (TT2 or booster) against the total number of pregnant women in a selected population during the study period.[*]

Formula:

$$\frac{\text{Number of pregnant women received full immunization (TT2 or booster)}}{\text{Estimated number of newborns}} \times 100$$

Note: the number of new-borns is used as a proxy for the number of pregnant women.

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[*] *Catalogue of health indicators. A selection of important health indicators recommended by WHO programmes.* World Health Organization, Geneva, 1996

Prenatal care coverage
This is the proportion of pregnant women in a population at point in time who were attended at least once during pregnancy by trained health personnel for reasons related to the pregnancy.

Formula:

$$\frac{\text{Number of pregnant women attended by trained personnel at least once during their pregnancy}}{\text{Number of live births during a fixed period}} \times 100$$

Note: the number of live births is used as a proxy for the number of pregnant women.

Births attended by trained health personnel
This is the proportion of births attended by trained health personnel in a population during specified time period.

Formula:

$$\frac{\text{Number of births attended by trained health personnel in a fixed time period}}{\text{Total number of births during the same period}} \times 100$$

Note: trained attendant means doctor or a person with midwifery skills who can diagnose and manage obstetrical complications as well as normal deliveries.

Current use of contraception by couples
This is the proportion of couples in the study population currently using contraceptive methods.

Formula:

$$\frac{\text{Number of couples currently using contraceptives methods}}{\text{Total number of couples}} \times 100$$

Prevalence of smoking
This is the proportion of the population who are smokers at a given time.

Formula:

$$\frac{\text{Number of smokers in the population surveyed}}{\text{Total size of the survey population}} \times 100$$

Access to health services
This is percentage of the population living within certain geographical boundaries who can reach an appropriate local health services facility by the local means of transport (or by walking) in not more than one hour.

Formula:

$$\frac{\text{Number of people having access to health facility by local transport or by foot within one hour}}{\text{Total population at the time}} \times 100$$

4. ENVIRONMENTAL INDICATORS

Access to safe drinking water
This is the proportion of the population with access to an adequate amount of safe drinking water in a dwelling or located within a convenient distance from a dwelling.

Formula:

$$\frac{\text{Population with access to safe drinking water in a locality}}{\text{Total population in that locality at that time}} \times 100$$

Access to sanitary facility for disposal of excreta
This is the proportion of the population with access to a sanitary facility for disposal of human excreta in the dwelling or located within a convenient distance (less than 50 m) from the user's dwelling.[*]

Formula:

$$\frac{\text{Number of population with access to a sanitary facility for human excreta disposal inside or near the dwelling}}{\text{Total population in that locality at that time}} \times 100$$

Housing
This is the proportion of the population which has adequate housing—a maximum of four family members living in one room of average size 4 × 4 metres.

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[*] *Catalogue of health indicators. A selection of important health indicators recommended by WHO programmes.* World Health Organization, Geneva, 1996

Formula:

$$\frac{\text{Number of families have houses for maximum four persons per room of standard size}}{\text{Total number of families in that locality at that time}} \times 100$$

5. SOCIOECONOMIC INDICATORS

Gross domestic product (GDP)

Gross domestic product measures the total domestic values added claimed by the residents. It is calculated by adding together the market values of all final goods and services produced during a year within the geographic boundaries of a country regardless of the producer's nationality. GDP is equal to total consumption, investment and government spending, plus the value of exports, minus the value of imports.

Gross national product (GNP)

Gross national product (in purchasing powers of currencies) measures the total domestic and foreign value added claimed by residents. It comprises GDP plus "net factor" income from abroad, minus similar payments made to non-residents who contributed to the domestic economy. Gross national product per capita is the value of a country's final output of goods ands services in a year, divided by its population. It reflects the average income of a country's citizens.

Formula:

$$\frac{\text{Total income of the country in a year}}{\text{Total population at mid year}}$$

Poverty rate

Poverty rate is the prevalence of the poverty among a defined community at point in time and is measured through the level of earning/expenditure fixed by the country for meeting basic needs. Income level less than US$ 1 per day for every individual is universally considered standard for considering income poverty. The poor are defined as those persons whose income or expenditure level cannot afford a minimum nutritionally adequate diet, plus essential non-food requirements.

Formula:

$$\frac{\text{Number of community members earning less than 1 US\$ per day}}{\text{Total population of the area at that time}} \times 100$$

Level of employment

This is the proportion of eligible people employed to earn their livelihood. The eligible people mean adult male and female (excluding those too old) willing and able to work.

Formula:

$$\frac{\text{Total number of adult males and females employed at a given time in a specified area}}{\text{Total number of adult males and females in in the area at that time}} \times 100$$

Literacy rate

Literacy rate is the proportion of people able to read, write and understand at least the local language at a given time in a specified area.

Formula:

$$\frac{\text{Number of people able to read and write at a given time in a specified area}}{\text{Total number of people living in the area at that time}} \times 100$$

Gender equity

This is the proportion of opportunities available to women for education, health, economic activities and decision-making compared to opportunities available for male population. It may be expressed in the form of the ratio of women to men.

Examples:

Numbers of educated women, including girl students	:	Numbers of educated men, including boy students
Number of women receiving health services	:	Number of men receiving health services
Numbers of women having opportunities for income generation	:	Numbers of men having opportunities for income generation
Numbers of women participating in decision-making (active members of community organizations)	:	Numbers of men participating in decision-making (active members of community organizations)

Part B
Module 4
Unit 4.1

Planning

Learning objectives

To gain a better understanding of:

- planning in the model and expansion phases
- planning tools in community-based initiatives

Expected outcome

Participants will understand the community-based initiatives planning process. They will also be able to carry out planning as required in both phases of the programme

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1. INTRODUCTION

Planning is a systematic process of forecasting and deciding in advance the goals and appropriate actions required to achieve the determined objectives and earmarking resources required. Planning should result in a clear map to be followed towards achieving the desired goal. All components should be placed in an orderly and logical pattern, ensuring cost-effective use of resources and timely accomplishment of goals.

Planning is the first milestone of the community-based initiatives process and must be performed carefully. The planning in the community base initiates pursue to:

- effectively respond to community needs and problems
- matching limited resources with priority needs and problems
- eliminating wasteful expenditure and duplication of resources and
- developing best course of action to accomplish defined objectives.

2. PLANNING PHASES

Planning of community-based initiatives comprises two phases: model area development and large-scale expansion.

Community-based initiatives in any country should start with a small-scale research and development project in one or more selected areas. This will involve limited risk and a reasonable cost and will be more convincing than any theoretical demonstration. It will also facilitate obtaining the essential political commitment and acceptance of this approach as a strategy for national health development. It also promotes consensus among the various sectors involved in these initiatives to work jointly for the attainment of integrated goals. The model area should be gradually expanded into the surrounding areas, a strategy which promotes technical cooperation among developing communities.

The expected outcome of the first phase is the large-scale expansion of community-based initiatives activities and their incorporation in the national plan as a strategy for achieving integrated community-based development. The rational use of existing resources and organizational infrastructures, facilitated by devolution of authority for bottom up planning and management, greatly facilitates the process. Additional resources for expansion should be mobilized mainly from the national, regional and local levels, and from partnerships developed with national and international agencies.

2.1 Phase 1. Model area development

- Planning should be in the context of the different managerial levels involved in community-based initiatives implementation and management as mentioned in Annex 4.1.2.

- Priorities should be identified, taking into account the availability of resources, and a development package for the area should be prepared.

- A work plan of all activities will be helpful for the execution, monitoring and evaluation of community-based initiatives. Formats for work plans are given in Annex 4.1.3

- Community development activities should be categorized as:
  – activities which can be accomplished by the community with little or no support from outside
  – activities which can be carried out jointly
  – other activities, mostly government responsibility.

- Planning at local level should facilitate the promotion of appropriate technologies and development of traditional skills.

- Plans should foster a sense of ownership by the community.

- A mechanism for effective organization and management should be evolved with a transparent accounting system.

- All planned action should focus on producing a direct impact for improving the quality of life and health status of the community.

Selection of model area

Significance

This is a crucial decision in community-based initiatives planning as the success of community-based initiatives:

- largely depends upon success in the model area
- facilitates further expansion
- promotes wider acceptance
- acts as demonstration and training site
- helps in team-building.

Major criteria for selection

Likelihood of success should be the major factor in the selection process. Other criteria are given below.

- Accessibility of the area.
- Presence of basic infrastructure for health and education activities.

- Manageable population size.
- Existence of social organizations and nongovernmental organizations.
- Potential for community development.
- Social harmony and a favourable environment.
- An interested and active community.
- A motivated local leadership.

Process

Selection of a model area should be performed according to considerations such as:

- frequent site visits
- active involvement of the district team
- extensive interaction with local people
- obtaining maximum information by using the checklist given in Annex 4.1.1
- adhering to the criteria as much as possible.
- final selection with the support and approval of higher authorities and the representatives of the relevant sectors.

The same criteria should be followed while selecting areas during the expansion phase.

2.2 Phase 2. Large-scale expansion

Planning for expansion phase is the second major event in the community-based initiatives implementation process. It should be based upon the experiences gained during the model phase and the outcome of regular evaluations of the programme.

While planning for this phase, the government hierarchy at different managerial levels of the country should be taken into consideration.

The main objectives should be devolution of authority and promotion of bottom-up planning for integrated socioeconomic development.

Planning for expansion should be the main task of the national community-based initiatives team, with the assistance of intersectoral advisory committees.

The programme documents should be prepared in accordance with national procedures and policies, taking into consideration the available resources and existing infrastructure. Community-based initiatives guidelines and tools should be consulted and followed while preparing programme documents and planning the expansion phase.

Bottom-up planning is initiated from the grass-roots level in the context of local situation and all local stakeholders are involved in the planning process

3. PLANNING TOOLS

Annex 4.1.1 Checklist for selection of community-based initiatives model areas

This checklist highlights key areas for collecting essential information that is required for selection of model areas during phase 1. The respondents for this checklist will be traditional community leaders, religious heads, schoolteachers, shopkeepers, heads of community organizations and other notables. The checklist explores the basic information required for selection process; however countries may adapt it according to their own needs and local situations. The objective is to carry out an in depth study of the area before introducing community-based initiatives. It will also assist in the development of the area development profile.

Annex 4.1.2 Planning process for phase 1

This annex provides a broad base to be followed for planning of model area development. During phase 1, planning will be mainly at two levels, national and local. While planning for the expansion phase and preparing programme documents, assistance can be obtained from *CBI guidelines and tools (Tool 1: Planning).*

Annex 4.1.3 Plan of action

All managerial levels should prepare plans of action and update them on regular basis. These may be used for monitoring and follow-up of community-based initiatives activities and measuring the performance. Preparation of such plans is necessary for all activities at local level. The forms can be adapted according to local requirements and nature of the activities.

4. GROUP WORK

Process

On the evening preceding the respective working session, participants should read the materials required for the respective group work. The group work should be conducted as follows.

Participants should be divided into equal groups, each not exceeding eight members.

Planning

Each group should select its own chairperson and presenter. (These responsibilities should be rotated during each group work assignment.)

The chairperson should watch the time and encourage every group member to participate.

The presenter should present the findings/report of the working group in the plenary session.

Facilitators should help the participants as resource persons and give feedback on the group presentations.

Assignment

During the working session, groups should perform the following:

- review and adapt Annex 4.1.1 according to their local conditions
- read and understand the contents of Annex 4.1.2
- prepare a detailed plan of action using Annex 4.1.3, describing different activities required for the establishment of a model area.

Annex 4.1.1

CHECKLIST FOR SELECTION OF MODEL AREA

Instructions for use

This checklist is quite flexible and should be adapted for local use.

Accessibility

Since the model area will be the entry points for community-based initiatives and will serve as demonstration and training units, better access to this area will facilitate the interventions. The area should be less than a one-hour drive from the main city from where the technical support team will travel. The assessment of the distance should be measured in terms of travelling time through public transport.

Demographic data

These will assist in assessing the scope of work and will help in determining whether the population size and number of households are manageable and practicable for the launch of community-based initiatives.

Means of livelihood

The percentage of families engaged in major means of livelihood like agriculture, livestock, small enterprises and traditional or local skilled professions should be estimated, in addition to assessment of the percentage of families living below the poverty line.

Life amenities

The profile of necessary life amenities available will indicate development gaps as well as the potentials and capacity for development of the community. Replies should indicate the exact status of the area. It should be noted whether the area is electrified? If so, how many of the families have access to this facility? If there is a water supply, is it safe for drinking? Are there connecting roads to other areas available? What is the system for disposal of wastewater? Are there communication facilities, like a post office and telephone? What other facilities are available?

Educational and training facilities

The presence of primary schools, both for boys and girls, should be noted. Additionally, facilities for vocational or technical training should also be assessed. If these are available, the category should be noted. This will indicate the gaps and scope for intervention in this sector.

Health facilities

Ideally, the community-based initiatives model area should have a health facility. If the health facility is situated in a nearby locality, the distance, both in kilometres and in travelling time, should be noted. If community health workers and traditional birth attendants are trained and placed in the area, their number should be indicated. Distance to the nearest first-level referral hospital should also be determined, both in kilometres and in travelling time on public transport.

Social harmony and peace

This will help to visualize the environment for community work and the interactions of the people with each other. It may be assessed by investigating any social, ethnic, religious or political disputes in the community and the frequency of police reports regarding any unlawful activities registered during the past 12 months.

Existing community organizations

The presence of community organizations or social groups show that the community can be further organized and can work in harmony. The name and number of the nongovernmental organizations and social groups should be noted. Ideally their scope of work should also be recorded.

Development programmes in progress

Ongoing development projects will indicate the presence of other stakeholders in the area. It will also show the community response towards development programmes and their level of participation in such activities may be assessed.

Observations regarding the potential for community development programmes

These observations will assess the potential for launching community-based programmes and their chances of success. Opinions will be made after open dialogue with community leaders and government functionaries posted in the area.

Community willingness to participate in socioeconomic development activities

This is the informal commitment of the people to launch community-based initiatives. The community leaders and opinion-makers can demonstrate their acceptance and willingness to participate in the programme.

Annex 4.1.1

CHECKLIST FOR SELECTION OF MODEL AREA

Name of area _____ District _____

Factors	Elements	Findings
Accessibility	Distance from nearby city	City _____ Distance in km _____ Travelling time _____
	Availability of public transport	Yes _____ No _____ If yes, type _____
Demographic Data	Population	Number_____
	Households	Number_____
Means of livelihood	% of families in different professions: agriculture livestock small trade skilled/technical labour employee other (please specify)	 _____ _____ _____ _____ _____ _____ _____
	% of families living below the poverty line according to national parameters	
Life amenities	Availability of: electricity water supply connecting roads wastewater disposal post office telephone other	 Yes _____ No_____ Yes _____ No_____ Yes _____ No_____ Yes _____ No_____ Yes _____ No_____ Yes _____ No_____ Please specify -_____ _____

Factors	**Elements**	**Findings**
Education and training facilities	Primary school: Boys Girls	 Yes _____ No_____ Yes _____ No_____
	Vocational/technical training	Yes _____ No_____ If yes, type_____
Health facilities	Health centre	Yes _____ No_____ If no, distance from nearest health centre _____
	Community health workers	Yes _____ No_____ If yes, number_____
	Traditional birth attendants	Yes _____ No_____ If yes, number _____
	Distance from first-level referral hospital	Distance, Km _____ Travelling time _____
Social harmony and peace	Any disputes in the community? Frequency of police reports registered during the past year	_____ _____
Existing community organizations: nongovernmental organizations community-based organizations other community groups		_____ _____ _____ _____
Any development programmes in progress: programme name sponsoring agency community share		_____ _____
Observations regarding potentials for community based initiatives for health and development		_____ _____
Community willingness to participate in socioeconomic development activities		_____ _____

Annex 4.1.2

PLANNING FOR PHASE 1 (MODEL AREA DEVELOPMENT)

Instructions for use

The planning is one of the key activities that provide a base for CBI. In model area phase, planning will be mainly at two levels: national level and programme area level. In heavily populated countries, similar interventions may be required at regional levels.

Level	Functions	Tasks	Responsibilities
National	Strategies and guiding principles	Strategic decision for implementation of the model phase, strategies, principles and broader guidelines	Government authorities (ministry of health and other concerned ministries), with technical assistance of WHO and other donor agencies
	Organizational set-up	1. Appointment of national focal person 2. Develop managerial set-up to implement and monitor the programme 3. Nomination of intersectoral council (at later stage)	Government authorities (ministry of health and other concerned ministries), with technical assistance of WHO and other donor agencies
	Planning of model programme	Plan to implement model sites in the country to be followed by provinces/regions/governorates	National focal person and intersectoral council
	Allocation of funds	Mobilization and allocation of funds from the national resources	Government authorities with technical assistance of ministries of health, planning and finance
CBI area	CBI organization	Formulation of CBI structures at local level (programme manager, technical support team, community development committee, cluster representatives and technical committees)	National focal person, ministry of health and representatives of concerned departments

Level	Functions	Tasks	Responsibilities
	Training of CBI structures	1. Training of programme manager and technical support team 2. Training of community development committee, cluster representatives and technical committees	Master trainers Programme manager and technical support team
	Needs assessment	Baseline and needs assessment survey to identify real problems and needs of the community	Community development committee and cluster representatives, with technical and managerial support of technical support team
	Prioritization of needs	Priority setting of the felt and unfelt needs according to their magnitude and availability of the resources	Community development committee and cluster representatives, with technical and managerial support of technical support team
	Projects preparation, feasibility and budgetary proposition	Project proposals, feasibility reports and budgetary propositions for health, social and income-generation projects	Community development committee and cluster representatives, with technical and managerial support of technical support team

Annex 4.1.3

PLAN OF ACTION

Instructions for use

Title

The name of the project or activity for which the plan of action is being prepared should be written which should reflect the whole theme.

Location

Location, where this activity or project will be undertaken, should be mentioned.

Objectives

Concise description of the main objectives for the project or activity should be earmarked to be perused in future.

Activity

The planned activities should be framed in order of their occurrence.

Tasks

The activities should be divided into tasks and mentioned in sequence.

Time frame

The target dates should be determined for the individual tasks, which should be in line with the natural flow of events

Responsibility

The persons responsible for the execution of the tasks should be nominated, so that accountability can be fixed and is known to all concerned.

Resources requirement

The monetary requirements should be earmarked and sources should be explored.

Expected outcome/monitoring indicators

The plan should indicate the expected outcome, which should justify the proposed actions. In future, the evaluation will be based upon the outcomes, in the context of determined targets and deployed resources.

PLAN OF ACTION

Title _____

Location _____

Objectives_____

_____

_____

Activity	Tasks	Time frame	Responsibility	Resources requirements	Expected outcome/ monitoring indicators

Part B
Module 4
Unit 4.2

Organization

Learning objectives

To gain a better understanding of:

- the organization process
- organization for community-based initiatives
- criteria for and functions of organizational structures in community-based initiatives

Expected outcome

The participants will have full understanding of the organization process in community-based initiatives. They will be able to assist in community organization and establishment of intersectoral support system

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1. INTRODUCTION

Organization is establishing a mechanism and structure that enables human and other resources to work effectively together to carry out plans for accomplishing objectives.

Community-based initiatives work in line with government infrastructure, earmarking roles and responsibilities of each level and assigning the community a proactive role. As a bottom-up approach, the community-based initiatives hierarchy is organized in a network pattern involving all social groups of the local community in addition to the related government sectors.

1.1 What is community?

A community is a group of people sharing common values, interests or identity, which distinguishes them from other communities. A community may comprise of groups of people with divergent values and interests; such as rich and poor, women and men, educated or illiterate. Some people classify community on the basis of geography or function.

Geographic community refers to a group of people living in the same geographic area

Functional community includes members who closely interact with each other but do not always live in the same geographic area; may be based upon religious, ethnic or occupational factors

1.2 Community participation

Community participation is involvement of people in the activities of common interest to achieve common goals. It is mostly voluntary and objective-oriented, working for a joint cause intended for the welfare or development of the people. Community participation is of paramount importance in the local development process.

Box 1. Main benefits of community participation

- All social groups feel involved and participate in community matters
- Solutions to problems are adapted to community capabilities and must be acceptable to all community members
- The community is empowered with increased sense of ownership, self-responsibility, self-awareness and self-reliance
- People are interested in having a well sustained programme, building on existing local knowledge, resources and capacities
- The generation of community resources, reducing the overall cost and the government expectation

1.3 Intersectoral collaboration and support

Intersectoral collaboration is central to all community-based initiatives activities and helps the community in achieving development targets. Community-based initiatives are intended to work within the existing governorate structure and in line with government strategies, involving the departments concerned in planning, training, monitoring and evaluation processes.

In community-based initiatives, fundamental collaboration of government departments is mandatory in order to give technical support to the community through integrated action, developing a link between planning at grass-roots level and the national planning process. Governments are encouraged to develop partnerships with civil society and other stakeholders for effective mobilization of resources. Government departments—mainly health, education, local government/municipality, agriculture, livestock, fisheries, interior ministry and social development—provide partnership to communities and support them to attain the desired goals.

Box 2. Main features of intersectoral collaboration in community-based initiatives

- Different departments collaborate to achieve a common comprehensive goal of better quality of life
- Input is integrated, resources rationalized and duplication of efforts is prevented
- Government provides support to the people to identify their problems and find relevant solutions, in the spirit of partnership
- Structures are decentralized with the aim of empowering the community and establishing self-financing and self-sustained development

2. ORGANIZATION FOR COMMUNITY-BASED INITIATIVES

All community-based initiatives have the common objective of achieving health for all through health and development interventions. Basic development needs and healthy villages programmes are implemented primarily in rural areas following common objectives, structures and process. A healthy city programme works in the urban localities, especially in the underprivileged suburbs, for improving environmental conditions and bringing health onto the agenda of local development.

2.1 Organization for basic development needs and healthy villages programmes

The basic development needs and healthy village programmes have identical organizational structures which involve the following two elements: community organization and the intersectoral support team.

Community organization

Community organization is established at the local level and is an essential component of community-based initiatives. The community is organized on a network pattern by selecting cluster representatives, each cluster consisting of a manageable number of houses. The community development committee is selected on an area/locality basis and has the main responsibility and authority for needs assessment, preparation of social and income-generating projects, and implementation and monitoring of the projects, including loan recovery.

Intersectoral support team

The intersectoral support team is established at all levels and in line with the government infrastructure in each country. In a community-based initiatives area, an intersectoral team is selected from different departments and led by a programme manager. Intersectoral councils are established at administrative levels such as district, province/ governorate/state and national.

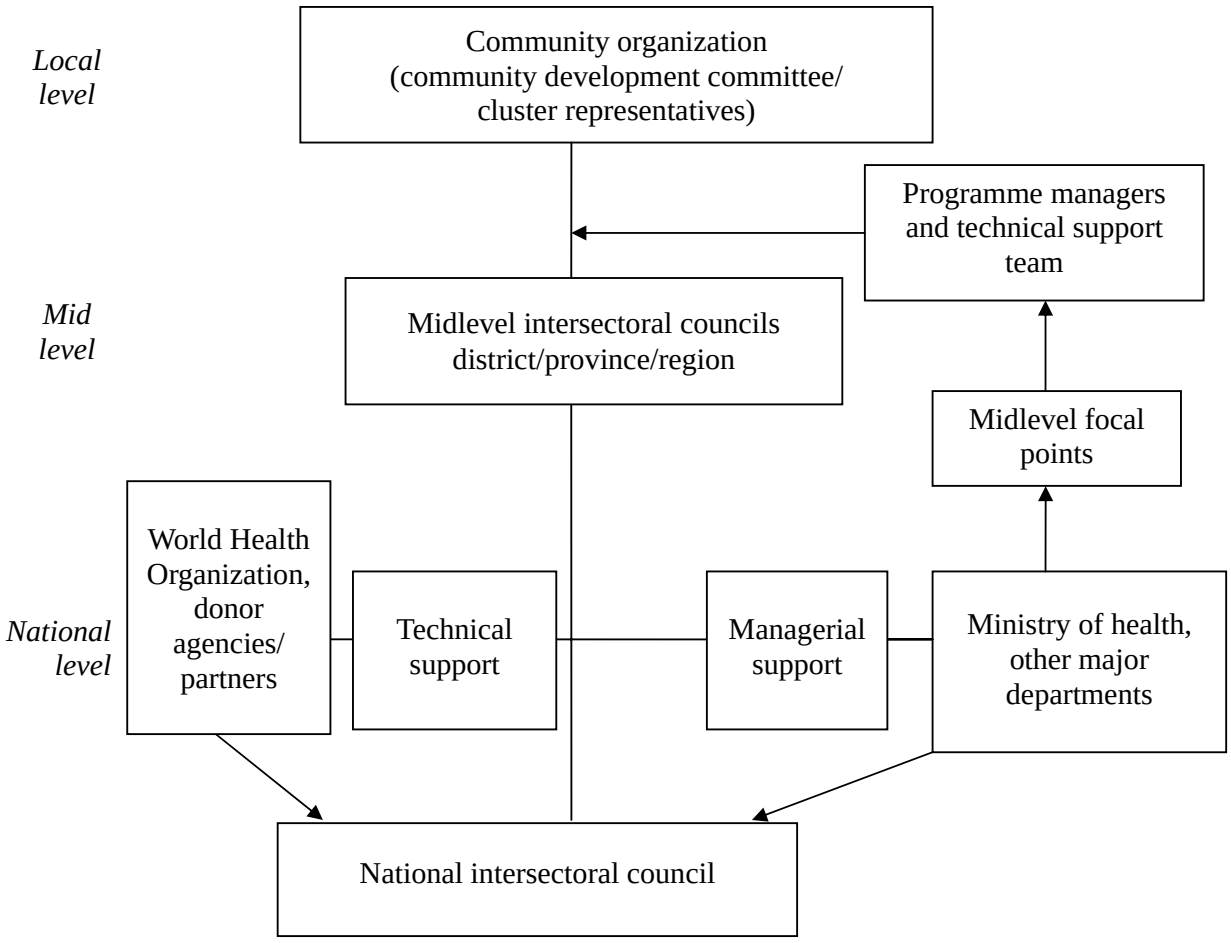
Organizational structures in both phases of basic development needs and healthy villages programmes are similar, with some additional structures required in the expansion phase.

Comparison of organization in model and expansion phase of basic development needs and healthy villages programmes

Administrative level	Model phase	Expansion phase
Programme locality	Cluster representatives Community development committee	Cluster representatives Community development committee
Programme area	Intersectoral technical support team Programme manager	Intersectoral technical support team Programme manager
District level	District council (desirable)	District council
Provincial or governorate level		Provincial/governorate focal person Provincial/governorate council
National level	National focal person National council (desirable)	National focal person National council District council

Annex 4.2.1 describes the details of organizational structures in phase 1, while details of the expansion phase can be obtained from *CBI guidelines and tools. Tool 2: organization.*

Organizational set-up for community-based initiatives (basic development needs/healthy villages projects)



Community development committee

Constitution

There is no fixed membership pattern or offices for the community development committee. These may be consistent with the local situation and norms; however the following community development committee membership is suggested:

- chairman/president
- general secretary
- finance secretary
- communications secretary
- women and youth representatives
- representatives of local nongovernmental organizations
- other members according to the local situation and needs.

Selection criteria

- Having permanent residence/workplace in the community.
- Preferably able to read and write.
- Accepted, trusted and selected by the members of the community.
- Having a good reputation in the community.
- Capable of managing community-based programmes.
- Willing to perform on voluntary basis.

Responsibilities and functions

The community development committee will be authority of the village, empowered for programme execution and management in the village. Its main responsibilities and functions are described in Box 3.

Box 3. Responsibilities and functions of the community development committee

- Identify local problems, prioritize needs accordingly and develop appropriate and feasible proposals
- Mobilize local and community resources to meet community needs
- Supervise and assist the cluster representatives in community mobilization and programme activities to improve the socioeconomic status of the community
- Screen and recommend the proposals of income-generation projects, prepare proposals and provide guarantees for loans, acting as signatory on behalf of the community
- Regular supervision and monitoring of projects, maintaining records and reporting
- Management of finances, including loan recoveries and partnership in the management of the revolving fund
- Ensure meeting the targets and objectives of the programme, giving priority to those of health

Cluster representatives

Selection criteria

- Having permanent residence in the cluster.
- Preferably able to read and write.
- Accepted, trusted and selected by the families living in the cluster.
- Having a good reputation among the community.
- Willing to perform on voluntary basis.

Responsibilities and functions

The cluster representatives perform their role through carrying out the functions indicated in Box 4.

Box 4. Responsibilities and functions of cluster representatives

- Creating linkage between families, the community development committee and the intersectoral technical support team
- Assisting and facilitating families of the catchment area in identifying their priority problems and the solutions
- Conducting household baseline and needs assessment surveys, based on socioeconomic indicators
- Identifying skilled human resources and marketable options of the mini-enterprise projects
- Disseminating technical information and knowledge to the members of the cluster and collecting requisite information
- Assisting community development committee in programme management and collection of loan recoveries

Intersectoral technical support team

The intersectoral technical support team at local level comprises the operational officials of different departments from the same area, who coordinate programme activities and work in close collaboration with the community organization. The training and retraining of these officials is the programme's main activity. It aims to build their managerial and technical abilities to implement and manage the programme and contribute towards development of the community. The team is also responsible for mobilizing departmental resources and coordinating local development with departmental plans.

Constitution

The intersectoral team should preferably be established at the local/subdistrict/district level according to the local administrative system and availability of staff. It should comprise local officials of the departments concerned, such as health, education, social welfare, women's development, youth development, environment, agriculture and livestock.

The criteria for selection of an intersectoral team member include:

- adequate qualification and experience in a relevant field and in community development
- sufficient technical and professional capability to provide support to the community
- preferably does not hold a key position in the department that can restrict his/her contribution to field activities
- commitment from the authorities, that once selected and trained the person will not be transferred for at least two years.

Responsibilities and functions

The technical support team, under the supervision of the programme manager, will carry out the duties laid out in Box 5.

Box 5. Responsibilities and functions of the technical support team

- Mobilizing, organizing and facilitating the community towards the attainment of self-help, self-reliance, self-management, self-financing and self-sustained development
- Training and capacity-building of the community in community-based initiatives methodologies and upgrading the existing local skills
- Assisting community in assessing needs and priorities, appraisal of the feasibility, technical viability and financial sustainability and preparation of project proposals
- Providing technical and managerial support to the community for planning, implementation, supervision and monitoring of projects
- Promoting intersectoral collaboration in support of the programme process, and provide technical and sectoral inputs from respective departments
- Mobilizing local and external resources for effective implementation of the planned activities
- Assisting in research and facilitating the promotion of appropriate technologies relevant to programme activities
- Assisting in financial management and documentation of programme activities

Programme manager

The intersectoral team in the model areas is led by the programme manager, who is obliged to manage the programme according to the standards and norms determined in the community-based initiatives guidelines and tools.

The programme manager will be the focal person at district level, nominated by the district administration according to the programme criteria. Preferably, he/she should be a senior health official or from any social services department, experienced in community development and having the skills to implement the programme in the district.

Responsibilities and functions

The programme manager is expected to execute the programme and translating the community-based initiatives concepts into practical realities, through the main responsibilities given in Box 6. Programme manger may be selected among member of technical support team preferably representative of health department at the district level.

Box 6. Responsibilities and functions of programme manager

- Management of the programme, including planning, implementation, supervision and monitoring, financial management, record-keeping and evaluation
- Maintaining harmony within the team and facilitating intersectoral coordination for community support
- Mobilization and organization of the community, ensuring its empowerment and involvement
- Conducting operational research in health and community development
- Maintaining horizontal and vertical liaisons and disseminating relevant information
- Carrying out advocacy for and promotion of the programme

National focal person

The national focal person holds the key position for executing community-based initiatives in the country. He/she should be nominated and verified by the national council. The key responsibilities of national focal person are described in Box 7.

Box 7. Responsibilities and functions of the national focal person

- Assistance to the national council in designing standards and procedures for programme implementation
- Orientation of government authorities and potential partners
- Advocacy and promotion of community-based initiatives in order to attain support of authorities and other partners/ donor agencies
- Assistance in development of the intersectoral coordination system
- Preparation of documents for programme expansion
- Decision-making on all technical and managerial aspects of the programme
- Mobilizing resources and partnerships for programme promotion and expansion
- Monitoring the implementation process and progress of the programme in the country

Intersectoral councils

The district and national intersectoral councils comprise key officials and authorities from relevant departments and representative of stakeholders. These councils are obliged to make strategic decisions, determine budgetary allocations, provide support and guidance to the field formations and ensure political commitment. The members are expected to streamline sectoral inputs and ensure integration of local plans with the national agenda. Intersectoral councils include district or regional councils and the national council.

District/regional council

This council has a membership of technical/administrative heads of key related departments, such as health, education, social welfare, women's development, youth development, public health engineering, agriculture, livestock and the environment, , as well as nongovernmental organizations and partner agencies. Representatives from these ministries and organization should be nominated by the offices concerned. The structure of the district/regional council should be duly notified by the chief administrative of the district or region. Their main responsibilities are described in Box 8.

Box 8. Responsibilities and functions of district/regional councils

- Providing technical and administrative support to the technical support team and community development committee
- Developing an intersectoral coordination system in the district/region
- Monitoring and supervision of the programme's progress
- Mobilization of the district/regional sectoral resources
- Preparing and approving the district/regional project documents for programme expansion and the allocation of resources
- Approving projects in the expansion phase

National council

A high-level intersectoral committee under appropriate leadership should be constituted at the national level, desirably in the model phase. It should have as members representatives of key sectors such as health, education, interior, finance, agriculture, environment, livestock and technology/small industries. Representatives of UN organizations including WHO, the private sector, nongovernmental organizations and other partners should also be involved. The national council should meet regularly and review the implementation and progress of community-based initiatives in the country. Main responsibilities are included in Box 9.

Box 9. Responsibilities and functions of national council

- Setting national policy guidelines and principles and approval of standards and procedures
- Ensuring the structuring of the intersectoral collaboration system at all levels
- Approval of the national plan for the expansion of the programme
- Mobilization of national resources and their allocation to different areas
- Monitoring the progress of the programme in the country

2.2 Organization of healthy cities programmes

Since healthy cities programmes work for health and environment in urban settings, they have a slightly different infrastructure from that of basic development needs and healthy villages programmes.

Focal point

The initial steps for starting healthy cities action are usually taken by one or two interested persons who usually become the focal points(s) for a healthy cities programme. These persons facilitate the collaboration between government, municipal authorities and WHO.

Support group

Ideally, after the initial contact and development of an official agreement for collaboration between WHO and a city, interested persons from different disciplines should be approached. These interested people, who are called the support group, include individuals and representatives from community groups, religious organizations, the municipal and city governments, universities, training institutions and nongovernmental organizations. The support group should be widely based, representing many aspects of city life.

Coordinating committee

A formal meeting of the support group is held to constitute a coordinating committee for healthy cities activities and projects. It is expected that this committee will consist of several key individuals in the city (municipal government staff, health workers in a health centre or community activists) who have the leadership skills and capacity to improve the health conditions of the city, along with the ability to stimulate the participation of the support group. The main functions of coordinating committee are illustrated in Box 10.

Box 10. Main functions of the coordinating committee

- Provide leadership to healthy city activities
- Contact and build alliances with city community and leaders, city health and environmental departments the private sector civil society nongovernmental organizations the media universities and research institutions etc.
- Develop healthy cities programme city development profile, work plans, projects and activities.
- Ensure extension of outreach services to the lowest levels of the community for priority health programmes.
- Encourage the involvement of community groups
- Facilitate the function of a city health forum
- Mobilize people and resources for priority projects

City health forum

In order to promote health, facilitate identification of health priorities and goals, prepare the city health profile and plans, city health forums are constituted to promote various activities covering such issues as road traffic accidents, smoking cessation programmes, prevention of noncommunicable diseases, nutrition and green industries.

3. GROUP WORK

Process

On the evening preceding the respective working session, participants should read the materials required for the respective group work. The group work should be conducted as follows.

- Participants should be divided into equal groups, each not exceeding eight members.
- Each group should select its own chairperson and presenter. (These responsibilities should be rotated during each group work assignment).
- The chairperson should watch the time and encourage every group member to participate.
- The presenter should present the findings/report of the working group in the plenary session.
- Facilitators should help the participants as resource persons and give feedback on the group presentations.

Assignment

During working session, each group will read out the contents of Annex 4.2.1 and will review and adapt the responsibilities and functions of the undermentioned structures according to their country situations and needs:

- community development committee and cluster representatives
- technical committees
- technical support team members
- programme manager
- district council
- national council.

Annex 4.2.1

ORGANIZATIONAL STRUCTURE FOR PHASE 1 (MODEL AREA DEVELOPMENT)

Instructions for use

The model area development phase requires the minimum possible organizational hierarchy. A focal person at national level generates national support and organizes programme activities in model areas. In heavily populated countries, regions/provinces/ governorates may have focal persons for similar tasks in their respective jurisdictions. The model areas should have a technical support team from the line department. This will work under the leadership of the programme manager, who should be preferably from the health sector, but governments may appoint him/her from any other social services department. The community should be organized in a systematic manner through clustering the locality and taking community representatives from each cluster. The community development committee, being the executive body for the locality, self-manages the programme at local level.

Organizational structure for phase 1

Level	Structure	Composition	Main functions
National	National focal person	A focal person from a lead department	The national focal person (NFP)**,** with the support of the intersectoral advisory committee, will be responsible for: • setting policy guidelines, principles and procedures • orientation of government authorities • establishing intersectoral coordination system • developing national plan for the implementation of the programme in both phases • mobilizing all potential resources • monitoring the implementation process and progress of the programme • conducting a periodic evaluation of the programme • advocacy and promotion to gain support of authorities and partners agencies

Organizational structure for phase 1

Level	Structure	Composition	Main functions
District/ locality	Programme manager	Focal person in community-based initiatives area may be the senior health official or from other community services/lead department according to country policies and circumstances	The programme manager will be the focal person at local level and will execute the programme. With the assistance of the technical support team, he will be responsible for: • management of the programme, including planning, implementation, supervision and monitoring, financial management, record keeping, and evaluation • maintaining harmony within the team and facilitating intersectoral coordination for community support • community mobilization and organization, ensuring their empowerment and involvement • maintaining horizontal and vertical liaisons and the programme advocacy and promotion
	Technical support team	Technical support team members will be the operational officers of the concerned departments, mainly health, education, local government, social welfare, agriculture and livestock will be members of the intersectoral technical team, named the technical support team	The intersectoral technical support team (technical support team) under supervision of the project manger, will exercise following duties: • community mobilization, organization and training • provide technical and managerial support to the community for planning, implementation, supervision and monitoring of the programme • facilitating promotion of appropriate technologies, providing technical and sectoral input from his department

Organizational structure for phase 1

Level	Structure	Composition	Main functions
			• mobilizing local and external resources for effective implementation of the planned activities. • assisting in needs assessment and planning for priority needs • appraisal of project applications for technical viability and financial sustainability, the technical feasibility reports and assistance in preparation of project proposals • support in implementation and monitoring of the projects • documenting the programme information and accounts • liaising with the respective line departments

Organizational structure for phase 1

Level	Structure	Composition	Main functions
Area/ locality	Community development committee	Respected members of the community selected by the community itself Offices may be chairman, general secretary, finance secretary and communication secretary as well as membership from women's organizations and nongovernmental organization (if any) Selection criteria will be: • having permanent residence or workplace in the locality • well known/ respectable, enjoying good reputation • preferably can red and write local language • accepted, trusted and selected by the community • willing to perform as a volunteer	The community development committee will be the authority of the village, empowered for programme execution and management in the area It will: • identify village problems, prioritize needs accordingly and develop appropriate and feasible proposals • mobilize local and community resources to meet community needs • supervise and assist the cluster representatives in community mobilization and programme activities to improve the socioeconomic status of the community • screen and recommend the proposals for income-generation projects, prepare project proposals, provide guarantees for loans, acting as signatory on behalf of community • supervise and monitor the projects, maintaining their records and disseminates reports • manage the finances, including the loan recoveries and partnership in the management of the revolving fund

Organizational structure for phase 1

Level	Structure	Composition	Main functions
	Cluster representative	Representative of a cluster of 15–30 houses Selection criteria will be: • having permanent residence in the cluster • respected, trusted and selected by the families of cluster • preferably can read and write • willing to perform as a volunteer	Cluster representatives will be responsible for: • creating linkage between families and the village/ community development committee team • assisting and facilitating families in their catchment area to identify priority problems and solutions • conducting a household baseline and needs assessment surveys, based on socioeconomic indicators • identifying the skilled human resources and marketable options of the mini-enterprise projects • disseminating technical information and knowledge to the members of his cluster and collect requisite information • assisting community development committee in programme management and collection of loans and work closely with the community health workers • participating in all community developmental activities

Part B
Module 4
Unit 4.3

Human resources development

Learning objectives

To gain a better understanding of:

- the characteristics of human resources development
- human resources development tools used in community-based initiatives

Expected outcome

Participants will understand different aspects of human resources development and will be able to plan and implement related activities while implementing community-based initiatives

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1. INTRODUCTION

Human resource development relates to developing people and building their capacities, aiming at their effective use in pursuit of collective and individual objectives.

Training and capacity-building of the community and related sectors is an essential component in implementing community-based initiatives in an area. It is of paramount importance in taking up new roles in self-managing local development. The community and other stakeholders should be encouraged to maximize their potential and upgrade their existing knowledge and skills to be more prolific in implementing community-based initiatives.

1.1 Objectives of human resources development in community-based initiatives

- Orientation of government authorities for attaining their political and managerial support.
- Orientation of potential partners to engage them with the programme, obtain maximum intersectoral support and sufficient resources.
- Development of master trainers.
- Training of community-based initiatives management and technical support teams in programme implementation and its effective monitoring.
- Training of communities and building their capacities to take charge of developmental action and programme management at local level.
- Training of social groups and community workers for engaging all of the community, initiating change in society and developing local partnerships.
- Orientation of the mass media on the programme philosophy and its potential for local development and national uplift.

2. CHARACTERISTICS OF HUMAN RESOURCES DEVELOPMENT

In community-based initiatives, human resources development programmes should be based upon certain characteristics. They should:

- be needs- and target-oriented, helping to achieve the programme objectives
- promote application of the team approach
- be cost-effective and efficient

- develop a team of master trainers (today's trainees are tomorrow's trainers)
- build local capacities and capabilities, and promote traditional and technical skills
- impart information on practical life skills such as communication, situational analysis, problem-solving, motivation and mobilization, and leadership practices
- assist in improving future actions and situations
- develop better awareness about the programme and health and development–related issues
- employ a flexible approach, adaptable to local situations, with respect to ethical and cultural values
- focus on the participatory approach, training and integrating all tiers and components of the system
- be trained on community-based initiatives guidelines and tools, including relevant technical issues and support materials.

3. TARGET GROUPS

Human resources development in community-based initiatives involves orientation and training of all those engaged in the local development process. The following target groups should be a special focus while training on community-based initiatives:

- government authorities and other partners
- programme management
- technical support teams from related sectors
- community organizations and representatives
- community groups, volunteers, nongovernmental organizations and other stakeholders.

4. TRAINING PLAN

During the model area development phase, in addition to formal training of programme mangers, members of the technical support team and community representatives, the concerned government authorities should be oriented about community-based initiatives approaches. During the large-scale expansion phase, teams of master trainers should be developed at national and regional/provincial levels to meet the training needs of the country.

4.1 Training of programme mangers and technical support teams

Training of programme managers and members of multisectoral technical support teams is an essential component of community-based initiatives. This aims at building their capacities for effective implementation and efficient management of the programme activities. These in turn will impart training to the community organizations. This community-based initiatives training manual (*Part A. Guidelines for facilitators*) contains a detailed course curriculum for providing training on community-based initiatives. The training plan given in Annex 4.3.1 describes the main objectives and contents of the training course. This training course should be based upon the community-based initiatives training manual by adapting it for national and local levels.

4.2 Training of community organizations

Training of community organizations such as the community development committee and cluster representatives intends to orient them about the programme concepts, its methodology and process. This aims to build their capacity for taking charge of local development and self-management of the programme. The training course is usually arranged for three to four days; however, the duration can be adjusted according to a group's composition, its needs and the training content.

It would also be advisable to orient and train community leaders, schoolteachers, health workers, traditional birth attendants and women's organizations on selected aspects of the programme focusing on their role in community development (details provided in Annex 4.3.1).

4.3 Development of master trainers

In both phases of community-based initiatives, a team of master trainers should be developed to meet extended training needs, especially in the expansion phase. The training will be based mainly on the community-based initiatives training manual. Annex 4.3.1 also provides basic information about the training plan.

4.4 Format for training plan (for individual training activities)

Annex 4.3.2 provides a format for preparing a plan for some specific training activity and may be adapted for local use. The contents of the training course and its duration should be in accordance with the needs of specific target group, considering the availability of resources, including the availability of the trainers.

5. GROUP WORK

Process

On the evening preceding the respective working session, participants should read the materials required for the respective group work. The group work should be conducted as follows:

- participants should be divided into equal groups, each not exceeding eight members
- each group should select its own chairperson and presenter (these responsibilities should be rotated during each group work assignment)
- the chairperson should watch the time and encourage every group member to participate
- the presenter should present the findings/report of the working group in the plenary session
- facilitators should help the participants as resource persons and give feedback on the group presentations.

Assignment

Groups should adapt the community-based initiatives training plan (Annex 4.3.1) for their country requirements.

They should develop a training plan using the format of Annex 4.3.2. Facilitators will assign separate targets to each working group. While preparing the training plan, assistance can be obtained from the lesson plan described in this community-based initiatives training manual (*Part A. Guidelines for facilitators*).

Annex 4.3.1

TRAINING PLAN

Instructions for use

During phase one, programme management, intersectoral teams and communities of model areas should be trained in the community-based initiatives concept, procedures and implementation process. During the expansion phase, a team of master trainers should be developed at national and regional levels to further train the programme mangers and intersectoral teams. These master trainers should also orient government authorities on programme advocacy. Subsequently, trained intersectoral teams should train communities. Specialized courses can be arranged as and when required for special target groups such as technical committees and community workers.

Level	Target group	Objectives	Duration	Contents	Methods	Trainers/ facilitators
National level	Master trainers team	Development of a team of master trainers, making them capable of: • training programme managers • orientation of authorities. Criteria for selection of master trainers: National and regional coordinators Members from lead	8–10 days	CBI concept, philosophy, approach and principles CBI procedures and process CBI planning, implementation, management and monitoring Community mobilization and organization CBI indicators, needs assessment and prioritization Health and development indicators Appropriate technologies and identification of the local skills. Projects planning and implementation	Training workshop and field visit	WHO staff, national focal person and lead ministry

Level	Target group	Objectives	Duration	Contents	Methods	Trainers/ facilitators
		ministry and line departments, having the capacity for programme advocacy, orienting authorities/media and possessing teaching and training skills		Intersectoral collaboration and technical support Programme advocacy and mobilization of resources Financial management Information management/ documentation and reporting Evaluation of programme		
Regional /provincial/ governorate level	National/ regional focal persons	Training focal persons at mid level, for making them capable of managing programme in their respective areas and provide further training to technical support team	8–10 days	As above	Training workshop and field visit	Master trainers, and national focal person
District level	CBI programme mangers and technical support teams from the districts	Training of the programme management for building up their capacity to manage the programme in accordance with national and regional strategies and guidelines	8–10 days	As above	Training workshop and field visit	Master trainers

Level	Target group	Objectives	Duration	Contents	Methods	Trainers/ facilitators
Community level	Community development committees and cluster representatives	Training of the community development committees and cluster representatives in the CBI philosophy, its methodology and process, organization and mobilization of community resources and attaining self-sufficiency, self-management and self -sustainability.	3–4 days	CBI concept and philosophy, approach and principles, procedures and process Technical support by intersectoral technical team Community organization and empowerment for self-sustained and self-help development Household survey for baseline data and needs assessment, prioritizing of community problems and mobilization of local resources Project planning and implementation Appropriate technologies, identification of local skills, socioeconomic community development Health expectations in CBI environment Increase of literacy, awareness and skills development Financial management at community level Information management and reporting	Training workshops and field visits	CBI intersectoral team

Level	Target group	Objectives	Duration	Contents	Methods	Trainers/ facilitators
				Community self-reliance, self-management and self-sustainability Healthy lifestyle and social well-being Advocacy for CBI promotion		
Community level	Community leaders such as teachers, imams NGOs and volunteers	Training and orientation of the community opinion makers and traditional community leaders on CBI concept and mobilizing their support in favour of programme	1–2 days	CBI concept and philosophy, approach and process, community organization and empowerment Community priority needs Mobilization of local resources. Community development Increase of literacy, awareness and skills development. Enhancement of quality of life and attainment of health for all. Advocacy for CBI promotion	Training session	CBI intersectoral team and community development committee
Community level	Community health workers, traditional birth attendants and field staff	Orientation of health workers and field functionaries in CBI process and concept as well as training them in primary health care services.	2–3 days	In addition to the above: Socioeconomic development of the community and health expectations in CBI environment. Promotion of primary health care, health and disease prevention	Training session	CBI team

Annex 4.3.2

FORMAT FOR TRAINING PROPOSAL

(For individual training activities)

This format may be used while planning individual activates. It is quite flexible and can be adapted according to local requirements and needs.

Format for training proposal

Element	**Description**		
Theme			
Target group			
Objectives			
Duration of training course			
Venue			
Contents of training course			
Means and methods			
Trainers/ facilitators			
Resources required	Nature	Quantity	Source
Costing of activity	Activity quantity.	Unit price	Total price

Agenda

Date and day	Time	Subject	Facilitators

Part B
Module 4
Unit 4.4

Community survey and prioritization

Learning objectives

To gain better understanding of:

- baseline survey including data collection, compilation and analysis
- prioritization of needs
- preparing area development profile

Expected outcome

The participants will be able to plan and undertake the baseline survey, and transform data into useful information required for implementing appropriate interventions and programme management

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1. INTRODUCTION

Baseline information is of great significance in community-based initiatives as it provides a base for future interventions and identifies priority needs. The survey tools are designed to acquire and convert data into useful information in order to help planning, controlling, monitoring and assessing a programme. In the survey process, the data collected from the community are converted into information and used for managing programme operations. Therefore in community-based initiatives, in addition to the baseline survey, a follow-up survey should be conducted, preferably after every one or two years. These will provide an effective mechanism for monitoring progress and measuring the changes occurring in developmental indicators as a result of the programme interventions.

Data refers to a collection of unorganized facts, statistics, opinions or predictions. When data take a meaning or value to a person, they become information. Information, rather than data, is required in decision-making processes

Converting data into useful information involves the following steps:

- collection
- compilation
- tabulation
- analysis
- presentation.

The information revealed is useful for the following purposes:

- understanding the baseline at the start of programme
- identification of gaps and required action
- comparison of local indicators with national figures
- planning of future action
- assessing availability of related resources
- determining implementation strategies
- monitoring progress
- future comparisons.

2. COMMUNITY SURVEYS AND NEEDS PRIORITIZATION

In order to determine the development needs of a community and the potential problems, it is essential to collect the relevant data from individual families, then compile, examine and interpret them in a useful manner to determine future action. The baseline data are collected through the questionnaires in Annexes 4.4.1 and 4.4.2, while Annexes 4.4.3 and 4.4.4 are used for presenting the collected information.

2.1 Baseline household survey

A baseline survey is an absolute prerequisite for initiation of programme intervention in any area. The salient features of a baseline survey conducted using Annex 4.4.1 are as follows.

- The baseline survey should be conducted on a house-to-house basis.
- All necessary information should be collected from the families according to the questionnaire.
- Cluster representatives should be trained by the technical support team in the survey process and tabulation of collected data. Semi-literate cluster representatives may get assistance from educated volunteers belonging to their cluster.
- At the time of survey, each family in the locality should be allotted a number that will be helpful in programme management and the planning/implementation of projects.
- Every house should be visited by the surveyor, and the information required in the questionnaire should be collected from family members or through personal observation according to the nature of the question.
- The community development committee and intersectoral team should supervise the survey process. The programme manager and technical support team should monitor the exercise and ensure the quality and validity of the collected information.
- The surveyors should submit the completed forms to their supervisors nominated from the community and intersectoral team, who will cross-check the collected information.
- The data should be jointly compiled by the surveyors and supervisors, first on a cluster basis and then at locality level.

During training, participants should read and understand the contents of Annex 4.4.1.

2.2 Baseline community survey

In addition to the household survey, general information about the locality such as facilities for health, education, civic amenities and social set-up should be collected according to the questionnaire in Annex 4.4.2. This information will be of great value, particularly for priority setting and preparing the area development profile. This information will also be helpful in monitoring the progress and evaluating the results of programme interventions.

The respondents should be community development committee members, cluster representatives, notables and leaders, staff of government departments and other people knowledgeable about the overall situation.

During training, participants should read and understand the contents of Annex 4.4.2

2.3 Priority setting

The problems of the community identified in the survey should be prioritized as follows:

- listing of identified (recognized and unrecognized) needs
- assessing the magnitude of the problem
- analysing their effects and the risks involved
- exploring resources available that are related to the problem
- estimating future requirements
- giving the needs and problems a priority number
- classifying the proposed solutions and setting the order for future action.

Criteria for prioritization of needs include:

- *the magnitude of the problem*: the extent of the problem in terms of the number of people affected

- *the effect on health*: the adverse effects of the problem on the community's and family's health, such as the spread of disease due to flies

- *sociocultural effects*: adverse effects of problems like addiction and unsocial activities on society and culture

- *economic effects*: financial effects of the problem such as reduction in purchasing power

- *problem-solving*: the community and technical support team may discuss a problem and if they are able to solve it with existing resources, then that problem should be given priority.

The format given as Annex 4.4.3 should contain information regarding priority needs of the community, the solutions designed and relevant measures that have already been undertaken by the community or concerned sectors for solving specific problems. The outcome of these efforts should also be recorded on this form. The community should be actively involved at all stages of this process. In fact, the community itself with technical support of the intersectoral team should design the solutions. The requisite monetary and material resources should be estimated in quantitative terms. The community resources available should be clearly earmarked, indicating the expected share of the community, government and other agencies. Needs prioritization should be performed carefully and must be reviewed regularly.

The technical support team and programme manager should guide the community on the feasibility of solving different hidden and apparent problems and needs, the extent of these problems and their impact on the quality of life of the people.

Once the priority needs are identified, the community should set long-term and medium-term targets. These targets should be clear, simple and realistic, helpful in mobilizing the community and concerned sectors. These targets should become an essential component of a social contract mutually agreed on by the community, government and other partners and provide direction for future intervention and implementation of development packages according to priority needs.

During training, participants should read and understand the contents of Annex 4.4.3.

3. AREA DEVELOPMENT PROFILE

The results revealed by the baseline surveys should be reflected in the area development profile that will prepared according to the format given in Annex 4.4.4, which can be adapted locally. Area development profile will indicate socioeconomic situation and high-risk factors in the area. It will consist of vital information, mainly the results of household and community survey, needs prioritization, and some other information gathered from other sources. A map of the area and its prioritized needs should also be made a part of this document. This profile will provide an overview and summary of all the information, highlighting the community set-up and its potentials as well as priorities and risk areas.

During training, participants should read and understand the contents of Annex 4.4.1.

4. GROUP WORK

Process

On the evening preceding the respective working session, participants should read the materials required for the respective group work. The group work should be conducted as follows:

- participants should be divided into equal groups, each not exceeding eight members
- each group should select its own chairperson and presenter (these responsibilities should be rotated during each group work assignment)
- the chairperson should watch the time and encourage every group member to participate
- the presenter should present the findings/report of the working group in the plenary session
- facilitators should help the participants as resource persons and give feedback on the group presentations.

Assignment

During the working session, each group should be assigned Annex 4.4.1 to adapt to the local situation.

Annex 4.4.1

BASELINE HOUSEHOLD SURVEY

Instructions for use

All questions in this questionnaire are significant, and the answers should be recorded correctly and carefully in order to ensure that authentic data are collected and key risk factors can be identified.

Particulars

Particulars regarding the name of the area and district, the cluster number, the survey date and the name of the surveyor/cluster representative should be recorded for identification purposes.

Family number

Each family in the area should be allotted a number, which will help in future planning and implementation of the projects. Numbering of families should be done in a systematic order, according to the sequence of clusters and houses.

Name of family head

The name of the family head should be written for identification of the house and family. In a joint family system or in case of more families living in a common compound, those with separate cooking arrangements may be considered independent families.

Demographic data

The population data (family members) should be recorded according to age and sex. There may be more than one married couple in one family. If a couple is not living together or is separated, a brief note should be made describing the situation.

Education and literacy

Information about primary school enrolment and adult literacy will indicate the educational status of the community.

Training and skills

The training may be technical or vocational, formal or informal. Similarly, skills may be traditional or acquired. The information related to the status of both male and female family members will help in exploring community potentials for future project and planning for interventions.

Water supply

Information about the availability of water for drinking and domestic use helps to assess a family's access to basic needs. Domestic use means the water required for cooking, washing, bathing and other home uses.

Housing and environment

Ownership of a house means that house is personal property of the family. It will indicate whether the family has a permanent residence in the locality or not. It will also show the economic status of the family. Maintenance of cleanliness in and around the home points out family awareness about environmental health and social behaviour. A sanitary latrine implies a safe latrine, having a proper method of disposal of excreta according to local conditions.

Agriculture and irrigation

Land holding indicates agricultural land as the sole property of the family and should be recorded in local measurement scales. Fertile land means the land on which crops can grow; whereas barren land is unfertile; crops do not grow on it. Reliable methods of irrigation indicate the irrigation methods which are available throughout the year and are easy to access.

Livestock and poultry

Exact information on livestock is essential for assessing milk and meat production. This will also help in future planning of income-generation projects relating to this sector.

Means of livelihood

The major income resources of the family and the collective monthly income will reflect the economic position of the family. The average income should be calculated on a monthly basis, considering all the income resources of the family. Usually families avoid providing information about their actual income; therefore the surveyor should confirm this information by observation the living conditions of the family or getting related information from other sources. Unemployment means those adults in the family who have the capacity to work, but do not have a job or are underemployed. Only those females who are willing to work outside the home should be considered unemployed.

Food, nutrition and growth monitoring

Nutritional status indicates purchasing power and family access to essential food items. Breastfeeding practices indicate community taboos and attitudes towards child health and can point out possible areas for work. Growth monitoring should be recorded very carefully. Normal growth of children can be assessed by comparing them with the same age group. Low-birth-weight children are those who weighed less than 2.5 kg at birth.

Health

The births of children during the past 12 months should be recorded. Illiterate families may record the date of birth by reference to the dates of national, cultural or religious events.

The deaths of children aged less than 1 year and 1–5 years during the past 12 months should be recorded carefully and should be confirmed from local records, if available.

Vaccination of children should be confirmed from Expanded Programme on Immunization cards and records of community health workers or the health facility.

The pregnancy rate may be difficult to assess in some communities. The help of traditional birth attendants, community health workers or female community leaders may be useful in obtaining correct information. Antenatal and postnatal care and vaccination of pregnant women is important information for assessing the availability of basic health facilities for maternal care. Availability of trained assistance at deliveries indicates the same.

The prevalence of chronic disease and disability is recorded in order to draw attention to the community members requiring assistance on priority basis.

The availability of health facilities and how they are used can be assessed by learning where people seek help in case of minor ailments.

Priority needs and recommendation /suggestions

Each family should be asked to identify its priority needs. One family can indicate a maximum of three needs in order of their priority in their opinion. Families should also give their recommendations, which will explore new ideas and will help to know how people visualise their future development.

BASELINE HOUSEHOLD SURVEY

Area_____ District_____ Cluster number _____ Survey date_____

Cluster representative_____ Surveyor_____

Family number												**Total**
Name of family head												
1. Demographic data	1.1 Family members	Total										
		Male										
		Female										
	Infants 0–1 year	Total										
		Male										
		Female										
	Children 1-2 years	Total										
		Male										
		Female										
	Children 2–5 years	Total										
		Male										
		Female										
	Children 5–6 years	Total										
		Male										
		Female										
	Children 6–15 years	Total										
		Male										
		Female										

1. Demographic data	Adults 15–49 years	Total								
		Male								
		Female								
	Adults 49–60 years	Total								
		Male								
		Female								
	Adults above 60 years	Total								
		Male								
		Female								
	1.2 Married couples in the house	No								
		If yes, number								

BASELINE HOUSEHOLD SURVEY

Area_____ District_____ Cluster number _____ Survey date_____

Family number									**Total**
2. Education and literacy	2.1 School-age children in the family (children 6–15 years)	Attending school	Total						
			Male						
			Female						
		Not attending school	Total						
			Male						
			Female						
	2.2 Adult literacy (can read and write local language) in the family		Notable						
			If yes, total						
			Male						
			Female						
3. Training and skills	3.1 Professional or technical training in the family		Not present						
			If yes, total						
			Male						
			Female						
			Type						
	3.2 Skilled persons in the family		Not skilled						
			If yes, total						
			Male						
			Female						
			Type						

BASELINE HOUSEHOLD SURVEY

Area_____District_____Cluster number_____ Survey date _____

Family number								**Total**
4. Water supply	4.1 Family has access to safe drinking water throughout the year	No access						
		If yes, source:						
		River						
		Well						
		Pond						
		Hand pump/ tube well						
		Piped water						
		Other						
	4.2 Sufficient water* for domestic use is available throughout the year	Yes						
		No						
5. Housing and environment	5.1 Family ownership of the house	Yes						
		No						
		If no, is it rented?						
		Other arrangements (specify)						
	5.2 Number of living rooms in the house (excluding kitchen/bathroom/ store)	1						
		2						
		More						
	5.3 Does the house have a separate kitchen?	Yes						
		No						

* Sufficient water for domestic use: 1 litre per person per day

BASELINE HOUSEHOLD SURVEY

Area_____District_____Cluster number _____ Survey date _____

5. Housing and environment	**Family number**							**Total**
	5.4 Is the house supplied with electricity?	Yes						
		No						
	5.5 Is there a place for a shower?	Yes						
		No						
	5.6 Is there a sanitary latrine in the house?	Yes						
		No						
		If yes, type						
	5.7 Is there a garbage container?	Yes						
		No						
	5.8 Does wastewater stagnate around the house?	Yes						
		No						
		If no, what is the disposal system?						
	5.9 Are the surroundings of the house clean and garbage-free?	Yes						
		No						
	5.10 Are there modern appliances in the house? (If yes, identify)	No						
		If yes, number of:						
		Radios						
		Tape recorders						
		Televisions						
		Refrigerators						
		Other (specify)						

BASELINE HOUSEHOLD SURVEY

Area_____ District _____ Cluster number _____ Survey date_____

Family number								**Total**
6. Agriculture and irrigation	6.1 Does the family own agricultural land? (If yes, ask questions 6.2–6.4)	No						
		Yes						
		Fertile land						
		Infertile land						
	6.2 Does the family use a reliable method for irrigation?	No						
		Yes						
		If yes, type						
	6.3 Does the family use better quality seeds in agriculture?	Yes						
		No						
	6.4 Does the family seek technical guidance from agriculture experts?	Yes						
		No						
7. Livestock and poultry	7.1 Does the family raise livestock?	No						
		Yes						
		If yes, number of: cows						
		buffaloes						
		sheep						
		goats						
		camels						
		other						
	7.2 Does the family keep poultry?	No						
		If, yes for family use						
		commercial use						

BASELINE HOUSEHOLD SURVEY

Area_____ District _____ Cluster no._____ Survey date_____

Family number								**Total**
8. Means of livelihood	8.1 Does the family have any means of livelihood?	No						
		Yes						
		Type: agriculture						
		livestock						
		small trade						
		skilled/technical professions						
		employment						
		labour						
		other (specify)						
	8.2 Does the family earn more than US$ 1 per person per day?	No						
		Yes						
		If yes, average monthly income?						
	8.3 Are any family members unemployed* (adults only)?	No						
		Yes						
		If yes, number: male						
		female						

* Unemployed**:** consider housewife as employed

BASELINE HOUSEHOLD SURVEY

Area_____ District _____ Cluster number _____ Survey date_____

Family number								**Total**
9. Food, nutrition and growth monitoring	9.1 Does family eat essential food items at least twice a week?	No						
		Yes						
		Meat, fish, eggs or milk						
		Fruit and vegetables						
	9.2 How many children under 2 years of age were breastfed?	Number of children under 2 years						
		Not breastfed						
		Breastfed up to 6 months						
		Breastfed more than 6 months						
	9.3 How many children under 1 year of age were weighed at birth?	Children weighed at birth (number)						
		Normal weight						
		Low birth weight *						

*Low-birth-weight if less than 2.5 kg

BASELINE HOUSEHOLD SURVEY

Area_____ District_____ Cluster number _____ Survey date _____

Family number								**Total**
10. Health	10.1 Children born during past 12 months?	If yes, number.						
	10.2 Stillbirths during past 12 months?	If yes, number.						
	10.3 Children born with congenital abnormalities during past 12 months?	If yes, number						
		Type						
	10.4 Children below 1 year died in past 12 months?	If yes, number						
		Age at time of death						
		Cause: neonatal tetanus						
		acute respiratory infection						
		diarrhoea						
		other (specify)						
	10.5 How many children of 1–5 years died in past 12 months?	If yes, number						
		Age at time of death						
		Cause: tetanus						
		acute respiratory infection						
		diarrhoea						
		other (specify)						

BASELINE HOUSEHOLD SURVEY

Area_____ District_____ Cluster number _____ Survey date _____

10.Health	**Family number**							**Total**
	10.6 Children completed 1 year of age vaccinated?	Not vaccinated						
		Vaccinated						
		*Complete vaccination						
		Incomplete vaccination						
	10.7 Are there any pregnant women living in the house at this time?	No						
		If yes, number						
	10.8 How many of them have been vaccinated against tetanus?	Number						
	10.9 Were the pregnant women examined by trained health workers?	No						
		Yes						
		If yes, number of visits						
		By: TBA						
		health centre						
		private clinic						
		hospital						
	10.11 Were the mothers attended by a trained health worker or trained TBA at least once in the six weeks after last delivery?	No						
		If yes, Number of visits						

*Complete vaccination: polio at birth of three doses, later on BCG one dose, DPT three times, measles one dose. (this may be differ from country to country; please follow national immunization schedule.)

BASELINE HOUSEHOLD SURVEY

Area_____ District_____ Cluster number _____ Survey date _____

10. Health	**Family number**							**Total**
	10.12 How many pregnant mothers died due to pregnancy during past 12 months?	Number						
	10.13 How many eligible couples are practising modern family planning methods?	Number						
		If yes, method: condom						
		IUD						
		pill						
		surgery						
		other						
	10.14 Does any family member suffer from a chronic disease*?	No						
		Yes						
		If yes, what is the health problem?						
		What is the age of patient?						
	10.15 Does any family member suffer from a disability?	No						
		Yes						
		If yes, type of disability						
		Age of the disabled person						

*Chronic disease: heart, renal, liver, diabetes, hypertension, cancer, etc

BASELINE HOUSEHOLD SURVEY

Area_____ District_____ Cluster number _____ Survey date _____

10. Health	10.16 Do family members get treatment for their minor illnesses from a nearby health faculty including health house, health post, etc	No						
		If yes: health faculty						
		hospital in the city						
		private physician						
		traditional healer						
		home remedies						

BASELINE HOUSEHOLD SURVEY

Area_____ District_____ Cluster number _____ Survey date _____

Family number							**Total**
Priority needs	1						
	2						
	3						
Recommendations/ suggestions							

Annex 4.4.2

BASELINE COMMUNITY SURVEY

In addition to the household survey, general information about the locality, mainly about availability of facilities, should be collected. This information should be gathered from the community development committee, cluster representatives and other people able to provide correct information.

Instructions for use

Health facilities

The presence of traditional birth attendants and community health workers is important for the provision of basic facilities. The distance to the health centre, if not present in the same locality, should be assessed both in terms of kilometres and travelling time.

Education

The presence of a primary school is important; however, intermediate and higher schools and technical or vocational training centres should also be recorded as this is helpful in planning social interventions related to education.

Civic amenities

The basic civic amenities, which are essential for a healthy life and also play a vital role in the process of community development, are recorded. The absence of these facilities indicates the extent of deprivation of the community.

Administrative offices

The presence of main government offices required at grass-roots level should be noted. This will help to assess what the community has and what gaps are to be filled through development interventions.

Sociopolitical situation

The presence of confrontation within and between community groups and a high level of crime will be negative factors. The existence of nongovernmental organizations and other community groups is a positive factor for organizing the community and developing social harmony. The community is also assessed for its response towards the development activities undertaken so far in the locality, the level of community participation, acceptance and ownership of projects, which are essential for the sustainability of the development process.

BASELINE COMMUNITY SURVEY

Locality _____ Surveyor_____ Date of survey _____

Respondent: locality notables, nongovernmental organizations and government officials

Availability of essential services	Question	Answer	Additional details
Health facilities	Health faculty	Yes _____ No _____ Type _____	Distance _____ km Time _____
	Community health workers	Yes _____ No _____	If yes, number _____
	Birth attendants	Yes _____ No _____	If yes, number. _____ Trained _____ Untrained _____
	Private clinic	Yes _____ No _____	Number _____
Education	Primary school for boys	Yes _____ No _____	If yes, distance _____ km Number of students_____
	Primary school for girls	Yes _____ No _____	If yes, distance _____ km Number of students_____
	Intermediate school for boys	Yes _____ No _____	If yes, distance _____ km Number of students_____
	Intermediate school for girls	Yes _____ No _____	If yes, distance _____ km Number of students_____
	Secondary school for boys	Yes _____ No _____	If yes, distance _____ km Number of students_____
	Secondary school for boys	Yes _____ No _____	If yes, distance _____ km Type of training _____
	Private school(s)	Yes _____ No _____	If yes, distance _____ km Number of students_____
	Technical training centre for males	Yes _____ No _____	If yes, distance _____ km Number of students _____
	Vocational centre(s) for females	Yes _____ No _____	If yes, distance _____ km Type of training _____

	Informal education centre for males	Yes _____ No _____	If yes, distance _____ km Number of students_____
	Informal education centre for females	Yes _____ No _____	If yes, distance _____ km Number of students_____
	Religious education centre	Yes _____ No _____	If yes, distance _____ km Number of students_____
Civic amenities	Electricity provided in all houses partial few none	 ☐ ☐ ☐ ☐	% of families using facility
	Drinking water source well river hand pump piped water other	 ☐ ☐ ☐ ☐ ☐	% of families house access to safe drinking water
	Sewerage system open drains covered drain no system	 ☐ ☐ ☐	% of families using sewerage system
	Garbage disposal away from locality near locality within locality	 ☐ ☐ ☐	
	Street paving complete incomplete no paving	 ☐ ☐ ☐	
	Transport facilities public transport private transport traditional means	 ☐ ☐ ☐	
	Nearest town	Name_____	Distance _____ km
	Grocery shops	Yes _____ No _____	
	Post office	Yes _____ No _____	

	Bank	Yes _____ No _____	
Administrative offices	Agriculture	Yes _____ No _____	
	Veterinary clinic or facility	Yes _____ No _____	
	Local government	Yes _____ No _____	
	Police Stations	Yes _____ No _____	
Sociopolitical situation	Any confrontation in the community	Yes _____ No _____	If yes, type
	Crime rate (reported cases during last 12 months)	Number_____	Major crimes
	Nongovernmental organizations/ community-based organizations working in the community	Yes _____ No _____	If yes, name and areas of work
	Other voluntary community groups working in the community	Yes _____ No _____	If yes, name ad areas of work
	Community response and willingness towards development activities	Positive_____ Negative_____	If positive, strengths and opportunities,

Annex 4.4.3

PRIORITIZATION OF NEEDS

In a community-based initiatives area, the prioritization of needs is of great significance and provides baseline for future planning and activities. Community representatives should take the lead role in this process, while the technical support team should provide technical assistance.

The problems and needs of the locality should be listed using the information collected through household and community surveys. All members of the community should be engaged in the discussion and identification process.

Each problem should be analysed individually and its magnitude should be calculated using the criteria mentioned below. The reasons for and effects of the problems should also be determined. This all helps to assess the priority of the problem. Each problem should be given a priority number according to the results of the above analysis.

Each criterion may be given a rate from 0 to 4 (five criteria in all; maximum score 20 and minimum 0).

Criteria for prioritization of needs

Magnitude of the problem

- The extent of the problem in terms of the number of people affected.

Effects on health

- The adverse effects of the problem on community and family health such as the spread of disease due to flies and increase in morbidity or mortality.

Sociocultural effect

- The adverse effects of the problem on the social aspects and cultural values of the community such as promotion of addiction and introduction of unsociable activities.

Economic effects

- Easy-to-solve problems: the country and technical support team may discuss a problem, and if it is easy to solve with existing resources, that problem should be given priority.

- The financial effects of the problem, such as reduction in purchasing power, loss of property.

Communities are capable of finding solutions for their own problems but may need encouragement and support, particularly for the technical aspects of problem-solving. The community should explore various ways and means for solving the identified problems and choose the most appropriate solutions by consensus, taking into consideration the availability of resources. These solutions will become the basis for future plans of action. The prioritization process should be performed very carefully and reviewed on a regular basis.

PRIORITIZATION OF NEEDS

Area/locality _____ Survey date _____

List of problems/needs	Score for priority analysis	Actions already taken	Recommended solution

Criteria for needs prioritization:

1. Magnitude of the problem

2. Effects on health

3. Sociocultural effects

4. Economic effects

Annex 4.4.4

AREA DEVELOPMENT PROFILE

The survey results collected from households and communities should be carefully analysed and documented in a presentable form that can provide a ready reference for future interventions and consultations. These forms may be used to present the cumulative outcome of the survey for the entire area.

The format of Annex 4.4.4 follows the sequence of information gathered in the household and community surveys (Annexes 4.4.1 and 4.4.2). Some information is gathered from other sources.

Data revealed by surveys must be verified and compared with the national figures. If there is missing or misleading information, a mini-survey may be conducted to fill the gaps.

The map of the area and prioritized needs is essential part of the area development profile. This summary information highlights the risk and priority areas. It also reflects the general overview of the community and the potential to develop and progress.

AREA DEVELOPMENT PROFILE

Area /Locality _____ District _____ Country _____

Indicator	Survey results					
	Male		Female		Total	
	Number	%	Number	%	Number	%
1. Demographic data						
Number of households						
Number of married couples						
Total population						
Children 0–1 year						
Children 1–2 year						
Children 2–5 years						
Children 5–6 years						
Children 6–15 years						
Adults 15–49 years						
Adults 49–60 years						
Adults above 60 years						
2. Educational and literacy						
No of 6–15 year children attending school						
No of 6–15 year children not attending school						
Total number of adults (15 years and above)						
3. Training and skills						
Technically trained persons in the community						
Skilled persons in the community						

Indicator	Result	
	Number	**Percentage**
4. Water supply		
Access to safe drinking water		
Water sources: River		
Shallow well		
Pond		
Hand pump/tube well		
Pipes water		
Other		
Access to sufficient water for domestic use (1 l/day)*		
5. Housing an environment		
Ownership of house		
Houses with rooms that can accommodate an average of four people		
Houses with separate kitchen		
Houses with electricity		
Houses with shower place		
Houses with sanitary latrine		
Houses with garbage container		
Houses with stagnant water in or around the vicinity		

Indicator	**Result**	
	Number	**Percentage**
If water disposal system; Closed sewage		
Open drains		
Other		
Houses with clean and garbage-free surroundings		
Houses with modern appliances		
Type of appliance:		
Radio		
Tape recorder		
Television		
Refrigerator		
Air conditioner		
Satellite antenna		
Motorcycle		
Car or other vehicle		
6. Agricultural and irrigation		
Families with agricultural land		
Families using reliable methods for irrigation		
Families seeking technical guidance form agricultural experts		

Indicator	Result	
	Number	**Percentage**
7. Livestock and poultry		
Families raising livestock		
Number of animals : Cows		
Buffaloes		
Sheep		
Goats		
Camels		
Other		
Families keeping poultry		
Families keeping poultry for family use		
Families keeping poultry for commercial use		
8. Means of livelihood		
Families with some means of livelihood		
Category of means: Agricultural		
Livestock		
Small trade		
Skilled /technical professions		

Indicator	Result	
	Number	**Percentage**
Employment		
Labour		
Other		
Families earning more than US$ 1 per person per day		
Families with unemployed males (adults only)		
Sex distribution of unemployed Males		
Females (willing to work)		
9. Food, nutrition and growth monitoring		
Families eating essential food items at least twice a week		
If yes, category of food item: Meat, fish, eggs, milk		
Fruit or vegetables		
Number of children under 2 years that were breastfed		
Breastfed up to 6 months		
Breastfed for more than 6 months		
Low-birth-weight newborns during last year (less than 2.5 kg)		
Number of children under 1 year not weighed at birth		

Indicator	Survey results	
10. Health **a) Child health**		
Number of children born during past 12 months	Number	Birth rate
Number of stillbirths during past 12 months	Number	% of total births
Number of children born with congenital problem	Number	% of total births
Number of children under 1 year died during past 12 months	Number	Per 1000 live births
Causes of death among children under 1 year: Neonatal tetanus	Number	% of deaths among children under 1 year
Acute respiratory infection	Number	% of deaths among children under 1 year
Diarrhoea	Number	% of deaths among children under 1 year
Other	Number	% of deaths among children under 1 year
Number of children 1–5 years died during past 12 months	Number	Per 1000 live births:
Causes of death among children 1–5 years: Tetanus	Number	% of deaths among children under 1-5 year
Acute respiratory infection	Number	% of deaths among children under 1-5 year
Diarrhoea	Number	% of deaths among children under 1-5 year
Other	Number	% of deaths among children under 1-5 year
Number of children under 1 year received complete	Number	% of children of under 1 year

Indicator	Survey results	
vaccination		
Number of children under 1 year received incomplete vaccination	Number	% of children of under 1 year
Number of children under 1 year not vaccinated	Number	% of children of under 1 year
b) Maternal health		
Number of pregnant women	Number	% of total women of childbearing age
Pregnant women in third trimester	Number	% of total pregnant women
Pregnant women not vaccinated against tetanus	Number	% of pregnant women in third trimester
Women received antenatal care by trained health worker	Number	% of total pregnant women
Women did not receive antenatal care by trained health worker	Number	% of total pregnant women
Mothers received postnatal care by trained heath worker during last delivery	Number	% of mothers responded
Mothers did not receive care by trained health worker during last delivery	Number	% of mothers responded
Mothers received postnatal care by trained health worker after last delivery	Number	% of mothers responded
Mothers did not receives postnatal care by trained health worker after last delivery	Number	% of mothers responded
Number of women died due to pregnancy during last one year	Number	
Number of families practising family planning	Number	% of eligible couples
c) Health services		
Number of family members with a chronic disease	Number	% of the total population
Main chronic diseases	1. 2.	

Indicator	**Survey results**	
	3.	
Number of family members with disability	Number	% of the total population
Main disabilities	1. 2. 3.	
Families receive treatment for their minor illnesses	Number	% of the total number
Health faculty in the area	Number	% of the total number
Hospital in nearby city	Number	% of the total number
Private physician	Number	% of the total number
Traditional healer	Number	% of the total number
Home remedies	Number	% of the total number

Part B
Module 4
Unit 4.5

Project preparation and implementation

Learning objectives

To gain a better understanding of:

- types of project
- mobilization of resources
- preparing proposals for social and income generation projects
- implementation of projects

Expected outcome

Participants will be able to prepare project proposals and their feasibilities for solving priority problems of the community-based initiatives areas and support the communities in this process

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1. INTRODUCTION

The community-based initiatives carry out the developmental process through appropriate interventions based upon the priority needs of each community. The area development profile prepared in this context is translated into a series of developmental activities. The developmental packages described in Module 3 also provide directions and guidelines for carrying out these activities. In this context, it is essential to emphasize that health should be the priority and central to developmental activities in the community-based initiatives areas.

2. TYPES OF PROJECT

In community-based initiatives areas, appropriate interventions are carried out to address the priority needs and assist the individuals, families, groups of people or the community. In general, projects may be classified as:

- social projects, including health, environment , women and youth development
- income-generation projects.

Social projects or activities are mostly related to health, food and nutrition, water supply, environment and sanitation, education and literacy, social welfare and skills development. They are intended to promote human development and improve the quality of life of the people with tangible health outcomes.

Income-generation projects are aimed at earning money to reduce the poverty level of the individuals and the families. These projects are objective-oriented and must be health friendly. The communities are supported for economic growth through providing no interest loans, development of their technical and professional skills and provide sectoral support.

2.1 Inventory of projects

The communities carry out projects according to the assessed needs and in accordance with the development packages. An inventory of the social and income-generation projects prepared based upon available knowledge in the communities and experiences of the countries of the Region may be helpful for adopting creative development approaches for preparing plans and proposals. The objective is to foster innovative ideas and introduce appropriate interventions to meet the developmental needs.

2.2 Social projects and activities

Health

- Extending comprehensive primary health care services and training of community health workers.
- Screening for major diseases, keeping records and managing incidences.

- Immunization of children and mothers.
- Growth monitoring of children and intensive follow-up of low weight children.
- Promotion of breastfeeding for infants and supplementary feeding in children.
- Screening of anaemic mothers and children, and management of cases.
- Promoting a healthy lifestyle and a system for improving health education.
- Promoting school and physical health.
- No-smoking campaign.
- Promotion of family planning among eligible married couples.

Housing, water supply, sanitation and environmental health

- Drinking water scheme/water supply system at village level on a self help basis, owned and managed by the community.
- Cleanliness/sanitation campaigns.
- Garbage/waste water disposal system, managed by the community.
- Promotion of use of sanitary latrines.
- Tree plantation and floriculture.
- Introduction of healthy homes as model houses in the community, having essential components of ventilated living rooms, separate ventilated kitchen, safe water supply, sanitary latrine, waste-water/solid waste disposal system, clean inside and surroundings and having trees and/or floriculture.

Education, literacy and skills development

- Promotion of basic and primary education.
- Facilitating admission of children who have dropped out of school.
- Establishment of informal education/literacy centres for adults and children who missed the opportunity of formal education.
- Introduction of health education to the school curriculum.
- Promotion of recreational and healthy activities like sports and literary competitions.

- Admission of school defaulters.
- Establishment of community libraries and promoting study circles.
- Establishment of computer training centres.

Development of women and youth

- Organization and capacity-building.
- Establishment of literacy vocational and technical training centres.
- Facilitation of skills development through formal institutes.
- Social activities for promoting gender development and the role of women and youth.

2.3 Income-generation projects

Agriculture projects

- Provision of loans for procuring quality seeds, fertilizers, pesticides and equipment.
- Promotion of growing of food crops.
- Promotion of modern techniques like quality seeds and fertilizers and pesticides for enhanced yield of food and cash crops.
- Supporting irrigation projects like wells, tube wells, diesel water pumps.
- Promotion of plants nurseries, gardening, tree plantation and forestry.

Dairy/livestock projects

- Keeping milking animals, dairy and milk products.
- Sheep and goat farming, fattening of calves.
- Poultry farming, bird farming.
- Apiculture.
- Fish farming, fishing boats and nets.
- Rabbit farming.
- Silk-worm keeping.

- Poultry and animal milk-enhancing feeds and fodders.
- Establishment of facilities and promotion of artificial insemination.
- Cooperative projects for dairy farming and milk supply.
- Encouraging the livestock sector by providing more technical knowledge regarding modern farming.

Cottage industries and technical professions

- Woodworks and furniture.
- Carpet-making.
- Garment manufacturing and tailoring.
- Iron or steel work.
- Plumbing, sanitary work and electrical work.
- Candle-making.
- Plastic articles and toys.
- Pottery.
- Detergent manufacturing such as soap and washing powder.
- Artificial ornament and jewellery making.
- Traditional weaving.
- Hosiery.
- Cosmetics.
- Electrical switches.
- Leather and plastic shoemaking.
- Tool making.
- Polyethylene bags
- Manufacturing of other products/articles from plastic, wood, rubber, chemicals, and iron according to local skills and demand.

- Repair workshops for vehicles, electrical goods and electronics.

Food technologies

- Bakery items.
- Jam.
- Jelly.
- Roasted peanuts.
- Potato chips.
- Salty and spicy items.
- Other food items according to local culture and marketing potential.

Handicrafts

- Hand and machine embroidery.
- Decorative pieces.
- Scenery making.
- Fabric painting.
- Glass painting.
- Handbag making.
- Bed sheets.
- Wood carving.
- Metal engraving.
- Flower making.

Small scale business

- Grocery shops.
- General stores and services.
- Vendors of household items.

- Development of a community market place for essential items.
- Marketing of community products.
- Public call office.
- Service shops like photocopying, repairing household items, etc.
- Preparation of detergents at home.
- Fruit and vegetable preservation.
- Solar cooker and oven.
- Energy saving cooker.
- Kitchen gardening.
- Local transport e.g. taxi/rickshaw/bus, horse, donkey and cart.

3. MOBILIZATION OF RESOURCES

Community-based initiatives being a participatory approach, the resources required for carrying out the interventions can be generated from various sources.

The resources may be mobilized from the following three levels:

- individual or community
- government sectors
- other stakeholders
- physical and material resources
- human resources
- monetary resources.

Community resources

- Community funds like revolving fund and community development fund.
- Community contributions.
- Family savings and assets.

Government resources

- National, provincial/governorate, district or local budget.
- Government/public assets.

Other resources

- Microcrediting by banks.
- Foreign aids and grants.
- Contribution by other partners and donors.
- Country budget of WHO and other international agencies.

4. PROJECT PREPARATION AND IMPLEMENTATION

Project preparation requires technical knowledge and great responsibility. The technical support team and community organizations should be well trained in the preparation of social and income-generation projects, the project feasibility report and other needs. Countries can modify and translate the attached tools in accordance with local needs. The project proposals may be made conditional on the social contract between the community and related partners.

4.1 Proposal for social projects

The community development committee should take a leading role in designing the project proposals. Technical support team members from relevant sectors should support and assist in the proposal formulation. The format prescribed for social projects as Annex 4.5.1 should include a feasibility report and a summary of the implementation plan.

Considerations for social projects

- Needs-oriented and impact on individuals and community
- Matching with the sociocultural norms and acceptable to the community
- Expected outcome in terms of improvement of social and heath indicators
- Increasing social services and enhancing quality of life
- Creating awareness and raising literacy rate as well as technical skills
- Promoting sustainable social enhancement
- Encouraging people in self-reliance, self-sufficiency and sense of ownership
- Feasible and manageable by the community
- Ensure contribution of local resources
- Technical assistance available at intersectoral team level

During training, participants should read and understand the contents of Annex 4.5.1.

4.2 Proposals for income-generation projects

The community as individual or group of people as cooperative can apply for the income generation projects. The community development committee with assistance of concerned sectoral member of technical support team should analyse the requirement of the project in the light of programme requirements. I

Considerations for income-generation projects

- Social preparation and demand
- Positive participatory attitude of the community
- Respecting and capitalizing on the specific traditions, culture and capabilities of the local community
- Impact on individual and community needs
- Existing traditional or inherited skills
- Availability of raw materials and resources locally
- Feasibility and job creation
- Availability of marketing opportunities
- Availability of proficiency and technical guidance
- Promoting individual, community and environmental health

- The applications by the beneficiaries for income-generation projects should be on the format given in Annex 4.5.2. These should be based on the needs assessment survey, on the recommendations of cluster representatives and the community development committee.

- The technical support team and programme manager should screen the application and assist the community to prepare a proposal on the format given as Annex 4.5.3; that should be supported by a feasibility study providing details of project requirements.

- Approval of the application in phase 1 may be carried out at the national level; however, in the expansion phase it should be at district level.

- All loan disbursements should be made through a contractual agreement between the village development committee as guarantor and the beneficiaries; see Annex 4.5.4.

- The beneficiary, under supervision of the community development committee, should implement the project with the support of the technical support team. The

implementation process should only be initiated after completion of the necessary documentation.

During training, participants should read and understand the contents of Annexes 4.5.2 to 4.5.4.

5. GROUP WORK

Process

On the evening preceding the respective working session, participants should read the materials required for the respective group work. The group work should be conducted as follows.

- Participants should be divided into equal groups, each not exceeding eight members.
- Each group should select its own chairperson and presenter. (These responsibilities should be rotated during each group work assignment).
- The chairperson should watch the time and encourage every group member to participate.
- The presenter should present the findings/report of the working group in the plenary session.
- Facilitators should help the participants as resource persons and give feedback on the group presentations.

Assignment

- During the working session, groups should perform the following tasks.
- Adapt Annexes 4.5.1 and 4.5.3.
- Each group will prepare proposals for one social and one income-generation project. The facilitators will assign the titles of the projects to the groups according to their background. Examples of projects are:
  - establishment of a literacy centre for adults
  - establishment of a women's development centre
  - introduction of a community-based sanitation system
  - cooperative projects for livestock farming
  - manufacturing and marketing of handicrafts.

Annex 4.5.1

PROPOSAL FOR SOCIAL PROJECTS

Instructions for use

Project title

The project title should clearly indicate the nature of the project and the area or locality where it will be carried out.

Introduction

The proposal should include background information on the priority needs of the community and their extent/magnitude, previous interventions and their outcomes and reasons for proposing this project.

Objectives

The objectives should be relevant to the community-based initiatives goals and should be consistent with the needs of the community. These should be comprehensive and number not more than three or four.

Targets

The targets should be fixed in relation to a time frame and should be clear, realistic and achievable.

Expected outcome

The forecast for the expected outcome should provide a very clear picture. The targets should be the basis for the assessment of the outcome.

Time frame

The schedule for the project activities should be in line with the targets and proposed activities. It should indicate the appropriate timing for all of the activities required in this process, so that the results may become visible and supportive of further development.

Requirements

There may be financial, logistic or other requirements necessary for the implementation of the project and these should all be noted.

Costing

The cost of project should be calculated in terms of capital and recurrent costs, indicating the cost of the various components of the project. The potential sources of financing and expectations from each partner should be indicated.

Signatories

The project proposal should be signed and forwarded by the chairman of the community development committee and the programme manager for approval from the concerned authorities.

PROPOSAL FOR SOCIAL PROJECTS

District _____ Area/locality _____

Project	

Introduction

Objectives

Targets

Expected outcome

Time frame
Requirements
Financial Logistic Other (specify)

Costing				
Component	Government	WHO	Other partners	Community
Capital cost				
Equipment and machinery				
Furniture and fixtures				
Loan for project				
Other				
Total 1				

Recurring cost				
Salary of staff				
Project allowance				
Stationery and printing				
Other supplies				
Operational expenditures				
Others				
Total 2				
Grand total (Total 1+2)				

Signatories

_____ _____

Chairman community development committee Programme manager

Date _____ Date _____

Annex 4.5.2

APPLICATION FOR INCOME-GENERATION PROJECTS

Instructions for use

Beneficiaries should apply on a prescribed application form, forwarded through the respective cluster representative and community development committee. The application should contain basic information about the beneficiaries' families.

Particulars

The particulars should include the names of the beneficiaries with father's/husband's name, age, sex, occupation, address, national identity card number (if any) and the number of family members dependent upon him.

Project type

The beneficiary should write the type of proposed project, providing a clear vision of the project and its location.

Expected loan

The beneficiaries should mention the approximate amount required as loan in order to implement the project.

Undertaking

The beneficiaries should give an undertaking regarding their commitment to abide by community-based initiatives rules, to repay the loan according to schedule and to contribute to the socioeconomic condition of their family and community.

Verification and recommendation

Screening and verification of the application by the relevant cluster representative and community development committee will be considered as an informal guarantee. They should verify the credibility and capacity of the family to successfully implement the project and repay the loan on time and ensure that the applicant meets the community-based initiatives criteria.

The technical support team and programme manager should also screen and verify the information provided in the application before preparation of the project proposal.

APPLICATION FOR INCOME GENERATION PROJECT

Particulars

Name of applicant	Age	Sex	Father's/ husband's name	Profession	National identity card number	Address	Family size

Project type	
Expected loan	

"I/we solemnly declare that:

- I/we shall abide by the rules and regulations as well as the terms and conditions of the project and shall return the loan according to the agreed schedule.
- I/we agree to pay a penalty in case of unauthorized delay or default.
- I/we shall make all efforts to improve the health, education and socioeconomic status of my family.
- I/we shall contribute to social mobilization and shall support other community members to improve their quality of life".

_____

Signatures with name and date

Verification and recommendation

"I/we agree to guarantee in time return of loan by the applicant. In case of any delay or default, I/we shall be responsible to arrange payment of the loan amount".

Cluster representative		Community development committee chairman	
Signature		Signature	
Name		Name	

Annex 4.5.3

PROPOSAL FOR INCOME-GENERATION PROJECTS

The project proposal is to be prepared by the community development committee with the support of the technical support team member from the concerned sector and in consultation with the programme manager. The project proposal should be prepared in the prescribed format which can be adapted according to the local and individual project needs.

Instructions for use

Note: the application of the beneficiary will be a part of this project document.

Project

The project title should describe the type and nature of the project.

Introduction

This should give background information, reflecting the need for the project in the community. Any experience with similar projects should be mentioned along with their outcome.

Objectives

The objectives should be in accordance with community-based initiatives goals. The objectives should preferably be comprehensive and not more than three or four in number.

Targets

Targets must be very clearly stated and achievable.

Expected outcome

The outcome can be predicted from the targets and objectives of the project. It should not be unrealistic or hypothetical.

General aspects

This section should provide information about the project schedule, lag period, loan source, the loan amount and the repayment schedule.

Budgetary requirements

The preparation of the budgetary requirements for the projects requires skill and knowledge of the market. The amount of each component should be in accordance with the needs of the project and should be realistic. The unit cost of different items quoted in this

statement should be comparable with market prices. It is advisable that the beneficiary and sectoral team member should explore the market first and get quotations for the items required. The total cost will be shared by the community member, who will contribute at least one-quarter of the total cost; the remaining will be the proposed loan. However, this will not exceed a limit fixed for each beneficiary.

Interest and user charges

If the countries impose any interest or user charges on the loan amount, this will be calculated in the proposal, its rate mentioned, and the monthly instalment fixed

Signatories

The signatures of the chairman of the community development committee and the programme manager should be affixed before forwarding to the loaning authorities.

PROPOSAL FOR INCOME GENERATION PROJECTS

Project	
Beneficiary/ies	

Introduction

Objectives

Targets

Expected outcome

General aspects	
Project period	
Lag period	
Loan source	
Expected loan	
Repayment scheme	

Budgetary requirements

Component	**Qantity**	**Unit cost**	**Period**	**Total cost**	**Community share**	**Loan**
Establishment						
Machinery and equipment						
Materials						
Operational expenditure						
Follow-up materials						
Labour						
Others						
TOTAL						

Calculation of interest/user charges (if any)

Category	**Rate**	**Total**	**Instalment amount**
Interest			
User charges			
Any other			
TOTAL			

Signatories

_____ _____

Chairman community development committee Programme manager

Date _____ Date _____

Annex 4.5.4

CONTRACTUAL AGREEMENT

Instructions for use

This agreement is morally and legally binding on the beneficiary to pay back the loan. It may be adapted according to country procedures and circumstances and preferably it should be registered with the legislative authorities of the country. The application and the project proposal should also become enclosures of this document.

Name of partners

The names of the loan issuing authority and the beneficiary shall be written in complete words.

Project

The name of the project as written in the project proposal shall be mentioned.

Location

This will indicate the place where the project is proposed to be implemented.

Loan amount

This shall be written in figures and words and should be reflected in local currency.

Loan return schedule

This should also be a part of the agreement. The instalment amounts and the target dates should be written.

User charges

If there are any user charges or interest payments, they should become a part of the project agreement.

Undertaking

The beneficiary shall give an undertaking for the timely return of the loan and for other terms and conditions as and if fixed by the country.

Signatories

The signatures of the partners going into the agreement, along with that of the guarantor and community development committee as collateral partner, will be affixed. On behalf of the loaning authority, the programme manager will affix his/her signature; however later on the loaning authority may sign it in person.

CONTRACTUAL AGREEMENT

between

1. Loan issuing authority _____

2. Loan receiving beneficiary _____

Project	
Location	
Loan amount	
Loan return schedule	
User charges	

With reference to the project proposal and the enclosed application by the beneficiary/ies, initiated and recommend by the community development committee on the request of the above mentioned beneficiary/beneficiaries,

1. The beneficiary agrees to undertake the aforesaid project in accordance with the enclosed project document and stipulated financial and administrative arrangements.

2. The community-based initiatives authorities agree to provide the loan to the community as the aforesaid amount, which is reimbursable according to the agreed schedule and the terms of reference in the project document.

3. The beneficiary will pay user charges if fixed by the community development committee/ community-based initiatives authorities.

4. The beneficiary will abide by all of the terms and conditions outlined in the project proposals and strive hard to meet the targets and objective of the project.

5. The beneficiary will not leave, shift to others or sell out the project and will not change the site without informing the community development committee and getting permission from the community-based initiatives loaning authority.

6. The beneficiary will to allow community-based initiatives management to collect data regarding this project as and when required.

7. The contract will come into force upon the disbursement of funds for the execution of the project.

Signatories

All clauses of the agreement and enclosed project proposal, feasibility and budgetary proposition, have been read out to us and we agree with their compliance. The community development committee and guarantor agree to pay back the loan user charges if the beneficiary defaults or delays the instalments.

_____ _____ _____

Beneficiary Guarantor Community development committee

Witnesses (1) _____ (2) _____

On behalf of the community-based initiatives authority _____

Part B
Module 4
Unit 4.6

Supervision and monitoring

Learning objectives

To gain a better understanding of:

- supervision and monitoring mechanisms
- supervision and monitoring in community-based initiatives

Expected outcome

The participants will fully understand supervision and monitoring mechanisms and will be able to establish the system in community-based initiatives areas

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2. Supervision and monitoring in community-based initiatives 299

3. Group work 301

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1. Evidence-based supervision and monitoring 302

1. INTRODUCTION

Supervision and monitoring are observing and comparing work at the operational level with predetermined criteria and set goals. It is a continuous process and should be an inbuilt system that facilitates the regular assessment of progress, problems and procedures. Community-based initiatives, being a multidimensional and intersectoral community-based approach, require supervision and monitoring involving all concerned partners, in particular the communities, government sectors and the sponsoring agencies. Programme activities should be closely monitored by the community itself, supported by the intersectoral teams. Similarly, the overall programme activities also need to be supervised by the lead ministry.

Monitoring

A continuing function that uses systematic collection of data to provide management and the main stakeholders of an ongoing intervention with indications of the extent of progress

Monitoring of programme

Continuous follow-up and assessment of programme activities and delivery to ensure that they are proceeding according to plan and that the expected results are likely to be achieved

This process should be carried out with the spirit of delegating authority and responsibility, setting examples, recognizing changed roles and commitment for community development and improving the situation.

Supervision and monitoring should not be hypothetical or merely based on personal observations. It must be founded on programme information revealed from reliable resources

2. SUPERVISION AND MONITORING IN COMMUNITY-BASED INITIATIVES

No programme or institution can work effectively without a system of checks and balances. The transparent implementation of community-based initiatives can be maintained only through a well defined system of supervision and monitoring. The involvement of local structures is of paramount importance and will augment the efficiency and credibility of community-based initiatives.

Monitoring and supervision, being key elements for strengthening every programme, require continuity of visits by supervisors. They must be based upon well defined indicators and checklists that illustrate the inputs and efforts for achieving desired goals, the processes for realizing the plans and the application of standards to quality of work and outcomes directed towards the expectations, people's satisfaction and improvement of the situation.

In community-based initiatives, three major elements support a programme's sustainability includes community involvement and mobilization, programme transparency and government's ownership at the local and national levels. Since programme is based upon different kind of developmental initiatives in the fields of health, social and income generation, one must make sure about the progress, level of community involvement in need assessment, prioritization, planning, implementation and project's management and decision making, in addition to the intersectoral collaboration and support, effects of training activities, logistics, use of available local resources, and partnership needs to be assessed carefully. The supervisors should also identify the strength points, major problem areas and short comings related to the programme activities during their supervisory visits. The intention is to find out feasible intervention in consultation with the actual implementers (community members, cluster representatives and community development committee). This can prevent any undesired effects in the programme areas through better communication, streamlining the programme operation and ensuring its transparency, and seeking the advice and support of government authorities.

Efforts must be made to put the community representatives on the front row of implementation and management. The community-based initiatives team must provide technical support in their respective areas. Financial transparency is also a key success element for community-based initiatives. In this respect, the community must be encouraged to plan and decide in the most effective way to overcome any problems. This must be supplemented through active community involvement, dialogue with those involved, informed decisions and need-based social action at local levels. All these cannot be achieved unless government authorities are actively involved in the monitoring and supervisory process, ensuring that the recommendations of supervisors are implemented properly.

This will enable the ministry of health and WHO to discover major problems and assist in developing appropriate interventions to streamline the programme's management. This requires sharing of this document with the national authorities responsible for community-based initiatives and training of district supervisors. The members of the community-based initiatives team and community development committee should also be aware of the contents of supervisory tools and know about the expectations, because this activity will encourage them to streamline programme implementation and management more effectively and in transparent manner.

The monitoring system should aim to keep the community-based initiatives goal-oriented and transparent. Its main features are as follows.

- It should be carried out through regular meetings with the community, cluster representatives and the community development committee as well as members of the technical support team, and records of these meetings should be maintained.

- The community may agree on a set of simple and understandable indicators for more systematic monitoring.

- Training of supervisory skills should be essential part of community-based initiatives management.

- The supervisory tool for local levels given in Annex 4.6.1 can be adapted in accordance with local needs.

- The regular supervision and monitoring activities must be undertaken as joint efforts with the community in order to create a sense of participatory ownership.

3. GROUP WORK

Process

On the evening preceding the respective working session, participants should read the materials required for the respective group work. The group work should be conducted as follows.

- Participants should be divided into equal groups, each not exceeding eight members.

- Each group should select its own chairperson and presenter. (These responsibilities should be rotated during each group work assignment.)

- The chairperson should watch the time and encourage every group member to participate.

- The presenter should present the findings/report of the working group in the plenary session.

- Facilitators should help the participants as resource persons and give feedback on the group presentations.

Assignment

During the working session, groups should review and adapt the tool for supervision and monitoring (Annex 4.6.1) for local use.

Annex 4.6.1

EVIDENCE-BASED SUPERVISION AND MONITORING

This tool for evidence-based supervision and monitoring is intended to assess the implementation of community-based initiatives in accordance with the set rules and guidelines. This checklist can be used by all supervisors and partners visiting the community-based initiatives area. It will provide comprehensive information, sufficient to observe the direction of community-based initiatives, indicating weak and strong areas, and bringing about appropriate suggestion for programme improvement. The same checklist with local adaptations can be used in both phases of community-based initiatives implementation.

Instructions for use

Community-based initiatives area

Name of community-based initiatives area visited.

District

Name of the district (for geographical identification).

Province

Name of the province (for geographical identification).

Date

Date of the visit.

Visitor

Name of the visiting authority, with his/her designation and name of department or organization.

Signature

Signature of the visiting authority.

Community organization and mobilization

This includes assessment of the formation and training of the community development committee, cluster representatives and technical committees for sectoral development according to community-based initiatives criteria in order to ensure capacity-building of local leadership to self-manage the programme. The efforts for social mobilization and organization of social groups are also included in this section.

Intersectoral collaboration and partnership

The status of the community-based initiatives team (also called the technical support team) and its training in the community-based initiatives process should be reviewed in order to verify that all related sectors are providing technical support to the community. The status of intersectoral structures at other levels should also be assessed. Information about partnerships developed at all levels should be ascertained and the extent of their contribution towards programme achievements.

Social and income generation projects

The information related to documentation of social and income-generation projects and their planning according to the priority needs and the area development plan should be noted. It should also be observed that these are being prepared and implemented by the community, assisted by the technical support team in accordance with predetermined criteria and procedures. In particular the information on the health and social development activities should be collected from community-based initiatives records and local records. This will indicate how much effort is being made for improving health, education, women's development, youth uplift and social welfare. Information regarding the number and nature of economic development and income generation-activities, the number of beneficiaries, total loans granted by community-based initiatives, the total loans recovered from the beneficiaries and the number of cases who are not repaying the loan and have been declared in default should be essential components of the supervisory report and can be verified from programme records. The community-based initiatives' financial records should be carefully checked and verified from the documents/records. It should also be verified that bank accounts for the principle amount and revolving fund, including the community development fund, have been opened and are being operated appropriately, the cash book has been prepared and updated regularly, and the loan returns are collected efficiently and deposited in the revolving fund on a regular basis without any delay.

EVIDENCE-BASED MONITORING AND SUPERVISORING

Area: _____ **Visit date: _____**
District: _____ **Visited by: _____**
Province: _____ **Signature: _____**

Questions	Status		Remarks
	Yes	**No**	
Community organization and mobilization			
1. Are the members of community development committees (CDCs) involved in needs assessment, programme implementation and management?			How? Make sure the CDCs are recording the evidence
2. Are the CDCs/cluster representatives (CRs) addressing all socioeconomic needs of the community?			Check the analysis of baseline survey and ongoing social and income-generating projects
3. Were any refresher courses organized for the CRs and CDCs, during the past six months?			If yes, identify date
4. Is there any evidence that supports involvement of other members of the community in developmental activities, particularly health, nutrition, sanitation and education, e.g., trained health volunteers and defined tasks, formation of community-based sanitary committee?			
5. Is there any sustainable working relation between, youth, women groups, CDCs, CRs, health workers and CBI team/TST?			How does it work? Clarify the process
Intersectoral collaboration and partnership			
6. Are all major development sectors[1] notified their representatives as members of the technical support team (TST)?			See availability of notifications in community records and note those sectors not yet notified
7. Is the meeting of CDC and TST scheduled for the next 3 months and members are informed?			See availability of invitations
8. Is there any scheduled plan for CBI team members indicating future three months' activities?			See documented plans for next three months (who will do what and when?)

[1] Major sectors are: health, education, agriculture, social welfare, local government, public health.

Questions	Status		Remarks
	Yes	**No**	
9. Are CBI team members capable to provide technical support to projects? Are the CDCs satisfied in this respect?			Discuss with CDCs, check inputs of TST, how often they visit the projects and how is effective their guidance and support?
10. Is the district steering committee for CBI formed?			Date? No of meetings?
11. Are there any other NGOs/partners in CBI implementation?			Who?/How do they contribute?
Social and income generating projects			
12. List of all social and income generating projects are available with the programme manager and CDCs?			See the list, select some of them randomly and visit
13. Are the women's vocational and literacy centres functional in the CBI area?			Visit some of the centres, make sure trainees are satisfied and training is based on their needs
14. Is any action taken by the CBI team on strengthening health, nutrition and environmental health status? (refer to records)			Discus with CDC and TST and monitor some of the planned interventions
15. Does the community has easy access to primary health care services such as growth monitoring, EPI, antenatal care, safe delivery, family planning services, nutrition advice, preventive measures for communicable and noncommunicable diseases?			With the help of health workers calculate some of the health indicators, e.g., EPI coverage in under 1% of pregnant women received antenatal care, % of children under three who areweighed regularly
16. Any workable relation between the health team and CDCs/CRs?			Note availability of any minutes of meeting or joint health support activities
17. Is there any documented list of beneficiaries from income generating loans available?			Check it with TST as well as at CDC level
18. Is the financial status of revolving fund and community development fund (CDF) documented regularly?			By going through the financial records is it clear to you, that how much has received during last one year, how much has disbursed and how much is in the balance?

Questions	Status		Remarks
	Yes	**No**	
19. Are the CDCs informed regularly of the status of the revolving funds, CDF and status of the defaulters?			When/how? Is there any evidence for sharing such information? Is there any mechanism to inform entire members of the community on the financial status of the programme?
20. Are the defaulters listed?			See the list and its availability with the CDCs and CRs
21. What actions has been taken against defaulters?			Check some of the actions being taken by CRs and CDCs
22. Was it effective?			
23. What is the percentage of loan recovery?			Can it be calculated by going through the financial reports?
24. Is the programme expanded to any other places/areas during the past year?			Where? Mention the name and population coverage
25. Was there any new investment on social projects, since last one year?			Name the new projects and number of beneficiaries
26. Was there any new investment on income-generating projects during the past year?			Name the new projects and number of beneficiaries
27. Did any developmental activities function through CDF?			What/how?
28. Are the CRs and CDCs involved in loan recovery?			How? Is there any report or evidence available?
29. Is there any development plan for the next year?			Check documents and see where the plan has been routed and what was the output and response from the competent authorities

Part B
Module 4
Unit 4.7

Financial management

Learning objectives

To gain a better understanding of:

- community financing
- the financial management tools used in community-based initiatives

Expected outcome

The participants will fully understand the community-based initiatives financial system. They will also be able to manage the finances in programme areas in a transparent and efficient manner by using these tools

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1. INTRODUCTION

Financing is concerned with the mobilization of monetary resources in order to support programme implementation and management. Community financing is related to management of financial resources at community level, ensuring their appropriate use in a cost-effective manner for local development. The community plays a proactive role in managing community finances and mobilizing resources and support from different stakeholders.

The following issues are related to community financing:

1. objectives of community financing
2. determining the role of the community
3. mobilization of resources
4. linkages with other financing systems
5. uses of community finances
6. training and capacity-building
7. management system
8. supervision and monitoring
9. documentation of relevant information from donors, UN agencies, nongovernmental organizations and the government.

1. Objectives of community financing

Community financing is aimed at making the community self-sufficient and self-reliant in financing its activities in addition to promoting self-sustained development. It also promotes economic development and poverty reduction by supporting microcredits and financing schemes for the underprivileged and poorest segments of the community in order to empower them and enable them to value and protect their health and productivity.

2. Determining the role of the community

The role of community members is of key significance in establishing a sound community financing system. The obligations, responsibilities and roles should be clearly defined and communicated to all concerned. The formation of a finance committee can make the system more accountable and transparent and will develop confidence in all partners.

3. Mobilization of resources

Community finances can be mobilized from different sources and community members may identify a variety of options.

Possible sources for community finances are:

- revolving funds raised from return of loans to income-generation schemes
- profit-sharing, service fees or user charges, such as the community development fund
- marketing of products, sale of tickets and local bonds
- festivals, competitions, variety shows and tournaments
- donations and contributions from donors, UN agencies, nongovernmental organizations, government sources.

4. Linkages with other financing systems

The community and community-based initiatives management can work together to explore such resources and develop close linkages with the most relevant schemes. The external sources may be government sources, social security, banks, industrial units, private service providers, etc.

5. Uses of community finances

The use of community finances requires very careful decision-making and should always be based on agreed principles and according to the stated plan of action. They are used to support community development activities, pro-poor actions, welfare initiatives, in addition to ensure programme sustainability at community level.

6. Training and capacity-building

The community is not likely to know about the technicalities involved in the management of finances. Therefore it is the obligation of the programme manager to provide training and to build up their capacities in this respect.

7. Management system

Community financing should have a sound management system. Community-based initiatives guidelines and tools provide a well defined system for managing finances. Communities may modify and adapt these tools according to their needs and requirements.

8. Supervision and monitoring

Managing the finances is always a very sensitive issue; therefore it needs very close monitoring and continued supervision. The community organization should take a lead role and ensure that the activities of the finance committee are not isolated and have an effective checks and balances system.

9. Documentation of relevant information

The use of funds should be regularly documented and accounted for. Regular reports and statements are part of the accountability system and should be open for everybody for checking and verification.

2. FINANCIAL MANAGEMENT IN COMMUNITY-BASED INITIATIVES AREAS

Financial management in community-based initiatives is intended to keep the process completely transparent and to use resources in an efficient manner.

In community-based initiatives, the ministry of health and sponsoring partners jointly approve the project proposals and issue funds for their implementation. The community development committee implement the projects under close supervision of the programme manager and the intersectoral technical support team.

Objectives of financial management in community-based initiatives

- Maintaining financial records adequately
- Updating financial figures for ready reference
- Transparency; prevention
- of malpractice
- Providing appropriate checks and balances
- Informing all members of community on a regular basis about the financial status of the programme

2.1 Guidelines for financial management

The following are the key guidelines for financial management.

- The financial control system should be clearly defined and transparent.

- Maintaining the accounts in community-based initiatives areas should be a key obligation of the technical support team and project manager.

- The community should nominate a member of the community development committee for financial management. He/she should collect repayments, keep records and maintain the community ledger for each beneficiary. This will help the beneficiaries to maintain ready records and built confidence in community-based initiatives. (The delegation of financial management to the community empowers them.)

- The technical support team should also keep a record of loan returns and their deposit in the bank. They should also maintain a master ledger register, thus having a village-wide record of loan returns of every beneficiary.

- Records of the revolving fund, principal account, operational expenditure and an inventory should be maintained at local level and must be a part of the regular reports.

- The reports of financial implications and loan returns should facilitate programme management.

- An annual or periodic audit of programme funds should be carried out and its results should be reported in the progress reports.

- Cost–benefit studies for income-generation projects should also be carried out periodically to evaluate programme efficiency, achievements and effectiveness.

The financial management in community-based initiatives involves:

- a principal fund account
- a revolving fund account
- a community development fund.

It is advisable to use the same accounts for all financial input regardless of their source of contribution.

Principal fund account

The principal fund account comprises the finances released for specific social and income-generation projects from the supporting agencies, such as WHO. These funds should be kept in bank accounts separate from other accounts, and proper record of their issue and disbursement should be maintained.

A principal fund account should ideally be opened separately for each area. The representative of the community development committee along with the head of the technical support team should manage this account jointly. The funds should be deposited in this account for a short transitory period, as these should be disbursed to the target beneficiaries soon after the verification of viability and feasibility for each social and income-generation project and in accordance with the area development plan. The funds should be given through a contract signed between the beneficiary/beneficiaries and the community development committee.

The intersectoral technical support team at local level and the community development committee should ensure the implementation of the following procedures while processing cases for loans.

- The funds should be invested in productive schemes and with recognized beneficiaries, according to the approved proposals.

- An independent assessment of a project's cost should be carried out, ensuring that the terms of the scheme remain cost-effective and transparent.

- The share to be contributed by the beneficiaries should be readily available.

- The beneficiaries should procure the project items and implement the schemes.

- The beneficiaries should agree with community development committee and intersectoral team the amount of the loan instalments to be recovered regularly, after the grace period, and on the timing of these reimbursements.

- The community development committee should guarantee and supervise the progress of the implementation and process of loan settlement.

- As part of the community-based initiatives training and capacity-building process, the people responsible for managing accounts at all levels should be trained on the community-based initiatives guidelines and tools.

Revolving fund account

The revolving fund is the money collected through repayment of loans, community development fund contributions and other resources generated at the community level. The revolving fund aims at self-reliance through mobilization of resources and community management. It also assists in maintaining the sustainability of the community-based initiatives areas after the initial support (seed money) from the supporting agencies. The beneficiaries repay the loans according to the schedules agreed and quoted in the project proposals. The instalments are usually calculated based on the total amount of the loan, the expected project period and the financial outcomes of any particular project. The loan repayments are collected by the community development committee with the assistance of the cluster representative concerned and deposited in a revolving fund account, managed by the community development committee in collaboration with the technical support team.

This account is operated with dual signatures—both that of the community representative (mutually agreed by the community) or finance secretary of the community development committee and that of the project manager. Its records are maintained at local level. The monthly statement contains information about collection, deposits in the bank and its use for approved activities. The bank statements are forwarded with the monthly reports to verify the debits and credits. The revolving fund account is used for reinvestment in new social and/or income-generating projects, thus increasing its amount and the number of beneficiaries.

Community development fund (CDF)

The community development fund is a mechanism for strengthening the sustainability of community-based initiatives and encouraging direct and indirect participatory local development through contributions from and sharing of benefits between community members. The community development fund comprises a part of the profit (5%–10% as

agreed by the community) earned by the beneficiaries on income-generation schemes supported by community-based initiatives.

At the time of approving any income-generation project, the community development committee and technical support team, along with the beneficiary, determine the percentage of this contribution, which will depending upon the nature, feasibility and expected profit of the project. The community development fund is a contribution by the beneficiaries that varies for different projects. If required, the community development committee may consider receiving the contribution in a non-monetary form equivalent to the percentage agreed with the beneficiary.

Some social projects have some revenue, such as fees for provision of safe water, which are monthly fees paid by beneficiaries, and the amount collected is used for covering the operational and maintenance costs. Their surplus amount should be deposited in the community development fund.

The community development fund contribution is deposited into the revolving fund account and maintained locally by the community development committee. The monetary and non-monetary community development fund contributions can be used for supporting community development activities, pro-poor action, welfare initiatives, catastrophic expenditure and operational costs for maintaining the programme at community level.

3. FINANCIAL TOOLS

Loan disbursement voucher (Annex 4.7.1)

A loan disbursement voucher should be completed while issuing the loan to the beneficiary. It should be prepared in triplicate, each with original signatures. One copy should be issued to the beneficiary, one to the community development committee and one for community-based initiatives records. Photocopies should be sent to the supporting partners.

Loan return card (Annex 4.7.2)

A loan return card should be issued to each beneficiary immediately after the start of income-generation project and this will remain with the beneficiary. Every time he/she deposits an instalment, the community development committee should update the loan return card and return it to the beneficiary.

Loan returns register (Annex 4.7.3)

This is identical to the loan return card and should be maintained by the community development committee at local level. One page should be reserved for each beneficiary. When the beneficiary pays a loan instalment, the entries should be made simultaneously on the loan return card as well as in the loan return register. This register will serve as the main tool for the preparation of monthly and quarterly reports for loan returns, revolving fund and community development fund .

Loan return voucher (Annex 4.7.4):

When the beneficiaries repay a loan instalment, in addition to making appropriate entries on the loan return card, the community development committee should issue a voucher to the beneficiary for the loan repayment. This loan return voucher should be prepared in triplicate, one copy for each of the following: beneficiary, community development committee receipt book and community-based initiatives record. This is an additional check to confirm accounting of returned loans.

Financial ledger (Annex 4.7.5):

This ledger should be used by the intersectoral team for all transactions made at all levels. It should contain information regarding payments and receipts of all kinds. The monthly bank statement should be reconciled with the entries in the ledger.

Loan returns status report (Annex 4.7.6):

In order to keep the higher offices informed about the status of loan recovery, a quarterly village/locality loan return status report should be prepared and disseminated to the supervisory office and community members. This should be consistent with the loan return registers.

4. GROUP WORK

Process

On the evening preceding the respective working session, participants should read the materials required for the respective group work. The group work should be conducted as follows.

- Participants should be divided into equal groups, each not exceeding eight members.
- Each group should select its own chairperson and presenter. (These responsibilities should be rotated during each group work assignment.)
- The chairperson should watch the time and encourage every group member to participate.
- The presenter should present the findings/report of the working group in the plenary session.
- Facilitators should help the participants as resource persons and give feedback on the group presentations.

Assignment

During the working session, groups should read, discuss and understand the contents of the financial management tools (Annexes 4.7.1 to 4.7.6)

Annex 4.7.1

LOAN DISBURSEMENT VOUCHER

At the time of project implementation, the loan issued to the beneficiary should be documented on the loan disbursement voucher. This voucher should be prepared in triplicate, each with an original signature, one to be issued to the beneficiary, one for the community development committee and one for community-based initiatives records.

Instructions for use

Voucher number

Every beneficiary should be allocated a number according to the sequence of the project. This should be used as the project number as well as the voucher number.

Project title

The project name for which the loan is to be disbursed should be in accordance with the approved project proposal.

Beneficiary's name

The full name of the beneficiary along with the name of his/her father/husband should be recorded.

Address

The complete residential address of the beneficiary should be recorded, including the house number, street number or name, locality and district. If the permanent address is different from the present address, both should be recorded

Loan amount

The loan amount should be recorded in the local currency, in figures and in words.

Loan disbursement detail

The loan issue date is the date on which the loan is disbursed to the beneficiary. If the loan is disbursed through a bank, the name of the bank and the number of the cheque should be entered on the voucher.

Signatures

The beneficiary should sign the voucher on receiving payment. The chairman of the community development committee and the community-based initiatives project manager should also sign to verify payment.

LOAN DISBURSEMENT VOUCHER

Voucher number _____

Project title			
Beneficiary's name			
Address			
Loan amount	**In figures**	**In words**	
Loan disbursement date	**Cheque number**	**Name of bank**	
Signatures			
Beneficiary	**Chairman: community development committee**	**Programme manager**	

Annex 4.7.2

LOAN RETURN CARD

Immediately after the implementation of an income-generation project, the beneficiary should be issued a loan return card that will remain with the beneficiary permanently. Every time the beneficiary repays an instalment, he/she should bring the loan return card for updating. This card will be in addition to the issue of the loan return voucher, as presented in Annex 4.7.4. An identical loan return register, as given in Annex 4.7.3 should be maintained by the community development committee. On each payment, both of these should be filled in identically and signed by the community development committee representative.

Project number

Each beneficiary should be issued a project number that is in sequence according to the date of disbursement of the loan/implementation of the project.

Project title

The title of the project and the name of the beneficiary should be the same as mentioned in the approved project proposal and the loan disbursement voucher.

Location

The place where the project has been carried out should be indicated with all its particulars.

Name of beneficiary

This should be in accordance with the project proposal and the loan disbursement voucher. In case of transfer of the project to another beneficiary, proper approval should be obtained and legal procedures should be carried out accordingly.

Loan issue date

This will be the date on which the loan will be disbursed. This will be helpful for the calculation of lag period and project maturity date.

Project period

The project period indicates the time period within which the beneficiary is expected to pay back the whole loan amount. This should be in accordance with the project proposal.

Loan amount

The loan amount should be entered both in figures and words.

Repayment schedule

The loan return instalments and their number along with the repayment period should be stated. This should be in accordance with the schedule agreed in the project proposal. The monthly instalments for repayment of the loan should be calculated according to the project period and the nature of the project, and should be clearly mentioned in the card so that the beneficiary knows the amount due in each month. In most cases, the instalments will be equal for every month, but in some cases they may vary. In all cases, the repayment schedule should be unambiguous.

Contribution to community development fund

The contribution of the project towards the community development fund should be agreed on and documented.

Community development fund contribution scheme

This will indicate how the beneficiary will deposit amounts to the community development fund. The instalments for contribution to the fund should be calculated according to the rate fixed and agreed between the beneficiary and the community. The payment schedule should be clearly stated so that the beneficiary knows the amount due each month. The payment of the instalments may be equal for every month, or may be paid in a few instalments.

Date

The date on which the beneficiary deposits the instalment for loan repayment and the community development fund should be written down. It should be recorded as day/month/year.

Repayment of principal loan

On the deposit of each instalment, entries should be made in the relevant columns. This should be in the same currency as the loan amount is described, normally the national currency. If the instalment repayment amount is less than the amount due in the month, the outstanding amount should be received the next month. In the case of delay in repayments, the community development committee and technical support team should discuss with the beneficiary the reasons for the delay and use all local means to prevent delays.

Total loan retuned

Total loan returned indicates the total amount repaid so far. At the time of deposit of each instalment, calculations should be made by adding the all instalments paid so far and entered in the relevant column. In other words, it will be the sum of the total payments made up to the previous month plus the current repayment.

Loan balance

The loan balance will be the amount yet to be paid by the beneficiary after deposit of the current instalment. It should be calculated by deducting the current instalment from the previous month's balance. It will be equal to the total loan amount minus the total loan returned.

Payment to the community development fund

The amount paid by the beneficiary to the community development fund should be recorded each month. Similarly, if the due amount is not paid in full, it should be reflected and adequate corrective measures should be taken to prevent recurrence.

Total community development fund paid

The total community development fund should be calculated and entered in the relevant column. It will be the sum of the total payments made up to the previous month plus the current payment.

Community development fund balance

The balance of the community development fund should be calculated by deducting the current instalment from the previous month's balance. It will be equal to the total community development fund minus the total paid into the community development fund.

Name and signature of recipient

The community development committee member assigned the duty of financial management and the receipt of loan instalments should sign the card as and when he/she receives the instalment. He/she should also record his name to clearly indicate who has received the instalment.

LOAN RETURN CARD

Project number		**Project title**		**Location**		**Beneficiary**	

Loan amount		**Loan return scheme**		**Contribution to community development fund**		**Community development fund deposit scheme**	

Date of deposit	**Repayment of loan**				**Contribution to community development fund**				**Name and signature of recipient**
	Instalment amount		**Total loan returned**	**Loan balance**	**Instalment amount**		**Total community development fund deposited**	**Community development fund balance**	
	Due	**Received**			**Due**	**Received**			

Annex 4.7.3

LOAN RETURN REGISTER

This register has identical columns and rows to the loan return card. It should be maintained by the community development committee at the locality level. Separate page should be reserved for each beneficiary. When the beneficiary pays the loan instalment, the entries should be made simultaneously on the loan return card as well as in the loan return register, following the instructions for Annex 4.7.2. Similar register may be maintained by the technical support team at area level. This register will serve as the main tool for the preparation of quarterly reports for loan returns and community development fund.

Project number		**Project title**		**Location**		**Beneficiary**	

Loan amount		**Loan return scheme**		**Contribution to community development fund**		**community development fund deposit scheme**	

Date of deposit	**Repayment of loan**				**Contribution to community development fund**				**Name and signature of recipient**
	Instalment amount		**Total loan returned**	**Loan balance**	**Instalment amount**		**Total community development fund deposited**	**Community development fund balance**	
	Due	**Received**			**Due**	**Received**			

Annex 4.7.4

LOAN RETURN VOUCHER

On deposit of the loan and community development fund instalments, the community development committee should issue a loan return voucher to the beneficiary for the payment. This will be in addition to the updating of the loan return card. It should be prepared in triplicate, one copy for beneficiary, one for community-based initiatives records and one for the community development committee, which will remain in the book.

Locality and district

This is essential to identify from which area the voucher is issued.

Date

This will be the date of making payment and issue of voucher.

Serial number

The serial number should be in order of sequence and the numbers should be printed on each leaflet of the voucher book.

Name of beneficiary

The name of the beneficiary and project title should be identical to that entered on the loan return card.

Project title

The name of the project should be same as mentioned in the project proposal.

Project number

The number of the loan return card issued to each beneficiary should be recorded.

Instalment for period

The period for which the instalment is being paid should be recorded.

Received amount

The amount of the loan instalment and the service charges should be entered in figures and words.

Signatures of payee and receiver

The receipt should bear the name and signatures of the community development committee member receiving the instalment as well as the person paying the instalment.

LOAN RETURN VOUCHER

Location _____ **District _____**

Date		**Serial number.**
Name of beneficiary		
Project title		
Project number		
Instalment for period: ***(indicate month and year)***		
Amount received	***In figures***	***In words***
Loan instalment		
Service charges/ community development fund		
Payer(s) **Name and signature(s)**		***Receiver*** **Name and signature**

Annex 4.7.5

FINANCIAL LEDGER

The ledger should be used by the technical support team for all transactions made at area level. The monthly bank statement should be compared with the entries in the ledger.

Programme area

The name of the community-based initiatives area or locality of the community-based initiatives office should be entered, indicating the location.

Month/year

The month and year should be entered on every page. At the start of every month, a new page should be started.

Currency

The currency in which all the transactions are made and recorded is usually the local currency.

Page number

Every page should be marked with number that should be continuous in sequence.

Brought forward

The amount of the balance should be brought forward from the previous page.

Serial number

The serial number is a sequential number for every entry/transaction and may be managed by month or by year.

Date

The actual date of each transaction, payment or receipt should be entered in the order of the activities.

Description

The detail of the transaction should be entered, such as payment, receipt, expenditure, bank deposit or bank withdrawal.

Reference

The reference column should reflect the purpose of the transaction and its approval. The references of the obligation, allotment and authorization should also be given for the transactions, if available. The number of the voucher for payment or receipt, loan return card and bank cheque involved in the transaction should be entered here.

Cash

The cash section is for recording the transactions made in cash and has three sub-columns:

- **received**: payments received in cash from any source
- **paid**: payments made in cash to anybody
- **balance**: cash available after this transaction. This comprises the previous balance minus the amount of this cash payment made or plus this payment received.

Bank account

The bank account section is for indicating transactions made through the bank and has three subcolumns:

- **credit**: amount credited to the bank account by cheque or deposit
- **debit**: amount withdrawn from the bank account by cheque
- **balance**: amount in the bank account after this transaction. This will be equal to the previous balance plus the money deposited or minus the money withdrawn.

Signature of authority

The authorized person(s) should verify the entries and append his signature on it.

FINANCIAL LEDGER

Project area/office		Month/year		Currency		Page number	

Particulars				Cash			Bank account			Signature(s) of authority
Serial number	Date	Description	Reference (authority, voucher/ receipt/loan card/bank cheque number)	Received	Paid	Balance	Credit	Debit	Balance	
Brought forward (total from previous page)										
Total (take forward to next page)										

Annex 4.7.6

LOAN RETURN STATUS REPORT

In order to keep the higher offices informed about the loan recovery status, quarterly loan return statements should be submitted. This report should be prepared separately for each locality and then be consolidated at area level.

Locality, community-based initiatives area and district

The name of the locality, programme area and district will help in identification of the report.

Period

This will reflect the reporting period.

Project number

As the report will have details of individual projects, the specific number allocated to each project should be mentioned. Preferably the report should be prepared in order of sequence.

Project and beneficiary

The title of the project and the name of the beneficiary should be mentioned as recorded in the project and loan return registers.

Loan issue date

This will be the date on which loan was disbursed to the beneficiary.

Total project period

This will be the period of the project as determined in the project proposal. The beneficiary is expected to return all loans in this period.

Lag period

This will be the grace period to the beneficiary before starting deposit of loan instalments. The instalments should be calculated by deducting this period from the total project period. The beneficiary is expected to start depositing the instalments after the lag period.

Principal loan

Under the section on principal loan, the following subcolumns should be filled:

- **total loan amount**: the amount of the loan issued to the beneficiary
- **due**: the amount of loan which is expected to be repaid at the reporting time
- **returned**: the total amount of loan repaid by the beneficiary at the reporting date
- **balance**: the amount of loan outstanding. This can be calculated as: loan amount granted minus the amount repaid so far.

Community development fund

In the section on community development fund, the information should include:

- **total**: the contribution to the community development fund calculated according to the agreed rate
- **due**: the community development fund contribution expected to be deposited at the reporting date
- **paid**: the total community development fund contribution the beneficiary has paid during the reporting period
- **balance:** the total community development fund contribution outstanding will be the difference between the total community development fund contribution to be paid and the payment made so far.

QUARTERLY LOAN RETURN STATUS REPORT

Locality _____ CBI area _____ District _____

Period: From _____ To _____

Project number	Project	Beneficiary	Loan issue date	Total project period	Lag period	Principal loan				Community development fund			
						Total loan amount	Due	Returned	Balance	Total	Due	Paid	Balance

Part B
Module 4
Unit 4.8

Documentation and reporting

Learning objectives

To gain a better understanding of:

- **documentation and reporting systems**
- **tools for documentation and reporting systems for community-based initiatives areas**

Expected outcome

The participants will fully understand the documentation and reporting procedures for community-based initiatives and will be able to establish such a system in the programme areas

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1. DOCUMENTATION AND REPORTING IN COMMUNITY-BASED INITIATIVES

Documenting community-based initiatives activities and reporting of results and achievements are of great significance in knowing the progress and current status of programmes. It is essential to collect the information on a regular basis and document the outcomes to provide an evidence base for the process. This practice promotes harmony, better understanding, trust and confidence. It also helps in future planning and maximizing the use of resources. It is a continuous process requiring patience, commitment and sense of responsibility.

All documents and information collected at community level (area profile, area development plans, projects records, financial records, etc.) should be updated regularly by the community development committee and cluster representatives with support of technical support team and should be communicated to the community in addition to higher offices and related sectors. Key information should be placed at a known place in the community-based initiatives area, accessible to the community. The information display should be preferably at the health centre or the place used for the regular meetings of the community development committee and cluster representatives and the joint meetings with technical support team.

The objectives of documentation and reporting systems in community-based initiatives are to:

- document and preserve data
- disseminate relevant information to the offices/partners concerned/community
- keep records of all vital events and activities
- ensure a simple and comprehensive reporting system
- involve all levels in the reporting system and the dissemination of information
- use documentation and reports for maintaining programme efficiency and effectiveness
- use documented information for programme advocacy and promotion.

The documentation should be maintained at local level by the technical support team, programme manger and the community. The formats and tools related to documentation and reporting should be adapted locally in the light of the local situation and requirements. It should be noted that the documentation and reporting system in phase 2 of community-based initiatives (expansion phase) will be identical to that of phase 1 (pilot phase), with the addition of intermediate tiers.

Guidelines for information sharing

- The community should maintain an area development profile indicating the results of the baseline survey, priority needs and plan of action. This will be the basis for future action and evaluating outcomes.

- The project records should be available at country level/district level as well as at the project area level. These records will help in compiling monthly, quarterly and annual reports.

- The outcomes of the projects and other valuable information should be shared with other stakeholders and community groups.

- The flow of information can be maintained through the participation of the technical support team in the meetings of the community development committee and regular home visits by cluster representatives.

- A local newsletter or a display board placed at a central place in the locality can be an effective tool for sharing information with the community.

- During the expansion phase, a pattern for information collection, processing and documentation similar to that of the model areas should be practised at local level.

2. SALIENT FEATURES OF DOCUMENTATION AND REPORTING TOOLS

Meeting register

The community development committee should keep a record of the meetings in a register after adaptation of the format given in Annex 4.8.1. The records of the regular community meetings, including the issues discussed, decisions made and follow-up action to be taken, should be documented in addition to a list of attendance and other relevant particulars. This register will facilitate efficient management of community-based initiatives by the community, and interaction between the technical support team and the community. The community development committee should make a summary from the meeting register and submit it regularly to the technical support team. Similar registers should be maintained by the technical support team for its internal meetings.

Project register

The project register, given in Annex 4.8.2, should contain the basic information about the implemented projects and programme activities. In order to maintain the separate records of all localities in an area, separate registers can be prepared.

Report by technical support team

Intersectoral technical support team members should submit regular reports to programme management in the format given in Annex 4.8.3. They should also keep their departments informed about their activities in the community-based initiatives area.

Quarterly report of community-based initiatives area

The programme manager should prepare and disseminate a quarterly report from the community-based initiatives area to higher offices, adapting Annex 4.8.4. Detailed information of the programme activities and events should be enclosed with the report.

Annual report

The annual report should be based on the consolidated information and the outcomes of the programme activities. The format in Annex 4.8.5 should be adapted and used for preparing the final report. Ideally, a representative sample study should be conducted in the community-based initiatives area to prepare an evidence-based report.

3. GROUP WORK

Process

On the evening preceding the respective working session, participants should read the materials required for the respective group work. The group work should be conducted as follows.

- Participants should be divided into equal groups, each not exceeding eight members.
- Each group should select its own chairperson and presenter. (These responsibilities should be rotated during each group work assignment.)
- The chairperson should watch the time and encourage every group member to participate.
- The presenter should present the findings/report of the working group in the plenary session.
- Facilitators should help the participants as resource persons and give feedback on the group presentations.

Assignment

Keeping in view the programme needs, groups should adapt Annex 4.8.4 to prepare a uniform and feasible format for monthly report from the programme areas.

Annex 4.8.1

MEETING REGISTER

Meeting registers should be maintained at all levels and used as tools for efficient management of the programme. The community development committee should particularly maintain the meeting register, which should be updated after every meeting. This register will indicate meetings of the community as well as their interaction with the technical support team. A similar register at local level should be maintained that will demonstrate the vigilance and performance of the technical support team and the programme manager. A separate page should be used for each meeting, documenting them in order of their occurrence.

Instructions for use

Locality/community-based initiatives area

This will show the venue and the area to which participants belong.

Date

The date on which meeting occurred should be recorded, including month and year.

Agenda

The agenda of the meeting should indicate the issues and points that were discussed.

Attendance

The list of the people who attended the meeting should be included, with their names and designations.

Follow-up of previous meetings

In every meeting, a follow-up of the previous decisions should be made and the results documented.

Decisions for current meeting

Decision made during the current meeting, including proposals and suggestions, should be recorded in a comprehensive manner. This will be the baseline for further activities and will be evaluated in the next meeting.

Date for next meeting

The date for next meeting should be fixed in every meeting. This provides a target date for implementing the decisions of present meeting. Participants should be informed in advance regarding the date, time and venue of the next meeting and its main purposes.

MEETING REGISTER

Locality/CBI area _____ Date _____

Agenda
Attendance

Follow-up of previous meeting
Decisions of present meeting
Date, time and venue of next meeting

Annex 4.8.2

PROJECT REGISTER

The project register contains basic data regarding the projects implemented, which are documented in order of their occurrence. The register may be divided into sections, one for each locality.

Instructions for use

Locality/community-based initiatives area and period

The name of the area should be indicated along with the time period of the recorded information.

Project number

Each project should be allocated a number. The numbering should be in sequence, according to the implementation date of the project and disbursement of the loan.

Project

The project title, as indicated in the project proposal and loan disbursement voucher. The project type must be indicated.

Beneficiary

The name of the beneficiary should be as written in the project proposal and loan disbursement voucher.

Date of approval

The date of the approval of the project by the competent authority should be noted. If there is any reference number for the approval, that should also be noted.

Date of loan disbursement

The date on which the loan was disbursed to the beneficiary is important for future reference. This will also be of use in determining the date for loan return and the maturity period of the project.

Project duration

The project duration should be as mentioned in the project proposal and will again be of use in the determination of the project maturity date.

Project cost

This should reflect the actual principal cost incurred on the project at the time of implementation, such as the purchase of items for establishment of the project. This cost will include the loan amount as well as the community share contributed in the project implementation. The sum of the loan amount and community share should be equal to the total cost of the project.

PROJECT REGISTER

Locality/CBI area _____ Period _____

Serial number	Project	Beneficiary	Date of approval	Date of loan disbursement	Project duration	Principal cost		
						Total	Community share	Loan amount

Annex 4.8.3

TECHNICAL SUPPORT TEAM MONTHLY REPORT

The members of technical support team should submit monthly reports, providing details of the activities scheduled, actions taken and their outcome/achievements.

Instructions for use

Month

This is the reporting month and the year.

Team member

Names of the team members, with their designations.

Department

The sector to which the team member belongs.

Community-based initiatives area

Name of the community-based initiatives area, so that supervisory offices are able to arrange reports coming from various areas.

Date

The date on which the visit was made.

Locality

The name of the locality which the team member visited and performed activities.

Planned activities

The activities which were planned and scheduled for that day and the locality concerned.

Activities performed

The activities carried out by the team members should be recorded in a comprehensive manner and classified in the appropriate column. Community mobilization will include activities related to community organization, meetings, training and awareness-raising sessions. The monitoring and supervision of the projects will relate to the implementation and

follow-up of the income-generation and social projects. The column for loan recoveries will indicate the loan repayments collected and follow-up of defaulting cases.

Remarks

Any additional information or specific comments may be recorded in this column.

Signatures by team member

The team member should affix his/her signature and submit the report to the programme manager.

Remarks by programme manager

The programme manager will append his/her comments and forward the report to the supervisory office and retain a copy for the community-based initiatives record.

MONTHLY REPORT BY TECHNICAL SUPPORT TEAM MEMBERS

Month_____ Year _____

Team member _____ Department _____

CBI area _____ Date _____ District _____

Date	Locality	Planned activities	Outcome			Remarks
			Community mobilization	Monitoring and supervision	Loan recovery	

Remarks by programme manager

Signature _____
(Technical support team member)

Annex 4.8.4

QUARTERLY REPORT OF COMMUNITY-BASED INITIATIVES AREA

The programme manager will submit a report on the community-based initiatives activities and results on a quarterly basis to his supervisory office. This reporting system for the local level will remain almost identical during both phases of implementation; however the format can be modified according to local requirements and situations.

Instructions for use

A detailed report of the activities referred to and any additional information should be enclosed with this form.

Community-based initiatives area and district

The name of the area and district will help to identify the reports in the supervisory office.

Period

The first and last dates of the reporting period should be indicated, including the month and year.

Localities having CBI

Localities where community-based initiatives activities started before the reporting period will come under the heading *Old*, while localities where community-based initiatives were introduced during the reporting period will come under *New*.

Income-generation projects

The number of income-generation projects, for all localities, implemented during this period and the projects which were already implemented will be noted separately.

Health and social projects

The number of health and social projects started during the reporting period and those already implemented should be mentioned in the relevant columns.

Financial statement

Categories

This will include the principal funds issued by the sponsoring agencies for the implementation of projects, revolving fund generated from loan recoveries and the community development fund raised from profit-sharing.

Balance for previous period

This is the amount in each account/fund before the start of the reporting period.

Amount received during this period

The amount received for all categories during the reporting period.

Total

This is the sum of the amount received during the reporting period and the balance from the previous period.

Funds used

This will indicate the use of funds during the report period. This includes loans for income-generation projects, grants for projects and activities, operational costs and the total.

Balanced amount

The amount is calculated after the deduction of used funds from the total available funds during the period. The cash and bank balance will help in determining the exact figures.

Loans and their recovery

Total loan

This is the total amount of loan issued to beneficiaries from both sources by the end of the reporting period.

Loan recovery

This reflects the total amount recovered from beneficiaries till the end of the reporting period.

Total income-generation projects

This is the total number of income-generation projects up to the end of the reporting period.

Projects matured

The matured projects are the projects which have completed the project period according to the project proposals.

Completed loan recovery

This indicates the number of projects where loan recovery has been completed.

Undergoing regular recovery

The projects not yet matured, and recovery is proceeding on a regular basis.

Delayed recovery

The recovery is proceeding but is delayed according to the repayment scheme detailed in the proposal.

Defaulted

The number of cases which have stopped repayment of loans for more than a period of three months and have not obtained formal permission for rescheduling instalments. There is no expectation of loan recovery in the normal situation, and extraordinary measures are required.

Meetings, training, and supervisory visits

Meetings

The number of the meetings held during the reporting period, including both those of the community-based initiatives team and the community.

Training

Training activities carried out during this period, indicating their type.

Supervisory visits

Visits by the supervisory officers, indicating the date and name of the visitor with his designation.

QUARTERLY REPORT OF COMMUNITY-BASED INITIATIVES AREA

CBI area _____ District _____ Period _____

CBI projects and coverage

Localities having CBI		Income generation projects		Health and social projects	
Old	**New**	**Implemented during this period**	**Previous**	**Implemented during this period**	**Previous**

Financial statement

Category	Balance from previous period (1)	Received during this period (2)	Total (1+2)	Use of funds during this period				Balanced funds		
				Loan	Grants	Opera-tional cost	Total	Cash	Bank	Total
Principal funds										
Revolving fund										
Community develop-ment fund										
Total										

Loans and their recovery

Total loan issued	Recovered loan	Loan recovery status					
		Total income-generation projects	Matured projects	Completed loan recovery	Undergoing regular recovery	Delayed recovery	Defaulted

Meetings training and supervisory visits:					
Meetings (number)		**Training**		**Supervisory visits**	
Technical support team	**Community**	**Number**	**Type**	**Date**	**Visitor's name and designation**
Remarks					

Enclose detailed reports of quoted activities

Signature_____ Date _____
(Programme manager)

Annex 4.8.5

ANNUAL REPORT

This report should be prepared on a yearly basis. The sources of information can be the yearly assessment and community-based initiatives/health records. The annual report should be mainly focused on outcome of the programme activities, which can be assessed through the improvement in the social and economic indicators. In this regard, a small study or assessment survey may be conducted at the end of every year on sample population and the change in the indicators can be compared with the baseline information.

Instructions for use

Note: the technical support team and programme manager should jointly prepare this report.

Community-based initiatives area

Name of the community-based initiatives area with the district/province/governorate where it is situated.

Year

This will be the reporting period, and the data will be collected at the end of the year.

Localities

The name of the localities will be entered in the numbered columns. The last column will be used for total or aggregate information of the community-based initiatives area. For more localities, extra columns may be created.

Baseline and post-community-based initiatives study

The baseline means the information collected in the baseline survey. Month and year of the baseline survey should be indicated. Post-community-based initiatives means the present status after community-based initiatives interventions. The post-community-based initiatives study should be made at least one year after the effective community-based initiatives interventions.

Birth rate

This will be calculated after obtaining the information about the number of births during the past 12 months and the mid-year population of the locality.

Infant deaths

The number of deaths in children under one year of age compared to the number of live births in the same year.

Stillbirths

The number of children stillborn after delivery to full-term pregnant mothers during the past 12 months.

Low birth weight

The percentage of children born during the past 12 months weighing less than 2.5 kilograms (preferably measured within the first hour of life).

Immunization

The immunization status of the children can be assessed from the Expanded Programme on Immunization and community health workers' records as well as the annual survey. This will be expressed as the percentage of children having completed vaccination in consistent with their age.

Pregnant women

The number of women with confirmed pregnancy. Again, the community health workers' records and the survey will be tools for obtaining this information.

Vaccination of pregnant women

The percentage of pregnant women who have completed the tetanus toxoid vaccination.

Maternal deaths

Maternal deaths due to pregnancy, childbirth or within 42 days of delivery/in the locality during the past 12 months. It will be expressed here in numbers and the community health workers' records will also be used to confirm the cases.

Antenatal care

The number of pregnant women receiving antenatal care by trained health workers.

Postnatal care

The number of women who gave birth during the past 12 months and were attended and followed-up by trained health workers.

Family planning

The number of married couples practising family planning during the reporting year.

Health education

The number of health education seminars or awareness meetings held during the year.

Primary school enrolment

The number of school-age boys and girls enrolled in school for formal education during this year.

Adult literacy rate

The number of literate males and females will be obtained from the surveys as well as the records of the literacy centres. The literacy rate will be calculated in relation to the total population.

Skills development

The number of males and females obtaining any skill during the reporting year. The information can be collected from the skills development centres.

Water and sanitation

Safe drinking water

The number of families having easy access to safe drinking water that is available to them throughout the year. This data will be expressed as a percentage.

Sanitation campaigns

The number of sanitation campaigns by the community during the reporting year. The campaigns should be target-oriented and have a definite outcome.

Families using sanitary latrines

The percentage of families using sanitary latrines.

Unemployment rate

The number of community members willing to work but not having job opportunities. The underemployed community members may also be considered as unemployed.

Families living below poverty line

The number of families living below the poverty line should be assessed on investigation of the monthly income of families. Poverty will be measured according to local standards (approximately 1 US$ per person per day).

Enclosure

The annual report should be supported by detailed information about the projects and the key activities in the programme area.

ANNUAL REPORT

CBI area _____ Year _____

Serial number	Indicators	1		2		Total	
		Baseline	Post CBI	Baseline	Post CBI	Baseline	Post CBI
		Year___	Year___	Year___	Year___	Year___	Year___
Health							
1	Birth rate						
2	No. of infant deaths						
3	Stillbirths (number of cases)						
4	Low birth weight (%)						
5	Immunization (%) BCG + Polio 0 DPT +Polio 1 DPT +Polio 2 DPT +Polio 3 Measles						
6	Number of pregnant women						
7	Vaccination of pregnant women (%)						
8	Pregnancy-related maternal deaths (number of cases)						
9	Antenatal care (number of attended case)						
10	Postnatal care (number of attended cases)						
11	Family planning (number of practising couples)						
12	Health education (number of seminars)						

Education, literacy and training							
13	Primary school enrollment: Boys Girls						
14	Adult literacy rate: Male Female						
15	Skill development (number of trainees) Male Females						
Water and sanitation							
16	Families having access to safe drinking water (%)						
17	Sanitation campaigns (number)						
18	Families using sanitary latrines (%)						
Economic status							
19	Unemployment rate						
20	Families living below poverty line (number)						

Enclosed: detailed information about the projects and other relevant activities

Part B
Module 4
Unit 4.9

Advocacy and promotion

Learning objectives

To gain a better understanding of:

- the concept of promotion and advocacy
- advocacy and promotion tools used in community-based initiatives

Expected outcome

The participants will be informed about the most effective methods of advocacy and promotion. They will be able to prepare practical and feasible advocacy plans and promotional materials for community-based initiatives

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2. Promotion and advocacy at national and regional levels 372

1. INTRODUCTION

Advocacy and promotion is a process of educating and convincing community leaders and decision-makers at different levels and the relevant sectors and agencies to accept support and commit themselves to the programme goals. Community-based initiatives are based on social mobilization and therefore implemented through introducing a change in the behaviour of the community and government functionaries. Being a nonconventional approach, community-based initiatives require a great degree of advocacy and promotion for creating a supportive environment and introducing the social changes. Promoting, advocating and marketing community-based initiatives are vital for a successful initiation, expansion and sustainability of the programme. Box 1 shows the objectives of promotion and advocacy in community-based initiatives.

Box 1. Objectives of promotion and advocacy in community-based initiatives

- Motivate political and sectoral authorities in order to obtain their commitment and support
- Establish a core group of decision-makers and community leaders in support of the programme
- Obtain commitment from national and community leaders
- Mobilize sectoral resources for joint ventures
- Create prime movers for programme advocacy and marketing
- Actively involve and mobilize the media
- Encourage the support of traditional leadership at local level
- Make the concept understood at all levels and at all stages of programme development
- Sensitize and mobilize the communities to change their conventional thinking and accept the concepts of self-reliance, self-management and self-sufficiency
- Motivate government functionaries towards partnership with the community

2. GUIDELINES FOR PROMOTION AND ADVOCACY

- Promotional activities for community-based initiatives should be carried out at all levels and target all groups, especially the community, key decision-makers and national/international agencies. The framework given in Annex 4.9.1 can be used for this after local adaptation.

- The strategy of action-based promotion should be adopted by building on the success of the implementation process and its capacity for bringing about desired change in the quality of life of the people.

- It should be helpful in promotion of motivational, educational and multi-media material.

- Methods for community-based initiatives promotion should include seminars, interpersonal communication and discussions with the community, study tours, exchange of expertise and information among the countries and the programme areas, local newsletters and pamphlets, research studies and effective use of print and electronic media.

- Training and orientation sessions should be organized for members of the media to orient them about the community-based initiatives approaches.

- The use of the local language is preferred in developing promotional material and during discussion with the community.

3. PROMOTION AND ADVOCACY AT LOCAL/COMMUNITY LEVEL

At local level, the community is the main target. Community-based initiatives are aimed at producing a positive change in behaviour and attitude and motivating people to accept new ideas. Promotion at local level should be based on the following principles:

- respecting local norms and values

- acting through traditional community leaders

- using the local language

- talking about community needs

- listening carefully to others points of view and experiences

- gaining peoples' confidence and developing credibility.

Box 2 gives a summary list of the target groups, possible channels of promotion and main messages to be delivered at local levels.

Box 2. Local level promotion and advocacy of CBI		
CBI target group	**Possible channel of promotion**	**Main message that can be delivered**
Community development committee and cluster representatives Elected representatives, traditional leaders, opinion-makers and influential and resourceful persons School teachers Religious leaders Women's groups Youth groups Literate people and volunteers Health workers and traditional birth attendants Families Community Field staff of various departments	Public meetings Social gatherings Cultural shows Exhibitions/fairs/festivals/ marches Visits by dignitaries Campaigns Community guide Posters, pamphlets and banners Notice boards Video spots Photographic displays Brochures and local newsletters Channel of promotion Promotional items like calendars, T-shirts, and other giveaways/gifts Training of prime movers and promoters Community awards Demonstration models Games/tournaments Literary competitions School assemblies Places of worship	Health rewards of reducing poverty Quality of life enhanced through integrated development Community empowerment and self-reliance for solving local problems Women's development for family development Literacy and awareness for a better life Education for all Sectoral awareness and appropriate technologies for development Sectoral collaboration at grass-roots level and an integrated problem-solving approach Literacy and skills development for better life Role of religion in health promotion and community development Social welfare Health determinants and role of community in health Disease prevention and promotion of healthy lifestyles Sanitation and environmental health Vaccination of children and mothers Healthy diet and nutrition Family planning

4. PROMOTION AND ADVOCACY AT NATIONAL/REGIONAL LEVEL

Promotion and advocacy at national and intermediate level is important during the planning and implementation of community-based initiatives. The mobilization of resources for the expansion phase also requires intense efforts. The authorities should be oriented and well motivated; potential partners and nongovernmental organizations should be approached, and the media should be mobilized to play a vital role in programme promotion.

The means used for promotion and advocacy will vary from country to country. Whatever methods are adopted should be target-oriented and focused on mobilizing the community and the national stakeholders for the cause.

5. GROUP WORK

Process

On the evening preceding the respective working session, participants should read the materials required for the respective group work. The group work should be conducted as follows.

- participants should be divided into equal groups, each not exceeding eight members
- each group should select its own chairperson and presenter (these responsibilities should be rotated during each group work assignment)
- the chairperson should watch the time and encourage every group member to participate
- the presenter should present the findings/report of the working group in the plenary session
- facilitators should help the participants as resource persons and give feedback on the group presentations.

Assignment

During the working session, groups should prepare a community-based initiatives advocacy plan on one of the following target groups and topics using Annex 9.1.1.

- community leaders, for the introduction of community-based initiatives
- women’s groups, for their support and participation in community-based initiatives
- minister of health and other decision-makers, to approve and allocate resources for the establishment of a community-based initiatives model area in the country
- different ministries and potential partners, for their collaboration and contribution towards community-based initiatives.

Annex 4.9.1

PROMOTION AND ADVOCACY AT LOCAL/COMMUNITY LEVEL

Instructions for use

The target population is the community at local level. The objective is to make changes in their behaviour and attitudes and to motivate them to take responsibility for their own problems in order to improve socioeconomic development and quality of life. A list of the main channels of promotion together with target groups and possible messages is given in Table 1 below.

The promotion and advocacy programmes should be developed according to:

- the needs of the community
- the targets of community-based initiatives
- the availability of resources, both financial and material.

Table 1. Target based community-based initiatives promotion at local/community level

Target group	Channels of promotion	Messages (to be delivered)
Community development committee, cluster representatives Traditional leaders and opinion makers Religious leaders Women leaders Youth groups Literate and influential community members Volunteers	Public meetings Social gatherings Visits by dignitaries	CBI concept and methodology Quality of life through socioeconomic development CBI approach for alleviation of poverty Disease prevention and health for all Self help, self-reliance and community empowerment Women's development for family reinforcement Education/literacy and awareness for better life
Volunteers Opinion makers Youth leaders	Training of prime movers and promoters	CBI concept, philosophy and approach Integrated socioeconomic development CBI advocacy and promotion
Community health workers Traditional birth attendants Field staff of department	Training workshops Printed material	Health promotion and preventing diseases Community involvement in sectoral services Intersectoral collaboration at grass root level Integrated problem solving approach

Table 1. Target based community-based initiatives promotion at local/community level

Target group	Channels of promotion	Messages (to be delivered)
Community at large	Campaigns in the community	Health education Environmental health Sanitation and hygiene Vaccination of children and mothers No Smoking
	Displays of: • posters • pamphlets • banners/boards	Health messages Health education like: "12 months - 12 messages" Messages for environmental health and sanitation/hygiene
	Notice board Newsletters	CBI promotional material CBI progress information
	Video spots Photographic displays	CBI projects: promoting change in the community Community participation for self-development Demonstrations for visiting dignitaries
	Speeches at religious places like mosques	Role of religion in health promotion and community development CBI advocacy and promotion
Families in CBI areas	Guide book for community (community manual for awareness and practices)	Health education Home health care General awareness Sectoral awareness Appropriate technologies for development
	Model healthy homes (development of focal houses as models for others)	Integrated approach in practice of health, hygiene, education, home management, food and nutrition, environmental health and appropriate technologies.
Youth Students	Games/tournaments Literary competitions School assemblies	Health education Awareness Sanitation Personal health care Literacy and skills development for better life
Youth groups Women's groups Social groups	Exhibitions/fairs/ festivals/marches Cultural shows	Mass awareness Health messages Social welfare fund raising
CBI teams Community development committee and cluster representatives CBI beneficiaries Youth and students Women's organizations	CBI awards (for special achievements and best performance) Distribution of promotional items like calendars, gifts etc.	Mass awareness Health promotion messages Social welfare services Community mobilization and development Literacy and educational campaigns

Table 1. Target based community-based initiatives promotion at local/community level

Target group	Channels of promotion	Messages (to be delivered)
General masses of the country	Electronic media (special programmes, talks and dramatized presentations) Press (features, columns, reports/diaries and news)	CBI concept, approach and policies Contribution of CBI in national building process Relation of poverty and disease and achievement of health and quality of life Community participation and empowerment for sustainable development Integrated community development process through intersectoral support. Progress of CBI in the country and the region

Annex 4.9.2

PROMOTION AND ADVOCACY AT NATIONAL AND REGIONAL LEVELS

The government authorities at national, regional and district levels play significant role in the decision making and resources mobilization, thus the advocacy should specially focus to develop core groups at all levels in support of the programme. The orientation should be through formal workshops as well as through informal meeting and it should be a continuous process. Along with the government authorities, the donor agencies and other partners, politicians, religious groups and nongovernmental organizations should also be briefed on community-based initiatives, with the aim of gaining their support and mobilization of resources. The media can play a vital role, and their involvement should be very supportive in motivating the national opinion-makers.

The means for promotion and advocacy may vary from country to country; however, these should be target-oriented and focusing to mobilize the communities and the national stakeholders (Table 2).

The promotion and advocacy programmes should be designed keeping in view the following:

- the needs of the community and the country
- the targets of community-based initiatives programmes in the model and expansion phases
- the availability of resources, both financial and physical.

Table 2. Target-based CBI promotion at national and regional levels

Target group	Channels of promotion	Messages (to be given)
Government authorities and ministers Parliament members Departmental heads and representatives of sectors	Orientation workshops Interpersonal meetings	CBI concept, philosophy, approach and objectives CBI and national developmental objectives CBI for socioeconomic development of community and rise of national economy Community self-reliance and self-financing reduces burden on public sector Integrated development in partnership with community and intersectoral collaboration Mobilization of national resources CBI expansion process and policy
Political leaders Religious leaders Social leaders Representatives of professional organizations	Seminars Presentations in meetings	Same as above, in addition to following: • CBI for national capacity-building • Relationship of poverty to disease • Community empowerment and self-help for sustainable development • CBI for equity and universality of development benefits
Political leaders Sectoral authorities Representatives of donor agencies	Orientation workshops Interpersonal meetings	Sustainable socioeconomic development, with active community participation and coordinated intersectoral support
Government authorities Line departments at all levels	News bulletins Documentaries Regular reports	CBI philosophy and approach CBI progress reports Evaluation studies
Representatives of donor agencies Nongovernmental organizations Academic and other sectoral training institutions	Inter-agency meetings Orientation workshops	CBI concept, philosophy, approach and objectives Poverty as a social evil causing disease and deprivation. Inter-agency collaboration and support to community through CBI Development of partnerships Mobilization of resources for integrated development.

Part B
Module 4
Unit 4.10

Programme assessment

Learning objectives

To gain a better understanding of:

- development indicators used for assessment and measuring progress of community-based initiatives
- process of assessment in community-based initiatives

Expected outcome

Participants will fully understand the process and the indicators to be measured during programme assessment. They will be capable of developing a continuous and inbuilt assessment system for the country programme

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4. Group work 382

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2. Community-based initiatives assessment process 385
3. Information required for community-based initiatives assessment 388

1. INTRODUCTION

Programme assessment is a mechanism built into the process of community-based initiatives implementation, especially at national and local levels. Community-based initiatives offer the community, intersectoral support team and programme mangers at national and local levels a useful set of research and rapid assessment tools to quickly obtain information regarding the current situation and enable them to plan together appropriate interventions based on the results of the assessment.

The important points for community-based initiatives assessment are as follows.

- Starting with the baseline survey, the inputs, process, outputs and impact of community-based initiatives implementation in model areas should be assessed periodically with the full participation of the community.

  - Inputs: the financial, human and material resources used for implementation of social and income generating projects, including community organization and mobilization
  - Processes: particular courses of action that transform inputs into outputs
  - Outputs: the products, capital goods and services which result from an intervention
  - Impact: positive and negative, primary and secondary, directly or indirectly, intended or unintended long-term effects produced by an intervention

- It should adhere to acceptable epidemiological methods for assessing the validity of the data generated.

- Assessment of community-based initiatives should include the following criteria while at the design stage:
  – effectiveness
  – equity
  – efficiency
  – inputs, processes and outcomes
  – community satisfaction.

- The results should be documented in a simple and acceptable manner.

- The research and assessment work should be carried out by representatives of the community, sector representatives, the national community-based initiatives team and partners.

- Adequate funds should be allocated for research and assessment activities.

- The lessons learnt from the assessment should be used as an entry point and basis for the large-scale expansion of community-based initiatives in the country.

- The results obtained should be properly documented, distributed to policy-makers, communities and other potential partners in order to enlist their support for the expansion of community-based initiatives activities.

It is important to mention that formal evaluation of community-based initiatives, which is carried by external evaluators and international experts, differs from programme assessment as shown in Table 1.

Table 1. The differences between programme evaluation and programme assessment

Programme evaluation	**Programme assessment**
Conducted every 3–5 years	Conducted every 1–2 years
Carried by external evaluators	Carried by nationals, TST and community
Using advanced tools and techniques and clear validation procedures	Using simple techniques (CBI tool for programme assessment)
Focused mainly on outcomes and impact (without ignoring the inputs, processes and outputs)	Focus mainly on inputs, processes and immediate tangible results
Using mainly indirect and proxy indicators	Using direct and simply measurable indicators
Results used mainly for CBI promotion, and institutionalization of programme at national and advocacy at international levels	Results mainly used for CBI promotion and advocacy at national, regional and local levels
High cost and time-consuming	Low cost and not time-consuming

2. EXPECTED OUTCOMES OF THE ASSESSMENT

- Better understanding of the status and achievements of the community-based initiatives implementation process in project areas.

- Strengthening of the partnership with related sectors, the community and other stakeholders.

- Better vision for the programme and review of the strategies which can enhance its sustainability.

- Documented evidence-based results and experiences for further promotion of community-based initiatives at national and local levels.

- Development of national plans to support large scale expansion of community-based initiatives, based on the findings of the assessment.

- Institutionalization of the assessment process as a systematic function of the programme.

- WHO, the countries and their partners will improve the performance of community-based initiatives.

3. FOCUS OF THE ASSESSMENT

It is necessary to acknowledge that in the first few years of the programme, assessment should concentrate more on community-based initiatives process and its adaptation to the local structural and sociocultural fabric of the country. However the study of inputs and outputs should remain an integral part of the assessment. Successful implementation of the process is by itself an assurance of an effective and reliable development as community-based initiatives promote proven strategies in the areas of its domain, such as health, education, agriculture and other essential community development activities.

Indicators to be assessed

In order to assess the inputs, process and output of community-based initiatives intervention in the programme areas, the assessment process will be based on essential community-based initiatives elements and their corresponding indicators. The processing and analysis of data will allow for inferences which will indicate the achievements of the project. The main indicators expected to be measured are given in Attachment 4.10.1.

Assessment process

Attachment 4.10.2 explains the main process for conducting an assessment in a country. This can be modified according to the local situation; however the main principles and procedures will remain similar.

Information required for assessment of community-based initiatives

Since the assessment is based mainly on the baseline data, area development profile and annual surveys, the assessment teams should collect all necessary information which helps in carrying out the task more effectively and can be verified and compared with the assessment results. The types of information required are listed in Attachment 4.10.3 (the format may change from country to country and for different initiatives).

4. GROUP WORK

Process

On the evening preceding the respective working session, participants should read the materials required for the respective group work. The group work should be conducted as follows.

- Participants should be divided into equal groups, each not exceeding eight members.
- Each group should select its own chairperson and presenter. (These responsibilities should be rotated during each group work assignment.)
- The chairperson should watch the time and encourage every group member to participate.
- The presenter should present the findings/report of the working group in the plenary session.
- Facilitators should help the participants as resource persons and give feedback on the group presentations.

Assignment

The groups will review and adapt the list of indicators provided in Attachment 4.10.1.

Attachment 4.10.1

INDICATORS FOR COMMUNITY-BASED INITIATIVES ASSESSMENT

Element	Indicators
Community mobilization	Committees for different groups, such as: • community development committee/cluster representatives • women committees • youth committees • others (specify)
	• Training activities organized for: · organizational/social preparation · vocational skills
	• Comprehensive work plans prepared for achieving defined target
	• Number of monthly community meetings
	• Number of reports prepared by community development committee/cluster representatives
	• Measures taken for propagating/sharing information
	• Appropriate technologies introduced through CBI, such as: (i) (ii) (iii)
Intersectoral linkages/ partnerships	• CBI integrated into local structure • Number of NGOs and other social groups involved • Number of sectoral support for CBI areas • Number of meetings of intersectoral team in a month • Number of reports prepared by intersectoral team
Inputs involved	• Number of orientation meetings held for mobilizing authorities • Number of meetings with potential partners and donors • Number of agencies involved for sponsoring the programme • Physical contribution by the public sector • Nature of partnership by each partner • Funds issued as loan for income generation projects • Funds used for operational and maintenance cost
Health and social services	• Number of children under one year receiving vaccination • Number of pregnant women vaccinated against tetanus and checked by a trained health worker at regular intervals • Number of children under one year died during the past year • Number of eligible couples using birth spacing methods
	• Number of children from 5 to 12 years of age enrolled in schools during past year • Number of children dropped out of school after enrolment during past year • Number of adults attending/attended literacy classes

Element	Indicators
Nutrition	• Number of infants with birth weight less than 2 5 kg • Number of malnourished children under 5 years • Schemes/steps taken for provision of nutritious food to children, young girls and pregnant women
Water	• Number of families receiving safe drinking water • Quantity of water used per person per day
Environment and sanitation	• Number of families who have sanitary latrines in their houses • Number of village clusters which have introduced garbage disposal measures
Means of livelihood	• Number of unemployed individuals provided with jobs inside/outside the CBI area • Number of families involved in efficient income-generating schemes • Number of families that introduced better quality seeds for cultivation • Number of families that received loans from the CBI • Number of loans given to women/projects aimed at women's development • Number of families regularly repaying/repaid their loans • Number of families who could not pay back the loans in due period and the reasons
CBI promotion and ownership	• Number of seminars/workshops on CBI arranged for policy-makers • Number of advocacy workshops for media • Government adopted CBI as a national approach and this is reflected in the national development plans • Amount and type of resources allocated for CBI by the government • Presence of a national advisory committee and an active national focal person
CBI outputs	• Number of seminars/ workshops on CBI arranged for policy-makers and other stakeholders • Level of acceptance by the community and national opinion holders • Observed change in the attitude and behaviour of the community • Level of community share in income-generation projects • Level of community contribution in social services • Community empowerment and self-management at local level • Enhancement of the capacity for resolution of social and domestic conflicts and improvement in social cohesion • Reduction in poverty rate and increase in income opportunities • Improvement in social and health indicators compared to baseline data

Attachment 4.10.2

COMMUNITY-BASED INITIATIVES ASSESSMENT PROCESS

Composition of assessment questionnaire

The countries should prepare a questionnaire according to the indicators to be studied considering the local situations. It should be composed of following parts:

- national support to community-based initiatives
- general information on the community-based initiatives area
- area development profile and plan
- summary of community-based initiatives reports on the following components:
  - social mobilization
  - programme interventions and their outcomes
    i) health
    ii) social development
    iii) economic development
  - partnerships
  - programme advocacy

Methodology

Application of questionnaire

The questionnaire forms the backbone of the assessment tool; therefore it should be developed very carefully, covering all key components which must be based upon the study indicators. The questionnaire should be divided into several sections for the convenience to conduct assessment. The questionnaire may be translated into local language for better understanding of the assessment team members and the community.

Filling out the questionnaire

Interviews, observation, data from registers and records, and focus group discussion techniques should be used while filling the questionnaire.

- Part 1 should contain general information to be completed only once.
- Part 2 should be for information of every individual programme area. In the case of a large number of participating community-based initiatives areas, sampling may be required.

- Computer software may be developed to ensure standardized analysis and sharing of information.

Sampling

Where respondents are the beneficiaries of the programme and the population size is large, sampling of minimum 10% of the community or beneficiaries is necessary when completing the forms.

Respondent/s

As there are several components of community-based initiatives, it is clear that there are several respondents. At the top of each section the category of the respondents should be indicated

Source/s of information/data

The likely source of information and data should be mentioned in the start of each section.

Assessment teams

The assessment should be basically a joint undertaking of community representatives, government department, community-based organizations and partners. It is important that team members should be well versed with community-based initiatives concepts, possibly through direct exposure to the community-based initiatives implementation process.

Cost

The expenditure for orientation, conducting of assessment, and orientation / training and results presentation workshops should preferably be met from the resources at the national, regional and local levels.

Steps for conducting assessment in the community-based initiatives area

- Preparing the proposal and making necessary arrangements.
- Building the teams for making assessment.
- Developing the questionnaire according to the criteria.
- Developing the plan of action.
- Briefing/orientation of related partners at the national and local levels on the purpose and methodology of programme assessment.

- Review and adaptation of the questionnaire and plan of action in consultation with the partners and stakeholders.

- Briefing and training of the teams at national and local levels.

- Conducting the assessment by application of questionnaire involving all partners and community.

- Processing and analysis of the data at local and national level.

- National and district workshops to provide feedback to the community, intersectoral teams, government authorities and partners on lessons derived from assessment and developing future plans to support community-based initiatives.

- Review and consolidation of assessment results as a document and future reference.

Attachment 4.10.3

INFORMATION REQUIRED FOR COMMUNITY-BASED INITIATIVES ASSESSMENT

The following information is requested before initiating the assessment.

- Organization of community-based initiatives:
  - structures for the programme in the country at all levels (hierarchy)
  - political commitment (extent and nature of government support at various levels, linkages with the national and local development plans)
  - partners and the nature of their engagement.

- Implementation processes:
  - year of introduction
  - training activities (types, resources, materials, target groups and results)
  - intersectoral collaboration (orientation, composition, roles and responsibilities, contribution by different stakeholders such as health, education, municipality administration, livestock, agriculture, women's development/social welfare, others)
  - community mobilization and organization (available structure and roles)
  - management, supervision and monitoring system of projects
  - financial management (operational arrangements, loan disbursement, recovery mechanisms, bank accounts of principal amount, revolving fund and community development fund)
  - advocacy and promotional activities at national and local levels
  - documents produced (number and type).

- Project activities and outputs:
  - total population covered
  - programme area profile (based upon the information from survey conducted at the start of the programme with special focus on the following:

Health	Special focus on maternal and child health, EPI, communicable diseases especially related to poverty (tuberculosis, malaria, AIDS) and healthy lifestyles
Other social sectors	Including education (formal and informal), environment, nutrition, role of women as partners and addressing their practical and strategic needs, youth development, community empowerment, vocational training, social harmony and solidarity
Social projects	• Project site • Number • Kind of project with brief details • Total cost • Contribution by WHO

	• Contribution by other stakeholders • Community share • Implementation, management and monitoring system of projects • Progress of the project and current status • Results/impact
Income-generation	• Project site • Number • Project kind with brief details • Beneficiaries and population covered • Total cost • Loan by WHO and other partners • Contribution by other agencies • Community share • Loan returned • Loan delayed and reasons for delay • Loan defaulted and reasons for default • Progress of the project and current status • Documentation procedures for loan granting and returns • Profitability of the project
Sustainability	• Extent at initiation stage and present status • Appropriate technologies introduced • Degree of self-reliance and self-management achieved

Part B
Module 5
Unit 5.1

Management techniques

Learning objectives

To gain a better understanding of:

- the management concept and its functions
- problem-solving and decision-making

Expected outcome

Participants will know about management and problem-solving techniques. They will be able to apply them while implementing community-based initiatives

Unit contents

1. **Management** **395**

2. **Problem-solving and decision-making** **406**

3. **Group work** **408**

1. MANAGEMENT

Management is the process of working with people and resources for accomplishing organizational goals. It is concerned with making the best use of resources like money, time, materials and manpower to attain the defined objectives. Management involves the creation of a conducive environment in which people can perform most effectively and harmoniously towards the common goal. Simply, management is “getting things done”.

Management by objectives (MBO)

MBO requires determining the objectives and striving for their achievement by asking the following key questions:

- What is to be accomplished?
- How much is to be done?
- Where is it to be done?
- When is it to be completed?
- How is it to be done?
- Who will do it?

Management functions

The management process involves a variety of activities for implementation of the following functions, which are the main tools of a manager to achieve the objectives:

- planning
- organization
- human resources development
- leadership
- team approach
  - coordination
  - communication
  - implementation
- supervision and monitoring
- evaluation.

1. Planning

Planning is a conscious and systematic process of forecasting and deciding in advance the goals, appropriate actions to achieve the determined objectives and earmarking the resources which are expected to be perused in future by an individual, group, organization or programme. It provides a clear map to be followed and specifies the course of actions to adhere to in order to achieve the desired goal. A good plan should give a clear picture of the future tasks and indicate the assigned resources to accomplish them.

A plan is a detailed expression of actions necessary to accomplish objectives. A good plan gives a clear picture of future of a programme or the organization; placing all components in an orderly and logical pattern; ensuring cost-effective use of resources and timely accomplishment of the goals

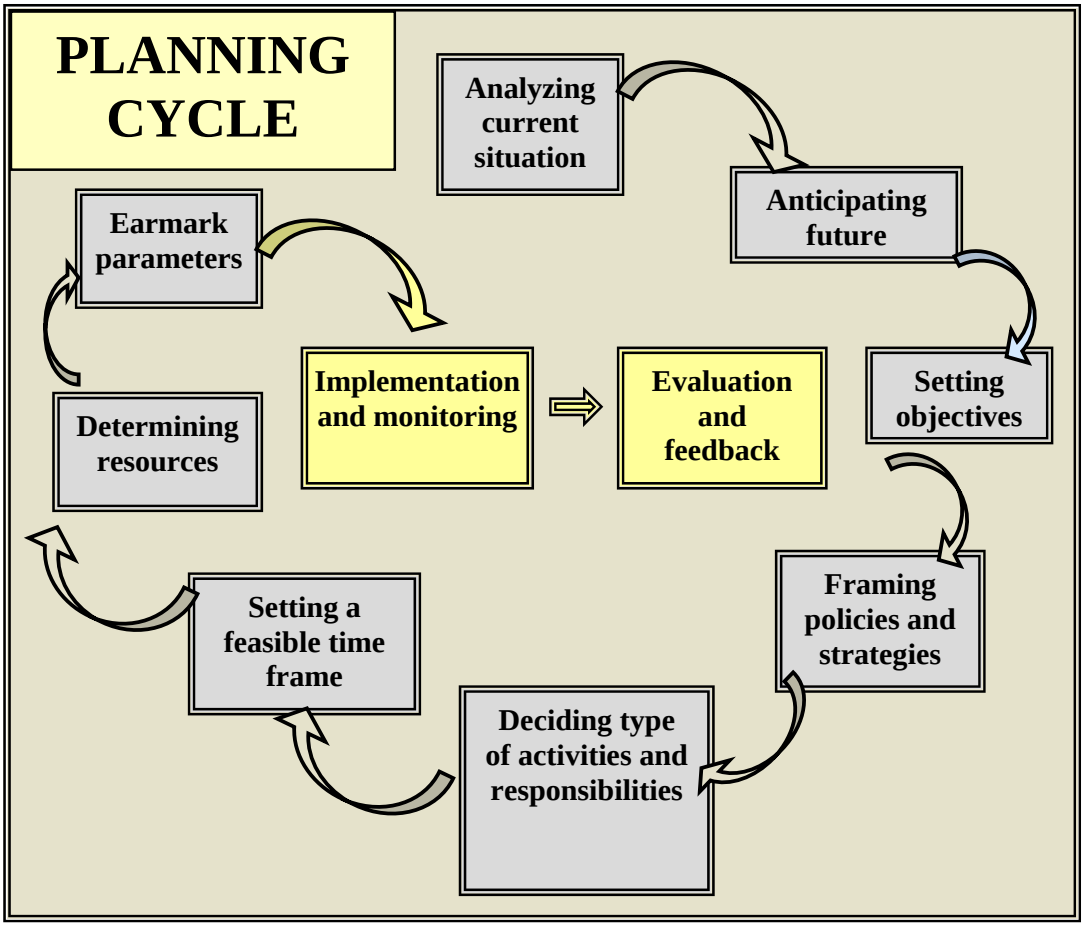
Planning is based upon the theme *if you do not know where to go, any path can take you anywhere*. Thus it is always necessary to clearly define and map out the path for future action.

Objectives of planning in community-based initiatives

- Effectively respond to community needs and problems
- Matching limited resources with priority needs and problems
- Eliminating wasteful expenditure and duplication of resources
- Developing best course of action to accomplish defined objectives

Important preconditions for planning:

- political commitment and administrative support
- availability of a database
- knowledge and capacity to plan and implement
- favourable environment
- availability of resources
- community needs as a basis for bottom-up planning.



Planning cycle

The following actions are usually associated with the planning cycle:

- analysing current situation
- anticipating the future
- setting objectives
- framing policies and strategies
- deciding type of activities and responsibilities
- setting a feasible time schedule
- determining resources needed to achieve the goals
- earmarking parameters and procedure for supervision and monitoring.

a. Analysing the current situation

The following are the main points to be followed for analysing a situation:

- identification of the problems and deciding which merit priority attention
- identification of the people at risk, such as those exposed to or affected by the problem

- discovering where risk groups live, work and might affect others
- determining the extent of the problem and the level by which it can be reduced in a set time.

b. Anticipating the future

This involves developing a vision for the future and setting goals keeping in view the vision.

The goal indicates the ultimate destination to be reached. For example, achievement of the optimum level of health for all is the ultimate goal of community-based initiatives.

c. Setting objectives

Objectives are concrete and specific aims to be achieved, often within a stated time period. Goals are always accomplished through formulating a set of feasible objectives which can facilitate the achievement of perceived future goals. Objectives provide direction; serve as standards for evaluating performance and assist in motivating people to give their best efforts towards the achievement of the goals.

Characteristics of soundly conceived objectives

S	Specific
M	Measurable
A	Attainable
R	Realistic
T	Time bound

d. Framing policies and strategies

Policies and strategies are significant tools for accomplishment of the objectives. These provide guidelines for reaching the destination and earmark ways and means for this task with broad limits to work within. Policies and strategies must be concise but consistent with the approach; in line with peer programmes, covering all related aspects and oriented to future needs in order to cope with the emerging issues and situations.

- **Policies** are the general guidelines for decision-making and carrying out the process
- **Strategies** indicate the line of action or methodology to be adopted to achieve the objectives

e. Deciding the type of activities

Activities are designed to provide a set of actions to be carried out in a logical sequence to reach the chosen goal. This part of the planning process is comprised of the following steps:

- indicate the activities required to be carried out for each task
- earmark the target individuals/groups/populations these activities will affect
- determine the scale of each type of activity required to reach the target groups
- decide on the techniques, methods, framework, sequence, frequency and location of these activities
- assign the tasks and responsibilities to individual members of the team to carry out the planned activities.

f. Setting a feasible time schedule

All activities are carried out within a time frame. In the beginning, a tentative time schedule is prepared that is revised during the course of implementation. The main factors to be considered while setting the time frame include:

- is it in line with the sequence of activities?
- is it feasible to practise and meets the needs of each activity as regards its volume and scope?
- is it flexible enough to cope with the emerging situations?
- does it ensure cost-effectiveness of activities in relation to time?
- Does it interconnect activities in a logical manner and prevent overlapping?

g. Determining resources needed to achieve the goals

Resources enable certain activities or groups of activities to be carried out. The planning process includes determination and extent of available resources according to the following:

- specifications of the nature of the resources required, such as human resources, equipment, supplies or money
- quantification of resources (the quantity of each category of resources)
- determination of the cost of the required resources
- identification of sources (contributors).

h. Earmarking parameters and procedures for supervision and monitoring

Planning includes setting of standards and procedures to be followed for monitoring and measuring progress in order to confirm that goals are being achieved according to the planned targets. This can be verified through the following steps:

- specifying standards and parameters for the determined activities
- deciding norms of performance and appraisal procedures
- applying specified activity records and reports forms as well as a reporting system
- identifying methods for resolving conflicts
- choosing supervisors and allocating responsibilities
- determining frequency of monitoring and supervision and procedures to incorporate their results into future decisions.

2. Organization

Organization is the process of assembling and coordinating human and other resources to carry out the plans for accomplishing the objectives. It refers to establishing a mechanism or structure that enables living things to work effectively together. Organization includes the following key obligations:

- departmentalization and assigning jobs for work units
- delegation of authority and assigning responsibilities
- finding and placing people within the structure
- procedural aspects to guide everyday activities and the appraisal system
- mobilizing and allocating resources
- creating conditions conducive to working together to gain maximum success.

3. Human resources development

Human resources development is the key process in management. It relates to developing people and building their capacities, aiming at their effective use in pursuit of the collective and individual objectives.

Human resources development is facilitated through:

- objective-oriented training and capacity-building
- skills development for self-grooming, job requirements and future needs
- awareness, knowledge and improvement in education
- on–the-job and cross-functional training
- demonstration, coaching, counselling and giving instructions on practical applications.

4. Leadership

Leadership is the art or process of inspiring and influencing people so that they perform and strive willingly toward the achievement of group goals. It is, in fact, mobilizing and channelling human energies in the best interests of the organization or the programme, and induce the people to work enthusiastically to secure the best contribution towards the desired results. The leader creates harmony throughout the system, motivates, inspires, directs and supports the people to foster the human efforts. The leadership role can be effective through adopting team approach, effective coordination and good communication skills.

a. Team approach

Managing programme activities is more complex than managing an organization. Understanding of the team approach is required for working harmoniously with the community. Relations among team members and with the community are important for better working conditions. The success of team work depends on good management, effective human relations, interdependence and mutual trust.

No person can perform or achieve the targets alone. It is the persons or group of people who can make a difference and bring about change

A team is a group of people working together for a common cause and achievement of a common goal. They work within a framework of certain rules and for earmarked objectives and within a defined area.

Community-based initiatives being multisectoral entities and require demonstration of a high level of team approach. This can be achieved through the following set of principles:

- setting and sharing objectives
- encouraging good interpersonal relations

- distributing tasks with equity and according to capability
- coordinating team activities in a determined direction
- applying sound principles of organization and team work
- understanding and communicating with the community
- encouraging community participation and capacity-building
- providing technical support to the community for solution of their problems.

b. Coordination

Coordination is an integration, harmonization and orderly pattern of group efforts towards the accomplishment of common objectives. It refers to organizing and balancing activities in a proper manner; to match with planned strategies; and to ensure smooth functioning and achievement of goals without any duplication of efforts or resources. Effective coordination uses the following principles:

- equity
- harmony
- collaboration
- direct contact
- reciprocity
- continuity.

Community-based initiatives are mostly joint ventures, and require the establishment of efficient coordination system, which may:

- facilitate problem-solving by helping forecast and prevent them
- respond to time constraints, policies, programmes and objectives
- work in all directions—vertical as well as horizontal
- improve interpersonal relations and contacts, mutual cooperation, understanding and confidence
- promote motivation and boost morale of team members.

c. Communication

Communication is interaction by words, letters, symbols or messages; and is a way of sharing meaning and understanding with others. Its intent is to tell, inform, show or disseminate information or exchange of thoughts. In other words, it is a process of conveying messages, facts, ideas, attitudes and opinions from one person to another so that they fully understand.

Communication is exchanging information or feelings between two or more people and is a basic component of human relationships

Communication is an indispensable part of management. No organization or programme can exist without an effective and purposeful communication system. Since management is a series of communication processes, it provides the means to unify activities that are important for the success of a programme or organization.

In community-based initiatives, the communication should have more personal implications than just the interchange of ideas or thoughts. It should be transmission of feelings, through personal and social interaction between people. In this context, communication can be graded as a social input which is fed into social systems to incorporate a change in behaviours, both of communities and government functionaries. Hence, in community-based initiatives, communication helps in motivating people to contribute to the programme efforts and strive for attaining the goals.

Types and modes of communication

Communication is generally carried out in three different modes:

- written
- verbal
- nonverbal.

In written communication, the sender considers the objectives and content of the message, and use the language and styles which suit the recipients most, producing a positive impact. In the community awareness and development process, to convey some message or transmit certain information written materials such as printouts or leaflets may be used.

Verbal communication is using the spoken words to convey the message; however the words and language may vary according to the culture, socioeconomic background, age and education of the people concerned.

Nonverbal communication is not mere exchange of written or verbal information; it includes all techniques by which an individual affects others, such as gestures, body language, expressions and touch.

Communication modes in community work

The main modes of communication involved in community work include:

- individual or group talks
- meetings
- workshops or seminars
- printouts
- audiovisuals.

Individual or group talk

The intersectoral teams in community-based initiatives areas frequently communicate with the community members. The following are the main principles to be considered during this process:

- ensure that communication is objective and relevant
- listen carefully to others' points of view and respond appropriately if required
- keep the environment friendly and do not get involved in cross talk
- use simple language, understandable to the community members
- end the discussion with some conclusion.

Meetings

Meetings are a formal type of communication and mostly are arranged with some pre-set agenda. The community should be informed about the time, venue, purpose and participants in the meeting. The team members should facilitate the process and ensure that the meeting proceeds in the right direction. Notes of the meeting results should be recorded and documented for future reference.

Workshops or seminars

Workshops or seminars are usually arranged on a particular theme or subject. The arrangements should be made in coordination with the community organization. The participants should be provided with information regarding objectives, agenda, time frame and venue. The facilitators should be in harmony with each other. The technical or professional presentations must be followed by a discussion session to ensure that the community members understand the message being delivered.

Printouts

Printouts are an effective medium for providing technical knowledge to educated community members. The printouts may be in the form of pamphlets, charts, booklets, leaflets, circulars or newsletters. The use of simple language and the avoidance of technical language are the main principles to be considered in preparing these materials. These should be in a presentable form and contain materials on key issues relevant to the community needs or situation. Sociocultural norms must be respected while preparing materials on issues such as family planning, prevention of AIDS and other sexually transmitted diseases.

Audiovisuals

Audiovisuals are an effective medium for conveying a message. Audiovisuals may include documentaries/films or displays of photographs. The materials presented must be relevant to the programme approach and the local problems. The community organization and target groups should be involved in organizing the audiovisual shows.

5. Implementation

Implementation means translating plans into practice. Management is concerned with achievements and best possible performance for putting ideas into actions. Implementation is the execution of plans, ensuring that all necessary activities have been carried out on a pre-determined schedule and have produced the required output in the right amounts and of the right quality. It takes the appropriate steps for:

- mobilizing human resources for actions and achievements
- allocation of required physical and financial resources available within the community
- execution of planned activities
- collection of requisite information, its processing and disseminating to the concerned.

6. Supervision and monitoring

Supervision and monitoring are performed to continuously observe and compare the work at operational level to ensure that actual outcome is consistent with the set criteria and procedures as well as meets the planned objectives. It provides feedback to carry out corrective measures or making strategic changes if required. It is a continuous process and should be inbuilt to facilitate the regular assessment of progress, problems and procedures, by analysing, measuring and comparing the actual operations against the established standards and planned results This process keeps the activities of individuals towards the goals and provides the fundamental forces to keep the system together.

Supervision and monitoring must:

- assess the planned objectives and activities
- focus on a limited number of well defined indicators
- be based on qualitative and quantitative information
- have an inbuilt evaluation mechanism.

Steps for establishing supervision and monitoring system

- Identify key issues, concerns, questions or demands which will become a base and focus for monitoring
- Determine indicators and parameters
- Determine strategies for collecting, analysing and reporting data
- Determine information flow and verification of information
- Pre-test the monitoring system and its adaptation to local needs
- Training and orientation of the staff to be monitored and the supervisory personnel

2. PROBLEM-SOLVING AND DECISION-MAKING

Problem solving and decision making skills are mandatory for the community to deal with the issues during local development process. Decision-making is the art of making choices from a number of possible alternatives or solutions in a given situation.

Step by step model

The following steps are required for solving problems. This model can be used as a road map for making efficient decisions and finding the right solutions in community-based initiatives settings.

Step 1: defining the problem and developing a problem statement

Managers, teams and community representatives should recognize and define the problem. If a problem is well defined, it can provide a sound foundation for finding a good solution. On the other hand if it is not well defined, people may have different perceptions and as a result, they may come up with an irrelevant solution.

The best way to ensure that the problem is clearly understood by everyone requires a clear definition written up in a short document. It should be a simple statement of the facts, indicating objectivity, scope of the problem, current situation, interpretation and the population affected. The statement should be written in clear and simple terms, avoiding any implied causes or solution.

Step 2: analysing potential causes

Decisions are not made in vacuum. They are based on systematic investigation and analysing the information related to a particular problem or concept. This process can be accomplished through following key sub-steps:

- identifying potential cause(s)
- determining the most likely cause(s)
- identifying the true root cause(s).

The process is, in fact, expanded listing and then short listing of the causes, finally reaching the root cause.

Depending on how large the problem is and how great its effect, further analysis may be necessary. This may be in the form of measurements, data gathering, interviews, observations of a process, or making a flow chart in order to reach the root cause. The team or manager should look beyond the symptoms of a problem to reach the real (or root) causes.

Step 3: determining the desired state or goal

Short-term or long-term expectations and goals (the desired state) should be determined and well defined. A measurable goal makes it possible to track future progress and evaluate the effectiveness of the chosen solution or decision.

Step 4: identifying possible solutions

Brainstorming elicits a large quantity and variety of unstructured ideas which are then categorized and organized. The problem-solving team can raise a wider range of possibilities, which will reveal more creative solutions.

The relative merits and demerits of different concepts are measured and the alternative courses of action are assessed, analysed and compared. These are thoroughly appraised and discussed with others involved in the process, considering possible solutions and their expected results.

Step 5: selecting the best solution

This is an act of making choice of most feasible alternative, which seems to be the best in the existing circumstances. It involves a high degree of decision making skills as the future success largely related to the choice of solution to solve the problem.

Step 6: developing an action plan

A detailed activity plan and time schedule is made, clarifying all stages and steps to be carried out for solving the problem, defining strategies, making time frame and fixing responsibilities and delegating authorities.

Step 7: implementing the chosen solution

Implementation of the chosen solution is a crucial step in problem solving. The decision on the solution and plan of action must be communicated by proper and timely means to all concerned. This will facilitate effective execution of the decisions. It is also important that merely telling people where to go, but not how to go may not be effective and everybody may make own way to the destination. Therefore, it is always essential to clarify the ways and means for achieving the desired destination.

Step 8: evaluating progress

The procedure and parameters laid down in the plan must be followed with periodic evaluation of the progress made in these aspects. Based upon the evaluation results and feedback information, the decisions may be reviewed to ensure achievement of the fixed targets and goals.

3. GROUP WORK

Process

On the evening preceding the respective working session, participants should read the materials required for the respective group work. The group work should be conducted as follows.

- Participants should be divided into equal groups, each not exceeding eight members.
- Each group should select its own chairperson and presenter. (These responsibilities should be rotated during each group work assignment.)
- The chairperson should watch the time and encourage every group member to participate.
- The presenter should present the findings/report of the working group in the plenary session.
- Facilitators should help the participants as resource persons and give feedback on the group presentations.

Assignment

During the working session, each group should design appropriate solutions for one of the following problems by using a step by step problem-solving model.

- The community is facing a major sanitation problem, as there is no outlet for wastewater disposal and no spare land around the village for solid waste disposal.
- There is no school for girls; as a result the majority of women are illiterate.
- The community has three political and racial groups with strong rivalry between them and they do not collaborate to make a joint community development committee.
- There are some families who are too poor to contribute their share in undertaking income-generation projects.
- There is a high unemployment rate among the educated youth; therefore many of them are engaged in nonproductive activities.
- There have been frequent episodes of diarrhoea in all age groups during the past year.

The facilitators may assign other problems often faced in community-based initiatives areas.

Part B
Module 5
Unit 5.2

Operational research and development

Learning objectives

To gain a better understanding of:

- the concept and definition of operational research
- the process and methodology of operational research
- proposal writing
- report writing

Expected outcome

The participants will understand the methods of operational research and be able to design and conduct field-based research projects, using the results to improve the performance of community-based initiatives

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1. INTRODUCTION

Research is the systematic collection, analysis and interpretation of data in order to answer a question or solve a problem. It is the major tool for developing scientific theories, identifying the best possible options in the management and decision-making process, and studying various social phenomena related to life perspectives.

In research, basic questions are asked in order to obtain appropriate answers and gain knowledge in order to produce, improve or manipulate something. A good researcher tries to generate as many questions as can be answered. In community-based initiatives areas, research is usually conducted on issues related to socioeconomic development, health services and operational matters.

Steps in conducting research

- Inspiration of ideas
- Developing research questions
- Developing research proposal
- Collecting data
- Analyse and interpret data
- Disseminate information

2. OPERATIONAL RESEARCH

Operational research helps managers to look into matters related to ongoing interventions with better vision and with the benefit of scientific results revealed through a research process. Operational research assists in:

- making choices between various alternatives available in order to accomplish specified objectives
- determining future plans and actions
- improving the operational aspects of health care delivery
- knowing services, inputs, distribution and outputs

Main characteristics of operational research

- analysis of the current problem
- development of the appropriate solutions on specified criteria
- field testing (if required)
- objectives are consistent with those of the organization

Essential steps in operational research proposal development

- Statement of a research problem.
- Literature and information review.
- Formulation of research objectives / and /or hypothesis.
- Selection of appropriate research methodSample size and sampling methods.
- Data collection and techniques.
- Data processing and analysis.
- Preparing a work plan.
- Preparing a budget.
- Ethical considerations.

Statement of a research problem

Choosing a problem to be investigated and its brief description are the most important steps. The problem should involve something observable and the study topic should be of interest and benefit to the community.

A problem is

- A perceived discrepancy between what is and what should be
- a question about why the discrepancy exists

Literature and information review

A literature review familiarizes researchers with the existing body of knowledge. It deals with how to analyse and use the available information.

Literature reviews

- identify problems for future research
- build the researcher's confidence
- formulate precisely the main research question
- formulate more effective research designs
- help develop a study's conceptual framework
- are a means of establishing a researcher's credibility

Formulation of research objectives and/or hypothesis

Objectives

The objectives of the study should be consistent with the study title and its need. Objectives are divided into two types:

- general (overall) objectives: address the different aspects of the study problem(s), specify what will be done, and refer to person, place and time.

- specific (sub-) objectives: break down the overall objective(s) into smaller practical complementary components.

Objectives should be clear, simple, specific, action-oriented, feasible, measurable, logically connected and achievable

Hypothesis

A hypothesis is a predictive relationship and association between the attributes under study, such as exposure(s) and outcome(s), which are to be tested during the research work. There are two types of hypothesis:

- *null hypothesis*: exposed groups are not different from unexposed groups with respect to the outcome(s) under study

- *alternative hypothesis*: exposed groups have different outcome(s) from unexposed groups under study (association may thus be direct/inverse; causal/protective)

Selection of appropriate research method

To test a hypothesis, a research method should be selected to collect the necessary data. The method should be appropriate, with its advantages and disadvantages taken into account. The first step is to select the study design which is a specific plan or protocol for conducting the study. It allows the investigator to translate the conceptual hypothesis into an operational one. The common designed used in operational research are the epidemiological designs, which are divided into:

- *observational designs*: studies that do not involve any intervention or experiment*experimental designs*: studies that entail manipulation of the study factor (exposure) and randomization of subjects to treatment (exposure) groups.

Observational designs can be:

- *exploratory*: used when the state of knowledge about the phenomenon is poor; usually small scale of limited duration

- *descriptive*: used to formulate a certain hypothesis; small/large scale; examples: case-studies; cross-sectional studies

- *analytical*: used to test hypotheses; small/large scale; examples: case-control, cross-sectional, cohort.

Experimental studies can be:

- *laboratory experiments*: testing a hypothesis in a laboratory environment

- *randomized clinical trials*: testing various aspects of diseases

- *community intervention studies*: making a study in a community setting.

These types are differentiated by number of participants and duration.

Factors involved in choice of study design

- status of existent knowledgeoccurrence of the problem
- duration of latent periodnature and availability of informationavailable resourcestime constraints

Sample size and sampling methods

- *Sampling*: choosing a subsector of the study population.
- *Sampling method*: mechanism of selection of subjects to be included in the study.
- *Sample size*: exact number of participants in the study.

A sample should be representative of the population of interest. This means that it possesses the most important characteristics of the population it is to be drawn from. **Types of sampling**

- *Non-probability methods*: convenience; quota.
- *Probability sampling methods*: probability; simple random sampling; stratified; cluster; multi-stage.

Data from the sample are useful if they can

- provide new leads of importance
- extend the area of information
- relate or bridge already existing elements
- reinforce main trends
- account for information already in hand
- exemplify or provide more evidence for an important theme
- qualify or refute existing information

Data collection and techniques

The quality of the data gathered must be of a satisfactory and reliable standard. It depends on the data collection procedure, methods chosen, sample size and its validity in representing the population, relevance of questions to the problems, communication between researcher and respondent, education and awareness of the data collector, confirmation of accuracy of information, etc.

Common data collection methods include survey questionnaires, focus group discussions, interviews, observations checklists; reviews of records and case studies. The data collection method depends on the type of research method, whether qualitative or quantitative.

Data processing and analysis

The classified information revealed from the research study should be analysed in accordance with the objectives and the results are extracted and compared. Data can be analysed manually or by using software programmes (Epi-Info, SPSS) for advanced statistical analysis.

Preparing a work plan

Preparing a work plan usually includes the preparation of a plan of action by using an activities chart, which is a planning and management tool that reflects the nature, order and duration of fulfilment of the various tasks of the study.

Contents of the activities chart

- what (tasks/activities to be accomplished)
- when (timing of fulfilment)
- whom (individual responsible for execution)
- where (place for carrying out activities)

Preparing a budget

The research budget is more than just a statement of proposed expenditures; it is an alternate way of expressing your research. It should be technically reviewed to see how well it fits with the proposed activities. Incomplete budgets or inflated budgets will make a proposal unreliable.

The research budget should be comprehensive in nature, in order to:

- provide sufficient resources to carry out the research
- include a budget narrative that justifies major budget categories
- present the budget in the format desired by the sponsor
- provide sufficient detail so the reviewer can understand how various budget items were calculated
- identify evaluation and dissemination costs.

Ethical considerations

Ethical considerations ensure that the dignity, rights, safety and well being of research participants are promoted and that the results of the investigations are credible. Every researcher must consider these questions at the time of developing a research proposal:

- why is there a need for ethics in health research?
- what are the critical issues?
- what must be done to address these issues?

Ethical principles

- Duty to alleviate sufferings.
- Autonomy and informed consent.
- Respect for persons.
- Sensitivity to cultural differences.
- Duty not to exploit the vulnerable.
- Equity and justice.

A cardinal principle of research involving human participants is “respect for the dignity of persons”

3. WRITING PROPOSALS

The main objective of writing a proposal is to get permission for conducting the research and asking for the required resources. It must provide alls relevant information required for approval process. The salient features of a sound research proposal are described below.

Rationale for statement of problem

This provides background information and presents the reason behind the research proposal. It specifies the conditions demanding investigation. The rationale should be supported by evidence drawn from statistics from reliable sources or from appropriate literature reviews. The problem statement should quickly summarize the problem, justifying why this problem should be investigated.

Research objectives

Research objectives specify the outcome of the exercise, the end product. The precise, measurable objectives also provide a yardstick for conducting evaluation.

Methods

The research proposal should provide detailed information on the method which will be suitable to achieve the objectives.

Data collection

Common data collection methods in community-based initiatives include questionnaires and surveys, interviews, observations and reviews of records; there may be tests or examinations. Researchers can either make their own data-gathering instruments or use existing ones.

Budget

All categories of expected expenditure should be classified and detailed according to the prevailing prices. The time schedule of the requirement for funds will facilitate the sponsoring agency to identify the project needs and arrange the funds.

Abstract

The abstract is usually the last written and first read section of a proposal. Generally, the abstract section is at least 250 to 500 words. It should be carefully written, providing a cogent summary of the proposed project. It should provide a quick overview of what you propose to do and a clear understanding of the project's significance, process and potential contribution. Project end products should be clearly identified.

Appendices

Appendices can be attached to the proposal if necessary. The appendices usually contain information peripheral to the proposal, such as reprints of articles, definitions of terms, subcontract, information or reports related to the programme, past success stories, significant case histories, résumés, and publications etc.

4. REPORT WRITING

After completion of the research, it must be documented in a universally prescribed manner. The researcher is responsible for consolidating the findings and analysing the data. He is also obliged to prepare the research report in a presentable form and distribute copies to the programme management as well as to the offices involved including the sponsoring agency, such as WHO. The research report should be according to the basic structure given below.

Cover/title page

The cover should contain the title of the report. The title should be concise, providing basic information about the research subject and the area where the study took place and when.

Contents

The part of the report provides headings and subheadings of the different components of the report in sequential order by indicating the page numbers. Names of the headings and subheadings should match with those included in the report.

Acknowledgments

The acknowledgments are a statement or a short note appreciating or recognizing any valuable support or efforts made in the research as well as report writing.

Executive summary

This is most important part of the report, the part which is mostly studied by others, especially the decision-makers. It should be brief while providing all the key facts and avoiding unnecessary details and explanations. It should not exceed two pages. Executive summaries, although written last, should be placed at the beginning of the report.

Introduction

The introduction provides a brief account of the circumstances in which the research study was conducted. This part of the report is largely based on the contents of problem statement and research proposal, providing a full account of the problem, relevant information and the reasons for performing the study.

Objectives

The study objectives should be consistent with those mentioned in the proposal. If there has been any change or modification, this should be clarified and justified, providing background information.

Materials and methods

This section should be written systematically and should be in line what was planned in the proposal and what was implemented during the research project. It should include details of the methodology adopted for the research process, the population and sampling methodology, selection criteria, tools used for research such as questionnaire, data collection techniques and work plan implemented during the process. The materials used for the study should be annexed along with the plan of action, list of surveyors and other relevant information. This section should also explain the methods used for validation of the data and the screening and tabulation process.

Results

This section of the report contains the results and findings in an elaborative and self-explanatory form. There are many methods for presenting the findings, such as narrative form, tables and graphs; and the choice depends upon the nature and quantity of the data and how they can best be presented in the most useful and expressive form.

Discussion

In this section, the results are discussed critically and compared with the control situation. Depending upon the findings, the hypothesis is either confirmed or disproved. Different situations emerging from the study are discussed and the underlying causes and effects of the problems are highlighted. Similarly, the strengths observed or experienced and weakness of the issue are also described.

Conclusion

A critical and logical discussion yields a sound conclusion. This should be comprehensive and productive.

Recommendations

In the light of experience and the factors and facts tested, a set of recommendations is proposed for future courses of action. This usually aims to deal with the underlying issues. The recommendations should not be hypothetical, but practical, feasible and in accordance with the problems and reasons examined.

References

These are textbooks, articles, publications, etc and the pages that the researcher quoted for authoritative facts. The reference list should identify references cited (e.g., book, journal article) in sufficient detail so that others may locate and consult these references. References should be listed in the same order that they were cited in the text with a number assigned to each reference. The original number assigned to the reference is reused each time the reference is cited in the text, regardless of its subsequent position in the text. References cited from the Internet should be quoted.

Annexes

As mentioned above, all of the tools used in the research along with the proposal, work plans, lists of materials consulted, the surveyors, explanation of the terminologies used and other relevant information should be annexed to the report.

Investing in health, particularly that of the poor, is central to the achievement of the Millennium Development Goals. In support of this strategy WHO's Regional Office for the Eastern Mediterranean is actively promoting in countries of the Region community-based initiatives like Basic Development Needs, Healthy Cities, Healthy Villages and Women in Health and Development. These approaches are based on the principle that good health status—an important goal in its own right—is central to creating and sustaining the capabilities of poor people to meet their basic needs and to escape from poverty. The Community-Based Initiatives Series is aimed at facilitating the management of such initiatives. Users of the series may include government authorities, community representatives, WHO and other international agencies and non-governmental organizations.

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ISBN: 978-92-9021-578-3