

In the Name of God

A Case Study on Intersectoral Action for Health in I.R. of Iran: Community Based Initiatives Experience

Prepared by:
Seyed Abbas Motevalian MD PhD
Assistant Professor of Epidemiology
School of Public Health
Iran University of Medical Sciences

*Teheran, Iran
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¹ Address: 52, Alvand Street., Argentine Square, Tehran, I.R.of Iran
Phone: +98-21-8877-9118
Cell phone: +98-912-147-3818
Fax: +98-21-8877-9487
e-mail: motevali@tums.ac.ir or amotevalian@yahoo.com

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Acronyms

5YDP	Five-Year Economic, Social and Cultural Development Plan
BDN	Basic Development Needs
CBI	Community Based Initiative
CR	Cluster Representative
CSDH	Commission on Social Determinants of Health
EMRO	Eastern Mediterranean Regional Office
FGD	Focus Group Discussion
HCP	Healthy City Program
HVP	Healthy Village Project
IRI	Islamic Republic of Iran
IAH	Intersectoral Action for Health
MDG	Millennium Development Goals
MOHME	Ministry of Health and Medical Education
NCCHCP	National Coordination Council for Healthy Cities Project
NCCHCHV	National Coordination Council of Healthy Cities and Healthy Villages
NGO(s)	Non-Governmental Organization(s)
SDH	Social Determinants of Health
TST	Technical Support Team
VDC	Village Development Committee
WHO	World Health Organization

Summary

Community-Based Initiatives (CBI) is a national initiative focused on social, economic and community development, with health sector as lead

CBI includes programs like Healthy City Program (HCP), Healthy Village Program (HVP) and Basic Development Needs (BDN). CBI aims at achieving a better quality of life through integrated socio-economic development and addresses all the determinants of health collectively through community empowerment and intersectoral actions. WHO's Regional Office for the Eastern Mediterranean (EMR) is prompting the member states to adopt these programs. Islamic Republic of Iran (IRI) started its Healthy City Program in 1991 and soon extended the program to the villages (HVP). BDN approach began in 2000.

In 2005, WHO country office sponsored a CBI evaluation study. An intersectoral team carried out the evaluation over 12 different program areas. The methods and results of the evaluation were validated by an external team of experts and the final report released in 2006.

Context

Rapid population growth and urbanization in past two decades has caused various social, economical, environmental and health problems in the cities of Iran.

The health sector deals with the diseases and injuries caused by unhealthy living conditions, while it lacks a significant capacity to change these situations and play its role during the planning of urban settlements.

Healthy City Program is concerned with the physical, social, economic, and spiritual dimensions and essential elements for health and environment in the cities.

On the other side, rural communities face a number of challenges. Despite considerable achievements in the provision of basic developmental facilities in terms of drinking water, access to primary healthcare services, rural roads, electricity, telephone network and housing facilities, there are many rural and slum communities in Iran where these essential needs remain unfulfilled. Concentration of public facilities and job opportunities in the city areas, have attracted the rural people to move for better prospects, this created scarcity of human and other resources in the rural dwellings. The traditional approach where local authorities are expected to provide and maintain all services is failing as they have limited resources and can not cope with these issues alone. These factors enhanced the need for innovative approaches like Healthy Village Program and Basic Development Needs as examples of Community-Based Initiatives.

Approach

The CBI structure consists of the following:

- National Coordinating Council for Healthy Cities and Healthy Villages (NCCCHCHV) - is established by the council of ministers and is responsible for CBI programs at national level. The members of council include vice president, 10 ministers and 4 heads of governmental organizations.
- National expert group - has members from all 14 ministries and organizations. They are responsible for selecting new areas to join CBI programs,

- implementation of training workshop for provincial and district intersectoral teams, and developing indicators and tools for monitoring and evaluation.
- National CBI secretariat (in MOHME) - a small secretariat is in charge of preparation of program guidelines, arranging NCCHCHV and expert group's meetings and workshops.
 - Provincial\ district intersectoral committees - are in contact with the community to define the priority issues. There are a number of subcommittees for planning intersectoral action targeting priorities. The name and mechanism of action of the district committees differs between CBI programs (HCP, HVP, BDN).
 - At community level, city or village councils are involved in CBI programs. The highest level of community involvement is in BDN programs where the whole community is organized by selection of cluster representatives (for every 15-25 households) and establishment of village development committees. In HVP and HCP the community involvement is not as organized as is in BDN.

The role of health sector:

- The NCCHCHV is headed by the minister of health and the national CBI secretariat is located in MOHME.
- At district level, although the governor is the head of the intersectoral committee, the leading role of health sector is irrefutable.

Impact

- A set of indicators have been developed for evaluation of healthy city programs in the country. The first round of data collection based on the national indicators was performed in some of the HCP areas. The results showed an increase in surface of green spaces, improved access to sports facilities, and a considerable increase in the number of active NGOs.
- A number of indicators were compared between CBI villages (both HVP and BDN) and their matched control villages; the results showed a significant decrease in migration to the cities in CBI program villages. Improvements in access to employment, drinking water and solid waste management were also observed.
- Some of the learned lessons are:
 - o To improve the level of integration, it is better to involve all of the relevant sectors and stakeholders from the beginning.
 - o Changes in key governmental positions may have a negative impact on intersectoral actions; trying to clearly and formally define the roles and responsibilities of all involved sectors might reduce the negative effects.
 - o Raised expectations both in the community and among the stakeholders are another problem; to avoid this difficulty it is helpful to be patient and be cautious in making a lot of promises.
 - o Monitoring, evaluation and documentation of programs and activities should be strengthened.

1. SUBJECT/SCOPE

This study is one of a series of case studies from 23 countries aim to reveal the nature of policy challenges addressed by intersectoral action in different countries; significant contextual factors; mechanisms used to support intersectoral action; the roles of various actors; the subsequent health and broader social outcomes; and lessons learned.

Iran's case study represents the experience of intersectoral action in Community-Based Initiatives (CBI). CBI has been actively supported and advocated by WHO's office of Eastern Mediterranean Region (EMR) for improvement of health and development. CBI aims at achieving a better quality of life through integrated socio-economic development and addresses all the determinants of health collectively through community empowerment in order to transform social lifestyles and enhance human development [1]. 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. CBI includes Healthy City Programme (HCP), Healthy Village Programme (HVP), Basic Development Needs (BDN) and Women in Health and Development (WHD) initiatives among the member countries. The CBI approach, by collectively addressing all the determinants of health, gives a broader perspective to the attitude of narrowly relating better health to the achievements of the health services only. It strongly advocates and implements the strategies which facilitate the access to essential social services, appropriate technologies, information and financial credit with the explicit aim of promoting fair distribution of resources to achieve equity at the grassroots level [2].

The International Healthy Cities movement was first conceived in Canada in 1984 as a result of "the Healthy Toronto 2000: beyond Health Care" symposium and was launched in Europe in 1986 by the WHO. The Healthy Cities programme in the EMR was formally launched in November 1990 in Cairo, Egypt, when the objectives, strategies and approaches of the Healthy Cities programme for the Region were adopted by the Member States. WHO defines a Healthy City as "one that is continually developing those public policies and creating those physical and social environments which enable its people to mutually support each other in carrying out all functions of life and achieving their full potential". While the entry point of the Healthy Cities approach is health, its underlying rationale has always been based on a model of good urban governance, which includes broad political commitment, intersectoral planning, citywide partnerships, community participation, and monitoring and evaluation. [3]. The objective of Healthy Cities in EMR is defined to improve health and environment in the urban settings giving priority to up-gradation of environmental health services and improving the quality of life in the underprivileged areas.

In December 1991, the Health City concept was introduced in the IRI following the "Healthy City symposium". The primary operational procedure of this project as a model was started in the '13th Aban' area in Southern part of Tehran. The year 1996 was a significant year for Healthy City programme in Iran. World Health Day 1996, with its theme "Healthy cities for better life" was welcomed in the country with great interest. This year the HCP was expanded vastly in Iran. On April 15, 1996 the Council of Ministers announced the establishment of the 'National Coordination Council for Healthy Cities Project' (NCCHCP). This council included nine ministers and four heads of organizations

with the mandate of improving and strengthening the status of intersectoral collaboration in the HCP. The NCCHCP held three meetings during 1996 and adapted the regulations and structure of the council and consequently the National Experts Group with representatives from the relevant ministries and organizations was established. Afterwards the HCP has been expanded to other cities in the country [4].

The remarkable experiences resulted from the activities of environmental sanitation in rural areas of Islamic Republic of Iran which were presented in EMR workshop in Rabat, Morocco in 1990 made WHO to hold the first 'Healthy Village' conference in Isfahan, IRI in 1995. The second conference was also held in Tabriz, IRI in 1998. The participants of the first healthy village conference held in Isfahan believed that the Healthy Village concept is the basic mechanism for achieving the objectives of Health for All strategy. After the 2nd Healthy Village conference in Tabriz, the need for intersectoral collaboration became essential. In this regard the issue was raised in the NCCHCP. The Council of Ministers decided to revise the previous approval and in 1999 based on 138th Principle of Constitution of IRI the council established the 'National Coordination Council of Healthy Cities and Healthy Villages' (NCCHCHV) and two other members, namely the Minister of Agricultural Jihad and the Head of the Management and Planning Organization, were added to the council. [4].

The Basic Development Needs approach is a process that aims at achieving a better quality of life and in which the goal of health for all is the most important component. It is integrated socioeconomic development based on full community involvement. It promotes self-reliance through self-management and self-financing by the people. It is a people-oriented strategy which offers vital support to intersectoral collaboration. In Iran, BDN program started in 2000 by involving ten pilot villages in three provinces, namely Chahar Mahal and Bakhtiari (four villages), West Azarbaijan (three villages) and Bushehr (three villages).

In 2005, WHO country office sponsored a CBI evaluation study. An intersectoral team (led by the author of this case study) carried out the evaluation over 12 different program areas. The methods and results of the evaluation were validated by an external team of experts (from AghaKhan Health Services, Pakistan) and the final report released in 2006. This case study is mainly based on the evaluation data and intends to discuss the common approaches to intersectoral action in CBI as well as to compare different structures and mechanisms which had been utilized for intersectoral action in the three CBI programs (HCP, HVP and BDN).

2. METHODOLOGY

In this case study, intersectoral action for health is defined as [5]:

“a recognised relationship between part or parts of different sectors to take action on issues to improve health and health equity”.

To describe the contextual factors, a number of reports and documents were used namely: Population and Housing Census of statistical center of Iran[6], country reports on Social Determinants of Health [7] and Millennium Development Goals (MDG) [8], United Nation's common country assessment report for IRI [9]. To explore the mechanisms, approaches and outcomes of IA in CBI, an extensive document

review was performed including program guidelines, progress reports and best practices in EMRO and other WHO's web sites as well as national CBI secretariat.

The main source of data in this case study was the recent evaluation report. Since one of the major objectives of the recent evaluation was to describe the process of intersectoral action; in almost all of the 47 Focus Group Discussions and 58 interviews there were questions about IA. Therefore all the written raw data of FGDs and interviews were again searched for a number of key words related to intersectoral action, community involvement, program history and other topics of case study, and the relevant sentences and phrases were re-analyzed for this case study.

Because of the important role of the data from recent evaluation in this case study; the detailed methodology of evaluation of CBI in Iran is appeared in annex A.

3. Context

The Islamic Republic of Iran (IRI) was established following the Islamic Revolution of 1979. The IRI with the area of about 1,648,195 square kilometres has a population of nearly 70.5 millions[6]. The country is administratively divided into 30 provinces ("Ostan"), each run by a General Governor ("Ostandar") appointed by the Ministry of Interior (see political map of the IRI in annex B). Each province is in turn divided into a number of districts ("Shahrestan") administered by a Governor ("Farmandar") again appointed by the Minister of Interior. Currently there are 324 districts. Each district includes a number of urban centers and villages. There are 865 sub-districts ("Bakhsh"), 982 cities and 2378 rural agglomerations ("Dehestan") and more than 65000 villages across the country [7].

Since CBI is focused on socio-economic development and improvement in quality of life; we need to discuss about population, education, poverty, employment, health outcomes and other socioeconomic development indicators and policies to better understand the contextual factors at play.

3.1. Demography

The IRI has experienced dramatic changes in fertility and population growth rates during the past 25 years. Following the revival of the family planning program in 1989, the fertility rate has fallen significantly and by late 2000 there were indications that fertility rate had dropped to around replacement level (a total fertility rate of 2.1) in all urban areas as well as some rural districts[10]. Table 1 shows some demographic indicators based on Population and Housing Censuses in 1966-2006[6].

Nevertheless, the growth rate during the first 15 years after the revolution was high enough to lead to a doubling of Iran's population during 1975-2000. The huge cohort of children born during 1979-1991 continues to present Iran with enormous problems. It has caused Iran's per capita GDP to remain at a low level despite encouraging signs of economic growth over the past decade. The current unemployment crisis is also largely due to the gradual entry of this cohort into the job market. Their ultimate entry into marriage and family formation phase will not only present Iran with a high demand for housing but is also likely to lead to a rise in fertility rate and the repeated cycles of baby boom. Meanwhile, since late 1990s the share of the elderly (age group 65+) has risen above 4.5% and may soon pose Iran's social security system with major problems [10].

Table 1- Selected demographic indicators of IRI [6]

Indicators	1966	1976	1986	1996	2006
Total population (million)	25.8	33.7	49.4	60.0	70.5
Sex Ratio (Male/Female)	107	106	105	103	104
Percent Aged 0-14 (Youth Index)	46.1	44.5	45.5	39.5	25.1
Percent Aged 65 or more (Ageing Index)	4.0	3.9	3.5	3.0	5.2
Annual population growth rate (%)	3.13	2.71	3.91	1.47	1.61
Employment Rate (%)	-	-	85.8	90.9	87.3
Average Household Size	4.99	5.02	5.11	4.84	4.03
Dependency ratio (per 100)	50.1	48.4	49.0	42.5	30.3
Urbanization Rate (percent)	37.9	47.0	54.3	61.3	68.5

The past 25 years have also seen a significant rise in the urbanization rate of Iranian population. Currently about two-thirds of the population live in urban areas. The share of rural population is expected to fall further to about 25% over the next two decades. While facilitating accessibility and provision of social services, including health, urbanization is associated with social and health problems of its own which are likely to present Iranian health system with new challenges. The urban population lives in some 982 cities and towns, while the rural population is living in over 60,000 villages scattered across the vast area of Iran. Providing health and other social services to this large number of small and hard to reach villages remains a major challenge facing the Iranian government[10].

The past quarter century has also witnessed a considerable rise (from 19.7 to 22.4 years for women and from 24.1 to 25.6 years for men) in age at first marriage. The rise, which is seen in both urban and rural areas, has happened despite government efforts to promote marriage as a basic Islamic value and to provide a variety of incentives for the newly-wed [10].

3.2. Education

The IRI has taken great strides in the area of public education. Total government spending on education has in recent years fluctuated between 4 and 5 % of the national income and 10-20 % of the government's budget [9, 11]. This is slightly higher than the world average and about equal to the average for middle-income countries. Public education, particularly at the primary level, is entirely free and consumes more than half of government spending on education. Iranian families also spend some 2% of their income on education and training. Salient indicators concerning education are given in table 2 [6].

The primary schools enrolment ratio steadily rose to 97 percent in 2002 from 85 in 1990. The proportion of pupils starting grade 1 who reach grade 5 increased from 87.1 percent in 1990 to 89.1 in 2002. In addition, the literacy rate for the 15-24 age group has risen from 92.2 percent to 97.6 for men and from 81.1 percent to 94.7 for women (1990-2002)[11].

Table 2- Literacy Rate (percent) in the IRI (among 6 years or more population) [6]

Indicators	1986	1996	2006
Total	61.8	79.5	84.6
Men, Urban areas	80.4	89.6	92.2
Women, Urban areas	65.4	81.7	85.6
Men, Rural areas	60.0	76.7	81.1
Women, Rural areas	36.3	62.4	68.9

Despite these achievements, education like other aspects of social development suffers from urban bias and there are regional disparities in terms of adult literacy and access to educational opportunities. Generally speaking, provinces with the lowest levels of development (e.g., Sistan & Baluchestan, West Azerbaijan, and Kurdistan) are behind the rest of the country with respect to measures of educational development. Women are particularly likely to be disadvantaged in these underdeveloped provinces [10].

3.3. Human development and poverty

IRI has recorded a steady improvement in the conditions of life for its citizens. Between 1960 and 1995 the country's human development index (HDI) increased 0.452, moving from a condition of low human development to one of near the top of the medium-level human development category. In 2006, IRI had a HDI of 0.746, placing it around the midpoint among countries of medium human development, and IRI ranked 96th of 177 countries listed[7].

Measured in national currency at 1991 prices, the rate of growth of GDP between 1991 and 2001 was about 4 percent a year, implying a growth of per capita GDP of about 2.5 percent. This means that current trends in income are producing a very small increasing tendency in the HDI. Strengthening the economy remains, therefore, an important challenge [9].

Percent population below US\$1(PPP) per day decreased from 1.2% in 1997 to 0.2% in 2005; and percent population below US\$2 (PPP) per day decreased from 9.1% in 1997 to 3.1% in 2005 [7]. The proportion of population living under poverty line has also improved from 47% in 1978 to 15.5% in 2000. [11].

3.4. Economy and employment

Iran's gross national income in 2002 is estimated to be 112.1 billion US dollars with a per capita value of 1710 US dollars. In purchasing power parity (ppp) terms, this amounts to 415 billion US dollars with a per capita value of 6340 US dollars. The GDP had grown at a rate of 5.9% during 2001-2002, while the per capita growth rate being 4.2 per cent. The fourth Five-Year Economic, Social and Cultural Development Plan aims at 8% growth rate[10].

One of the major social and economic challenges currently facing Iran is a high level of unemployment. The unemployment rate, which had fallen significantly from 14.2% to 9.1% during 1986-1996, had jumped back to 14.6% by 2001. The problem is partly due to the increased number of unemployed which rose from about one and half million to about 3 million, an annual rate of increase of nearly 9 percent. The unemployment rate is particularly high for those aged 15-24. In the year 2001, it amounted to 35% of men and 40.6% of women aged in this group[10]. According to the latest census conducted in 2006, the unemployment rate is 12.8 percent in the economically active population. However, the unemployment rate in rural areas (14.7%) was still more than urban areas (11.8%) [6].

In 2004 there were 2.9 m employed women over the age of 15 years, compared to 16m employed men, a clear reflection of the greater proportion of men in the “official” labour force. University-educated women form a higher proportion of the total working population (23.5%) compared to males (9.3%). This reflects an increase in the number of women graduates; today, there are more women than men enrolled in universities. But female unemployment rates indicate that many qualified women fail to find employment [7].

3.5. Health Outcomes

Improvements in health status have been recorded in IRI since the early 1980s, in spite of the 8-year war and continuing international problems. The percentage of Primary Health Care coverage which was negligible in early 1980s raised to more than 95% in 2004. The Life Expectancy increased from 55 years in 1980s to more than 70 years in 2004. The Infant Mortality Rate which was 120 per 1000 live births in 1976 decreased to 28 in 2006. Underweight children under five fell from 15.9% in 1991 to 5% in 2002. Non-communicable diseases are now the most important causes of mortality and morbidity in IRI, indicating the completion of the epidemiological transition on the country level. According to the 2003 burden of disease study, non-communicable diseases and injuries composed more than 90% of total burden (Table 5).

3.6. Key characteristics of the policy environment

3.6.1. Political leadership, political system and processes

It is worth briefly noting how the government in the Islamic Republic of Iran is structured. The type of government is Islamic Republic ratified by more than 98 percent of voters after the Islamic Revolution in 1979. According to the constitution, the head of state or Supreme Leader of the Revolution has many powers, particularly in maintaining the principles of Sharia Laws of Shiite Islam and in making appointments. The popularly elected Assembly of Experts (composed of 96 religious clerics) selects the Supreme Leader. The head of government is the directly elected President who appoints a cabinet of ministers. The government proposes laws that are discussed by the parliament and, when passed, are reviewed by the Council of Guardians of the Constitution (an appointed upper house consisting of 6 clerical Islamic canonists and six civilian jurists) before ratification. In addition, the Expediency Council of the System is a body of high religious and political figures appointed by the Supreme Leader and one of its duties is to mediate differences between parliament and the Council of Guardians [7].

3.6.2. Macroeconomic policy

Following the Islamic revolution in 1979, the new constitution set the scene for the development of an economic system, in accordance with Islamic criteria, to eliminate poverty and to enable citizens to live in dignity and equity (Article 43 of constitution of IRI) [7]. In past two decades, Five-Year Economic, Social and Cultural Development Plans (5YDP) of IRI have been prepared and conducted to improve the economic as well as social conditions. The major economic policies in the fourth 5YDP includes the establishment of “Foreign Currency Reserve Account of the Oil Income”; increasing tax and other non-oil incomes to lessen the dependency of budget to oil income; provision of Article 44 of the constitution of IRI about continuity of privatization program and empowering of non-governmental sector; expansion of stock exchange and strengthening economic competitiveness [12].

Nevertheless, due to the special emphasis placed on social justice and consequent to the generous investment in social sectors and adoption of distributive strategies

involving both direct transfers and indirect subsidies, the IRI has already succeeded in reducing the prevalence of absolute poverty or the proportion of population living on one dollar a day to the level recommended by the MDG standards[10].

Despite these efforts, however, Iran still faces three major challenges: (i) it has a high rate (estimated between 15-25%) of relative poverty; (ii) the basic manner it has dealt with poverty, like through handouts and charitable transfers than through employment and empowerment; and (iii) while these explicit subsidies and transfers have the merit of reaching the poor, Iran also maintains, often in the name of the poor, an excessively expensive and inefficient system of implicit subsidies that is untargeted, increasingly unsustainable and distorting the overall picture[10].

3.6.3. Policies in health care system

Health and related programs continue to maintain a focus on health equity, and to recognize the importance of social determinants in health outcomes. The Primary Health Care (PHC) system which is established in 1980s is recognized as a pioneer in EMR, and in 2004 provided > 95% coverage in rural areas.

A network of facilities serving the whole country extends from the health house providing basic PHC to urban health centers, hospitals and specialist referral centers. Table 3 indicates the number of facilities at different levels in 2006.

Table 3- Health Network facilities in IRI, 2006

Type of health center	Number
Health house	17000
Rural health centre	2321
Urban health centre	2191
Health post	1387

Health Houses, the first level facility in rural areas, are supported by two native community health workers from the same area that they work; a female who provides basic preventive and curative care particularly family health, and a male health worker who is responsible for environmental health and provision of PHC to the satellite villages around the main village where the health house is located. Community health workers (Behvarz) are trained for two years in an institute located in each district (Behvarzi Training Center). The number of Health Houses has increased from 13,500 in 2001, which represents an improvement in health provisions in rural areas. Health posts are expanding in urban areas and providing active services (outreach) through Women Health Volunteers rather than the former passive services, with staff waiting in the facilities for the local people to come to them.

The PHC system in IRI scores well in the three major child health areas:

95+% of all children had been treated with ORS during their last episode of diarrhea (DHS 2000)

Over 90% of children with ARI had been correctly taken care of at home (DHS 2000)

Vaccination coverage for one year olds was 99% for BCG; 95% for DPT3 and OPV3; 94% with HBV3 in 2005 (EMRO 2006).

The Family Physicians Programme has now expanded to remote rural areas, even to Sistan-Baluchistan, with a 90% overall coverage. The program, run in collaboration with the Ministry of Welfare, which pays the physicians' salaries, provides physicians for

health houses. This program responds to clients needs for professional consultations at the PHC level, in an era of increased client expectations and the increase in non-communicable diseases which require preventive and curative interventions beyond the scope of the community health workers (Behvarz).

The PHC programme in IRI has built a strong foundation for community empowerment with involvement and fostering a generation of local community health staff (facilitated but not directed by professionals). Such participatory action involves local needs assessments and the development of strategies to increase the utilization of existing and new services.

The Ministry of Health and Medical Education (MOHME) was established in 1985 when all health-related schools and institutions were moved from the Ministry of Higher Education and integrated into the ministry health that called as a new Ministry of Health and Medical Education (MOHME). Thus medical education could be more closely linked to the objectives of the health system, especially the pursuit of social determinants and health equity. This required the reversal of the trend towards a highly sophisticated urban-based curative system, to a more equitable expansion of primary health care services.

The MOHME with its 41 Universities of Medical Sciences and Health Services (UMS) undertake the responsibility of public health, treatment and training of health professionals across the country. In each province there is at least one UMS; the chancellor and vice chancellor for health of each UMS are currently leading the health network in their catchment area which is mostly a province.

Environmental and Occupational Health Office in undersecretary for health of MOHME; is the focal point of CBI activities.

3.6.4. Other initiatives that focused on SDH approaches and intersectoral work

Establishment of Supreme Health Council

The IRI government recently (in 2006) established the Supreme Council for Health and Food Security headed by the President. The council intends to promote intersectoral cooperation and collaboration for improving quality of life and equity in health. Other members of this council are ministers of Health and Medical Education, Agricultural Jihad, Education, Commerce, Industries and Mines, Welfare and Social Security, Interior, Justice and Energy; and also directors of Management and Planning Organization, IRIB (TV, Radio), Department of Environment, Sports Organization and Medical Council Organization.

CBI officials believe that the establishment of Supreme Health Council is the consequence and accomplishment of their National Coordinating Council of Healthy Cities and Healthy Villages which was established in 1996 and its members are very similar to Supreme Health Council.

In each province and district, there is a Provincial or District Health Council that has the same duties of supreme health council in its region.

3.6.5. Policies and processes for community involvement

Establishment of City/ Village Islamic Councils

Despite the emphasis of the constitution of IRI that “the Provincial Councils, and the City, Region, District, and Village Councils are the decision-making and administrative organs of the country” (Article 7 of the Constitution), the establishment of City and Village Islamic Councils did not occur earlier than 1999. In this year, for the first time, the Iranians elected members of City or Village Islamic Councils for a period of four years.

The establishment of these councils has enforced the role of civil society in local decision-making and administrative processes and improved the relationship between community and governmental or non-governmental organizations.

3.6.6. The policy environment factors with significant impact on the CBI work

In most of the EMR countries CBI approaches have been used to provide or expand primary health care services in underprivileged areas. But the PHC system in IRI with its high (>95%) coverage that is effectively providing equitable health services in the country gave the opportunity to CBI officials to focus on other issues like income generation, drinking water supply, waste collection and disposal, sports and recreation and so on.

The establishment of City/ Village Islamic Councils helped CBI programs to involve the civil society. In CBI programs, particularly in villages, these councils have been used as entry points to the community.

3.6.7. Community-Based Initiatives: origins, nature and objectives

Rapid population growth and urbanization has caused various social, economical, environmental and health problems in the cities. Many cities around the country suffer from crowded population, traffic, housing shortage, air and industrial pollution, shortage of water resources, and inadequate sewage and solid waste management systems. Green areas around the cities are being eroded or destroyed in many cases.

The cities do not have homogenous entities and are composed of a variety of social and income groups. Health within these groups also varies according to gender, education, income, employment and other socioeconomic indicators.

The health sector deals with the diseases and injuries caused by unhealthy living conditions, while it lacks a significant capacity to change these situations and play its role during the planning of urban settlements.

Healthy City Program is concerned with the physical, social, economic, and spiritual dimensions and essential elements for health and environment in the cities. It addresses issues like water supply, sanitation, pollution, and housing. It can also focus on promotion of healthy life styles, improve education, address women's issues, children's needs, and enlist the support of volunteer groups.

On the other side, rural communities face a number of challenges. Despite considerable achievements in the provision of basic developmental facilities in terms of drinking water, access to primary healthcare services, rural roads, electricity, telephone network and housing facilities, there are many rural and slum communities in Iran where the essential needs remain unfulfilled. Lack of equity is prominent, as large differences exist in underprivileged provinces. Concentration of public facilities and job opportunities in the city areas, have attracted the rural people to move for better prospects, this created scarcity of human and other resources in the rural dwellings. The traditional approach where local authorities are expected to provide and maintain all services is failing as they have limited resources and can not cope with these issues alone. These factors enhanced the need for innovative approaches like Healthy Village Program and Basic Development Needs as examples of Community-Based Initiatives.

The HVP is a tool to enhance and accelerate the process of achieving health for all. In this process priority is given to creating a supportive environment with a focus on village development for improving health and quality of life of the people. Provision of potable water, sanitation, solid waste removal and village cleanliness are major components of such an environment. For achieving these targets organized participation of communities

and strong intersectoral collaboration at all levels are considered essential. HVP offers health professionals and community leaders a unique opportunity to adapt health activities to local circumstances and bring about effective intersectoral collaboration at the local levels.

In view of the importance of the interrelation between economy and health, CBI approach has further evolved to include economic development. A basic development needs approach was adopted to promote the concept of community self-help and self-reliance through intersectoral collaboration, creating an environment where people could take an active part in the development process, with the Iranian government providing the necessary support to achieve the desired level of development.

As discussed before, the leading role of WHO was an important driver for CBI. Besides this, the political will of the governments had also a considerable role in CBI activities. President Khatami's government came to power in 1997 and the slogan of one of his major supporting political parties was "Iran for all Iranians". So, during his government the City and Village Islamic Councils were formed (although the Constitution of Islamic Republic of Iran had predicted the establishment of these councils; practically their establishment occurred after about one decade delay), the new ministry of welfare and social security was established, many new non-governmental organizations came into existence around the country and community-based programs like CBI had been widely supported.

Following firm commitment from the Iranian government and technical support from the World Health Organization Regional Office, basic development needs was assigned a high priority in health and health-related sectors, reflected in the fourth Five-Year Economic, Social and Cultural Development Plan (2005-2009).

The central issue of president Ahmadinejad's presidential campaign was 'equity'. To specify time and energy of the government to all provinces more equally, he decided to travel to provinces and arranged many of the meetings of his council of ministers in different provinces. To give more power to local governments, the National Management and Planning Organization was eliminated and its duties were transferred to provincial governments. It is expected that CBI; which aims to empower local communities and improve equity; receives more attention in the new government.

In some cases like the '13th Aban' Healthy City program in Tehran, or Saveh Healthy City a strong central agency (in these examples the Tehran Municipality and Saveh governorate respectively) played a key role in supporting intersectoral action. There are a few examples that how negative reports became strong advocates of CBI projects. For instance the first report of national death registry in 2000 showed that traffic injuries are one the three main causes of deaths, this report led to the implementation of a traffic injury prevention project in CBI program areas (it was one of the seven projects suggested by NCCHCHV).

4. Approaches

A mix of approaches has been applied in intersectoral action of CBI. It is obvious that all the three CBI programs (HCP, HVP and BDN) are place-based and focused on a specific geographic community that may be a city (e.g.: Saveh Healthy City), part of a city (e.g.: '13 Aban' Healthy City Program in Tehran, or Hassanabad Neighborhood Healthy City Program in the city of Yazd) or a village (HVP or BDN). In some cases,

especially Healthy Cities, the programs are setting-based (like: healthy schools). At national level, NCCHCHV approved seven targeted projects for issues like traffic injury prevention, nutrition, water supply, solid waste management, communication and IT, and mental health promotion.

4.1. Policy entry points

The common policy entry point of CBI programs is community involvement. For example, in BDN program the Technical Support Team (TST); which is an intersectoral team at district level; enters the community by involving village council and other influential persons in the village community.

Besides this common policy entry point; different CBI programs had other different policy entry points. The policy entry point in BDN program was reducing social stratification by income and employment generation and granting micro-credit loans. In HCP, the policy entry point was to reduce exposure of people living in underprivileged areas to different risk factors by improving environmental conditions; like solid waste disposal, providing safe drinking water, traffic injury prevention measures, organizing healthy schools and establishment of recreational or cultural facilities. In HVP, the policy entry points were more similar to HCP.

There were other policies in CBI programs aiming:

- to reduce vulnerabilities of disadvantaged groups; like public nutrition project in Healthy Cities, and
- to reduce unequal consequence of illnesses; like mental health promotion and Narcotic Anonymous groups in Healthy Cities.

4.2. Information and knowledge transfer

The national CBI secretariat and the expert group of NCCHCHV are responsible for developing the practical guidelines, determining national indicators, training regional staff, and monitoring and evaluation of the programs at the national level. At district level, the Healthy Cities/ Healthy Villages Headquarters and Technical Support Teams (BDN) are leading the program. Each district is expected to submit progress reports to the national level. A national newsletter for healthy cities is supposed to be published quarterly to strengthen communications between all partners.

The findings of our evaluation showed that a set of indicators for healthy cities have been developed by the NCCHCHV expert group at national level. In all of the evaluated program areas; local intersectoral teams and program staff had participated in training workshops that were held by the national expert group. Although there were some translated books and guidelines about the HCP/HVP (for BDN, there were enough books and guidelines for program implementation, monitoring and evaluation); the need for developing national guidelines on principles of Healthy Cities/ Healthy Villages program management; including the methods of community involvement, intersectoral collaboration; monitoring and evaluation existed. There were some progress reports from different program areas; but they were not well structured and did not have a similar format. Only one of the evaluated program areas (City of Saveh) had a Health Profile.

The national healthy city newsletters were regularly published for a period of few years; but at the time of evaluation it was not publishing anymore. There were also local newsletters in some of the evaluated program areas. Most of the representatives of different sectors in NCCHCHV keep complaining of lack of a system (specially a web site) for updating their information about similar activities in the world. Also many of the respondents emphasized on the necessity of a strong communication system (again a

web site and a newsletter) to facilitate sharing knowledge and experiences of all stakeholders at different levels.

4.3. Institutional arrangements

As it was mentioned earlier, the council of ministers approved the establishment of National Coordinating Council of Healthy Cities (NCCHC) in 1996. The council included nine ministries and four organizations as follows:

- Ministry of Culture and Islamic Guidance
- Ministry of Education
- Ministry of Energy
- Ministry of Health and Medical Education
- Ministry of Housing and Urban Development
- Ministry of Industries and Mines
- Ministry of Information and Communication Technology
- (Formerly known as Ministry of Post, Telephone and Telegraph)
- Ministry of Interior
- Ministry of Labour and Social Affairs
- Department of Environment
- Islamic Republic of Iran Broadcasting Organization
- State Welfare Organization
- Tehran Municipality

The following principles were also approved about NCCHC:

- The director of the council will be minister of health and medical education.
- The ministers and heads of organizations could introduce one of their deputies to participate in council meetings.
- Provincial and district health councils are in charge of NCCHC's duties at province and district levels, respectively.
- The establishment of this council should not lead to formation of new institutions or organizational expansion.

In 1999, two modifications were made in NCCHC and this was again approved by council of ministers:

- Adding villages to everywhere cities were mentioned in 1996 act. Thus, the name of the council became "National Coordinating Council of Healthy Cities and Healthy Villages" (NCCHCHV).
- Adding two new members to the council:
 - Vice President and Head of Planning and Budget Organization.
 - Minister of Agricultural Jihad (Formerly known as the Ministry of Agriculture)

The structure and important relationships of NCCHCHV have been approved by the council itself in 1999 (Fig1).

The Healthy Cities and Healthy Villages Expert Group includes members from all of the fifteen ministries and organizations.

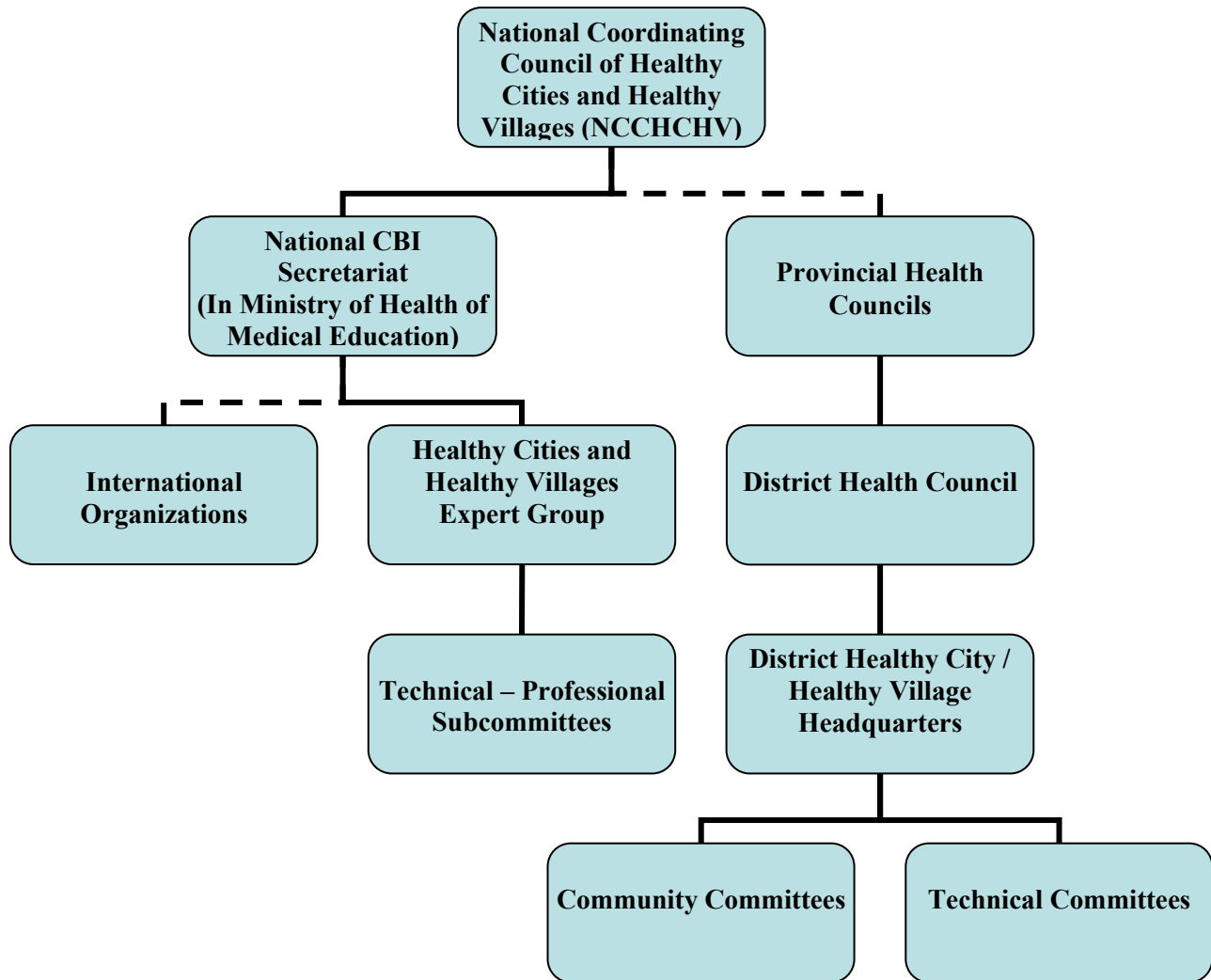


Figure2- Structure of institutional arrangements for HCP/HVP in I.R. of Iran

4.4. Financial mechanisms

In most of the CBI projects, the tasks of the sectors were formulated in intersectoral committees and then each sector had to carry out its defined task in line with others. Key informants believed that under current regulations it is difficult for organizations (especially governmental) to spend their budget on common projects defined by the intersectoral committees; but it was more practical to perform a task (which is related to the organization's missions) or to specify a place, person or an instrument for an intersectoral action. For example, in Hammamlar village (a BDN program area in Uromiya province) the people expressed their need for a kindergarten; the intersectoral team discussed the issue and education department accepted to specify a place in the village school. As another example in Yazd Healthy City Program area there was an unsafe intersection with repeated occurrence of severe car accidents; the people demanded a preventive action from healthy city headquarters, then the headquarters arranged an intersectoral action by involving three partners: the municipality to change the intersection to a square, the police to fix traffic signs and the electricity office to improve the lighting of the site.

Therefore, lack of a specific fund for the projects defined by intersectoral committees has been one of the problems of CBI. In some case; the governors (or CBI program coordinators) were successful in fund raising. For example, in Saveh Healthy City the governor was successful in absorbing a considerable amount of money for the healthy city projects from private sector or provincial and national budgets (e.g. 19 billion Rials ≈ 2 million US dollars for Saveh Drinking Water Supply as a nationally funded project).

One of the strategies in BDN program was the establishment of Village Development Fund. WHO granted a seed money (about 5000 US\$) to each village's fund and then the villagers were invited to be a shareholder of the fund. This fund was used for granting small loans (1-5 million rials ≈100-500 US\$) to the shareholders for income generating projects. It was planned that the loan users pay a little benefit to be used for implementation of health or social projects; but practically the amount of loans and their benefit were too small to be used for this purpose.

In some projects the people themselves had a considerable monetary contribution; for example in Hureh village (BDN program area) people paid 600 million Rials (about 65000 US\$) for gas piping.

4.5. Legislation and regulation

The approval of NCCHCHV by council of ministers was a fundamental action for regulation of intersectoral action in CBI. The NCCHCHC passed its bylaw, but the details of how intersectoral action should take into account the specific regulations of different sectors was not discussed. The results of evaluation revealed that some of the stakeholders are concerned about the absence of specific laws or regulations to support the intersectoral action in CBI. It was found that in some cases the heavy bureaucracy had been a barrier for intersectoral collaboration, for example in BDN program the banks did not pay loans to Village Development Funds; because according to their regulations the loans could only be paid to individuals not to a fund; another regulation of banks was that the potential loan grantees should introduce governmental employees as guarantors which was hard to do especially for poor people. So, occasionally the authorities of collaborative sectors were obliged to either overlook the regulations of their own organizations to perform an intersectoral action or not do anything to keep the regulations. Many of the interviewees believed that a specific law to be passed by the parliament to clarify roles and responsibilities of different stakeholders in intersectoral projects is needed.

“The rights and limits of organizations are not defined in healthy city headquarters. For example; normally, if water organization needs to dig a street for piping, they should pay to the municipality. But in healthy city headquarters these kinds of relations are not defined.” Head of Yazd city Islamic council

4.6. Planning and priority setting

The CBI programs have different approaches for the planning and priority setting. The community-based bottom-up approach is the guiding principle for all the planning process in BDN program [13]. The systematic approach of BDN program begins with training Technical Support Team (TST); that have members from relevant departments and organizations; in a five-days workshop [13]. The intersectoral group (TST) holds meetings with Village Council, other influential people in the village and finally a general village meeting to organize the villagers by electing Cluster Representatives (CRs) and forming the Village Development Council (VDC). The TST undertakes the responsibility of training CRs and VDC. The results of community needs assessment performed by the

CRs are summarized in a common meeting; where TST, CRs and VDC participate; and the priorities of the village are defined. The villagers write proposals for projects tackling prioritized problems. The proposals which are approved by TST and district officials will be supported. The evaluation confirmed that in all of the five studied BDN program areas the same process had happened.

In HCP and HVP, the community needs assessment is again one of the first steps. Afterwards the intersectoral committee makes decision about the feasibility of projects according to availability of resources. It is expected that (at least for healthy cities) a City Health Plan be prepared by all stakeholders. The evaluation study indicated that in most (not all) of the studied Healthy Cities and Healthy Villages a community needs assessment was carried out; but a comprehensive City (or Village) Health (or Development) Plan was not found in any of the studied program areas.

Besides these, some of the CBI projects are based on the priorities defined by specific sectors. In these projects, usually the planning process is integrated to synergize all the efforts.

In summary, the priority issues are mainly defined by the community and usually all of the relevant sectors are involved in the planning process.

4.7. Capacity building

The secretary of NCCHCHV; which coordinates BDN program at national level as well; is located in Environmental and Occupational Health Department of Ministry of Health and Medical education. Therefore the occupational or environmental health officers; whose jobs usually requires working across different sectors; are involved in CBI activities at national, provincial and district levels. The district governors and sub-district governors are another group with key roles in CBI programs. These people's jobs again necessitate working across sectors. Some of the key informants believed that involvement of these groups had benefits both for their routine jobs and for the intersectoral action in CBI.

Education and capacity building can influence community participation, intersectoral collaboration and even political commitment. A large proportion of resources have been spent on capacity building in CBI activities of IRI. Since 2001, about 50 workshops with more than 1500 participants have been held in 25 districts across the country by national CBI secretariat.

Most of the participants of these workshops were members of district intersectoral teams, but community members such as VDC have been among them. Most of these were explanatory workshops to justify the CBI programs for district level managers, raise their awareness, and teach them some skills of CBI activities. In some cases the participants should immediately use the learned skills or train other trainees, for instance in BDN program, TST was expected to transfer their learned knowledge and skills to VDC and CRs.

4.8. Playing actors and their roles

At national level, the playing actors include members of NCCHCHV and its expert group (members of both are introduced in section 4.3) and CBI officers working at CBI secretariat of MOHME. The expert group have the responsibility of program development, monitoring and evaluation. They consider the profiles of local communities who want to join the CBI programs and set the timing for program expansion. For each new program area, a team of national expert group and/or CBI secretariat will train the intersectoral team at district level. The national expert group also determines priority issues to be addressed by CBI programs (like the seven projects approved in 2001 for healthy cities: traffic injury prevention, nutrition, water supply, solid waste management,

communication and IT, and mental health promotion). The NCCHCHV will finally ratify the expert group's suggestions. The expert group also is responsible for monitoring and evaluation of CBI activities. For this purpose, they have defined a set of indicators for evaluation of healthy cities and a checklist for monitoring of the projects.

Most of the job of program implementation and actual intersectoral action is taking place at district level. The governors ("Farmandar"); as the heads of the Healthy City/ Healthy Village Headquarters; are the most influential actors in CBI implementation. The CBI program coordinators (most of whom are from health sectors but some of them are officers of local governments or municipalities) also are playing a key role.

Other members of district intersectoral committee (which is named Healthy City and Healthy Village Headquarters for HCP/HVP and Technical Support Team for BDN) like representatives of governorate, health, education, welfare, water and wastewater organization, agriculture, housing and other departments are supposed to:

- participate in district and/or national CBI training courses and be active in national CBI seminars;
- be in contact with local community members to define their needs and involve them in the decision making and project implementation processes;
- actively participate in district-level intersectoral meetings (both the main intersectoral committee and different subcommittees) to arrange their sectoral and intersectoral action plans;
- implement their defined actions; and
- provide data and project documents.

In different program areas; representatives from 12 to 40 ministries and organizations were involved.

The main actors lobbying for intersectoral action were mostly the governors and the CBI program coordinators. The governors were the head of Healthy City/ Healthy Village Headquarters and the CBI program coordinators were secretary of this headquarters. The headquarters had regular meetings, mostly in governor's office, and the decisions on intersectoral action were made in these meetings. The involved sectors were expected to report the progress in their intersectoral action in the meetings. In Healthy City Headquarters, there were also subcommittees for various issues.

4.9. The role of health sector

The national CBI secretariat is in the Department of Occupational and Environmental Health of MOHME. The minister of health and medical education (or his deputy for health) is a member and the secretary of the NCCHCHV. Therefore it is obvious that health sector has had a leadership role in CBI program. At province level, Chancellor of each University of Medical Science is a member and also the secretary of provincial health council which is responsible about CBI related issues at province level. At district level, head of district health network is a member (and again the secretary) of healthy city/ healthy village headquarters in HCP/HVP.

National CBI secretariat, in MOHME, have prepared practical guidelines and conducted training workshops in all program areas. This secretariat is also responsible for monitoring and evaluation of the CBI programs; so they receive progress reports from program areas and should assist them if they encountered any problem at province and/or district level. Most of CBI program coordinators were from health sector; although some of them were from other organizations like municipalities. The health professionals

involved in CBI have broadened the focus of their interests and activities to include all aspects of development like: employment and income generation, environment and information technology instead of just focusing on topics more closely related to health.

4.10. Participatory Mechanisms

Social preparation in BDN aims to transform the dependency psychology of *aid, assistance, relief and donation* resulting from the paternalistic approach of government workers and aid agencies to real community empowerment through dynamic partnerships among all stakeholders facilitating *self-help, self-financing, responsibility and accountability* [13].

Each village was divided into clusters of 15-25 households and a cluster representative (CR) was elected. The CRs selected a village development committee (VDC) including all members of Village Council and some other members from CRs. CRs and VDC members were trained by the intersectoral team (TST) to advise them about the concept of the BDN programme and its methodology, implementation, monitoring and evaluation [14].

CRs and VDC representatives, under the supervision of the intersectoral team, collected and analyzed baseline household and community surveys which comprised simple needs assessment and semi-structured priority-setting questionnaires.

Through these questionnaires, the VDC representatives established the village needs in terms of income generation, cultural, social, leisure, environmental and health issues.

The community formed proposals based on their identified community needs. Each community developed its own unique range of social and income generation projects. CRs, VDC members and the intersectoral team in each village reviewed applications and prepared proposals for final selection according to feasibility, cost-effectiveness and potential community benefits. Successful proposals became eligible for financial support.

The participatory mechanisms in HCP/ HVP were not structured as it was seen in BDN. At the beginning of the program, a community needs assessment was conducted based on a household survey. The results of needs assessment were analyzed in Healthy City/ Healthy Village Headquarters and the projects were selected according to priority of needs, availability of resources, and compatibility with national and regional development plans. The City or Village Councils; as representatives of the community; were supposed to give feedbacks on decisions of intersectoral team.

<p style="text-align: center;">Ten practical steps towards a Basic Development Needs approach</p> <p>The intersectoral teams implemented the following activities:</p> <ol style="list-style-type: none">1. Village clustering2. Selection of cluster representatives (CRs)3. Selection of village development committees (VDCs)4. Training of CRs and VDCs on household and community surveys5. Conducting village survey6. Data analysis at village level7. Identifying needs in order of priority8. Designing projects to meet the needs9. Selection of feasible projects based on human and monetary resources, and appropriate technology10. Funding projects and starting implementation
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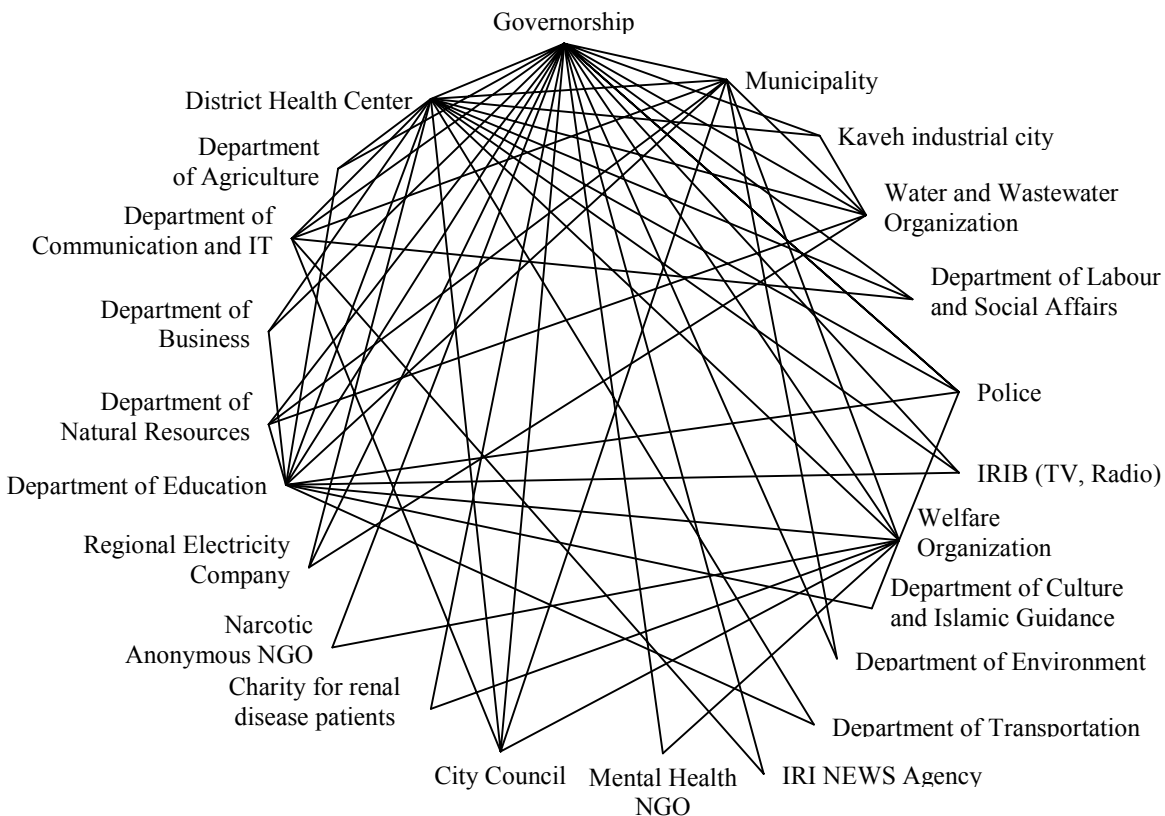
4.11. Level of integration and the model of the relationship

At national level, the NCCHCHV and its expert group provide a basis for intersectoral action. The members of expert group usually share the information about their organizational priorities and future plans to avoid parallel activities and make use the contribution of other sector to improve their own programs (cooperation). In one occasion; all the members of expert group tried to determine seven national priority subjects and plan seven projects for these priorities. Then these seven projects were approved by the NCCHCHV (coordination).

Box 1- Saveh Healthy City

Saveh; a city with population of 150'000 in central part of Iran; started Healthy City Program in 1996. Community needs assessment showed that inappropriate quality and quantity of drinking water; lack of recreational facilities; and low surface area of green space were among top 10 problems identified by the Saveh citizens in 2001.

The Healthy City Headquarters have 27 fixed members including representatives from 14 ministries and organizations who have a member in NCCHCHV, as well as members from other sectors like police, judiciary, Saveh municipality, City Council, "Hoday-e-rahmat" NGO, Mental health co-workers (NGO), NA group, "Hojjat-ibn-alHassan" charity, "Ali-ibn-abitaleb" institute, "Teflan-e-Zeinab" religious group, and Association for Supporters of Renal Disease Patients. Saveh Healthy City Headquarters established seven subcommittees: Traffic Injury Prevention (headed by district health center), Nutrition (headed by district health center), Water Resources (headed by water and wastewater organization), Solid Waste Management (headed by Saveh municipality), Information Technology (headed by department of communication and IT), Healthy Schools (headed by department of education) and Mental Health Promotion (headed by welfare organization). The following map is a schematic presentation of the relationships in Saveh Healthy City Headquarters and its seven subcommittees:



Schematic map of relationships in Saveh Healthy City
(Some of the less involved organizations are not shown in the map)

The water resources subcommittee; included representatives from local government, municipality, district water and waste water department, district health center, Kaveh industrial city, provincial water and wastewater department and ministry of energy.

District water and wastewater department, Kaveh industrial city and district health center jointly worked to: prevent pollution of underground water resources by industrial sewage; refine the industrial wastewater and monitor the chemical and biological characteristics of the refined water. It was also planned that the Saveh municipality make use the refined water to extend the surface area of green space in the city, and build a recreational facility (Roof of Saveh) and also the natural resource department use it to develop a green belt around the city (Horizontal integration).

The efforts of governor, district and provincial water and wastewater department and ministry of energy made it possible that Saveh Drinking Water Supply Project be approved as a national project (with 19 billion rials; or about 2 million US\$; budget) in which drinking water will be provided from sources out of the province (Vertical integration).

At district level, different levels of integration could be observed in various projects. In some projects, the organizations informed other sectors to avoid their interference or to contribute in the project by performing a specific task (cooperation); there were other cases that a full integrated action was observed like Saveh drinking water project (see Box1- Saveh healthy city program).

The models of relationships were different in various program areas. At national level, the health sector is working as the primary coordinator and all other members of NCCHCHV would contribute as they were able. At district level, the governorship is the primary coordinator. Besides the governorship; the health sector is expected to play a leading role in the district intersectoral committee.

In program areas where subcommittees are active (mostly the healthy cities), the model of relationship becomes more complicated; because in each subcommittee a sector plays the leading role. (See Saveh example in Box 1)

5. IMPACT

5.1. Policy outcomes

- BDN program

Findings of evaluation: The majority of respondents mentioned to improved participation, solidarity, self-confidence, self-belief and sense of independence in the community; as most important benefits of BDN program. Other advantages have been as follows: decreased migration to the cities, clarification of community needs, better communication between people and local government, increased absorption of governmental budget and better access to public services. Income and employment generation projects improved economic conditions. It was found that other adjacent villages had expressed their willingness to join the BDN program.

- Healthy Village Program

Findings of evaluation: Most of the interviewees believed that community self-reliance and their hope for the future have been intensified; therefore they are less willing to migrate to the cities. It was also declared that a positive change has occurred in health-related behaviors of the people and a new mentality inspired into the minds of managers. Some of the members of intersectoral team opined that other villages have adapted parts of the program in their own villages.

- Healthy City Program

A set of indicators have been developed by national expert group for evaluation of healthy city programs in the country. The first round of data collection based on the national indicators was performed in some of the HCP areas. Evaluation study found that increased financial resources from governmental and private sector to be spent for public services occurred in Saveh healthy city. Many of the activities and projects that used to be implemented by a single sector, now is done as intersectoral action. HCP improved the communication between people and the government.

Improvements in water resources and regular practice of waste collection and disposal, increased city green space, better public transportation and traffic conditions, increased number of recreational facilities and activation of many NGOs are considered as achievements of healthy city programs.

5.2. Impact on health equity

Although in many other countries in EMR the CBI have been used to expand PHC and implement health programs, in Iran; because of the presence of widespread Health Network which has particularly a high coverage at villages; the health services component in CBI programs was less significant.

However, the CBI interventions were successful to decrease the gap between rich and the poor and to improve access to various public services (e.g. solid waste management, drinking water supply, sewage disposal; gas piping; sport and recreational facilities; healthy schools and so on) among underprivileged populations. It can be concluded that CBI have improved the social determinants of health toward more equitable health. So, it is expected that CBI would lead to a better equity in health in long-term period.

For CBI to be successful in improving health equity in short-term, the health component in CBI should be strengthened.

5.3. Changes in indicators

Some of the findings of CBI evaluation regarding changes in indicators are as follows:

Basic Development Needs program

In five studied BDN villages (located in 3 districts of 3 different provinces) compared with all other villages of the same districts:

While the population of the five villages was approximately stable; changing from 7678 in 2000 to 7623 in 2004 (-0.7%); the population of all other villages decreased from 378521 to 351159 (-7.2%) in the same period.

The proportion of households who had access to sanitary waste disposal in five BDN villages, raised from 22.5% in 2000 to 92.4% in 2004; while at the same time this proportion in all other villages of the same districts changed from 48.6% to 66.8%.

The results of Social Capital Household Questionnaire in program areas (3 BDN villages and 2 Healthy Villages) compared with their matched villages showed that:

The proportion of households of BDN villages with limited access to employment (51.7% vs. 59.0%), loans (40.7% vs. 57.4%), drinking water (11.9% vs. 27.9%), hygienic solid waste disposal (33.9% vs. 57.4%) and agricultural consultation (25.4% vs. 35.4%) are less than control villages.

While 39.1% of BDN village respondents estimated the community participation in their village as “very high”, this proportion was far less (14.2%) in control villages; inversely 3.5% of BDN villagers estimated participation as “very low” or “low”, while this proportion was 16.3% in the control areas.

In BDN villages, 65.8% of the respondents opined that their neighbours spend “very much” time or money for common developmental projects, while in control villages only 25.4% had the same idea.

Healthy Village Program

In five studied Healthy Village Programs (located in 4 districts of 4 different provinces) compared with all other villages of the same districts:

The population of Healthy Villages increased from 11112 in 2000 to 11792 in 2004 (+6.1%); while the population of all villages of the same districts decreased from 285404 to 251241 in the same period (-12.0%).

The results of Social Capital Household Survey in two of HVP villages and their controls showed that:

The problems in access to employment (78.5% vs. 89.2%), solid waste management (48.4% vs. 66.7%), agricultural promotion (23.7% vs. 36.6%) and police (8.6% vs.

20.4%) were better in HVP villages than their controls. In HVP villages, more respondents believed that the trust between people have been increased compared with both previous years (45.1% vs. 27.2%) and other villages (69% vs. 50%).

So, the stability (or even increase) in the population of CBI villages compared to the decrease in population of other villages (due to migration to the cities) imply two points: 1) If the living conditions in villages be improved, we are able to stop migration to the cities even despite continuation of the trend in adjacent villages; 2) CBI programs (both BDN and HVP) have been successful in improving living conditions in the villages.

Healthy City Program

In Healthy Cities, no control area was studied and most of the indicators have been measured only once. So, for most of the indicators it was not possible to observe a secular trend or compare the indicators with another city. However, the following changes were observed in indicators:

- In Saveh Healthy City, the surface of green spaces was doubled in a seven year period (200 acres in 1997 raised to 395 in 2004).
- Number of public sports facilities in Saveh raised from 13 (1997) to 44 (2004).
- Number of active NGOs in Yazd city increased from 1 (1997) to 36 (2004).

5.4. The actors' responses to the process and outcomes

Majority of involved stakeholders of CBI programs were satisfied with their own activities. Most of the provincial and district CBI coordinators who were officers of occupational and environmental health departments, were very interested in CBI.

Some of the governors and also province governors involved in CBI programs became strong advocates. They continued their support for improvement of CBI programs even when they changed their positions.

In none of the evaluated program areas, there were incentives for intersectoral team members or community volunteers (CRs or VDC members of BDN program). So, the level of activity of government or non-government sector actors relied on either their personal interests or the relationship (official and non-official) between them and program leaders (governors and CBI coordinators).

The health sector paid more attention to intersectoral action because of CBI successful experience. In 2006, the Supreme Health Council was established which is headed by the President. The CBI officials believe that this event has been a consequence of CBI activities particularly the actions of National Coordinating Council for Healthy Cities and Healthy Villages.

Besides improvements in community participation and intersectoral collaboration; one of the advantages of CBI was positive changes in policy making at different levels.

Two cases of effects on policy making at national level are mentioned in the following quotes:

"I was the representative of ministry of housing and urban planning in national healthy city expert group. When the idea of healthy city was transferred to our ministry, gradually it changed the minds of ministry authorities; thereby the law for establishment of new cities was changed. In previous law, the ministry was the only responsible agency for building new cities; but the new law emphasized that construction of a new city is a multisectoral decision and the ministry of housing was just the administrative agent, not responsible for everything. I was a close witness of this great success of healthy city program." *Member of NCCHCHV*

"We have a defined schedule for extension of telephone network for each area. Wherever the HCP or HVP was implementing, we did our programs sooner than the schedule without any delay or change in other areas. I mean we considered it as an extraordinary job." *Member of NCCHCHV*

In all of the studied healthy villages it was observed that health has become an important topic in public agenda. The community asked for broader health services and was willing to invest on their health more than before.

The summary of comparison of the three CBI programs is shown in table 4.

Table 4- Comparison of intersectoral action for health in three CBI programs

	<i>Healthy City Program</i>	<i>Healthy Village Program</i>	<i>Basic Development Needs</i>
Context	Rapid population growth and urbanization, crowded population, traffic, housing shortage, air and industrial pollution, shortage of water resources, and inadequate sewage and solid waste management systems	Inequality in access to public services and employment between cities and villages, migration to the cities, scarcity of human and other resources	At present, the BDN approach have been implemented just in villages; so the context is similar to HVP
Approach	Place-based: a city or part of a city Setting-based: healthy school Targeted (approved by NCCHCHV): mental health promotion, traffic injury prevention, nutrition, water supply, solid waste management, communication and IT, and mental health promotion.	Place-based: a village	Place-based: a village
Policy entry point	To reduce exposures of people living in underprivileged areas to health damaging factors	To reduce exposures of people living in underprivileged areas to health damaging factors	To reduce social stratification by income and employment generation
Structure at national level	NCCHCHV	NCCHCHV	NCCHCHV (although this structure was not fully involved at the beginning of BDN)
Intersectoral committee at district level	Healthy City Headquarters	Healthy City and Healthy Village Headquarters	Technical Support Team (TST)
Community involvement	Informing	Consulting	Collaborating
Impacts	Increased financial resources for public services, increased surface of green space, improvement in water resources	Decreased migration to the cities, improvement in solid waste management	Decreased migration to the cities, better access to employment, improvement in access to drinking water and solid waste management

Although the CBI activities have been mostly led by Ministry of Health and Medical Education, other organizations adopted the CBI strategies in their organizations' plans; for instance ministry of housing and urban development has used the principles of healthy city in revising the new cities law; or ministry of welfare is considering to expand BDN approach for development of rural areas.

The fourth five-year development plan (2005-2009) referred to BDN as one of the essential strategies for social justice:

"The government should enhance community participation and empowerment, based on Basic Development Needs approach and community social services need assessment. The mechanisms involved are micro-credit development projects with consideration of local capacities." (article 95)

Some structural changes have happened to support the leadership role of MOHME in CBI programs. The CBI secretariat; with at least two fixed officers; has been established in occupational and environmental health department of deputy for health of MOHME to manage all CBI related activities e.g.: arranging NCCHCHV and the expert group meetings, preparation of program guidelines and educational materials as well as monitoring and evaluation. In every province or district that implements CBI programs; the occupational and environmental health departments of province and/or district health centers are involved and the head of the department is working as CBI technical officer besides his/her other duties.

The results of evaluation have already been presented in the following occasions:

1) A one-day symposium for National Healthy Cities and Healthy Villages Expert Group took place in Tehran. The results of evaluation and the detailed recommendations for future were presented and there was a discussion over the results and conclusions. Generally, the experts had a sense of ownership to the findings of evaluation and were discussing to decide how to implement the recommendations.

2) A two-day workshop for provincial CBI coordinators and representatives from program areas involved in evaluation was held in Qeshm Island. The results of evaluation were presented and a panel discussion occurred regarding the applications of the evaluation findings and reviewing lessons learned.

6. Lessons learned

6.1. The role of evidence in stimulating action

The CBI has prepared an appropriate basis for implementation of health\ or social interventions. So, in many cases the information regarding social disparities or health inequities have been used for action in the CBI background. For example, the national death registry; which was established in 2000; showed that traffic injuries are one of the three main causes of death in IRI and the most vulnerable road users are motorcyclists. Based on this evidence, the NCCHCHV planned an intersectoral action tackling traffic accidents. This decision led to establishment of a traffic injury prevention committee at national level and in some of the healthy cities like Saveh. The intersectoral action against traffic injuries planned in the committee and the tasks of each of the acting sectors were assigned.

6.2. Elements of policy and strategy to be developed from the outset and issues to be addressed as the process develops

Creating a strong political commitment especially among general governors at province level and governors at districts who have both the power and the responsibility of

coordinating different sectors in their territory is the key initial step. In most of the program areas; the trigger of CBI programs was willingness of provincial and district authorities to join the program. After expressing the local willingness to the program, a team of national experts was sent to the province to describe principles of CBI for the general governor, governor and heads of various departments. This was usually a two-day workshop aimed to provoke the interests of top-level managers to the CBI and acquisition of a strong political commitment of different sectors. In next step, it was supposed that intersectoral committee; headed by the governor himself; be established. The CBI coordinator; who was from health sector in most (but not all) of the cases; was appointed by the governor.

One of the other initial steps was community needs assessment and priority setting. According to the results of needs assessment and considering feasibility of interventions, a number of subcommittees were organized under the intersectoral committee like: water and waste water, accident and injury prevention, public nutrition, communication and IT and so on.

The tools and indicators for monitoring and evaluation should be developed and/or introduced in initial steps to help the action to be more targeted.

Organizational and community financial contribution is better to be addressed later. It is better to discuss financial issues after creating a sense of cooperation and ownership among all stakeholders.

6.3. Optimum timing for involving key players

For involving the political actors (especially the governors), making them committed to the program is more important than time. But usually the two-day workshop is enough to justify the program for this group. For the intersectoral team who should practically be involved in CBI, a 5 to 10 days workshop is necessary to make them ready for action and to discuss the essential concepts of working with communities.

6.4. The effectiveness of structures, platforms and mechanisms

The existence of Islamic councils in all cities and villages has provided a good opportunity for community-based activities. Council assistants and neighborhood councils are another group who are elected for each neighborhood in the cities, to facilitate the communication between people and city Islamic councils.

Considering these councils and council assistants as entry points to the communities seems to be a reasonable choice for community-based initiatives; the successful examples of such an experience were observed in healthy villages like Jelikan, Tabl and Holor. In the two studied healthy cities, the potential capabilities of city council and especially council assistants were not fully used.

Most of financial mechanisms applied in CBI did not work properly:

- No specific funds were available for intersectoral projects; therefore the collaborative organizations had to use their own budget for the common projects. If the project was not defined in an organization's particular plan of action; it was too difficult to involve that sector to the project.
- There were not any incentives or inhibitory mechanisms to push organizations to participate in intersectoral actions.
- In most of the BDN villages, people were complaining of both small amounts and small number of loans. The amounts of loans for income generating activities given by banks (20-30 million Rials) are much higher (4 to 30 folds) than BDN loans (1-5 million Rials).

6.5. Some of the barriers and how to overcome them

- The evaluation found that in cases that a single organization starts the CBI activities and does not involve other sectors from initial steps; they will face a resistance if decide to involve other sectors in the future. For example; the Free Zone Organization started Healthy Village Programs in some of the villages of Qeshm Island; they worked closely with the community but the other sectors were not involved. In later years, it was too difficult to involve the local government and other sectors in the program. To overcome this barrier, it is important to involve all sectors and stakeholders from the beginning.

- Change in key position is another important barrier that may even lead to cessation of the program; for example both healthy city programs studied in the evaluation had been suspended for a period of 1-2 years because of changes in key positions. For a program that has lasted for more than a decade, it is not surprising that many of the individuals in key positions have been changed. It looks natural and is not expected to adversely affect the program. But when the program does not have a separate budget; and the level of involvement and activities of stakeholders are mostly dependent on their personal views and interests rather than defined duties, the changes in key positions becomes very important; especially when a self-motivated program coordinator or an interested governor is going to be changed. To decrease the negative impact of such changes, it seems necessary to pass a new law to clearly define the roles and responsibilities of stakeholders and specify how the needed resources should be provided.

- The heavy bureaucracy and tight regulations have had some adverse effects on intersectoral action in CBI programs; for instance the banks did not pay loans to village development funds; because according to their regulations the loans could only be paid to individuals not to a fund, another regulation is that the potential loan grantees should introduce governmental employees as guarantors which is hard to do especially for poor people. Following quote shows another example of negative effects of bureaucracy on intersectoral collaboration:

“The rights and limits of organizations are not defined in healthy city headquarters. For example; normally, if water organization needs to dig a street for piping, it should pay to the municipality (besides reconstructing the street). But in healthy city headquarters these kinds of relations are not defined.” Head of Yazd city Islamic council

To overcome this barrier, the issues have been discussed in district or national (NCCHCHV) intersectoral committees case by case and decisions were made; but to systematically solve these problems new laws to facilitate the intersectoral actions and decrease the bureaucratic processes are needed.

- Another problem occasionally encountered both in communities and among other stakeholders, was high expectations from the programs. In some cases, communities have seen a window of hope and then expected immediate resolution of all their needs, and started complaining of the program or insufficient resources. In several cases, government or program officials had promised things to the community and then either forgot their promise or were not able to keep it. To prevent such events, it is necessary to warn the program staff and intersectoral members from the initial steps to be patient; move step-by-step and be very

cautious about making a lot of promise to the community (and also themselves) throughout the program.

6.6. Recommendation for improvement

- Legal establishment of a structure for CBI, officially defining the roles and responsibilities of various stakeholders; especially the key persons like governors; and clearly determining mechanisms for intersectoral collaboration is recommended.
- Adding a process of designation for healthy cities and healthy villages at national level is strongly recommended. Minimum characteristics for designation could be: existence of an intersectoral committee with community (city or village council, or NGOs) representatives, presence of a program coordinator, having a city (or village) health profile and a city (or village) health plan.
- Preparation of a city or village health (or development) plan by involving all stakeholders should be considered. Setting measurable objectives for this plan can facilitate monitoring and evaluation. Such a plan should be based on community priorities and be in harmony with national and local developmental plans.
- Networking between various community based initiative program areas is essential for sharing knowledge and experience.
- Monitoring and supervision should be more regular and efficient. Specific tools to measure and monitor the intersectoral action will be very useful.
- Documentation and reporting need to be strengthened. Tools for conducting standard needs assessments and baseline surveys need to be revised and the results of such surveys and assessments should be easily accessible. Development of guidelines and templates for preparing progress reports, best practices, and case studies is recommended.
- Program managers at all levels should be encouraged to record all costs of the programs to be used for future evaluations and analyses.

6.7. How has this initiative changed "business-as-usual"?

Most of the members of intersectoral teams believed that CBI has changed their routines for decision making. Now, most of decisions are made by a group of intersectoral experts rather than a single organization. The same thing has happened in practice; in most of developmental projects more than one sector is involved. The role of community in defining their needs, priority setting of the problems and participation in projects has also been improved.

6.8. Applicability of mechanisms to other policy environments

The diversity of projects implemented throughout the CBI programs like: solid waste disposal, mental health promotion, drinking water supply, income generating activities (agriculture, making handicrafts, broidery, computer skills development, etc.), building public places (like general library, health center), traffic injury prevention, violence prevention, communication and IT (like creating electronic government and increasing public access to internet) and many other projects shows that the CBI basis have already been used for many other policy environments.

CBI approach and mechanisms is going to be used for social justice. In the fourth Five-Year Economic, Social and Cultural Development Plan (2005-2009) it has been mentioned that the government should try to improve social justice through the Basic Development Needs approach. The ministry of welfare is trying to adopt BDN approach for improving socioeconomic conditions in rural areas.

7. ADDITIONAL INSIGHTS

7.1. What arguments were most/least persuasive in making the case for intersectoral action?

Successfulness of CBI model in evoking intersectoral action has yielded similar activities in health and other sectors, like establishment of Supreme Health Council. This fact has been very persuasive in making the case.

The dependency of intersectoral action to certain individuals (like governors or program coordinators); plus changes in key positions and the necessity of justification of the program for the new officials are issues concerning the sustainability. The findings of the evaluation study emphasize this issue: both of the two Healthy Cities studied in the evaluation had been tapered (after changes in key positions) for a period of 1-2 years and then restarted.

7.2. How was commitment sustained over time?

Establishment of NCCHCHV, approved by the council of ministers in 1996 which includes ten ministries and five organizations, provides a strong basis for political commitment at highest level. The CBI-related intersectoral committees headed by the governors at districts are important advocates of intersectoral action.

The continuity of activities of National Healthy Cities and Healthy Villages Expert group; which has representatives from 15 ministries and organizations and is responsible for training, monitoring and evaluation of CBI activities at national level; for about a decade is an important factor regarding the sustainability. This expert group had 62 meetings from 1998 to 2005 on a monthly basis.

7.3. How can the health sector strengthen its capacity for intersectoral action?

The followings may help the health sector to strengthen its capacity for intersectoral action:

- Bringing the issues of community health and health equity to the public agenda.
- To convince other sectors that health is the essential element of sustainable development and health equity can not be achieved without equity in health determinants.
- Preparation of evidences on decomposition of determinants of health inequities. Quantifying the share of each sector in creation of health inequities can be a strong advocacy tool for health sector.
- Providing more equitable health services will show the other sectors that how committed and serious the health sector is.
- In the IRI, the health sector was successful to convince the other sectors to consider health and health equity in development of fourth Five-Year Economic, Social and Cultural Development Plan (2005-2009). The widespread health network that provides primary health care to almost all of the country established after the Islamic Revolution as well as recent reforms like: Family Physician Project and Rural Health Insurance Promotion Program are serious actions undertaken by the health sector.

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Annex A- Methodology of CBI evaluation study in the IRI

Selection of program areas

The list of program sites of CBI in Iran, which is available in WHO/ EMRO website, included 17 BDN, 19 HCP and 47 HVP.

In a meeting at CBI secretariat in MOH, the new program sites (less than 3 years) and currently inactive ones were identified and excluded from the list. From the rest of the program areas, twelve were selected by stratified random sampling. Stratification was based on program type, and the twelve selected areas included five Healthy Villages, five BDN villages and two Healthy Cities (Table 1).

Table A-1- List of randomly selected program areas for CBI evaluation in I.R. of Iran

Program area	Population (2004)	Year started	District	Province
<i>BDN villages</i>				
Hammamlar	921	2000	Uromiyeh	West Azarbaijan
Mohammadsalehi	1395	2000	Ganaveh	Bushehr
Shole	941	2000	Ganaveh	Bushehr
Hureh	1496	2000	Shahrekord	Chaharmahal and Bakhtiyari
Savadjan	2870	2000	Shahrekord	Chaharmahal and Bakhtiyari
<i>Healthy Villages</i>				
Holor	4686	2000	Qeshm	Hormozgan
Tabl	2774	2000	Qeshm	Hormozgan
Jorjafk	938	2002	Zarand	Kerman
Jelikan Sofla	861	2001	Noor	Mazandaran
Taraznahid	2533	2002	Saveh	Markazi
<i>Healthy Cities</i>				
Saveh	159700	1995	Saveh	Markazi
Yazd	465000	1994	Yazd	Yazd

Study design

The study was carried out in two phases; the first phase was a description of the programs at national, district and community levels in all twelve selected program areas; the second phase was a quasi-experimental study to compare some social/ health indicators (mostly social capital) between five selected BDN or HVP program areas and five control villages.

Selection of five villages for the second phase was based on the results of first phase of the study; three BDN and two healthy villages that had shown higher success in implementation of programs were recruited, namely Hureh (BDN), Savadjan (BDN), Mohammadsalehi (BDN), Jelikan (HVP) and Taraznahid (HVP).

The criteria for selection of control villages were:

1. Being in the same sub-district as intervention village;
2. The number of population in control village be near to the intervention village;
3. Comparable history of participatory activities.

Thus, following five control areas were selected matched to above mentioned intervention villages respectively: Shourab-e-saghir, Garmdarreh, Chahar rousa, Maasoumabad and Aaveh.

Study areas and study population

The study areas covered the CBI programs at national level and selected program areas including mid levels (8 districts in 8 provinces) and local levels (2 cities, 10 intervention villages and 5 control villages).

The study population for the first phase of evaluation included:

- Community structures like city Islamic councils, village Islamic councils, Village Development Committees, cluster representatives and NGOs
- Other members of communities in general including men, women, youth, students, beneficiaries of social and income generating projects
- Policy makers, government managers, health system officials at national and local levels
- Intersectoral team members at national and local levels including National Healthy cities and Healthy Villages Expert Group, district healthy city/ healthy village headquarters, BDN technical support teams
- CBI programme managers and staff at all levels

For the second phase of evaluation (Social Capital Comparative Study) which was a comparative study between five selected intervention villages and five control villages; 40 households were chosen by systematic random sampling in each village. Therefore, totally it became 200 households in program areas compared to 200 households living in control areas.

The sample frames were obtained from household folders of health houses, which is available in almost all of the villages across the country.

Data collection methods

Following approaches were used by the evaluation teams for gathering information:

- A number of forms and checklist regarding the details of program implementation, site selection, projects, publications, training and education, budget and etc.
- Review of programme documents at all levels;
- Interviews with key informants including: national expert group, program managers, provincial/ district/ sub-district governors, health network officials, and other stakeholders;
- Focus Group Discussions (FGDs) with intersectoral teams and community groups;
- Structured questionnaire (social capital questionnaire adopted from World Bank's social capital assessment tool) to carry out a household survey in five villages and their controls;
- Collecting data from available data sources like: health horoscope (available at health house), surveillance data, baseline and serial surveys to find the changes in indicators before and after program implementation as well as compare these changes with non-CBI areas within the same period of time.

Collectively 47 FGDs and 58 interviews were carried out. The participants and interviewees are summarized in table2.

Organizing the evaluation team

To organize an intersectoral team for evaluation; all of the ministries and organizations that have a member in National Coordinating Council for Healthy Cities and Healthy Villages were requested to introduce a representative.

A group of four delegates from ministry of education, ministry of agricultural Jihad, department of environment and national broadcasting agency (IRIB) were recruited. Three members of national CBI secretariat and one of the provincial CBI coordinators were added to form the national evaluation team. The team was trained in a 4-days workshop in first week of November 2005. The field visits and two phases of data collection were carried out from November 2005 to February 2006.

Data analysis

The voices of almost all of the interviews and FGDs were recorded. All of the voices were transformed to written format by a number of public health students. Then the written texts of all interviews and discussions, as well as notes written by interviewers and note-takers were

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carefully read and coded by a number of independent academic experts (epidemiologists or social medicine specialists).

Statistical analysis of quantitative data was carried out using STATA (version 8.0) and Microsoft Excel.

Table A-2- List of interviewees and participants of Focus Group Discussions (FGDs) met in CBI evaluation of I.R. of Iran

Level	Interviews Interviewee	No.	FGDs Participants	No.
National	Policy maker	2		
	Current national CBI coordinator	2		
	Former national CBI coordinator	2		
	Member of national expert group	7		
Mid-level (province or district)	Province governor	1	BDN Technical Support Teams	3
	District governor	5	HCP/ HVP headquarters	4
	Sub-district governor	7		
	Chancellor of UMS	1		
	Vice chancellor for health of UMS	4		
	Director of district health center	6		
	CBI Program coordinator	9		
	Mayor	2		
	Others	7		
	Community	Head of City Islamic council	2	Village Islamic council
Head of Village Islamic council		1	City Islamic council	1
			VDC	4
			Men (BDN beneficiaries)	2
			Women (BDN beneficiaries)	2
			Youth	5
			Men	9
			Women	10
			Healthy schools	2
			NGOs	2
Total		58		47

Annex B- Map of the Islamic Republic of Iran

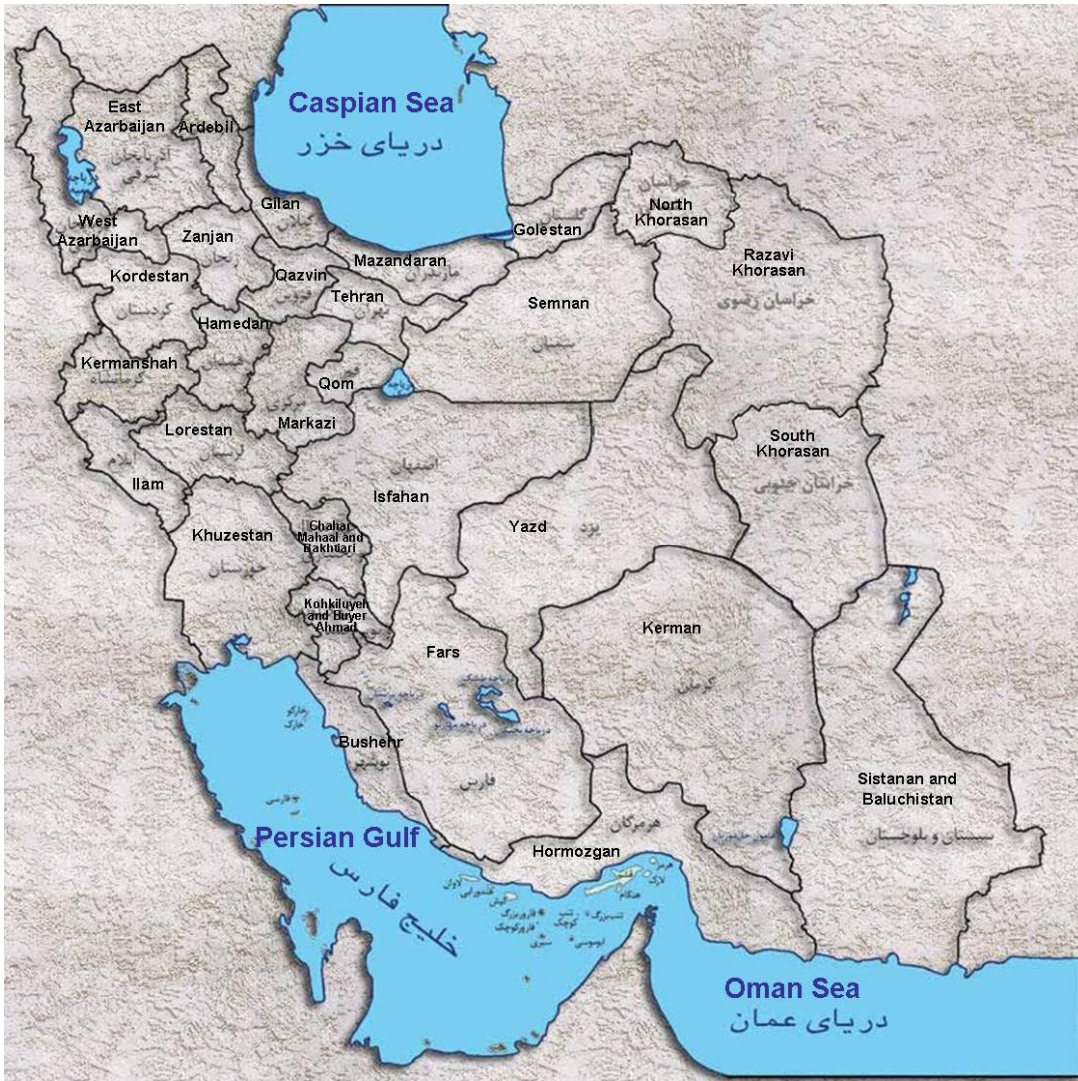


Fig B-1. Political map of the Islamic Republic of Iran