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REPORT ON THE

CEHA FIRST REGIONAL CONFERENCE ON HEALTHY VILLAGES

Isfahan, Islamic Republic of Iran
6 - 9 November 1995

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE EASTERN MEDITERRANEAN
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1. INTRODUCTION

The Eastern Mediterranean Region (EMR) of WHO consists of 22 Member States and the Palestinian Self-Government Authority. 56% of the Region's population live in rural areas. Almost all Member States are undergoing rapid urbanization. Population pressure and demand for services in urban areas attracts attention and resources towards cities, a situation which has left the rural areas in many countries with limited resources to deal with their health and environmental problems.

Improving the health of the rural population is a prerequisite to improving their quality of life. The health sector has, for many years, been involved in the control of communicable diseases, vector-borne diseases, water supply and sanitation and other elements of primary health care. However, efforts are needed to bring about an integrated implementation process. In order to address the physical, social and economic issues that affect health at the village level, the healthy village concept was initiated by WHO/EMRO.

The healthy village concept is a holistic approach aimed at improving the quality of life, health and environment in the rural areas. As a priority, it seeks to improve environmental conditions through healthy housing, proper water supply and sanitation, safe handling and disposal of refuse, safe food preparation and storage, control of disease vectors in the environment and prevention of risk from chemicals/ pesticides. The healthy village concept also addresses income generation and other health-related requirements that are essential for sustainable rural development.

Current emphasis in the rural areas is almost entirely on water supply and sanitation with other related elements of environmental health being neglected. Despite major efforts during the International Drinking Water Supply and Sanitation Decade (IDWSSD), water supply coverage to rural populations still requires a great deal of improvement in many countries of the Region. Many people still do not have adequate access to sufficient and safe water. Rural sanitation coverage is critically low. It is believed that lack of latrines and open defecation around villages contribute heavily to infant mortality and morbidity.

2. OBJECTIVES

The First Conference on Healthy Villages, which was organized by the Regional Centre for Environmental Health Activities (CEHA), was held at the Isfahan University of Medical Sciences and Health Services, Isfahan, Islamic Republic of Iran from 6 to 9 November 1995. This first conference of its kind on healthy villages was organized to provide a forum to high level local and government decision-makers for discussion of the concept of the healthy village and its integration with similar approaches under implementation in the Region, such as the basic minimum needs approach, and all of which are aimed at improving the quality of life in rural areas.

The objectives of the conference were to:

1. Review, assess and discuss the basic principles of the healthy village approach and its application in the context of the socioeconomic, cultural and religious background of the Region;

2. Promote and encourage the implementation of the healthy village approach in the Region in order to improve the quality of life in rural areas;

3. Promote regional collaboration and exchange of information by bringing together the interested professionals and officials of the Member States through a forum of discussions and exchange of experiences;

4. Formulate a regional strategy/policy for guiding and setting the direction of future action plans for healthy village programmes in the Region;

5. Adopt the strategy of "Training trainers"; the participating trainers will take part in the further training of other professionals who will be involved in the future national training activities of CEHA.

The agenda and programme of the conference are given in Annexes 1 and 2, respectively.

3. PARTICIPANTS

The conference was attended by 16 participants from nine countries, as well as by seven observers of the Iranian Ministry of Health and Medical Education from different provinces. Representatives of WHO to Afghanistan, Egypt, Islamic Republic of Iran, Morocco, Pakistan and concerned staff members of WHO Headquarters, WHO/EMRO and CEHA also attended. A list of participants is given in Annex 3.

4. OPENING SESSION

4.1 Address by the Chancellor, Isfahan University of Medical Sciences and Health Services

Dr Hamid Reza Jamshidi, the Chancellor of Isfahan University of Medical Sciences and Health Services gave the opening address. He welcomed the participants and expressed his appreciation to WHO/EMRO for choosing Isfahan to host the conference. He noted that the total population of Isfahan Province was 3 830 000, of whom 1 034 000 were rural residents. Isfahan University of Medical Sciences and Health Services was responsible for providing the whole population of the province with health services. For this purpose, 614 active health houses and 136 active rural health centres had been established. The infant mortality rate in rural areas was 23.6 per 1000 live births and the average annual rural population growth rate was 1.6%.

In addition to the eight main elements of primary health care, mental health, occupational health, environmental health in addition to water supply and sanitation, and noncommunicable diseases had been added to the functions of some health centres. In the near future another component, oral and dental health services would be offered by some of the health centres. In order to achieve the goals of community participation in providing health care, 6200 health volunteers had been trained so far to facilitate the services of health centres. Medical students received training in rural areas as part of their course of study, with emphasis being placed on community medicine.

4.2 Address by the Regional Director for the Eastern Mediterranean Region of WHO

Dr Hussein A. Gezairy, Regional Director, WHO Eastern Mediterranean Region, pointed out that this conference was particularly timely as it coincided with the initiation of several valuable healthy village projects and programmes in the Region, and so created a golden opportunity for discussion and guidance on these new initiatives.

He noted that almost all Member States in the Region were undergoing rapid urbanization, with population pressure and demand for services in urban areas attracting attention and resources to cities and away from rural areas. This situation had left the rural areas in many countries with limited resources to deal with their health and environmental problems.

WHO/EMRO had introduced the concept of healthy villages for the first time during the Informal Consultation on Urbanization and Environmental Health in Relation to the Healthy Cities Concept, held in Alexandria, in July 1989. It was a holistic approach aiming at creating an environment which supports the health and socioeconomic development of villages. The concept was founded on the premise that the full health benefits of environmental measures could only materialize when undertaken simultaneously and in coordination with each other. Thus, the positive impact of the provision of water supply and sanitation facilities would be more pronounced when coupled with proper establishment of refuse collection and disposal facilities, food safety, control of disease vectors in the environment and personal hygiene.

In conclusion, Dr Gezairy stated that the healthy village approach depended largely on the involvement and participation of the community concerned, both individually and collectively, as essentially it aimed at the community's own development. It implied action for the people, by the people, with the full support of government and local authorities.

4.3 Address by the Minister of Health and Medical Education, Islamic Republic of Iran

His Excellency Dr A. Marandi, Minister of Health, Islamic Republic of Iran, welcomed the participants and stated that the healthy village was a new concept which had been first put forward at the Alexandria Healthy City Conference in 1989. As with "healthy city", the term "healthy village" had no precise and universally accepted definition, and would be interpreted according to the social and economic conditions of each country and locality.

In the course of the first five-years social and economic plan of the Islamic Republic of Iran (1989-1993), this movement had been integrated into the country's health service network. Community health workers who, despite their training, were only engaged in combating disease at that time, became active also in the area of environmental sanitation. They acted as coordinators of rural environmental sanitation plans under the supervision of the health centre experts and technicians. Now, one of the most important activities of these health workers was intersectoral cooperation in environmental sanitation projects.

In the Islamic Republic of Iran, the healthy village project was considered an integral part of the primary health care services and a cornerstone of sustainable development. The success of the project is inevitably, depended on community participation and intersectoral cooperation. Community health workers' and health councils' views were taken into account when determining priorities in such extensive projects.

The statutory "health councils" at the national, provincial, town, district and village levels provided a fundamental support for both the health units and for environmental health activities. The achievements of the community health workers so far included: establishing community organization and community participation, promoting intersectoral cooperation and mobilizing resources. All of these were encompassed under a programme entitled rural environmental sanitation activities, which formed the basis of the healthy village concept.

Dr Marandi concluded by wishing participants a pleasant stay in the city of Isfahan, a unique city with a vast historical, architectural and Islamic heritage.

4.4 Election of Officers

Eng. H. Salmanmanesh (Islamic Republic of Iran), Adviser to the Under-secretary of Health Affairs, Ministry of Health and Medical Education, was elected Chairman of the conference and Mr Abdullah Ibrahim (Sudan) was elected Rapporteur.

5. PRESENTATIONS

5.1 Objectives, scope and purpose of the conference

Dr Adnan Gur, Information and Technology Transfer Adviser, CEHA presenting the item, noted that the rural population in many Member States of the Region represented,for the most part, the poorest, the least-educated and therefore least developed section of the population. This is the situation facing 56% of the Region's population. The system of government in most of the developing countries is centralized and "top-to-bottom". This means that all decisions and the resources affected by those decisions, such as finance, trickle down through the levels, with considerable reduction in quantity and intensity the lower it reaches. What arrives at the grassroots level, the bottom is usually the least of everything.

In order to solve this chronic problem, a means had to be found which will develop rural life. The healthy village concept or approach is the latest proposal. The approach is composed of two basic and important elements:

1. Adoption of the "bottom-to-top" model. This means involving the community in its own affairs. To do this successfully, motivation, creation of awareness and mobilization of the community is an absolute necessity;

2. Providing effective intersectoral coordination and collaboration. These are the characteristics on which the holistic nature of the approach is based.

As a natural outcome of adopting a mode opposite to the way in which governmental systems usually function, it is necessary to provide effective coordination and collaboration for sustainable support of governmental services.

5.2 The conceptual framework and development of healthy villages in the EMR

Mr Khosh-chashm, Regional Adviser, Water Supply, Sanitation and Housing WHO/EMRO presenting the item, referred to the healthy village as a part of local development, which ideally should be supported by some form of decentralized institutional structure. Before the International Conference on Primary Health Care in Alma Ata in 1978, the health sector aimed to improve health through the basic health service. It soon became clear that basic health service and the development effort of the health sector alone could not bring about health development.

The primary health care strategy comprises among other things, the principles of self-reliance, community participation and equitable distribution of health resources. With health for all as the cardinal goal and primary health care as the main strategy, a number of approaches such as basic minimum needs, the healthy village and the healthy city, can be used to implement the primary health care strategy. The basic minimum needs approach is usually adopted to address the needs of poor and economically deprived areas and areas of acute need. The healthy village has a long-term objective. It is a holistic approach to address health and the environment in general, giving priority to improvement of environmental services.

The healthy village approach basically aims to promote and mobilize health and environmental measures at the local level, stimulate intersectoral collaboration, raise community awareness, improve environmental services, facilitate local level decision-making, promote the use of appropriate technology and give special attention to the needs of women and children. The healthy city and healthy village concepts are practical health promotion processes, and both are excellent tools for local level application of Agenda 21.

Healthy villages should be supported through a carefully planned structure. A healthy village committee is necessary at the village level, with representatives from the village as its members. Healthy village committees should be supported by a technical and administrative group at the district level. A similar provincial and national support group or council are also desirable.

Healthy village activities might include, for example, improvement of environmental services, improvement of drainage systems, pathways and bridges, construction of a health post and raising of community awareness.

5.3 Rural environmental health with special reference to the role of women

Mr Sadok Atallah, Director Environmental Health Programme, WHO/EMRO presented the subject. He noted that more than half of the Region's population lived in rural areas and that these rural populations, especially the poor who are underserved by environmental health services, are affected by a number of environmental health problems. The regional average for the rural coverage of safe drinking water is around 54% while the regional average for rural coverage of adequate sanitation is only 34%. Cholera, unspecified diarrhoeas, intestinal helminths, dracunculiasis, schistosomiasis, dengue fever, malaria, trachoma and other skin and eye diseases, are just some of the health problems which occur as a result of these conditions.

If women are aware of the relationship between health and easy access to safe and sufficient water and sanitation facilities, many of these diseases could be prevented in the most efficient and economic way. In this regard women are felt to be the front-line health workers and to hold the key to family and child health. They should play an important role, not only in drinking water and sanitation, but in environmental health issues in general, including disposal of solid waste, lighting and ventilation of houses, use of chemicals at home and in agriculture, and food safety including storage, preparation and service practices in relation to food handling and conservation.

Women have a crucial role to play in supporting sustainable development concept and global environmental conservation. The involvement of women in the provision of water supply services can be seen as a beginning in the efforts to improve women's status in other important areas, such as income-generating activities. Mr Atallah called for the mobilization of women to lead the efforts and facilitate the technical and managerial actions for water, sanitation and health for all by the year 2000.

5.4 Main environmental health elements required for a healthy village

Dr G. Watters, Rural Environmental Health, WHO Headquarters presented the item. In presenting his paper, Dr Watters emphasized several issues important to the implementation of a healthy village approach and/or programme.

The healthy village concept is not a new approach to health in rural areas, competing with or replacing primary health care, but a mechanism for the more effective delivery of primary health care at the community level in rural areas. The focus on rural communities is essential for primary health care and its stress on equity in particular. Around 65% of the population of the developing countries in the world live in rural areas, and are generally among the poorest segments of society. In the Eastern Mediterranean Region the proportion is 56%.

WHO as a whole, recognizes the need to develop a healthy village approach. EMRO has already taken the initiative in this area, and its experience should be used as the basis for the development of the draft proposals for such a global policy. This policy should be in the form of a framework, and should not be so broad as to lack specificity and thus fall short of being the basis for specific action at the level of the individual community.

The healthy village approach should identify those basic minimum needs which should be fulfilled in order for a village or rural community to be considered "healthy", e.g. adequate and safe water supply, appropriate sanitation, hygienic solid waste disposal, drainage, adequate shelter. Once identified as basic minimum needs these should be clearly defined. These definitions will probably have to be country and even project or community specific. Although priorities should be established by communities, agencies external to the community should provide guidance and make suggestions during the decision-making process. It is only in this way that experience external to the community will be able to be brought into the process.

Community pride has an important role to play in the success of a healthy village approach, particularly in terms of solid waste management, general cleanliness and appearance. Although the latter may not have a direct bearing on the health of the community, it is symptomatic of the general state of cleanliness on which health is often dependent.

Although community participation and empowerment are key elements in the healthy village approach, this should not be taken to mean that central or district authorities should delegate the issue and forget it. For communities to effectively take over responsibility for systems such as water supply, sanitation, health facilities and clinics, etc. they must have a reference point to turn to for back-up and support when problems are beyond their capacity, or spare parts are required.

Although the initiatives will be at the community level and healthy village programmes will be developed and implemented with individual villages or groups of villages through the existing community structure this must be on the basis of a strong government policy and commitment. The workshop should also draw attention to the other elements which are essential to the healthy village concept, such as access to health clinics, education, literacy and communications.

The final proposal for the healthy village approach should clearly refer to it as a contribution to the chapter of Agenda 21 "Agricultural and Rural Development".

5.5 Raising the awareness of communities concerning the importance of a healthy environment in rural areas

Dr M. Assai, WHO Temporary Adviser, presented the item, pointing out that in order to raise public awareness it was important to involve the public. Without active involvement of the community it was not possible to achieve complete success in any kind of health activity.

Dr Assai discussed Iranian experience of community participation, and the success achieved through implementation of the women health volunteers' project. Women health volunteers had raised health awareness of communities and had been instrumental in up-grading the health status; this was reflected in country health indicators.

Dr Assai mentioned other methods of achieving community participation, such as the use of television, radio, religious leaders and highlighting the responsibility of community leaders to encourage people. He also highlighted the role of health workers (behvarz) and the keypart they had played in mobilizing and involving people. Health workers working in health houses were pivotal to the Iranian health network system. The experience in Kharanagh village was used to demonstrate how, the real needs of people, by their active participation, were evaluated and prioritized. Then through local planning, implementation and supervision needs were satisfied.

He also discussed the training of behvarz and the successful experience of involving them in environmental health activities in rural areas and in the establishment of rural health councils on which behvarz are members together with village teachers, religious leaders and local personalities. All these people had their role in the healthy village approach.

5.6 Implementation of environmental health measures through the primary health care network in rural areas based on the healthy village approach in the Islamic Republic of Iran

Mr H. Salmanmanesh, WHO Temporary Adviser, presented the item. He noted that the healthy village project was based upon the primary health care network in the Islamic Republic of Iran. Community health workers are responsible for implementing the approach in the rural areas. The healthy village project is intended to lend support to village-based health promotion. The concept implies that the village is the place which shapes human possibility and experience and that it has a crucial role to play in determining the health of those living in it, in the same way as do cities.

A healthy village has defined components, requires a particular infrastructure and has various levels, but community participation and intersectoral collaboration are its two important and fundamental principles. The Ministry of Health and Medical Education started to implement the environmental health criteria within the context of primary health care as a pilot project in 1990 and extended it in 1991. The project was translated into a plan of action compatible with a variety of cultures and traditions, an important and challenging task for leaders of any rural project. The healthy village concept addressed the following issues: safe drinking water, wastewater and disposal, solid waste collection and disposal, excreta disposal, sanitary inspection and food safety, warming of houses, and the surface drainage system.

5.7 Healthy villages, an issue paper

Dr G. Watters, Rural Environmental Health, WHO Headquarters presenting the item, stated that the definition of health as "a state of complete physical, social and mental well-being and not merely the absence of disease" recognizes the fact that environmental factors play an important role in its attainment.

Health for all is therefore not to be viewed as the absence of disease, a situation impossible to attain, but as a level of health which will permit a socially and economically productive life for everyone; the objective of the healthy village approach is to be supportive of this concept. Translated more precisely in terms of primary health care the objective of the healthy village approach is to create conditions conducive to physical, social and mental well-being for social and economically productive lives in the rural environment. The healthy village concept as developed in the Eastern Mediterranean Region was based on experience in the implementation of rural water supply and sanitation programmes in individual countries of the Region, including Egypt, Islamic Republic of Iran and Sudan.

Experience to date has indicated that there is, in general, a lack of information on which to plan and develop programmes in rural areas. Too often priorities and agendas for village development are set outside the community, and the methodologies necessary to bring about change either do not exist or are not applied. This situation is contrary to the entire healthy village concept, which focuses on community development, a holistic integrated approach to rural environmental health and development, community participation, and mechanisms to stimulate change built on existing village structures. Within this framework the main issues to be addressed within a healthy village programme or project are sanitation, solid waste management, water supply, drainage, housing, vector control, handling of agricultural chemicals, and the indoor environment. Increased involvement of women in planning and implementation should be given particular attention, while population factors, such as migration and age distribution, will have particular bearing on priorities.

He noted that the healthy village principles to be developed by the conference should have as their foundation the fact that they are mechanisms within the primary health care approach to health for all and should be aimed at strengthening action at the community level.

5.8 Community participation and community-based management in a healthy village approach

Mr Salmanmanesh presented the item. He stated that community participation may be defined as the opposite of centralized decision-making. It is considered equivalent to involvement in the process of social change and growth, as the word "development" implies.

A healthy village project is intended to provide support to village-based health promotion. Such a project is founded on two basic principles: community participation and intersectoral collaborative action. A healthy village project needs cooperation in all aspects. Residents may be unwilling to make sacrifices unless they are convinced that it is for their own benefit.

Planning at the early stages of the community participation process is the most effective means of creating interest and involvement among local residents, and is thus essential for the success of the project. Key individuals of the village, such as the head of the village administration, religious leaders, teachers and respected older people of the village should be among those first involved. Experience has proved that people care most for the operation and maintenance of those projects to which they contributed during construction. Also, unless the community bears the majority of the cost of the project, the government itself will not be able to manage such expensive investments as water supply, sewage disposal, solid waste management, and surface drainage systems for all such projects throughout the country.

It is necessary to establish a healthy village council in order to organize a community's contributions to the project. This is most likely to be successful if it is built on the existing community institutions whose authority is generally accepted and respected rather than a new system. The council should be representative of the community and should include women. It should have between five and seven members from whom a chairperson, secretary and treasurer should be appointed. Other members may be responsible for technical matters, voluntary labour, public relations, etc., functioning on a voluntary basis.

The formation of a coordinator committee is a prerequisite step for proper functioning of a healthy village project. It should be organized by the responsible authority with members representing the ministries of health, education and the interior, as well as the water and wastewater authorities who have responsibilities in the rural areas. The committee should organize regular meetings with the health village council and the local authorities for successful implementation of the healthy village project.

Once the council has been formed and the community has agreed to provide its support, a workplan and plan of action for the implementation of the project should be drawn up. The action plan should be divided into phases for realistic implementation and should be presented to the community in one or more meetings for discussion, possible modifications and final approval.

5.9 Egypt case study

Dr M. I. Al Khawashky, WHO Representative, Egypt presented a case study in Egypt. He stated that WHO/EMRO had a long history of collaboration with the Ministry of Health in water quality control, vector control and food safety. This cooperation had expanded with UNDP and UNICEF to involve water supply, sanitation and waste disposal in the early 1980s as an activity within the International Drinking Water Supply and Sanitation Decade. It addressed community participation, intersectoral cooperation, appropriate technologies for water supply and wastewater disposal, leakage reduction, technology transfer and demonstration, human resources development, household hygiene, and health education, with particular emphasis on women.

Building on the successful implementation of this 1980s project on "Drinking Water Supply and Sanitation Sector Support" and the two projects on quality of life and basic minimum needs, implemented in rural and urban communities in Alexandria, and utilizing the experience gained from both, a WHO/UNDP collaborative programme, prepared in consultation with International Labour Organization (ILO) was proposed in 1991 and approved by the Government in 1994. The Organization for Reconstruction and Development of the Egyptian Village (ORDEV) which is a semi-autonomous

organization under the Ministry of Local Administration, participated in the project. Simultaneously, a healthy city and healthy village project was initiated in Fayoum Governorate, jointly supported by WHO/UNDP/LIFE, and a memorandum of understanding for its implementation was signed in 1995. This project includes the town of Temiya and the two nearby villages of El-Azab and Qasr-Rashwan.

The healthy villages and healthy cities projects were both directed at achieving reasonable progress for integrated socioeconomic development of communities targeted as being least developed and most in need. Health and, in particular, safe drinking water and sanitation, were the entry points, but other environmental health aspects, such as housing, school health, drainage, food safety, health care facilities and occupational hazards, and socioeconomic aspects of development, such as basic education, income generation and job creation, were also included.

Water and sanitation aims in healthy villages in Egypt were concentrated on the following three objectives under the umbrella of the national programme for comprehensive integrated rural development entitled shuruq (sunrise):

- implementation of 26 waste stabilization ponds and successful testing, and design and execution of the ponds based on labour intensive and cost recovery approaches to create permanent and temporary job opportunities at the local level;
- adoption and demonstration of WHO's healthy village concept under real conditions in 10 representative villages out of the 26 targeted ones;
- strengthening of governmental and nongovernmental institutions at all levels, from village to central government in their capacity to plan, design, construct, operate and maintain water and wastewater systems in a healthy village infrastructure.

5.10 Field visit

The conference participants visited Haji-Abad Village with the Deputy Chancellor of Isfahan University of Medical Sciences and Health Services and the Director-General of the Environmental Health Department of the Ministry of Health and Medical Education. The purpose was to observe, in the field, the implementation of village project.

Haji-Abad Village has several satellite villages and is administratively connected to Najaf-Abad City and has a population of about 2000. The health house is the smallest health unit in the village. Male and female officers of the health house are called behvarz. They are given two years of training on primary health care covering all aspects of environmental health. About 65% of the villages of the Islamic Republic of Iran (38000) is covered by such an infrastructure of health houses.

Questions were raised concerning afterschool activities for children, whether the lead taken by environmental health officers in emptying cesspits, pumping groundwater to the village after chlorination, etc was typical in such villages all over the country, and concerning the cost-effectiveness of the new roads and houses for a village of 2000 inhabitants.

The relationship between the basic minimum needs approach and the healthy village concept was discussed. The two approaches are not intended to be competing. Basic minimum needs may be initiated in very poor communities to begin with. The functions and services of health houses may then be broadened into a healthy village approach, as observed in this village.

It was also queried whether the village visited was a standard one. Since it seemed to be quite well off and no income generation activity was observed in the village. It was observed that intersectoral collaboration was not greatly in evidence in the village. Almost everything appeared to be managed by the Ministry of Health and Medical Education.

The Regional Director noted that this was a good example of accelerated progress towards health for all. It was true that very little had been done for income generation in the village visited. However, some intersectoral cooperation and coordination must have taken place for the achievement of such a level of progress. The addition of an income generation scheme would make a good model for rural development. This was confirmed by a local adviser who acknowledged the importance of income generation for sustainability.

Another local adviser stated that when the Environmental Health Department started the healthy village project in 1990, environmental health was the entry point and this had been successful. Generally, in the Islamic Republic of Iran few sectors were engaged in the rural areas. Water supply and solid waste problems were the responsibility of the Jehạd Ministry who were also involved in activities to motivate children. Most infrastructure costs were met by the Government, but the community had also made some contribution.

5.11 Jordan case study: Noor Al Hussein Foundation, quality of life project

Mr Isam Zawawi of the Noor Al Hussein Foundation stated that this was a nongovernmental, nonprofit organization which had launched the Quality of Life Project in 1989, in collaboration with the Ministry of Health and with the financial and technical assistance of WHO. The Quality of Life Project is one of the major schemes intended to translate the philosophy and objectives of the Foundation into integrated, sustainable development for the lessfortunate communities in Jordan, especially in rural and remote areas. The first village to benefit from the project was Sweimeh near the Dead Sea. However, by 1995 expansion had involved 12 villages in various governorates.

The Quality of Life Project was launched with the following objectives:

- to achieve sustainable development for the less fortunate communities;
- to promote self-reliance, in order to achieve an increased participation in the project and sustain a vital role in communities;
- to activate the role and participation of concerned organizations in the overall national development framework;
- to develop and improve the level and the quality of the minimum needs indicators, and therefore to have a better understanding of how to improve the quality of life in the target communities; and
- to replicate and generalize this expertise to both local and regional levels.

The Quality of Life Project follows the basic minimum need approach which is a socially oriented, community-based, intersectoral and scientifically-based development process that is carried out by the community with support from the government. It aims at fulfilling the basic human and community needs. The objectives of the basic minimum need approach include:

- improving the quality of life of all communities by meeting their basic needs;
- promoting reallocation of resources towards better social justice and equity;

- strengthening intersectoral cooperation and collaboration among and between government sectors and creating effective partnerships between the people and the government;
- ensuring community self-reliance in reaching development objectives.

The ultimate aim of the quality of life/basic minimum need approach is total human resources development, whereby the poor and the underprivileged are empowered to promote their own development and to achieve a better quality of life for their families and communities. Promoting community organization is a key element of the project in order to help the people become self-reliant. The three pillars of self-reliance as defined by the project are: community organization for planning; management and evaluation of development schemes; mobilization, training and development of human resources for active participating in the community development process. Community financing for social and economic development schemes was also important. The organizational and developmental structure adopted in the project included:

- higher technical support committees consisting of 14 members representing ministries and national agencies; their job is to give general advice and technical support to the project;
- technical support committees in each village consisting of five to seven members representing local agencies and government directorates and bearing responsibility for technical support to and execution of project programmes;
- local development councils of between five and nine members formed from local leadership figures chosen by community members and whose mission is to participate in managing project activities in the villages;
- neighbourhood representatives committees whose members are chosen from neighbourhoods within each village, where one member (male or female) represents 10 to 20 families;
- mothers' club whose members are women's leaders, and whose job is to participate in the local development council on issues concerning women; and
- activity committees, such as environment conservation clubs and youth committees, each of which will have a particular role and duties.

5.12 Importance of training and orientation of community health workers in the Islamic Republic of Iran

Dr Assai discussed the experience of the Islamic Republic of Iran in training community health workers. The training course is divided into three standard modules (theoretical and practical) and takes two years to complete. Behvarzes learn how to deliver primary health care to their defined population and have several tools to register their activities, e.g. the household file, vital horoscope and statistical forms.

Environmental components of the behvarz training course include: social and geographical reconnaissance of the village and preparation of village schematic map; information regarding the area; safety of water and other resources; improving water sources such as springs, ghanats and wells; chlorination of water; appropriate disposal of waste and excreta; food safety; and environmental health activities during outbreaks of natural disaster.

Important issues in the training of behvarz are: selection; whether they are from the village where they will work; inservice training; use of appropriate technology; quality of training; constant supervision; and integration of activities into primary health care.

5.13 Basic minimum needs as prerequisites of a healthy community or village

Dr M. A. Barzgar, WHO Representative, Pakistan presented the item. He noted that basic minimum needs was an innovative and convincing approach aimed at poverty elimination and human resource development through the promotion of a spirit and zeal of self-help and self-reliance among the people of the community. The concept leads to the attainment of a better quality of life while ensuring community involvement and intersectoral participation.

In Pakistan, extensive efforts have been made in the last few decades to improve the quality of life of the rural population. However, social indicators like health, education, availability of safe drinking water and sanitation continue to be unsatisfactory. The basic minimum needs approach provided the means to tackle the challenges related to ill-health and represents a way out of the vicious circle. The basic minimum need initiative was launched in the village of Jabbi, in the North West Frontier province, based on the achievements of the Somali experience.

The conceptual difference between the primary health care and the basic minimum need approaches can be appreciated from the fact that primary health care is a revolutionary approach aimed at changing the very complexion of the health sector while basic minimum need is a methodological concept that facilitates intersectoral collaboration and community involvement. The expected outcome of the basic minimum needs approach will be an improved quality of life, sustainable development and self-reliance in a healthy community. Among the features of the approach are empowerment, viewing human beings as both the object and subject of development, bottom-up planning based on "people as the priority" rather than the sector, income-generating activities, appropriate technology, collective partnership of the people, government and the development agencies including United Nations, and bilateral agencies and nongovernmental organizations for sustainable development and self-reliance.

WHO, through basic minimum needs is well placed to play a leadership role among sister organizations, particularly now, when poverty elimination and sustainable development are common objectives of most of the United Nations agencies.

5.14 Healthy villages

Mr T. Zeribi, WHO Representative, Morocco presenting the item, discussed the concept, framework, principles, activities and basic issues to be resolved, and the potential WHO input in relation to the healthy village. The aim of healthy village concept is to improve, maintain and respect the quality of life for better individual and community health at the village level. Political will, at national, provincial and village level, are essential. Social commitment to serving and being useful to the community and leadership potential are required from among the village population so that the villagers can express their needs and work together.

Integrated activities at the primary health care level, taking into account cultural aspects such as beliefs, religion and local traditions concerning the role of women, are among the priorities and should be considered in the early stages of the preparatory phase for a healthy village project. Among the basic principles, it is most important that government interests at each level are kept very low with minimum intrusion. Maximum variety and a large range of activities, as closed a system as possible with little dependency on outside input and attainment of an optimum balance between local capability, activities and political ambition are among the main issues to be tackled. WHO's role and input are crucial in promotional expertise, training and information activities.

6. COUNTRY PRESENTATIONS

6.1 Islamic Republic of Iran

Water supply and sanitation activities were started in Iran in 1950. At that time, water supply as a health priority was not considered by the decision-makers. In the early 1960s the task of providing water supply and sanitation in rural and urban areas rested between different ministries.

Following the United Nations water conference in Mardel Plata, Argentina, and in the early years of establishment of the Islamic Republic of Iran a new national health system, based upon primary health care was designed. A high priority of primary health care was water supply and sanitation. So, along with the implementation of water supply in urban and rural areas the Government also took necessary action to develop a sanitation programme in rural areas within the framework of primary health care.

A district health network in each province was selected as a pilot project for implementation of sanitation activities and villagers were invited to participate in this exercise with the help and guidance of the community health worker. The purpose of the pilot project was to plan the strategy for the extended application of the demonstrated activities in other parts and villages of the province. The project was designed to include the different components of sanitation: water quality control and sanitary improvement for drinking water resources; sanitary measures for excreta disposal; and provision of liquid and solid waste collection and disposal. Other sanitation activities included giving guidance and help in promotion of sanitary conditions in food shops and public places, educating people to separate their living quarters from those of their animal, home visits and controlling the environmental health conditions from a checklist. All these activities were carried out with the participation of villagers.

Experience gained from the selected pilot projects, enabled the General Department of Environmental Health to design a country-wide project of rural sanitation which was later called the "Healthy Village Project". At present, this project is under implementation in numerous health houses according to the ability of community health workers and village councils, and the levels of community participation, intersectoral cooperation and budget allocated.

The result of the first provincial "rural sanitation campaign", which was performed by the environmental health section of East Azarbayjan in 1992, was very helpful in this respect.

6.2 Jordan

Several nongovernmental organizations are interested in community development in Jordan. The Noor Al Hussein Foundation carries out 25 programmes, of which the most notable is the Quality of Life Project. The project aims at ameliorating the quality of life in rural communities in 12 villages, with special emphasis on women and health care. In addition, the Foundation is interested in water source protection.

The Queen Alia Fund supports people in building their future by emphasizing children's education, women's education in health care, birth spacing and training.

In general, Jordan suffers from a scarcity of water resources, so many villages depend on groundwater and some on shallow spring water and surface water, which is unsafe and untreated. Most houses receive only small amount of water (40 litres per capita) per day. Water quality control is carried out by the Ministry of Health and the percentage of unsafe samples of treated piped water is about 20%. Most village houses have individual pits for sanitation purposes and there is no governmental agency in charge of this sector.

Concerning solid waste management, the village council services are generally inadequate because of lack of financial resources and technical ability. Solid waste usually remains between the houses or is burned in the open. Refuse areas, where they exist, are distant and not controlled. Control of flies is practised by the villagers themselves, although sometimes village councils conduct fly control in collaboration with ministry of health staff and major municipalities. Food safety at home is addressed through health education in schools and health centres.

6.3 Lebanon

The war and its socioeconomic consequences resulted in the loss of many skilled people through emigration while the reconstruction in Lebanon is happening at a very fast pace with little coordination between the various sectors at central and local levels. Similarly, there is a lack of coordination concerning the health and environmental consequences of rapid redevelopment and, therefore, urgent action is needed. Lebanon being a relatively small country, development of local healthy villages and healthy cities initiatives is determined by national factors, and therefore requires the skill and ability to work at very senior levels in the country and to disseminate models of good practice to local levels. Although aware of the existing situation concerning promotion of health and environment, the Government faces many constraints. These include: the lack of human resources in many government departments; lack of support, both in terms of finance and of other human resources; the low level of salaries and incentives for government personnel; inadequate horizontal coverage; and the historical dependence on government agencies to provide and implement projects.

All these factors mentioned can have a negative impact on the application of a healthy villages programme in Lebanon. There is therefore, a great need for collaboration and cooperation among governmental and nongovernmental organizations and academic institutions on environmental issues for the promotion of health and environment. Involvement of the community on environmental issues is necessary at all levels if environmental conditions are to improve.

6.4 Morocco

The experience gained from former development programmes and projects for rural areas indicates the difficulties of implementing sustainable systems for drinking water or sanitation when the population concerned is not sufficiently involved and intersectoral collaboration is lacking. There are some ongoing projects and programmes which aim to develop involvement of population, the community and of local nongovernmental organizations and to reinforce intersectoral collaboration. These include Project UNICEF-Morocco on basic integrated services in rural areas, Project CRS on health and water, the national programme for drinking water in rural areas and the National solidarity fund to address drought impacts. All these projects could represent supportive environments for promoting the concept of healthy villages.

6.5 Pakistan

The rural population in Pakistan is 72% of the total. the major rural health problems are absence of environmental sanitation, control of communicable diseases, inadequate maternal and child health services, absence of health education in rural areas, lack of primary health care, and lack of communication and transport facilities for workers in public health. The major biological needs are for supply of safe water and safe nutritions food, safe sanitary disposal of excreta and disposal of surface drainage.

Village personnel require training in community organization and awareness raising. Staff of nongovernmental organizations require training in community organization, conducting village surveys, identifying priority needs, feasibility studies of priority needs, formation of village support teams, preparation of community plans for action, and management and monitoring of the plan of action at village level.

Current national strategies and plans of action cover provision of natural gas for combustion, sanitary programmes for installation of biogas plants, bore-hole latrines and hand pumps, installation of the Prime Minister's programme in family planning and primary health care and the basic minimum need project.

6.6 Sudan

Large cities are provided with safe piped water; some villages have access to shallow wells and others draw directly from the river or canals. A few villages receive water by tanker. Most households lack latrines so people defecate in the open. As a result flies and pollution are a problem. Solid waste disposal is usually not carried out satisfactorily largely because of a lack of appropriate transport. Fly control activities are usually associated with solid waste management, although collection depends mainly on community participation. Mobile units are designated for the detection and removal of breeding sites. Heavy rainfall thus results in the formation of pools. There are few properly designed permanent drains, while in the rural areas drains for surface drainage are completely lacking.

Concerning food safety, there is very low awareness of personal hygiene in the home which is compounded by lack of resources and poor socioeconomic conditions. Health education activities are either weak or nonexistent. Short courses in environmental health are required for trainers, village volunteers, environmental health staff and other related agencies staff. There is also need for creation of awareness. This could be done through developing person-to-person contact programmes, person-to-group programmes and meeting with different community groups.

Current efforts are focused on provision of sanitary facilities and development of proper solid waste management, creation of public awareness and provision of safe water supplies to both urban and rural areas. Preparatory measures have been taken to implement the healthy village concept in White Nile State, including acceptance of the concept by state authorities, formation of a state coordinating committee; formation of healthy village committees and selection of villages where the concept is to be implemented. This will be followed by collection of basic data, sanitation analysis and setting of priorities.

6.7 Syrian Arab Republic

A proposal for a comprehensive population development project has been prepared in Syria and it is anticipated that UN agencies will support this project. The main objective of the project is to improve health and quality of life, especially in rural areas. The strategies of the project are: development of a decentralized programme based on primary health care principles in selected governorates; effective training of health workers, supervisors and community leaders, the training being designed in such a way that a well-defined set of tasks can be carried out; development of the confidence of the local community to utilize and support primary health care services to ensure the sustainability of these services.

A rapid and comprehensive analysis of the health and environmental situation in the selected areas is essential before the implementation of the project. The analysis will be undertaken by the local community and will be the basis for planning. Health education activities related to the prevailing health problems, with special emphasis on health promotion, will be supported.

6.8 Tunisia

The environmental health strategy in Tunisia focuses on important infrastructure projects, such as water supply, water quality, primary health care, schools and electricity. A local committee, consisting of community representatives, is responsible for the implementation, monitoring and assessment of different programmes in villages. The main objective of the environment programme is to improve health and the quality of life in rural areas. Three leader programmes have been proposed are in operation: the Collective Interest Association (AIC) programme; National Funds for Solidarity; and the Sanitary Monitoring Programme. The implementation of these supported by different participants and communities will also play an important role.

Since the end of 1992, the Ministry of Agriculture has cooperated with the Ministries of Interior and Public Health in the implementation of AIC programmes to improve environmental health conditions in rural areas through the promotion and monitoring of the AIC collective interest association. The AIC programme consists of a self-management of drinking water programme covering financial management, hydraulic maintenance, and disinfection of drinking water.

National Funds for Solidarity was created in 1992 to provide extrabudgetary financing for basic equipment for poverty clusters. Up to 1994 250 villages had benefited from this fund, with the total number of projects reaching 574.

Sanitary Monitoring Programmes aims to improve pubic health by preventing the adverse health impacts of harmful and toxic pollutants in the environment.

6.9 Yemen

Yemen has not yet addressed the issue of healthy villages. However, the Government recognizes that, as environmental problems are the responsibility of various ministries, so environmental activities are the concern of all ministries. Nevertheless, the Ministry of Public Health expects to have the lead for all concerned governmental bodies in environmental health issues.

The healthy village concept in Yemen will need support from various ministries and from national and international health agencies; adopting this concept will enhance primary health care services.

Strong and real community involvement, provision of community basic minimum needs to ensure health improvements and sustainability, raising community awareness, giving more attention to health education activities, focusing on person-to-person health education, using all available channels but with emphasis on direct ones, such as schools, mosques and markets, are all necessary components.

7. WORKING GROUP SESSION

Conference participants divided into two working groups to discuss and come up with a group report which would be the basis for the regional strategy document on healthy village implementation. They were also requested to come up with recommendations for the conference.

During the plenary session, the reports of the two groups were read out and a committee composed of Mr Khosh-Chashm, Dr Watters, and Dr Gur was requested to compile the reports of the two groups into a regional strategy document to guide healthy village implementation in the Region. A draft regional strategy document is given as Annex 5. This will be finalized and published in the form of a brochure.

8. CONCLUSIONS AND RECOMMENDATIONS

8.1 Conclusions

1. The healthy village concept is an effective tool to enhance and strengthen the primary health care strategy at the local level. The healthy village concept can build on the existing primary health care structure, giving priority to further improvements in environmental health.

2. Commitment at the highest national level is necessary for the promotion and implementation of the healthy village concept.

3. The healthy village concept will enhance the efforts of primary health care at the local level to achieve equity in health and environmental services and improvements in quality of life.

4. For the healthy village initiative to be sustainable, it must be implemented within the available resources of the community itself. At times, it may be necessary to support the village through assistance from national and international sources.

5. Interference from outside the community should be as minimal as possible, taking into account the potential capabilities of the villages and the existing institutional infrastructure.

6. The healthy village concept will best be implemented when the national institutional framework has a decentralized structure and the capacity to respond to village development needs.

7. The coordinating authorities in the villages, districts and provinces should be the agencies and ministries that are concerned with health and environment, such as the ministry of health and ministry of local administration.

8. External assistance and technical support will be needed from WHO, other concerned United Nations agencies, international nongovernmental organizations and external support agencies to assist the healthy village concept.

9. The healthy village, healthy city and the basic minimum need approaches are all effective tools for implementation of primary health care strategy. All these approaches are components of the effort to achieve health for all and to raise quality of life.

10. The healthy village concept places a major emphasis on raising awareness of the rural people and orientation of concerned local and national officials. Raising community awareness is the fundamental element of the healthy village concept.

11. Advocacy and promotion are elements which are vital to familiarizing concerned national authorities, local authorities and the public in general. In this respect the role of the mass media and exchange of information and communication are crucial.

8.2 Recommendations

Member States

1. The concerned national ministry or agency should take the lead and initiate activities for mobilization of a healthy villages programme.

2. To begin the activities, a national workshop should be held to familiarize the concerned key national authority with the concept. Similar provincial level meetings may also be organized.

3. The concerned national agency should approach key national decision-makers and ensure political commitment to the healthy village concept and programme.

4. An appropriate national agency should be designated to coordinate and develop the programme in the country.

5. The national focal agency should develop a national strategy, plans of action and necessary activities for implementation of the strategy. The issues to be considered, such as local level responsibilities, should be defined.

6. In the early stages, special attention should be given to promotion and advocacy. The national authority may consider starting with prototype or test projects.

WHO

1. WHO may consider requesting its governing bodies at the global and regional levels to pass appropriate resolution(s) requesting the Member States to initiate action and develop programmes for implementation of healthy villages.

2. WHO may consider increasing its support for the healthy village concept at the country, as well as regional level, utilizing resources under primary health care and environmental health.

3. WHO may consider inviting other United Nations agencies, international nongovernmental organizations and donors to collaborate in and assist national healthy village programmes and activities.

4. WHO may consider developing the necessary technical guidelines, manuals and documents which will assist in planning, implementation, monitoring and evaluation, including indicators.

9. CLOSING SESSION

Six women volunteers involved in field work for the health house system of the several healthy village programmes being carried out by the Environmental Health Department of the Ministry of Health and Medical Education in Isfahan Province joined the conference at its closing session. They described some aspects of their work, education and training, difficulties encountered and their collaboration in the health house system to facilitate the health services offered to villagers. They also answered questions raised by the participants about their work.

The Chairman expressed his appreciations to WHO/EMRO and CEHA for organizing the conference and thanked the participants for their valuable contributions to the conference. Dr Kasimi, Acting Chancellor of the Isfahan University of Medical Sciences and Health Services, on behalf of the Chancellor, also thanked the organizers and all those who had contributed to the success of the conference. Mr Atallah, on behalf of the Secretariat thanked His Excellency, the Minister of Health and Medical Education, and the Regional Director, EMRO for inaugurating and attending some sessions of the conference. He also extended his thanks to the Chancellor of the Isfahan University of Medical Sciences and Health Services, and to the Director-General of the Environmental Health Department and his staff for their efforts on behalf of the conference and to the conference chairman, local temporary advisers and secretarial staff for their services.

Finally, Dr Assai, Deputy Under-Secretary for Health Affairs, Ministry of Health and Medical Education, on behalf of the Minister of Health and Medical Education, expressed his thanks and good wishes to the Regional Director and staff of EMRO for holding the first conference on healthy villages in Isfahan and for their valuable contributions.

Annex 1

AGENDA

1. Opening session
2. Objectives, scope and purpose of conference
3. Development of healthy village concept in the Eastern Mediterranean Region
4. Healthy villages
5. Environmental health elements required for a healthy village
6. Training and orientation of community health workers and leaders
7. Raising awareness of community on healthy environment
8. Role of women in rural environmental health
9. Country presentations
10. Case studies (Jordan and Egypt)
11. Community participation and community based management in healthy village approach
12. Basic minimum needs of people
13. Working group sessions
14. Closing session

Annex 2

PROGRAMME

Monday, 6 November 1995

08:30 - 09:30	Registration
09:30 - 10:00	Opening ceremony
10:30 - 10:45	Introduction/election of officers
10:45 - 11:00	Objectives, scope and purpose of the conference, by Dr Gur, ITA/CEHA
11:00 - 11:30	Development of healthy villages concept in the EMR and a draft conceptual framework and proposed organization, by Mr Khosh-chashm, WSH/EMRO
11:30 - 12:00	Rural environmental health with special reference to the role of women, by Mr S. Atallah, DEH/EMRO
12:00 - 12:30	Main environmental health elements required for a healthy village, by Dr G. Watters, REH/HQ
12:30 - 13:00	Raising awareness of community on the importance of healthy environment in rural areas, by Dr Mohammad Assai, LTA
14:00 - 14:20	Film on healthy villages in Iran
14:20 - 16:20	Country presentations (6 presentations)

Tuesday, 7 November 1995

08:30 - 10:00	Country presentations
10:30 - 11:00	Country presentations (continued)
11:00 - 11:30	Healthy village - an issue paper, by Dr Watters
11:30 - 12:00	Community participation and community based management in healthy village approach, by Mr H. Salmanmanesh, LTA
12:00 - 12:30	Egypt case study, by Dr M. I. Al Khawashky, WR/Egypt
13:30	Field visit

Wednesday, 8 November 1995

07:30 - 08:00	Discussion on the field visit
08:00 - 08:30	Jordan case study, by Mr Isam Zawawi, Noor Al Hussein Foundation, Jordan

08:30 - 09:00	Importance of training and orientation of community health workers/health staff, community leaders and teachers, by Dr Assai
09:00 - 09:30	Meeting the basic minimum needs (BMN) of the people, a prerequisite of healthy community i.e. healthy villages/healthy cities, by Dr Barzgar, WR/Pakistan
09:30 - 10:00	Healthy village, by Mr T. Zeribi, WR/Morocco
10:30 - 16:30	Working group sessions

Thursday, 9 November 1995

08:30 - 10:00	Working group session
10:00 - 10:30	Presentation of group reports
11:00 - 12:45	Plenary session (conclusions and recommendations)
12:45 - 13:00	Closing session

Annex 3

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Annex 4

THE HEALTHY VILLAGE CONCEPT

Introduction

This document contains the general principles for application when government, provincial, and/or district authorities have decided to implement the healthy village approach to strengthen primary health care and to accelerate its efforts to bring health for all to the rural population. These are intended as guidelines for application in the development of community and country-specific plans of action.

Objectives

Basic objective

The basic objective of the healthy village concept is to improve health and quality of life of people in rural areas through a focus on village development, and though the creation of supportive physical, social, cultural, institutional and economic environment. Since villages normally act as foci for the more scattered populations living in the rural areas in which they are located, improvement in quality of life, environment and health in these centres can have wider implication for health promotion and development in the surrounding district which would be conducive to a socially and economically productive life.

Specific objectives

The specific objectives are:

a) to stimulate, educate and assist rural populations and their leadership, through increased awareness and training to have a sustained dialogue and focus on health and environment, enabling them to take responsibility and become involved in the decision-making process with regard to the development of an enabling environment in their community;

b) to develop and implement a quality of life health and environment plan for the village and coordinate this plan with similar district master development plans, so that overall development will be undertaken in a coordinated manner with a full awareness of the potential of all sectors (agriculture, housing, ed ucation etc.) to contribute to health and well-being;

c) to strengthen village, district, township and other local level authorities and institutions in their capabilities, and increase their awareness of their responsibilities for the provision of health and environmental services to the rural population.

Approaches and guiding principles

Physical environment

Seven basic approaches are contained in this guideline. These require application at community (village), district, provincial and central government levels to varying degrees and with varying emphasis, however the thrust of their application will have to be at the community level since the healthy village concept is a mechanism within the framework of primary health care which is based on the principles of community participation and responsibility. The seven approaches are:

a) to strengthen and improve environmental health within the framework of and as a component of primary health care, building on the existing primary health care structures and augmenting institutional capacities at the local level;

b) to promote collaboration at community, district, provincial and central level between the institutions and persons responsible for health care delivery and those responsible for delivery of services in other sectors (education, culture, religion, communications, etc.);

c) to make all efforts to realize equity for health and environmental services;

d) to consult with and involve the community in all stages of projects; planning, resource mobilization, implementation, maintenance, monitoring and evaluation;

e) to raise community awareness regarding quality of life, health, and hygiene practices as a means of promoting desired behavioural change, and strengthen understanding of health and hygiene norms and standards;

f) to strengthen the decision-making capability at the community/village/local level through increased delegation of responsibility, decentralization, and greater involvement of the beneficiaries and the health care and other services providers in the development of action plans and programmes;

g) to promote the adoption and use of appropriate technologies as a means of responding to social and cultural preferences, as a mechanism for containing costs, to facilitate self-reliance, and to ensure sustainability;

The healthy village and the basic minimum needs approaches as elements of primary health care to ensure that they contribute within the broad framework on an integrated approach to the betterment of health and well-being. A focus on basic minimum needs will be a particular policy and a strength of the healthy village concept in economically deprived and socially lacking areas.

Socioeconomic environment

Three main considerations related to the socioeconomic environment are included in the approaches. These are:

a) to give special attention to the needs of women and children, in terms of the home and community environment and their specific needs within the health care delivery system. Also, to utilize the potential of women, schoolchildren and the elderly for implementation of the healthy village concept;

b) to promote income generation within the community through taking advantage of local skills, developing potential cottage industries and commercial activities, providing financial seed support to create economic activities such as poultry farming, fruit growing etc., and rendering ongoing activities more effective in creating employment for health;

c) to provide recreational facilities for the physical and mental well-being of the community, e.g. sports grounds, recreational areas, community halls, libraries.

Education and training

Education and training as a mechanism for capacity building at the community level is an important aspect of the healthy village approach. In the guiding principles three facets of this are included. These are:

a) to educate and raise awareness of the rural population to recognize the relationship between health and hygienic conditions and behaviour, and the preventive measures which can be taken to reduce the risks of infection and injuries;

b) to create village level dialogue on health and environment issues as part of the community decision-making process;

c) to support the development process within the community upgrading the vocational skills of artisans and youth through the organization of practical training courses, e.g. carpentry, masonry, simple plumbing, mechanical maintenance. This will assist in increasing economic development capabilities and sustainability of local development.

Institutional environment

To facilitate the implementation of the healthy village approach, there are certain institutional requirements and changes that will have to be made. To respond to this, the guidelines include:

a) the provision of orientation and training to those concerned with health and environment at the local, district, provincial and national level;

b) the promotion of the strengthening and realignment of the institutions responsible for health and environment so that they can respond to the needs of the healthy village approach, particularly in relation to the needs for coordination and intersectoral collaboration at all levels. Also, the institutional framework should be capable of providing sustained technical and managerial support at the peripheral level;

c) to develop and enact the necessary legislation, rules, regulations and procedures at national, provincial, district and local level for planning and implementation of the healthy village concept.

Activities

To ensure that the healthy village approach is practical it is necessary that these guidelines address the key issues within the physical environment which will have to be tackled through concrete action at the village/community level. The main areas in which such action will be called for are:

a) Water supply. An adequate and safe water supply should be available to provide for the potable, domestic and hygiene requirements of the population. In terms of safety, the supply should not contain any agent, microbial and/or chemical which will cause adverse health effects either in the long- or short-term . In the rural setting, an adequate water supply also includes sufficient quantity to cater for the needs of the domestic animals which normally are kept adjacent to the family house.

b) Sanitation (excreta disposal). The method of excreta disposal is most important for the creation of an environment supportive to health in the rural areas, where the majority of people have no access to appropriate sanitation facilities. Facilities should be such that the excreta-human contact and the excreta-food contact are broken, and the associated risk to health thus removed. The number of facilities provided should be in accordance with the number of household members and should take fully into account traditions and cultural aspects.

c) Shelter (housing). Housing should provide sufficient well ventilated, lit and heated (when required) living and sleeping space for the needs of the number of household members. It should be provided with separate cooking space adequately ventilated for the evacuation of fumes from food preparation and fuel. The house should be durable with a life expectancy of at least five years.

d) Drainage (stormwater and irrigation). Drainage should be provided to ensure that no water forms in pools around water collection points, and is sufficient and laid into such gradients as to avoid the ponding of surface water and water-logging at times of heavy rainfall, and hence eliminate nuisance and vector breeding grounds within and/or around the village. In villages where housing lies on the lowland and in the flood zones, lack of adequate drainage can cause property damage and even loss of life.

e) Solid wastes (garbage). An appropriate means of garbage disposal will include its retention in the community in a sanitary manner (possibly at a designated collection site), its regular collection and removal from the community, and its disposal in a hygienic manner which will not attract vermin and/or disease vectors (rats, flies etc.) at a distance sufficiently far from the community to avoid nuisance.

f) Domestic animals (sanitary conditions). Domestic animals should be housed separately from quarters occupied by people and there should be no connecting doors between animal and human living space. Also, sufficient distance should be provided between the animal stockade and the entrance to the house to minimize the risk of insects, odours, etc. from the animals impinging on the living quarters. Only a suitable number of domestic animals should be kept in enclosures close to living accommodation. Animal enclosures should be kept clean at all times.

g) Food safety (commercial and home). Within the village, all premises handling and selling food (shops, restaurants, cafes, etc.) should be maintained according to established hygiene regulations and should be regularly checked to ensure that these standards are being maintained. Within the home, the safe handling, preparation and serving of food should be ensured through awareness of proper hygienic techniques on the part of the individual residents (mainly the women who are normally responsible for food handling and preparation within the home).

h) Vector control (insects and vermin). Vector control is achieved through various interventions such as appropriate sanitation, drainage, sanitary garbage disposal, household hygiene, proper control of domestic animals. A vermin control function within the terms of reference of the health-house could play an important role here.

i) Chemical safety (agriculture and home). In rural areas, the overuse and misuse of agricultural chemicals (pesticides and fertilizers) is a common threat to health through their accumulation in the environment, including their presence in ground and surface waters. Through awareness and education programmes in healthy villages these problems will be avoided. Also, a common problem in households is poisoning from household chemicals such as detergents. The main victims are children. This problem can be avoided in healthy villages through the safe storage of such substances within the house, and good housekeeping practices introduced through health education. Health houses/clinics have an important role to play in this regard.

j) General community environment (roads, parks, laundries, public baths etc.). The general state of cleanliness and appearance of the community/village has an impact on the mental health of the population and it is important from the standpoint of community pride. The overall appearance of a village is a good indication of the general status of community spirit and health.

In addition to the environmental health criteria listed above, a healthy village will require other features such as access to adequate health and educational facilities.

Organizational structure

Healthy village committee

The healthy village committee should be a component of any village development committee which may already exist and operate within the framework of the village health (primary health care) committee. In fact, the healthy village committee could comprise a strengthening of the environmental capacity of the village health committee. The emphasis has to be on operating within the framework of, and respecting, existing organizational structures at the local level. The committee should comprise members elected by the community, and/or recognized and respected community leader, and the local health personnel (health of the health-house/clinic, environmental health assistant etc.).

Administrative and technical groups

Administrative and technical support will be required by the healthy village committee. This support will be at several levels. In the community itself, since the healthy village approach is multisectoral, technical coordination and support will be required in relation to the different participating agencies, agriculture, education, etc. At the district level, similar coordination mechanisms will be required to provide backstopping with regard to issues which are outside the capacity of the local level.

Political and administrative instruments and support at national level

It is important that strong mechanisms are established to ensure coordination and that support flows effectively through the various levels of national administration, from the community to the central level through the district, provincial and state administrations. All levels must be committed to and support the healthy village initiative. The district level in particular will have a role to play in monitoring progress in individual villages and providing information and exchange on experience and ideas.

Information

To achieve a more effective participation, activities should be initiated to promote information and communication taking into account cultural diversity, attitudinal and social resistances to change. Media could be a key resource for information and communications. Use of Friday prayers, messages on television, radio, newspapers, local leaders, schools and informal means for informing and sensitizing the public on issues pertaining to the healthy villages approach are examples which may help the process of information, communication and public awareness.

Responsibilities

Village

The individual villages which have introduced the healthy village initiative must take the key responsibility for the implementation of the programme. They must develop their plans and organize the mechanisms for their implementation including funding and technical aspects of the work.

District level authorities

At the district level, a role will exist for bringing ideas to the programme and keeping the village level informed of developments in other villages participating in the initiative. Here, an important coordination and harmonization role exists to ensure that the efforts of the individual villages are part of a whole, a district healthy village programme. The district can also provide support in the programme planning phase, as well as providing guidance on request during implementation.

Provincial and national level authorities

At the provincial and national level, the main role will be in providing policy guidance, coordinating external inputs and monitoring and evaluation. The latter is important in relation to the implementation of activities within the framework of a national healthy village policy/programme.

Issues

Initiation

Programme initiation is basically required at two levels, the national and the community level. At the national level, the political commitment to introduce the healthy village approach to strengthening primary health care is required, as well as at the district and local levels. Once this has been done the main initiative is the responsibility of the individual villages which will decide whether to take up the challenge or not. Even in the absence of a national policy of the introduction of the healthy village concept, the health authorities through flexibility in their operations should respond positively to initiatives coming directly from communities.

Institutions/Coordination

Institutional arrangement at the village level must be flexible and fit into existing community structures. They should be built on the existing primary health care institutional structures, with the village health centre/house playing a focal role. In addition to the village health committee there should be a village technical group which brings together the expertise available locally from the different technical agencies (agriculture, roads, education, etc.). It is important that the health sector is able to bring in other expertise if the holistic approach to healthy village mechanisms is to be a success. In this regard, the involvement of nongovernmental organizations at the local level is important, with intersectoral collaboration and coordination being a priority. Proposals for coordination structures and mechanisms should be based on an analysis and assessment of current responsibilities (who is doing what), and different vested interests within the framework of health, the environment and rural development. An agency and/or institution with lead responsibility for health or local administration/development should be identified as the moderator for coordination.

Resources

Seed financing will be required from central or other sources outside the community for the promotional and initiation phase of the programme. However, if a healthy village initiative is to be sustainable it must be implemented within the financial capabilities of the community itself. The majority of projects must be self-sustaining. Income should be generated at the local level and innovative approaches to funding should be investigated and identified. These can include revolving funds operated by agricultural banks, cross subsidies on electricity and/or water bills etc.

An awareness of potential sources of external funding will also be an asset. Local political and religious leaders could also have an important role to play in the fund-raising process. Examples of innovative approaches to funding such development project include the 2626 Account in Tunisia, the 111 Account in Morocco, and similar mechanisms in Iran and Egypt. Possibilities for voluntary funding should also be explored, while resources of both local and international nongovernmental organizations should be harnessed; e.g. the Red Cross/Red Crescent, etc. Fees for services to the community, even if only symbolic, should be considered since these do not only raise funds, but also give value to the service.

To plan for the resources necessary, it will be required to undertake specific needs assessment exercises with the full involvement of the community. Part of this assessment will focus on the potential of the community itself to contribute in cash, kind, local materials and manpower. Studies should be undertaken by an appropriate institution, supported at the national level, to examine development costs and prepare norms and criteria for project cost estimations and projections.

Evaluation

Evaluation is important if the momentum of a programme is to be maintained and plans and programmes are to be kept on target. Evaluation should include health and socioeconomic indicators, a means of data collection and analysis, and monitoring and evaluation should be community based and involve the institutions implementing and leading the programme.