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During the past few decades, fundamental changes have been witnessed in the economic, political, social, technological and environmental areas, changes which have contributed to reshaping the future and resulted in a continuous redefinition of the processes and goals of development. It is a growing recognition that development should go beyond economic growth and ensure social justice, respect for human rights, ecological stability, freedom, community participation and good governance in order to strengthen civil society and encourage the extensive processes of human development. Unfortunately, global development has created more disparity in the economic, social and health status between rich and poor, resulting in the emergence of new vulnerable groups and new forms of deprivation. The continual process of change and persistent increase in the combination of negative effects on the underprivileged has profoundly affected human health, escalating associated effects like unemployment, economic poverty, illiteracy, poor housing, malnutrition, gender inequality, social apathy and lack of will and initiative to strive for change.

WHO’s Regional Office for the Eastern Mediterranean has developed an innovative strategy of community-based initiatives for health and development in which simultaneous emphasis is put on economic growth, improvement in standards of living, health status and quality of life. These approaches provide a new orientation for multidisciplinary and multisectoral efforts to ensure that health considerations are at the core of all development and environmental activities, from policy planning to project implementation, monitoring and evaluation. Indicators on which community-based initiative policies are based cover the full life-cycle and range of conditions that affect people, in particular the poor. With a strong belief that the health sector can play a catalytic role, the nature of the development process is redefined and a creative environment provided for a participatory approach to holistic development.

This document provides orientation about the community-based initiatives implemented in the countries of the Region and gives examples of the successes achieved during the past years. The main intention is to introduce and promote these modest approaches to the stakeholders and agencies involved in health and human development. This document will also assist allied and related government sectors to renew and reshape their strategies in the light of experiences of other countries. As development is a continuous process, this document is also a milestone in an information sharing process that will continue, along with further developments and experiences in the ongoing programmes.

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Health for All by the year 2000 was an objective set by the World Health Assembly in 1979 following the International Conference on Primary Health Care held in Alma-Ata in 1978. Over time, it has been recognized that the primary health care approach could not be realized in full because the strategy was primarily focused on the delivery of health services and on the role of the health sector in improving health outcomes. Subsequently, WHO and its Member States acknowledged that the reasons for persisting inequalities in health are largely poverty, limited national resources of all kinds, lack of education, increase in population, poor sanitation, and lack of awareness of the importance of health and other basic needs. It is evident that certain major determinants of health lie outside the health sector; consequently health cannot be achieved in isolation from other sectors. The right approach, therefore, to achieving health for all should include the full spectrum of human needs, taking into account social, political and environmental influences.

Health is defined by WHO as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. This concept equates health with a productive and creative life, focusing on living conditions rather than on categories of disease causing illness or death. It is also linked with human development, as health plays a vital role in the progress, prosperity and development of a society. Health is considered a fundamental human right and a major social investment goal. This holistic view provides a broader spectrum to collectively address all relevant issues, determinants and factors. The community-based initiatives (CBI) strategy outlined in this document advocates this view, that human health and well-being are the ultimate goals of development; health services should no longer be considered as a complex of solely medical measures. In fact, health contributes to and results from social and economic development.

### Poverty – a multidimensional issue

Despite the overall growth in world economy, differences in health status between rich and poor are growing. Poverty as the root cause of all social evils, including ill health, is a multidimensional issue, deeply intertwined with national growth and economic development strategies and quality of life, including health status. It has adverse effects on all aspects of life. The links between health and poverty run in both directions. Good health allows poor people the opportunity to participate in gainful and productive activities, while bad health adds miseries and further reduces socioeconomic opportunities.

Over the past two decades, the issue of poverty has emerged as one of the most challenging socioeconomic problems in developing countries. At the beginning of the 21st century, the number of people living in absolute poverty continues to rise, with grim health consequences. Currently, about 20% of the world’s population, 1.3 billion people, live in absolute poverty with an income of less than US$ 1 per day. These people have been excluded from the many benefits of economic development and advances in human health that occurred during the 20th century. Those living in absolute poverty have much higher morbidity and mortality compared to the rich, as indicated in Table 1.

Epidemiological studies show that a few preventable conditions are responsible for a high proportion of ill health, especially among the poor. About 8 million deaths each year are due to conditions such as HIV/AIDS, malaria, tuberculosis, childhood infectious diseases and prenatal maternal conditions, all of which can be averted by the basic measures of family planning, immunization, proper nutrition, hygiene and treatment.

### Table 1. Life expectancy and mortality rates, by country development category (1995-2000)

<table>
<thead>
<tr>
<th>Development category</th>
<th>Population in 1999 (million)</th>
<th>Annual average income (US$)</th>
<th>Life expectancy at birth (years)</th>
<th>Infant mortality rate (Per 1000 LBs)</th>
<th>Under five mortality rate (Per 1000 LBs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Least developed countries</td>
<td>643</td>
<td>296</td>
<td>51</td>
<td>100</td>
<td>159</td>
</tr>
<tr>
<td>Low-income countries</td>
<td>1777</td>
<td>538</td>
<td>59</td>
<td>80</td>
<td>120</td>
</tr>
<tr>
<td>Low-middle income countries</td>
<td>2094</td>
<td>1200</td>
<td>70</td>
<td>35</td>
<td>39</td>
</tr>
<tr>
<td>Upper-middle income countries</td>
<td>573</td>
<td>4900</td>
<td>71</td>
<td>26</td>
<td>35</td>
</tr>
<tr>
<td>High-income countries</td>
<td>891</td>
<td>25730</td>
<td>78</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

Low-income countries can improve health by appropriate measures

<table>
<thead>
<tr>
<th>Issues</th>
<th>Strategies</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• HIV/AIDS</td>
<td>Poverty reduction</td>
<td>• Low infant mortality rate</td>
</tr>
<tr>
<td>• Malaria</td>
<td>Access to health services</td>
<td>• Low maternal mortality rate</td>
</tr>
<tr>
<td>• Tuberculosis</td>
<td>Awareness and partnerships</td>
<td>• Low malnutrition</td>
</tr>
<tr>
<td>• Childhood infectious diseases</td>
<td></td>
<td>• Low burden of disease</td>
</tr>
<tr>
<td>• Maternal and per-natal conditions</td>
<td></td>
<td>• High life expectancy</td>
</tr>
<tr>
<td>• Micronutrient deficiencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Tobacco-related illness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

with appropriate measures. Similarly, noncommunicable diseases, such as cardiovascular disease, diabetes, mental illness and cancer, can be prevented through low cost interventions, especially preventive actions relating to diet, smoking and lifestyle.

The world’s political leaders have recognized this global interdependence in solemn commitments to improve the lives of the world’s poor by the year 2015. The millennium development goals, described in Table 2, adopted at the Millennium Summit of the United Nations in September 2000 call for a dramatic reduction in poverty and marked improvement in the health of the poor. The Commission on Macroeconomics and Health, constituted by WHO in 2000, presented a strategy for investing in health for economic development, especially in the world’s poorest countries, based upon a global partnership of the developing and industrialized countries. It is expected that the additional investment called for in health would result in millions of lives saved each year, enhanced economic development and strengthened global security. Indeed, without such a concerted effort, the world’s commitment to improving the lives of the poor embodied in the millennium development goals will not be met.

Findings of the Commission on Macroeconomics and Health

- Health is a priority goal in its own right as well as a central input for economic development and poverty reduction.
- A few health conditions are responsible for a high proportion of the health deficit.
- The HIV/AIDS pandemic is a distinct and unparalleled catastrophe in its human dimension and its implications for economic development.
- Investment in reproductive health, including family planning and access to contraceptives, accompanies investment in disease control.
- The level of health spending in low-income countries is insufficient to address the health challenges they face.

- Poor countries can increase the domestic resources they mobilize for the health sector and use those resources more efficiently.
- Donor finance will be needed to close the financing gap, in conjunction with better efforts by the recipient countries themselves.
- Increased health coverage of the poor would require greater financial investment in specific health sector interventions, as well as a properly structured health delivery system that can reach the poor.
- An effective assault on diseases of the poor will also require substantial investment in global public goods.

Sustainable development for health

Health is a central goal and an important outcome of development. Development can only be sustainable if social and economic dimensions are considered at all levels and stages. A community or country cannot be graded as developed on the basis of high per capita income, if its people are illiterate, have poor health status and lack the infrastructure necessary for a healthy lifestyle. Therefore sustainable development should always be measured in terms of social indicators mainly health, reduction of absolute poverty and improvement in the quality of life. Health and poverty reduction has therefore assumed the highest priority on the agenda of most international development agencies. A series of United Nations summits during the past decade produced millennium development goals aiming to halve the number of people living in absolute poverty by the year 2015, in addition to reduction in infant mortality rate, maternal mortality ratio and the prevalence of HIV/AIDS. The millennium development goals are an expression of humanitarian concern and call for investment in human well-being. These targets can be reached by developing an enabling policy and institutional environment and promoting an effective health dimension to social, economic, environmental and developmental policies.

### Quality of life

Quality of life is the condition of life resulting from a combination of the effects of a complete range of factors such as those determining health and happiness (including comfort in the physical environment and a satisfactory occupation), education, social and intellectual attainment, freedom of action, justice and freedom from oppression. This concept is a composite measure of physical, mental and social well-being as perceived by each individual or group of individuals. Quality of life must be considered in the context of local development and human needs.

Improvement in quality of life and having a healthy lifestyle prevent many illnesses and disabilities, facilitating health promotion and protection from many risk factors, whereas poor living conditions increase misery and add to the burden of diseases. The emphasis is on development which will assist people to improve their quality of life, and on searching for innovative means to make it possible for individuals to contribute to the improvement of their own health status and living conditions.

Quality of life is central to human and social development, and its determinants require a set of multidisciplinary developmental actions at both the community and the individual levels.

#### Table 2. Millennium development goals

| Goal 1 | Eradicate extreme poverty and hunger | • Halve, between 1990 and 2015, the proportion of people whose income is less than US$ 1 a day
|        |                                  | • Halve, between 1990 and 2015, the proportion of people who suffer from hunger
| Goal 2 | Achieve universal primary education | • Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling
| Goal 3 | Promote gender equality and empower women | • Eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education no later than 2015
| Goal 4 | Reduce child mortality | • Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate
| Goal 5 | Improve maternal health | • Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio
| Goal 6 | Combat HIV/AIDS, malaria, and other diseases | • Have halted by 2015, and begun to reverse, the spread of HIV/AIDS
|        |                                  | • Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases
| Goal 7 | Ensure environmental sustainability | • Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources
|        |                                  | • Halve, by 2015, the proportion of people without sustainable access to safe drinking-water
|        |                                  | • Have achieved, by 2020, a significant improvement in the lives of at least 100 million slum dwellers
| Goal 8 | Develop a global partnership for development | • Develop further an open, rule-based, predictable, non-discriminatory, trading and financial system (including a commitment to good governance, development, and poverty reduction, both nationally and internationally)
Community-Based Initiatives

Since the 1980s, WHO’s Regional Office for the Eastern Mediterranean has been advocating poverty reduction as the most potent strategy to facilitate equitable development for achieving health related goals. This strategy is consistent with the high priority given to this area of work on the agenda of most international development agencies for achieving the millennium development goals. This is based on the realization that ill health and poverty are mutually reinforcing. In order to have a real impact on the quality of life of the people and to gain substantial and sustainable health gains, it has been considered necessary to address all determinants of health and to support individuals, families and communities to attain self-sufficiency and self-reliance through integrated and comprehensive development. In support of this strategy, the Regional Office is actively promoting, among the countries of the Region, Community-Based Initiatives (CBI) such as Basic Development Needs (BDN), Healthy Cities Programmes (HCP), Healthy Villages Programmes (HVP) and Women in Health and Development (WHD). The common goal of these approaches is to create political, physical and economic policies and plans of action for all segments of the community that will produce a positive impact on the overall environment and quality of life. Since the inception of these initiatives, a majority of the countries have adopted various schemes and approaches, shown in figure 1, which are currently at different levels and stages of development.

All community-based initiatives have the common objective of achieving health for all through health and development interventions. BDN and HVP schemes are implemented primarily in rural areas following common objectives, structures and processes. The HCP operates in urban localities, especially in the underprivileged suburbs, for improving environmental conditions and bringing health onto the local development agenda. The WHD initiatives are implemented through the existing structures of community-based programmes which have established women’s organizations and committees.

Objectives

The main objective of CBI is to facilitate the integration of health policies and programmes in national strategic development agendas. It aims at improving health and environmental conditions, reducing poverty and achieving better quality of life through the attainment of the millennium development goals. The work is focused on promoting equity, especially within the human rights perspective, gender mainstreaming and enhancing the role of women in health and sustainable development.
Table 3 Components of development packages

<table>
<thead>
<tr>
<th>Health</th>
<th>Social</th>
<th>Economic</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Availability of health services</td>
<td>• Education and literacy</td>
<td>• Agriculture and irrigation</td>
</tr>
<tr>
<td>• Health promotion and protection</td>
<td>• Adequate housing conditions</td>
<td>• Livestock, dairy farming and fisheries</td>
</tr>
<tr>
<td>• Integrated management of child health</td>
<td>• Social welfare actions</td>
<td>• Income-generation and microcrediting</td>
</tr>
<tr>
<td>• Making pregnancy safer</td>
<td>• Women’s development and empowerment</td>
<td></td>
</tr>
<tr>
<td>• Control and prevention of communicable and noncommunicable diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Environmental health and safe drinking-water</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Development packages

To achieve the desired target outlined in the social contract, development packages have been produced related to the various components and elements of the health, social and economic sectors. These packages, outlined in Table 3, guide the communities and the technical support teams in designing projects and activities by ensuring uniform development in all sites. Health is the main focus and requisite actions should be carried out irrespective of the priorities defined by the communities; the interventions related to social and economic sectors are needs based with the aim of promoting comprehensive and sustainable development.

Strategies

- To generate and disseminate information on the role and centrality of health in sustainable development, highlighting the socioeconomic and environmental determinants of health;
- To support the countries of the Region in developing a shared vision for health and development and in the formulation of national strategies focusing on the health of the poor, based on assessment and analysis of poverty;
- To assist both national authorities and civil society in reducing health inequalities and poverty through dynamic intersectoral collaboration, and to tackle challenges pertaining to globalization, human rights and emerging technologies;
- To help in empowering communities and vulnerable groups, particularly women, to play a leading role in health and development;
- To build and expand partnerships within and outside the Region in support of WHO policies and programmes for resource mobilization and joint advocacy and actions;
- To assist the countries of the Region in incorporating community development approaches into national poverty reduction policies and programmes.

Social contract

CBI works through joint collaboration of the community, intersectoral technical teams, programme management and other stakeholders, including WHO. In order to formalize these partnerships, a social contract is agreed upon by all partners at the start of the programme implementation in each area. The social contract identifies key targets to be achieved in a specified period and describes the roles of each partner in attaining the desired goal. The contract keeps the partners, especially the communities, focused on the set of targets determined and provides a broad base for programme implementation.

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CBI tools facilitate the following functions:

1. Planning
2. Organization
3. Human resource development
4. Community survey and prioritization
5. Project preparation and implementation
6. Supervision and monitoring
7. Financial management
8. Documentation and reporting
9. Promotion and advocacy
10. Programme evaluation

CBI guidelines and tools

To facilitate the process of planning and implementation of community-based initiatives, a set of comprehensive technical/administrative tools and uniform, user-friendly guidelines have been developed. This is an attempt to address some of the most frequent and important questions and comments about the CBI from different sectors and agencies. They are by no means exhaustive or rigid, and require adaptation by each country by selecting the most appropriate, relevant and applicable sections. The government, WHO and other contributing agencies should evaluate their plans in the light of these guidelines. When assessing the inputs, processes and outcomes of national CBI programmes, these guidelines should be used as the reference material.

CBI training manual

A CBI training manual has been developed which provides a comprehensive package of academic information and practical training on the implementation and operation of CBIs for health and development. It assists in the orientation and capacity building of the programme managers, intersectoral teams, and communities. Part A of the manual contains guidelines for the facilitators for organizing and conducting the training, while part B contains five modules covering different aspects of CBI management. The contents, study framework and duration of this training manual can be adapted according to the needs and levels of target groups. The modules and units are outlined below:

Module 1 Basic concepts
- Unit 1.1 Health and quality of life
- Unit 1.2 Sustainable development and poverty reduction for health
- Unit 1.3 Community-based initiatives in the Eastern Mediterranean Region

Module 2 Social mobilization and development
- Unit 2.1 Community mobilization and social contract
- Unit 2.1 Health development
- Unit 2.2 Social development
- Unit 2.3 Economic development
- Unit 2.4 Health and development indicators

Module 3 Public health
- Unit 3.1 Concept of health, health for all and primary health care
- Unit 3.2 Health promotion and protection
- Unit 3.2 Disease prevention and management

Module 4 Management of CBI
- Unit 4.1 Planning
- Unit 4.2 Organization
- Unit 4.3 Human resources development
- Unit 4.4 Community surveys and prioritization of needs
- Unit 4.5 Project preparation and implementation
- Unit 4.6 Supervision and monitoring
- Unit 4.7 Financial management
- Unit 4.8 Documentation and reporting
- Unit 4.9 Promotion and advocacy
- Unit 4.10 Programme evaluation

Module 5 Leadership skills
- Unit 5.1 Management techniques
- Unit 5.2 Problem-solving approach
- Unit 5.3 Effective communication
- Unit 5.4 Operational research and development

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3 Guidelines and tools for management of basic development needs, Cairo, World Health Organization Regional Office for the Eastern Mediterranean, 2003 (unpublished document no. WHO-EM/CBI/004/E/G/ available from Community-Based Initiatives, WHO EMRO, PO Box 7608, Nasr City 11371, Cairo, Egypt).

Basic Development Needs

Introduction

In order to address the challenges of poverty and the high burden of mortality and morbidity in underprivileged communities, the BDN approach is under implementation in the Region. This is an integrated socioeconomic development process aimed at achieving a better quality of life and improved health outcomes. It promotes self-reliance, self-financing and self-management within the organized communities, which are empowered for local development. This approach represents a conceptual shift from implementing the more conventional, but isolated, activities towards a more holistic development where the community itself assesses and prioritizes their needs plans, supported and assisted by government departments. Priority is given to those activities which will further improve the health indicators of the community.

Currently, BDN activities are being implemented in 15 countries of the Eastern Mediterranean Region, where it has been considered an effective instrument for improving the socioeconomic and health indicators.

Objectives and strategies

- Mobilizing and organizing communities, promoting self-management, self-reliance and self-dependence;
- Encouraging communities to work as partners in the planning, implementation and monitoring of the development process;
- Supporting communities for leadership roles and enhancing their capabilities in this respect;
- Encouraging the government to develop effective collaboration between the departments involved in the programme; partnerships with civil society and other stakeholders; and coordination of intersectoral actions in support of the communities;
- Upgrading the managerial and technical capacities of government functionaries;
- Mobilizing communities and government resources in a single direction towards integrated socioeconomic development.
- Identification and promotion of appropriate, health-friendly technologies for community development and encouragement of healthy lifestyles within the communities;
- Introducing socioeconomic interventions and supporting the mobilization of community resources and technical, physical and financial inputs by both government and international agencies;
- Reducing poverty – the root cause of social evils and ill health;
- Operational research for designing developmental models to facilitate replication of programmes in other communities;
- Enhancing the educational status, literacy and awareness of the people, making them responsible partners of society;
- Improvement of health indicators through comprehensive health services and improved quality of life as an outcome of socioeconomic development.

The five main strategies are:

- Community organization and active participation: The community is mobilized, organized, trained and empowered to play a proactive role in self development. This empowers people to take charge of their own lives and take action for improving quality of life.
- Coordinated intersectoral support: Key public sector ministries are involved in local development and mobilize their resources to support the communities.
- Bottom-up planning: The community identifies and prepares feasible plans in order to address the priority issues.

<table>
<thead>
<tr>
<th>Country</th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jordan</td>
<td>42%</td>
<td>85%</td>
</tr>
<tr>
<td>Pakistan</td>
<td>83%</td>
<td>98%</td>
</tr>
<tr>
<td>Sudan</td>
<td>54%</td>
<td>95%</td>
</tr>
<tr>
<td>Syrian Arab Republic</td>
<td>88%</td>
<td>97%</td>
</tr>
</tbody>
</table>

Immunization of children (2002)
• Integrated and sustainable development: The community carries out integrated multidisciplinary interventions, based upon local needs and targets outlined in the social contract and in harmony with national and regional plans. The health, social and development packages facilitate this process.

• Self-reliance and self-management: The communities self-manage activities by mobilizing and contributing their own resources to ensure programme sustainability.

Organizational set-up

As a bottom-up approach, the BDN hierarchy is structured on a network involving all social groups of the local community. A community development committee (CDC) is nominated by the people to represent the area and manage the programme. Systematic division of the area provides an opportunity to seek representation from all sectors and parts of the locality as cluster representatives (CRs). Various technical committees and groups such as women and youth assist the CDC in the development process. A team representing various allied sectors operating in the area provides technical and professional support under the leadership of a programme manager. A national focal person manages the programme at the country level and collaborates with national and international agencies.

Baseline assessment, prioritization of needs and area development profile

A baseline survey is conducted to gather information on, and interpret the prevailing conditions of the village. The data for the survey is collected by the CRs and CDC and compiled at village level, after which it is analysed and transformed into a useful form. The assessed needs are prioritized by the community according to the magnitude and extent of adverse effects. Based upon this prioritization and the survey results, an area development profile is prepared that becomes the road map for future actions and progress reviews. This baseline survey also serves as an important tool to monitor the programme activities and outcomes.

After adaptation, assessments should be repeated after every one or two years to measure the impact of programme intervention compared to the baseline status and the targets outlined in the social contract and area development profile.

Types of projects

The BDN projects and activities pertain to the following categories:

Health and environment

• Extension of health services seeking active community participation, with an emphasis on immunization, maternal and child health, family planning; control and prevention of communicable and noncommunicable diseases; availability of essential drugs through community pharmacies; and school health;

• Improved education on nutrition and food safety; promotion of a healthy lifestyle; and reduction in substance abuse, including tobacco;

• Mobilization of community for environmental health, safe drinking water, sanitation and garbage disposal; tree plantation; promotion of energy saving schemes; and promotion of healthy homes.

Social

• Promotion of basic and primary education, and facilitating readmission of school drop-outs;

• establishment of literacy centres for girls and boys who missed opportunities;

• Recreational activities such as sports and literary competitions;

• Women’s development through their organization and the establishment of vocational training centres for handicrafts and life skills;

• Youth support through skills development and technical training.
Economic

Soft loans are provided to the poor families as seed money for income generation in the following areas:

- Agriculture and allied fields, including quality seeds, fertilizers, food crops, gardening, forestry; irrigation projects like tube wells, diesel water pumps;
- Dairy livestock and allied fields related to milking animals, sheep and goat farming; fattening of calves; poultry and rabbit farming; honeybee farming; fishing boats and nets;
- Cottage industry, which may include projects of community interest like shoe making, iron work, woodwork/carpentry, steel welding, electronics/electrical, garment making and tailoring, pottery and carpet manufacturing;
- Small-scale businesses such as grocery shops, fruit and vegetable shops, food shops, vendors of household items, local transport;
- Handicrafts, in particular for females, such as hand and machine embroidery, decorative articles, wood carving, handbag manufacturing, fabric and scenery painting.

How does BDN bring about change?

Changes take place through the following:

- Transformation for encouraging change in self and society;
- Introducing intersectoral coordination and partnerships;
- Breaking the vicious cycle of dependency by active community participation and ownerships (community development for the people, by the people);
- Developing awareness among the masses concerning their needs and rights, coping with problems, practising healthy lifestyles and health care measures;
- Encouraging decentralization and local empowerment by bottom-up planning and management;
- Mobilizing local and public resources;
- Changing the attitude of government functionaries to be more supportive to the community;
- Improving health status through increased family income and self-care;
- Reducing poverty and improving quality of life.
Quality of life programme in Jordan

Jordan was among the first countries in the Region to introduce community-based initiatives (Quality of Life) in 1989 in the village of Sweimeh. The project, being implemented in collaboration with the Noor Al Hussein Foundation, has subsequently been extended to more than 50 villages across the country. An in-depth evaluation was conducted in 2001 to review the programme and to assess the development strategies and the outcome in the context of programme objectives and indicators. The salient findings of the evaluation are presented here to demonstrate the remarkable achievements of the programme in a number of indices pertaining to health, social development and economic improvements. The evaluation report also pointed to the remarkable impact of the programme on women through better awareness and skill development.

### Case Study

- **Villages 19 old, 2 new**
- **Households 7659**
- **Population 47 270**

<table>
<thead>
<tr>
<th>Social interventions</th>
<th>Projects 383</th>
<th>Population directly covered 8735</th>
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<td>Projects 922</td>
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<td>Income-generation schemes</td>
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### Participation of women in income-generation schemes (2001)

- **Sweimeh**: 0%
- **Al Hemyeh**: 42.81%
- **Iraq al Amir**: 45.14%
- **Um Qais**: 23.08%
- **Iraq al Karak**: 20.30%

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- **Male beneficiaries**
- **Female beneficiaries**
Case Study

27 partners, including WHO, collaborated in providing technical and material support

- Water supply and sanitary latrines (2001)
- Antenatal care and family planning coverage (2001)

- Social interventions
- Income generation
- Operational cost

- Loan recovery: 84%
- Average profit rate: 80 to 150 Jordanian dinars per month

Antenatal care and family planning coverage (2001)

- Water supply and sanitary latrines (2001)

Social interventions: 41.78%
Income generation: 11.44%
Operational cost: 46.77%
### Introduction

The rural communities in the Eastern Mediterranean Region face a number of unique challenges. With rapid urbanization, the changing physical and social structures and situations of rural settings have posed serious threats to the health and well-being of the people. The health and environmental challenges are multiplied due to the serious problems of water supply, sanitation, housing and personal hygiene. The rising poverty index and limitation of resources have further aggravated the problems of underprivileged communities. As a result, rural people suffer complex socioeconomic problems and a greater burden of disease. The centralization of public facilities and job opportunities in urban areas has attracted migration of rural people to the cities in search of better prospects, creating a scarcity of human and other resources in rural areas. The traditional approach, where local authorities are expected to provide and maintain all services, is failing as they have limited resources and cannot cope alone with these issues. This has created a demand for innovative approaches like HVP.

The HVP has been developed to address the above-mentioned environmental, health and social issues in an integrated manner. This is a tool to enhance and accelerate the process of achieving health for all. In these programmes, priority is given to creating a supportive environment with the focus on village development in order to improve the health and quality of life of the people. Provision of a potable water supply, improved sanitation, solid waste removal and village cleanliness are major components. In view of the importance of the interrelationship between economic status and health, the healthy village approach has further evolved to include economic development. In order to achieve these targets, the organized participation of communities and strong intersectoral collaboration at all levels are considered essential. The 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 level. Healthy village actions try to facilitate, not duplicate or interfere with, ongoing development activities and provide an opportunity for the people and the authorities to build a partnership to overcome these problems.

### Objectives and strategies

The HVP is a holistic development approach which takes into consideration settings such as the home, workplace, neighbourhood, school and marketplace, where people live and work.

The following are specific objectives of the HVP:

- To promote and mobilize health and environmental measures;
- To facilitate collaboration between health and other sectors at the local level;
- To raise community awareness and standards of health and hygiene education;
- To place a high priority on improving environmental services (water supply, sanitation and cleanliness);
- To stimulate and strengthen local-level decision making and empowerment;
- To encourage and promote the mobilization of resources and economic development.

The strategies of HVP aim to:

- Forge dialogue at all levels on health and environmental issues for rural settings;
- Strengthen the capacity of rural communities to initiate, plan and sustain environmental health projects;
- Use the basic development needs methodology as a tool for communities to mobilize participation, assess community needs and set agendas;
- Place a high priority on improving environmental services (water supply, sanitation and cleanliness);
- Stimulate and strengthen local-level decision making and empowerment;
- Encourage and promote the mobilization of resources and economic development.

A village or rural community can be graded as healthy when rates of infectious diseases are low, community members have access to the basic services and health care, and the community lives in a state of reasonable harmony and well-being.

### Characteristics of a healthy village

- Physical environment is clean and safe
- Social harmony is achieved by involving everyone
- Community has access to varied experiences, interaction and communication
- The historical and cultural heritage is promoted and celebrated
- The health services are accessible and appropriate
- The economy is diverse and innovative
- There is sustainable use of available resources for all people

A village or rural community can be graded as healthy when:

- Rates of infectious diseases are low
- Community members have access to basic services and health care
- The community lives in a state of reasonable harmony and well-being.

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**Healthy Villages Programme**
- Help communities to implement development projects and resources in the areas of health, environment and education;
- Promote the use of appropriate technologies as a means of responding to social and cultural preferences, containing costs and ensuring sustainability;
- Develop mechanisms to ensure that women especially, play a central role in defining the problems and selecting the strategies to solve them.

### Types of projects

The types of projects expected to be introduced in programme areas include the following:

- Environmental improvement through:
  - Sanitation (excreta disposal)
  - Shelter (housing)

### Case Study

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<thead>
<tr>
<th>Healthy villages programme in the Syrian Arab Republic</th>
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<td><strong>Programme expansion</strong></td>
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<td><strong>Immunization of children</strong></td>
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<td><strong>Vaccination of mothers</strong></td>
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<td><strong>Family planning practice</strong></td>
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<td><strong>Antenatal care</strong></td>
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<td><strong>Implementation of family health care and vital statistics network</strong></td>
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<td><strong>Safe potable water supply</strong></td>
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<td><strong>Sanitation coverage</strong></td>
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<td><strong>Establishing public gardens</strong></td>
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<td><strong>Tree plantation</strong></td>
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<td><strong>Training and distribution books on childcare, family health and life skills</strong></td>
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<tr>
<td><strong>Computer training</strong></td>
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<td><strong>Women’s development actions</strong></td>
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<td><strong>Income generation</strong></td>
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- Drainage (wastewater/storm water irrigation)
- Solid waste (garbage) disposal
- Domestic animals (sanitary conditions)
- Food safety (commercial and domestic)
- Chemical safety (agriculture and home)
- General community environment (roads, parks, laundries, public baths, markets)
Healthy Cities Programme

Introduction

The Eastern Mediterranean Region has one of the fastest rates of population growth in the world. This rapid growth has caused a multitude of political, social and financial, environmental and health problems. Many major cities suffer from congestion, air and industrial pollution, and inadequate sewage and solid waste management systems. Additionally, rapid urbanization has affected traditional social bonds and cultural affinities. People are becoming more and more anonymous in big cities and the strong sense of belonging to a neighbourhood or a city has started to deteriorate.

Many cities suffer from a housing shortage as urban land and housing prices have risen above affordable levels. Green areas around cities are being eroded or destroyed in many cases; urban sprawl is extending into the desert and dry lands creating an inhospitable environment. Some countries have little or no town planning, as a result, chaotic developments have been built, aesthetic architecture has been lost and visual pollution has prevailed. Shortage of drinking water is major issue in the rapidly growing cities. Average renewable water resources per inhabitant per year have declined rapidly since 1960, as the population has rapidly increased. The average person in other parts of the world has almost 5 times more water than a person in the Eastern Mediterranean Region.

Physical and social factors such as health services, environment, economy, population growth, education, and awareness directly or indirectly affect health. Cities are not homogeneous entities; they are composed of a variety of ethnic, social and income groups. Health levels within these groups, therefore, also vary according to income, age, physical condition, environment and lifestyle. The urban poor, especially in the low-income and middle-income countries of the Region, are at the interface between underdevelopment and industrialization, and their lifestyle and disease patterns reflect the problems of both. They are affected by inadequate diets and sedentary lifestyles. As a result, they suffer from a heavy burden of communicable diseases and high maternal, infant, and child mortality as well as high incidence of cardiovascular disease, hypertension, diabetes, cancer, drug and alcohol abuse, accidents, violence, sexually transmitted diseases and HIV/AIDS. There has also been an increase in tobacco smoking, especially among women, in certain countries. In addition, drug abuse is a serious social and health problem in some areas.

The healthy city programme

The basic objective of the HCP is to improve health and environment in urban settings, giving priority to the upgrading of environmental health services and improving the quality of life in underprivileged areas. The intention is to provide public health and environmental leadership and stimulate partnerships between the community, intersectoral departments and agencies as well as mobilizing their skills, potentials and resources.

Objectives and strategies

The dilemma is that 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.

The programme works on the principle that health and quality of life can be improved by modification of living conditions in the home, school, workplace, city – the places or “settings” where people live and work. Health status is often determined more by the conditions in these settings than by the provision of health care facilities.

Looking at the health determinants in an urban setting, the HCP goes beyond the health sector and look at related factors, including economic status, employment and social needs. Moreover, it creates an awareness of factors related to the pace of urbanization, rapid population growth rates, the impact of national development plans on cities, poverty in urban slums and squatter settlements.
The strategies of HCP include:

- Developing a strong promotional process, which focuses on increasing awareness of the influence of health and environmental issues in urban development;
- Developing a city health and environment plan aimed at improving environmental health services and conditions in the city, including water supply, sewage, solid waste management, pollution control, green areas, housing, etc.;
- Mobilizing community participation and political support for the implementation of health and environment projects;
- Increasing the capacity of the municipal government to manage urban problems using participatory approaches and strengthening other relevant municipal institutions;
- Developing broad social partnerships with nongovernmental organizations, international organizations, universities and other interested groups;
- Establishing and encouraging networking and information exchange.

Facilitate collaboration between government, municipal authorities and WHO.

Support group

Ideally, after the initial contact and the development of an official agreement for collaboration between WHO and the city, interested persons from different disciplines should be approached to constitute a support group. This will comprise representatives from community groups, religious organizations, the municipal and city governments, universities and training institutions, nongovernmental organizations, etc. This support group will be widely based in, and representative of, many facets of city life.

Coordinating committee

A formal meeting of the support group is held to constitute a coordinating committee for HCP activities and projects. It is expected that this committee will consist of several key individuals in the city (municipal government staff, health centre staff or community activists) who have leadership abilities and the capacity to improve the health conditions of the city along with the ability to stimulate the participation of the support group. The coordinating committee is also expected to collect and analyse information and make contacts with the key individuals needed to address priority issues.

City health forum

City health forums are constituted to promote health, identify health priorities and goals, and prepare the city health profile and plans. City health forums are mainly concerned with road traffic accidents, reducing tobacco smoking, prevention of noncommunicable diseases, nutrition, and promotion of green industries.

Type of projects

In addition to health promotion projects, the following areas usually attract special attention in urban settings:

- Waste management
  - Hospital waste management
  - Hazardous waste management
- Water and wastewater
  - Sewage, wastewater treatment and reuse
  - Drinking water quality control
  - Intermittent water supply systems
- Food safety
  - Imported vegetables
  - Public eating places
- Chemical safety
- Environmental protection in industrial areas
- Healthy schools
- Healthy hospitals and promotion of healthy lifestyle
- Women’s development

Organizational set-up

The HCP is implemented by establishing the infrastructure outlined below.

Focal point(s)

The initial steps for starting the healthy cities action is usually taken by one or two interested persons who usually become the focal points(s) for the HCP. These persons
Healthy cities programme in Islamic Republic of Iran

The Islamic Republic of Iran initiated a healthy cities programme in 1991 through collaboration between WHO, the Department of Environmental Health, the Minister of Health and Medical Education and the mayor of Teheran. In 1996, the government established a high level national coordination council for healthy cities and healthy villages, subsequently reviewed in 1999, under the chairmanship of the Minister of Health and Medical Education, and including representatives of key ministries. The intent was to incorporate health and environmental measures and objectives in the development programmes for urban and rural areas, and to provide political and administrative support for achieving the objectives and goals of the HCP and HVP. Over time, 55 cities from 22 provinces, have initiated HCP, which are now at various stages.

Cities having initiated HCP activities in Islamic Republic of Iran

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<th>Isfahan province</th>
<th>Azarbijan Gharbi province</th>
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Introduction

The improvement of the status of women, including their empowerment, is essential to the economic, social and environmental dimensions of sustainable development. Especially in the developing countries, women lack empowerment in matters of daily life and in health opportunities. Half the world's population are women but their income is far less than that of men: they receive only one tenth of the total income. They account for two-thirds of working hours but they only own one per cent of the property. Women comprise seventy per cent of the poor in the world but still have less access to the labour market. This wretched situation is aggravated by the fact that the sectoral support they receive is often inadequate. They are more prone to household accidents and face a higher ratio of violence. Social discrimination and powerlessness have exacerbated their mental health problems, in particular depressive neurosis. The health situation of females deteriorates when coupled with poverty. They suffer a different pattern of mortality and morbidity, not only due to biological reasons, but also mainly due to inequality and lack of awareness. Although life expectancy is slightly higher among women, they suffer more from mainly preventable chronic and acute illnesses.

The gender perspective is not only concerned with biological differences between women and men, but acknowledges the effects of socially, culturally and behaviourally determined relationships, roles and responsibilities of men and women, especially on individual, family and community health. To address the issue, it is essential to consider the gender perspective and ensure that gender-sensitive policies and programmes are designed, implemented and monitored with the full participation of women.

As a matter of policy and good public health practice, the Eastern Mediterranean Regional Office of WHO has integrated gender considerations in all facets of its work, supporting the countries of the Region to promote the proactive role of women in health and development issues. This aims to facilitate the development of gender-sensitive policies and programmes in a multisectoral framework in order to improve the socioeconomic status of women. The Regional Committee for the Eastern Mediterranean, at its Forty-sixth Session, called upon Member States (resolution EM/RC46/R.8) to enhance the role of women in major community-based development initiatives such as BDN, HCP, HVP etc.

Objectives and strategies

The objective is to enhance the role of women and to mainstream gender as an essential component of the CBI and other WHO programmes. The approach focuses on the empowerment of women as central to all efforts for reaching sustainable development.

Its main strategies include:

- Performing gender analysis and supporting gender-sensitive research studies;
- Encouraging gender awareness and capacity building;
- Supporting the human rights, dignity, self-worth and abilities of girls and women;
- Creating opportunities for the participation of women in decision-making at all levels;
- Addressing harmful traditional health-related practices and misinterpretation of religion;
- Integrating health concerns and issues into economic development processes;
- Developing gender-based health information systems;
- Sensitizing the media on gender issues;
- Taking into account the special health related needs of women living under difficult circumstances;
- Promoting positive cultural, traditional and religious values.

Implementation

Gender mainstreaming in a WHD framework is a cross-cutting intersectoral issue and is implemented through capacity-building, establishing gender units, creating opportunities for the development of women's leadership skills, introducing mechanisms for health concerns and issues, attending to the special needs of women throughout life and the integration of WHD in the socioeconomic development of all developing communities. The Regional Office has established a steering committee for gender mainstreaming and the integration of women's health and development in different health programmes and policies. The committee guides activities, provides support for the accomplishment of the objectives and strategies.
of certain tasks such as the development of a technical base on gender and health, and promotes information exchange and networking both within and outside the Region. The Regional Office has also initiated an action-oriented research project on the role of women in non-traditional areas of environmental management for health and sustainable development in Egypt and Jordan. WHD activities are also integrated into programmes such as those for tuberculosis, malaria, HIV/AIDS, noncommunicable diseases, environmental health, blindness and road traffic accidents and in all countries implementing CBI as an essential component of its needs-based interventions.

Model projects supported by WHO have demonstrated that developing women's potential can be instrumental in sustainable community development. It has been shown that women's education, training, empowerment and participation in decision-making remain the main strategies for transforming the place of women in health and development and harnessing their role as equal partners in society.

Case Study

The role of women in environmental protection in Alexandria, Egypt

The Eastern Mediterranean Regional Office of WHO initiated the Alexandria healthy city and women's development project in 1996. Other partners include PLAN International, the University of Alexandria, city and local authorities and members of the community. The project aims to demonstrate the effective role women can play in environmental protection for sustainable development. It focuses on environmental protection by addressing the plight communities in informal periurban settlements (where environmental conditions are appalling and the unemployment rate among women is high) and serves as a model for the low-income and middle-income countries in the Region.

Activities and achievements

1- Training and empowerment of 180 women as environmental promoters from each cluster
2- Awareness of community of public health and environment through workshops, benefited 2000 women
3- Eight training sessions and lectures for children, benefiting 100 children
4- Environmental health projects such as:
   • Cleanliness campaigns and environmental protection measures
   • Solid waste disposal system and recycling of solid waste
   • Healthy schools and school sanitary conditions
   • Hygienic preparation of food for school children
   • Tree plantation
5- Social projects like:
   • Improvement of local schools and health clinics
   • Establishment of women’s centres for vocational training
   • Kindergartens
   • Income generation projects
   • Establishment of the healthy hospitals initiative, upgrading hospitals

The project has demonstrated that incorporating women into environmental health work can serve as an effective entry point for development activities relating to the environment, school health, primary health care and income generation for self-reliance. Within a short period, the project has succeeded in expanding to neighbouring communities as well as attracting major donors and the attention of authorities in other countries.
Investing in health, particularly that of the poor, is central to the achievement of the Millennium Development Goals. In support of this strategy WHO’s Regional Office for the Eastern Mediterranean is actively promoting in countries of the Region community based initiatives like Basic Development Needs, Healthy Cities, Healthy Villages and Women in Health and Development. These approaches are based on the principle that good health status—an important goal in its own right—is central to creating and sustaining capabilities of poor people to meet their basic needs and to escape from poverty. The Community-Based Initiatives Series is aimed at facilitating the management of such initiatives. Users of the series may include government authorities, community representatives, WHO and other international agencies and non-governmental organizations.