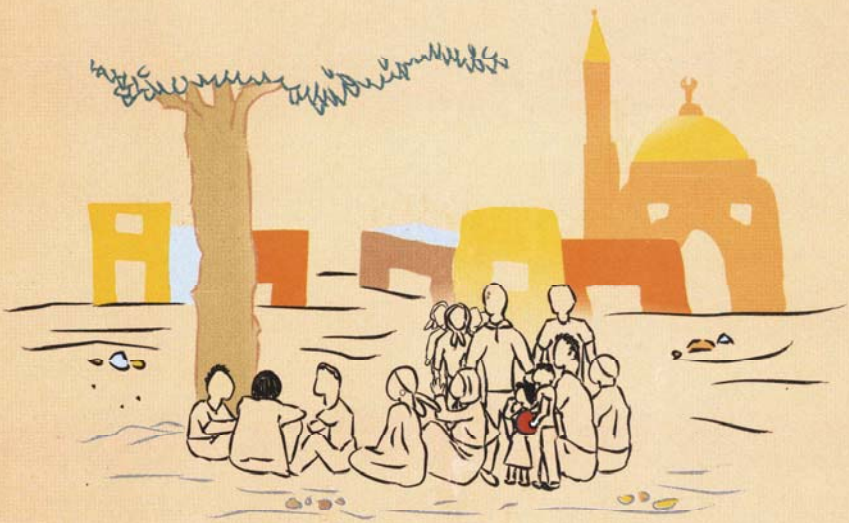
Community-Based Initiatives Series 6

WHO-EM/CBI/015/E/G
Distribution: General

Gender Mainstreaming in Development Strategies



World Health Organization
Regional Office for the Eastern Mediterranean

Community-Based Initiatives Series 6

WHO-EM/CBI/015/E/G
Distribution: General

Gender mainstreaming in development strategies

World Health Organization
Regional Office for the Eastern Mediterranean
Cairo
2003

Cover design by Suhaib Al-Asbahi
Printed in Cairo, Egypt, by El-Zahraa for Arab Mass Media

Document WHO-EM/CBI/015/E/G/10.03/500

CONTENTS

1. INTRODUCTION

The past two decades have created an active interest with regard to the gender dimensions of the human, economic, social and environmental development processes. One of the major approaches to development identified by the eight world conferences convened during the 1990s, in which WHO participated, was that the "improvement of the status of women, including their empowerment, is central to all efforts to reach sustainable development in all of its economic, social and environmental dimensions" [*1*].

The links between health and the socioeconomic status of women are well documented. Historical evidence suggests that government policies and societal practices, coupled with low investment of resources in women's potential, have created a serious imbalance between the opportunities afforded to women to develop themselves and thereby contribute to the socioeconomic development of the country and those afforded to men. Globally, low levels of literacy among women, their lack of economic power and their low rates of participation in development and in the political decision-making processes are among the key factors that have led to continued poor health status for women, including high levels of maternal mortality, in almost all societies, but especially in poor and developing countries.

A gender perspective in health leads to a better understanding of the factors that influence the health of women and of men and is vital if equitable and effective health policies and strategies are to be developed and implemented. It is not only concerned with biological differences between women and men, or with women's reproductive role, but acknowledges the effects of the socially, culturally and behaviourally determined relationships, roles and responsibilities of men and women, especially on individual, family and community health. A gender perspective, linked to the advancement of equity, must be incorporated into health policies and programmes. Specific aspects include:

- performing gender analysis and encouraging gender awareness;
- attending to the special needs of girls and boys, women and men, throughout life;
- supporting the human rights, dignity, self-worth and abilities of girls and women; and
- creating opportunities for full participation of women with men in decision-making at all levels.

Gender mainstreaming is a strategy for achieving equity between women and men in access to and control over the available resources. It evolved from the Women in Development approach (WID) promoted by development theory in the 1970s and 1980s. This approach itself arose out of the concern that women were being excluded from the development process and its benefits and, therefore, focused on women-specific programmes and projects as a way of "integrating women into development". The approach, while important, tended to isolate women as a separate and homogeneous category and did not bring about sufficient long-term changes in the social and economic conditions experienced by women. The Gender and Development (GAD) approach aims at redressing the inequalities between women and men, and emphasizes that women's disadvantaged position needs to be analysed and addressed, not in isolation but in relation to that of men.

The Fourth World Conference on Women, held in Beijing in 1995, noted that "it is essential to design, implement and monitor, with the full participation of women, effective, efficient and mutually reinforcing gender-sensitive policies and programmes" [2]. Following the Beijing Conference, most countries of the Eastern Mediterranean Region established National Committees for Women, developed national plans of action to implement their commitments, and set up monitoring systems to regularly map the progress made towards mainstreaming gender in the national development process. Following

the Beijing Conference and its resolutions and commitments, the United Nations system, including WHO, formally endorsed the conclusion of the United Nations Economic and Social Council (ECOSOC), stated in July 1997, that "gender mainstreaming in all activities of the United Nations system is a high priority" [3]. Subsequently, at the Fifty-first World Health Assembly, WHO adopted the World Health Declaration, endorsing the health-for-all policy for the 21st century which underscores gender mainstreaming as a key value, along with equity, ethics and the right to health, for achieving Health for All.

WHO, as the specialized agency responsible for health in the United Nations system, and the leading international health organization, is committed to improving the low health status experienced by women by addressing the existing gender gaps and disparities between women and men. To this end, WHO has initiated, at global, regional and country level, the process of developing a policy framework to mainstream gender in health and health-related development.

The basic principles of most cultures of the countries of the Eastern Mediterranean Region of WHO support, protect and promote women's rights, including their right to a high standard of health and quality of life. This principle of gender equity is enshrined in the religions of the Region, which all emphasize that men and women have equal responsibility for building and maintaining human life on earth; have the same rights to undertake any profession; have the same rights to education; and have equal responsibilities in the home.

2. REGIONAL SITUATION ANALYSIS

2.1 General

The level of socioeconomic development, lifestyle, extent of coverage and quality of the health care system, the environment, and a health-for-all policy that incorporates principles of social equity and a gender perspective, are among the determinants of the health of both men and women in the societies they live in. As the concept of development centres around development of the human being, both men and women should each be given equal opportunity to participate in the process of development.

A number of indicators on health and development can be used to identify gender gaps in health and development. Women's participation in the development process is governed by traditions, values and religious beliefs. Tables 1–6 compare available data for 1985 with available data for 2000 on education, literacy, health, contribution to economic activity, employment, political participation and decision-taking.

2.2 Education

Although the education gap between men and women is narrowing in many countries of the Region, still more men than women are literate. In 1985, the percentage of adult literacy was higher in males than females in all countries of the Region. The difference ranged between 2% and 37%. Good progress in female adult literacy had been achieved in most of the countries by 2000. In Djibouti, the difference between males and females decreased from 33.8% in 1995 to 21.2% in 2000, and in the Republic of Yemen the percentage of literate women increased from 23% of the population in 1995 to 25.2% in 2000, narrowing the gap between the percentage educated among males and females to 42.3%, from 45.4% in 1995 (Table 1). Adult literacy rates for

females in 1995 were higher than 74% in Bahrain, Cyprus, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Oman, Palestine, Qatar and United Arab Emirates; 50% and higher for Iraq, Saudi Arabia, Syrian Arab Republic and Tunisia; and less than 50% for Afghanistan, Djibouti, Egypt, Morocco, Pakistan, Somalia, Sudan and Yemen.

In 1995, the gap between male and female secondary school enrolment ratios showed wide variation between countries. From 1985 to 1995, it decreased in Egypt, Islamic Republic of Iran, Iraq, Oman, Saudi Arabia, Sudan, Syrian Arab Republic and Tunisia. The gap also decreased, but at the same time was accompanied by an increase in the female enrolment ratio over the male ratio in Bahrain, Cyprus, Jordan, Lebanon and Qatar. The male/female secondary school enrolment gap increased in Afghanistan, Pakistan and the Republic of Yemen. Morocco was the only country that retained the same gap in 1985 and 1995, while Kuwait and the Libyan Arab Jamahiriya showed no gap (no difference) between males and females (Table 2).

Lower enrolment levels of girls in secondary school are still mostly due to social, cultural and economic factors. Such factors include early marriage and childbearing, household duties, son preference and limited work opportunities.

Table 1. Adult literacy rate (%) by sex in the Eastern Mediterranean Region, 1985–2000

Country	1985[a]			1995[a]			2000[b]		
	M	F	*D*	M	F	*D*	M	F	*D*
Afghanistan	39	8	31	45.2	13.5	31.7	...	...	...
Bahrain	79	64	15	89.7	80.3	9.4	90.9	82.6	8.3
Cyprus	98	94	4	98.0	90.3	7.7	98.7	95.4	3.3
Djibouti	34	14	20	73.8	40.0	33.8	75.6	54.4	21.2
Egypt	59	30	29	63.0	37.0	26.0	66.6	43.8	22.8
Iran, Islamic Republic of	62	39	23	84.7	74.2	10.5	83.2	69.3	13.9
Iraq	95	85	10	63.0	51.0	12.0	...	...	...
Jordan	83	63	20	91.2	80.9	10.3	95.1	83.9	11.2
Kuwait	84	80	4	90.0	86.0	4.0	84.0	79.7	4.3
Lebanon	86	69	17	92.8	84.0	8.8	92.1	80.3	11.8
Libyan Arab Jamahiriya	81	50	31	91.0	74.0	17.0	90.8	68.2	22.6
Morocco	45	22	23	55.1	30.5	24.6	61.8	36.1	25.7
Oman	47	12	35	84.0	75.5	8.5	80.1	61.5	18.5
Pakistan	44	22	22	51.0	28.0	23.0	57.5	27.9	29.6
Palestine	...	...	...	91.5	77.0	14.5	...	...	...
Qatar	51	49	2	79.0	80.0	–1.0	80.4	83.1	2.7
Saudi Arabia	74	37	37	85.1	64.5	20.6	83.1	66.9	16.2
Somalia	18	7	11	36.0	14.0	22.0	...	...	...
Sudan	44	17	27	66.0	40.8	25.2	69.5	46.3	23.2
Syrian Arab Republic	76	53	23	89.4	68.7	20.7	88.3	60.5	27.8
Tunisia	68	41	27	79.0	55.0	24.0	81.4	60.6	20.8
United Arab Emirates	61	36	25	83.0	89.0	–6.0	75.0	79.3	4.3
Yemen	32	7	25	68.4	23.0	45.4	67.5	25.2	42.3

D Difference = male rate – female rate

... Data not available

[a] Source: EMRO HST database

[b] Source: [5]

Table 2. Secondary school enrolment ratio (%) in the Eastern Mediterranean Region, 1985–1998

Country	1985[a]			1995[a]			1998[b]	
	M	F	*D*	M	F	*D*	F	F as ratio of M
Afghanistan	11	5	6	20	10	10	...	...
Bahrain	83	70	13	89	94	–5	85	112
Cyprus	94	95	–1	95	99	–4	79	117
Djibouti	...	...	...	13	10	3	...	...
Egypt	68	45	23	81	69	12	...	...
Iran, Islamic Republic of	47	32	15	82	77	5	...	...
Iraq	70	39	31	53	34	19	...	...
Jordan	80	78	2	67	72	–5	62	107
Kuwait	...	...	...	100	100	0	58	101
Lebanon	57	56	1	61	68	–7	79	109
Libyan Arab Jamahiriya	...	...	...	95	95	0	76	113
Morocco	33	22	11	40	29	11	...	...
Oman	30	12	18	96	84	12	58	102
Pakistan	31	12	19	62	36	26	...	...
Palestine	...	...	...	...	100	...	...	...
Qatar	71	67	4	82	86	–4	69	107
Saudi Arabia	39	27	12	81	70	11	...	...
Somalia	15	8	7	...	...	...	...	...
Sudan	23	17	6	24	19	5	...	...
Syrian Arab Republic	63	40	23	54	43	11	36	92
Tunisia	38	24	14	55	49	6	56	103
United Arab Emirates	48	59	–11	85	83	2	73	106
Yemen	12	3	9	32	11	21	20	40

D Difference = male ratio – female ratio

... Data not available

[a] Source: EMRO HST database

[b] Source: [5]

2.3 Fertility

Considerable reduction of the total fertility rate was observed between 1985 and 2000 in many countries of the Region, such as Bahrain, Egypt, Jordan, Kuwait, Lebanon, Qatar, Sudan, Syrian Arab Republic and Tunisia (Table 3).

2.4 Socioeconomic and public life

The gender gap exists not only in education but in income and ownership of resources. Women's participation in the regional labour force is still low (Table 4), ranging between 8.5% and 37.1% in 1997. A 1996 study in Egypt [4] on technology and training and its effect on women's employment confirmed the phenomenon of the feminization of poverty. The study noted that the feminization of poverty represents a vicious circle of illiteracy, lack of training opportunities and lack of ownership of resources. The technology accessible to women is usually of a traditional kind and generates very modest income. Because of their multiple roles inside and outside the home, women have very little time for training and acquiring new skills in non-traditional areas.

Table 3. Total fertility rate and percentage change in countries of the Eastern Mediterranean Region, 1985–2000

Country	1985[a]	1995[a]	2000[b]	% change
Afghanistan	6.9	6.2	...	...
Bahrain	5.9	3.4	2.63	22.65
Cyprus	2.3	2.1	2.0*	–4.76
Djibouti	6.6	5.8	6.10	5.17
Egypt	5.3	3.6	3.40	–5.55
Iran, Islamic Republic of	...	2.6	3.20*	23.07
Iraq	6.7	4.7	5.25	11.70
Jordan	6.8	4.4	4.69	6.60
Kuwait	4.9	3.2	2.89	–9.68
Lebanon	3.8	2.5	2.29	–8.40
Libyan Arab Jamahiriya	7.2	4.1	3.80	–7.32
Morocco	5.4	3.0	3.40	13.30
Oman	7.2	4.8	5.85	21.90
Pakistan	7.0	5.3	5.50*	3.80
Palestine	...	4.6	...	...
Qatar	5.9	2.8	3.70	32.15
Saudi Arabia	7.3	5.9	6.15	4.24
Somalia	6.6	6.8	7.25	6.61
Sudan	6.6	5.7	4.90	–14.03
Syrian Arab Republic	7.2	4.2	4.00	–4.76
Tunisia	4.9	3.2	2.31	–27.81
United Arab Emirates	5.2	4.9	3.17	–35.30
Yemen	7.8	5.9	7.6	28.81

Total fertility rate = average number of births by women aged 15–49 years

% change = (2000 rate – 1995 rate × 100) / 1995 rates

... Data not available

* refers to the period 1995–2000 (others refer to 2000)

[a] Source: EMRO HST database

[b] Source: [5]

Table 4. Women in socioeconomic and public life in countries of the Eastern Mediterranean Region, 1995–2002

Country	Participation of women in adult labour force (%) age 15+		% of national labour force in agriculture		Seats in Parliament held by women (%)		Women at ministerial and sub-ministerial level (%)	
	1995[a]	1997[b]	1990[a]	1995–2001[b]	1997[a]	2002[b]	1995[a]	2000[b]
Afghanistan	...	...	...	....	...	....	...	...
Bahrain	19	20.6	2.00	....	0	1.0		...
Cyprus	38	...	14.00	10	5.4	10.7	5	14
Djibouti	...	...	...	...		0	1	...
Egypt	29	22.1	40.00	35	2.0	2.4	2	10
Iran, Islamic Republic of	24	...	32.00	...	4.9	3.4	0	...
Iraq	18	10.3	16		...		0	
Jordan	21	18.4	15	...	1.7	3.3	2	...
Kuwait	31	24.7	1	...	0.0	0	6	...
Lebanon	28	18.1	7	...	...	2.3	0	...
Libyan Arab Jamahiriya	21	12.9	11	...	...	....	0	...
Morocco	34	27.1	45	6	0.7	0.5	1	...
Oman	14	8.5	45	...	0	...*	4	..
Pakistan	26	...	52	66	2.6	...*	2	9
Palestine	...	...	...		0	1.0	...	
Qatar	13	22.0	3	...	0	...*	2	...
Saudi Arabia	13	10.4	...	...	0	...*	0	...
Somalia	...	37.1	...	...	...	...	...	
Sudan	28	22.7	69		5.3	9.7	1	...
Syrian Arab Republic	25	16.2	33	...	9.6	10.4	4	...

Tunisia	30	28.9	28	...	6.7	11.5	5	...
United Arab Emirates	13	18.9	8	...	0	0	0	8
Yemen	27	17.7	61	...	...	0.7	0	...

... Data not available

* No parliamentary body exists

[a] Source: UNDP. *Human development report 1998.*

[b] Source: UNDP. *Arab human development report 2002.*

According to a recent study by UNDP [5] on the relationship between women's education on the one hand and fertility and income on the other, for every additional year of education, a woman's fertility rate decreases by 10.5% and her income increases by 15%.

The lack of opportunities for women to participate equally in economic and political life is reflected in the indicators relating to women's participation in decision-making in economic and political activities (Table 4). Despite the trend towards democracy, nowhere do women enjoy the same opportunities for participating in public life as men. They occupied only between 0% and 9.6% of parliamentary seats in 1997 and between 1% and 11.5 % in 2002. In ministerial positions, women's positions increased to up to 14% in 2000. However, it is known that many women play a large part in civil society organizations (nongovernmental organizations) and in pressure groups. This grass roots progress towards greater participation deserves further study in the Region.

2.5 Access to health care

From 1985 to 1995, the percentage of women delivered by trained personnel increased in all countries except Djibouti (Table 5); 100% of Cypriot, Kuwaiti and Qatari women were delivered by trained personnel. The increase in the rate varied considerably between

countries, especially among those with originally low rates. Although reliable data on maternal mortality are not available for many countries of the Region, there is a well-known inverse correlation between the percentage of pregnant women delivered by trained personnel and maternal mortality rate.

2.6 Life expectancy

During 1985–2000, life expectancy at birth increased for both men and women in most countries of the Region (Table 6). Regionwide, one of the fastest levels of progress in raising life expectancy since the 1980s was in Oman and the Republic of Yemen. In 1985, in most countries females had a longer life expectancy at birth than males except in Afghanistan, Djibouti and Pakistan.

The same pattern continued in 1995 with some variation in the difference between life expectancy of females and males. Some countries showed a reduction in the life expectancy gap, to the benefit of males (Cyprus, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Morocco, Qatar, and United Arab Emirates). Most other countries showed an increase in the difference between life expectancy of females and males, to the benefit of females. By 2000, only one country, Pakistan, had a longer life expectancy for males than females.

Table 5. Women's access to health care in countries of the Eastern Mediterranean Region, 1985–1999

Country	Women delivered by trained personnel (%)		
	1985[a]	1995[a]	*D*
Afghanistan	10	15	5
Bahrain	98	98	0
Cyprus	100	100	0
Djibouti	73	60	–13
Egypt	24	62	38
Iran, Islamic Republic of	...	86	...
Iraq	60	83	23
Jordan	75	92	17
Kuwait	99	100	1
Lebanon	45	96	51
Libyan Arab Jamahiriya	76	99	23
Morocco	24	47	23
Oman	60	92	32
Pakistan	24	35	11
Palestine	...	97	...
Qatar	96	100	4
Saudi Arabia	79	92	13
Somalia	2	20	18
Sudan	20	86	66
Syrian Arab Republic	35	83	48
Tunisia	60	81	21
United Arab Emirates	96	99	3
Yemen	...	35	...

D Difference = 1995 ratio – 1985 ratio

... Data not available

[a] Source: EMRO HST database

[b] Source: [5]

Table 6. Life expectancy at birth in the Eastern Mediterranean Region, 1985–2000

Country	1985[a]			1995[a]			2000[b]		
	M	F	*D*	M	F	*D*	M	F	*D*
Afghanistan	40	41	–1	44.0	43.0	1.0	...	....	....
Bahrain	68	64	4	75.3	70.4	4.9	71.6	75.8	4.2
Cyprus	77	72	5	79.8	75.3	4.5	75.8	80.2	4.4
Djibouti	44	56	–12	...	...	...	41.6	44.2	2.6
Egypt	61	58	3	66.4	62.9	3.5	65.7	68.8	3.1
Iran, Islamic Republic of	69	66	3	70.0	68.0	2.0	68.0	69.8	1.8
Iraq	65	63	2	59.0	57.0	2.0	....	....	....
Jordan	71	67	4	69.5	66.0	3.5	69.1	71.8	2.7
Kuwait	74	70	4	76.4	73.8	2.6	74.5	78.6	4.1
Lebanon	67	63	4	72.0	69.0	3.0	71.5	74.6	3.1
Libyan Arab Jamahiriya	60	57	3	67.0	65.0	2.0	68.8	72.8	4.0
Morocco	62	58	4	70.7	67.1	3.6	65.8	69.5	3.7
Oman	55	53	2	74.2	71.8	2.4	69.7	72.6	2.9
Pakistan	56	57	–1	62.1	62.9	–0.8	60.2	59.8	0.4
Palestine	...	...	...	73.5	69.0	4.5	....	....	....
Qatar	74	71	3	74.5	74.2	0.3	68.7	71.3	2.6
Saudi Arabia	67	65	2	73.4	69.9	3.5	70.5	73.0	2.5
Somalia	50	49	1	47.9	44.7	3.2	....	....	....
Sudan	50	48	2	55.5	52.5	3.0	54.6	57.4	2.8
Syrian Arab Republic	65	63	2	69.0	67.0	2.0	70.0	72.4	2.4
Tunisia	63	62	1	73.3	69.5	3.8	69.0	71.4	2.4
United Arab Emirates	72	67	5	74.0	72.0	2.0	73.7	78.0	4.3
Yemen	45	43	2	59.0	56.0	3.0	59.4	61.6	2.2

D Difference = female life expectancy (years) – male life expectancy (years)

... Data not available

[a] Source: EMRO HST database

[b] Source: [5]

2.7 Other indicators

Additional indicators that are valuable for assessing women's status in society but for which no data exist are:

a) % of women below poverty line
b) % of women-headed households
c) % of elderly living alone
d) % of violence against women.

2.8 Summary

It was assumed for a long time that development was gender neutral and had a positive impact on all groups in society. In reality, that has proved not always to be the case. However, countries of the Region have made good progress over the past decade in achieving more equitable distribution between women and men of the fruits of development. Gender gaps in education and health have narrowed rapidly. In the more affluent countries of the Region almost all boys and girls are enrolled in both primary and secondary schools and there has been a noticeable advancement regarding female education in schools and universities.

3. IMPEDIMENTS TO PARTICIPATION OF WOMEN IN DEVELOPMENT

- Use of the women in development approach rather than the gender and development approach;
- Absence or lack of institutionalization of multisectoral national committees for women;
- Lack of resources, e.g. allocation of budgets; weak coordination between government and nongovernmental organizations and

within government ministries; and absence of research into the gender perspective in health;

- Lack of capacity, skills and gender-sensitized approaches and tools (e.g. gender-specific indicators, and communication methods to reach out to women and to listen to their voices) for generation of gender- and age-specific data; lack of check-lists and guidelines to undertake situation analysis; and lack of appropriate and informed policies and programmes;
- Lack of policy support to integrate gender as an intersectoral issue.

4. MAINSTREAMING GENDER IN WHO REGIONAL PROGRAMMES

WHO's role in promoting women's participation in health and development in the countries is to advocate for and support the development of policies, strategies and programmes that incorporate a gender perspective. WHO approaches to women in health and development emphasize that gender is a cross-cutting (intersectoral) theme, and therefore the women in health and development programme works in collaboration with all divisions and programmes. It has three main targets:

- Establishment in each country of a multisectoral National Committee on the Role of Women in Health and Sustainable Development, including also membership from nongovernmental organizations;
- Development of national information systems on the status of the role of women in health and development;
- Formulation of national plans of action to promote the role of women in health and development.

To achieve these targets the following priority actions have been taken.

- Women in health and development focal points have been identified in 21 countries of the Region so far.
- In some countries WHO provided technical expertise to develop gender-sensitive indicators for the health information systems.
- The role of women in development has been promoted in other regional programmes, such as the healthy cities programme. For example, the Healthy Cities and Women's Development Project to encourage local level initiatives in Alexandria, Egypt, has demonstrated that empowerment of women is among the approaches basic to the success of WHO's collaboration with countries. The methodologies developed in this initiative are now being applied to a variety of projects dealing with other priority health issues in other countries of the Region, such as the role of women in traditional medicine, health promotion and protection and basic development needs.
- WHO has raised awareness regarding the need for national health agendas to take account of and address obstacles to women's development (e.g. violence and female genital mutilation).
- WHO has also started discussions in some of the countries to prepare hardship profiles in order to document the impact of poverty, armed conflict, displacement and other traumatic events on the health and quality of life of women, and on women's role in the health and development of their families, communities and nation. The aim is to develop appropriate strategies to meet the special health-related needs of women from these groups and to promote women's role in health and development processes in their communities.

5. STRATEGY FOR GENDER MAINSTREAMING IN THE EASTERN MEDITERRANEAN REGION

a) Establish/support/strengthen gender focal point(s)/gender unit(s) for health to be represented in national committee(s) for women with clear terms of reference in order to:
   - ensure the required promotion and advocacy for promotion of gender mainstreaming in health and health-related development processes;
   - provide technical advice to formulate health and development plans and programmes with a gender focus;
   - assist and facilitate identification and mobilization of resources;
   - coordinate and liase with all other ministries and agencies concerned with gender issues, such as ministries of planning, education, labour, justice, rural development, social affairs and agriculture, development banks, etc.

b) Create opportunities for capacity building and leadership for women in order to promote their active participation in health and health-related development sectors, such as primary health care, environmental health, traditional medicine, health care reform, and in the strategic health-focused development initiatives such as basic development needs, healthy villages and healthy cities.

c) Integrate health concerns and issues into economic development processes.

d) Address harmful traditional health-related practices and misinterpretations about religion through dialogue, education and awareness-raising, in order to introduce appropriate socio-legal changes for protection of women's health and their quality of life.

e) Conduct gender-sensitive research studies to map the factors affecting women's role in health and sustainable development processes, and to identify women's health needs and other related development issues.

f) Develop gender-disaggregated health information systems.

g) Sensitize the media to create gender awareness among the public, especially by presenting positive images of women that enhance and promote the importance of women's role in health and health-related sustainable development.

h) Give special attention, including provision of policy support and allocation of resources, to meeting the special health-related needs of women living under difficult circumstances, such as armed conflict or civil strife, or as refugees and in displaced communities.

i) Recognize and strengthen positive cultural, traditional and religious values, and related practices, that promote and protect women's interests and benefits concerning their quality of life and health.

REFERENCES

1. *Health for all in the 21st century.* Geneva, World Health Organization, 1998 (draft presented to the Executive Board, document no. EB101/8).

2. The Beijing Declaration and Platform for Action, Fourth World Conference on Women, Beijing, China, 4–15 September 1995.

3. United Nations Economic and Social Council (ECOSOC). Agreed conclusions on "Gender mainstreaming in all activities of the UN System", July 1997 (E/1997 L30 Para adopted by ECOSOC 14.7.97).

4 UNDP study reviewed by *El-Nahas* magazine (Beirut, November 1996) extracted from the Survey on Economic and Social Development in Western Asia, 1996–1997, issued annually by ESCWA.

5. United Nations Development Programme. *Human development report 2002.* New York, Oxford University Press, 2002.

Investing in health, particularly that of the poor, is central to the achievement of the Millennium Development Goals. In support of this strategy WHO's Regional Office for the Eastern Mediterranean is actively promoting in countries of the Region community-based initiatives like Basic Development Needs, Healthy Cities, Healthy Villages and Women in Health and Development. These approaches are based on the principle that good health status–an important goal in its own right–is central to creating and sustaining the capabilities of poor people to meet their basic needs and to escape from poverty. The Community-Based Initiatives Series is aimed at facilitating the management of such initiatives. Users of the series may include government authorities, community representatives, WHO and other international agencies and non-governmental organizations.

For enquiries please contact:

Women in Health and Development Programme
Community Based Initiatives Unit
World Health Organization
Regional Office for the Eastern Mediterranean
P.O. Box 7608 Nasr City
Cairo 11371, Egypt

e-mail: CBI@emro.who.int
postmaster@emro.who.int

Internet: http://www.emro.who.int/cbi/bdn