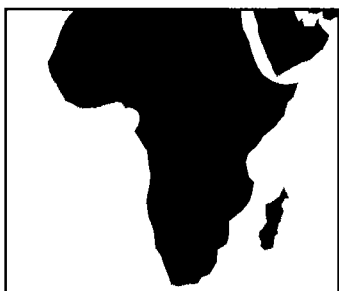


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Intersectoral Action for Health

**A Cornerstone for Health-for-All
in the Twenty-First Century**

Report of the International Conference

**20-23 April 1997
Halifax, Nova Scotia, Canada**



World Health Organization

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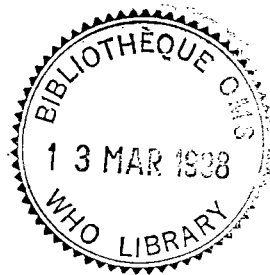
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Report of a Conference on

Intersectoral Action For Health

A Cornerstone for Health-for-All in the Twenty-First Century

20-23 April 1997
Halifax, Nova Scotia, Canada



World Health Organization

Intersectoral Action for Health

A Cornerstone for
Health-for-All in the
Twenty-First Century

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MINISTRY OF
SOCIAL AFFAIRS AND HEALTH



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MERCK FROSST



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Preface

As a result of working in a newly established interdisciplinary academic institution for health and environment during the early 1970s I was privileged and fortunate to be able to cooperate with colleagues of many different professional origins. This taught me the value of crossing the barriers of sectoral and professional boundaries in order to address complex problems. Hence, the cornerstone of my entire professional life became the importance of building on the experience of individuals and groups with different professional backgrounds and specialities and representing different sectors, in order to identify and solve problems in the area of health and environment. When I joined WHO, cultural diversity was added to my previous experience of sectoral and professional diversity.

WHO's recognition of the need for and importance of intersectoral action for the promotion and protection of health can be traced back to the creation of the Organization. The WHO Constitution states that the Organization shall "promote, in cooperation with other specialized agencies, where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene." In one of the first World Health Assembly technical discussions in the early 1950s, Dr C.E.A. Winslow emphasized the interaction between economic development, social problems and human health status. The full recognition of the intersectoral approach is often associated with the Alma-Ata Conference (1978) and WHO's technical paper *The Role of Intersectoral Cooperation in National Strategies for Health-for-All* (1986)(1).

With this extensive history taken into account, the Intersectoral Action for Health (IAH) project was established at WHO headquarters in 1996 in support of the renewal of the policy of Health-for-All in the Twenty-First Century. As chairman of this working group I had the privilege of steering the project from its original conception. The IAH initiative undertook extensive reviews of intersectoral work at the local, national and global level, in both developing and industrialized countries. This groundwork provided a frame of reference for an international conference — Intersectoral Action for Health: A Cornerstone for Health-for-All in the Twenty-first Century—that was held in Halifax, Nova Scotia, Canada, 20-23 April 1997. The IAH review process and conference were made possible by the generous support and foresight of the Ministry of Social Affairs and Health, Finland; the Swedish International Development Cooperation Agency (Sida); a consortium of four Canadian donors consisting of Health Canada, the Canadian International Development Agency (CIDA), the International Development Research Centre (IDRC) and the Canadian Public Health Association (CPHA); as well as and Merck-Frosst Canada and Merck and Co. Inc. The generosity of the Province of Nova Scotia, which hosted the conference and will also print the final conference report, deserves a special note of thanks.

The conference in Halifax was truly a meeting of IAH minds from all over the world. Over 60 international experts from health and non-health sector backgrounds representing over 20 countries attended this gathering. The conference itself has been described as "intersectoral action in motion", because professionals from diverse cultural backgrounds with a range of work experiences were brought together with the common

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aim of reaching consensus on the key recommendations that needed to be incorporated into the renewed Health-for-All policy. Moreover, the way the conference was organized and the means by which this conference report has been drafted represent another example of superb inter-agency collaboration: the Canadian Public Health Association has collaborated with WHO from the very beginning of the IAH project, providing logistic support for the organization of the conference, collaborating with WHO in the drafting of this report, and nominating a writer, Mr Brian Bell, to synthesize the complex strands of the conference proceedings into a coherent and thought-provoking report. This example of collaboration should provide a template for future WHO conferences.

A pivotal theme of the conference was global change. Within this context a new global framework for sustainable human development is needed, which considers the contribution of health and social programmes to economic development and promotes complementary actions in all development efforts. New and emerging challenges for health improvement in the 21st century, including globalization, environmental degradation, population growth, the health effects of global trade and health system reform will require a new type of health system. Moreover, the decentralization of government responsibilities to the local level means that local action is becoming more important: the networks of Healthy Cities, Villages, Islands, and Marketplaces, for example, are important vehicles for strengthening local intersectoral action.

The re-shaped health system of the future will comprise interconnecting webs of institutional and community interaction. Towards this end, it was felt that health should be seen in terms of a "global commons" in the 21st century. This, however, does not imply that the health sector would be placed in a "commanding" position in relation to other sectors; rather, addressing the broad determinants of health through intersectoral cooperation provides a catalyst for linking sectors and disciplines together according to shared interests and mutual goals. In other words, the whole is greater than the component sectoral parts.

In summary, the overarching theme resonating from the discussions in Halifax is that the health sector is just one player in health development. Intersectoral action is, therefore, an essential component of any strategy to improve human health status in the 21st century, given the complexity of new and emerging health determinants. If any one message must emerge clearly in the renewed Health-for-All policy, this is the one. Although Halifax represents just "another step in the journey", it is quite clear that those sectors whose work intersects with the broad determinants of health must be ready for the long haul, so to speak, if sustained health improvements are to be made in the 21st century.

*Dr Wilfreid Kreisel
Executive Director
Health and Environment
WHO, Geneva*

Another Step in the Journey

At a very early point in discussion, this conference was associated with a journey that began in 1978, at the International Conference on Primary Health Care in Alma Ata. We had convened in Halifax from around the world out of a common interest in exploring successful intersectoral action for health (IAH) experiences and strategies, and assessing their impacts on reducing the burden of disease. In many respects, we were looking for ways to improve our own practices in this area. However, we were also anxious to strengthen our capacity to convince others that this was a journey on which all sectors should embark.

In the course of our travels over several days, through listening carefully to what we heard and reflecting on developments around us, we began to look at the journey differently. Health has so often appeared as a mirage, real in the distance but illusory when approached. We began to realize that what we were really working towards was “sustainable human development”. And if we were going to complete our journey successfully, we would need to be joined by a very diverse group, with different motivations, skills and experiences.

Thus, at the conclusion of the conference and the resumption of travel, there was a sense that we all could be walking closer together, short legs and long legs: that we would be sharing a vision of sustainable human development and an appreciation of the changes that we will all have to make in concepts, paradigms and practices to get there. Intersectoral action would be the very walking itself. And as walking calls for care and nourishment of the body, so too intersectoral action for health invites continuing care and attention, including creative inquiry, continuous learning, strategic application and rigorous testing.

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*“We are all walking
along the same
road. Some of us
have long legs and
others, short and it
is painful for those
with the short legs
to keep up. We
must remember that
we have legs of
differing lengths
and yet we are all
on the same
journey. We have to
find a way to
proceed together,
respectful of the
differences.”*

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1. Background

The Intersectoral Action for Health (IAH) project forms an integral component of WHO's Renewal of Health for All. The terms of reference were approved during the World Health Assembly in May 1996. The project has been closely linked with other organizational renewal initiatives to ensure alignment of this work with them.

To expedite the work of the project, experts were commissioned to address certain unique issues applicable at local, national and global levels and also more general common issues. This work included the development of case studies of intersectoral action, including assessment of the probable impact of such action on the burden of disease.

The final element of the work plan included an international conference of over 60 international participants representing over 20 countries, to be held in Halifax, Nova Scotia, Canada, on 20-23 April 1997. The participants list is included as Appendix A.

The original objectives of the Intersectoral Action for Health Conference were two-fold:

- ❖ to identify and recommend specific and realistic policy directions and strategies at the global, national and local levels of Intersectoral Action for Health in the Twenty-First Century. These strategies should address the urgent challenge of closing the health gap experienced by the poorest countries and communities;
- ❖ to assess the progress made in implementing IAH since Alma Ata, particularly since WHO's technical discussions on this subject in 1986.

Principal outputs of the meeting were identified, in advance, as being:

- ❖ a synthesized conference report containing details of national, local and global reviews, in addition to the outputs of discussions and recommendations made at the meeting;
- ❖ recommendations and findings of this synthesized report that would be reflected in the policy for Health for All in the Twenty-First Century;
- ❖ recommendations for the UN follow-up to recent global conferences.

Discussion over the course of the conference suggested that while it would be useful for the report to address these points, it should be informed primarily by the nature and content of the dialogue over the four days.

This Report is organized along the lines of the Conference Program, which is included as

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"Evidence of intersectoral action for health dates back to the earliest civilizations."

Antezano (2)

WHO technical discussions in the early 1950s stressed the need for IAH. Since then landmark conferences and technical discussions have re-emphasized its importance. The 1977 World Health Assembly identified intersectoral action for health as an important component in achieving the goal of "Health for All by the Year 2000". It was further developed in a number of international (and regional/national) fora, including the Alma Ata Conference (1978), the World Health Assembly Technical Discussion on Intersectoral Action (1986), international conferences on health promotion in Canada (1986), Australia (1988) and Sweden (1991), and included in the Global Strategy on Health and Environment (1993) adopted by the World Health Assembly.

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Appendix B. The first section reviews IAH experiences at the global, national and local levels, partnerships, strategies and measures of success. The next section addresses world change, which presents unprecedented challenges for IAH and health. The Report then reviews changes required within the health system to strengthen future IAH efforts for health gains. It concludes with comments on the policies WHO needs to integrate into a global IAH strategy and on the role of national and local governments in facilitating IAH.

The contents incorporate the background documentation prepared for the conference (e.g., case studies/expert reports), responses to a questionnaire distributed by WHO to participants to assist them to conceptualize and describe their own IAH experience, the conference discussions, including plenary and panel presentations, and reports of the Working Group deliberations. The case studies and other background documents

constitute an important component of the conference proceedings and should be read in conjunction with this Report. These are listed in Appendix C.

Renewing Health-For-All

The main aims and purposes of renewing the health-for-all strategy include:

- ❖ reaffirming the principle of health for all;
- ❖ applying what we have learned from experience and research in the last 20 years about what works and what does not work, particularly with regard to making the health services effective, efficient and equitable;
- ❖ adapting existing approaches to new realities or introducing new approaches.

Yach (3)

As a part of the conference process, WHO commissioned a participatory action research intervention to strengthen communication and understanding among conference participants. The highlights of this experience are summarized on page 25.

Finally, it is expected that this Report may be integrated into the next steps of the WHO HFA Renewal process. It may also be of assistance to conference participants in the next steps of their own IAH journeys within their regions, countries and communities.

2. Intersectoral Action For Health

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2.1 The Determinants of Health

A consideration of the biological, social, environmental and economic factors that contribute to health served as an initial backdrop for IAH discussions during the conference.

The list of relevant determinants was extensive and included a range of factors extending considerably beyond the traditional list, such as genetics, personal health services, environment, income and social status, employment and working conditions. In the light of rapid technological and political change and globalization, a new set of factors, including environment, trade, demographic issues, urbanization, violence and conflict, are emerging as determinants that must be addressed in intersectoral action on health. These new determinants provide both major challenges and opportunities for the improvement of health in the 21st century and thus must be addressed as a matter of urgency.

"IAH works. We know it is possible and effective."

There was also agreement that the determinants, their interactions and impacts are contextual, and it is only in "community" context that a ranking or prioritization may be useful. Consequently, careful analysis or filtering is necessary to determine where the best investment can be made in terms of policy decisions and expending human and fiscal resources.

2.2 Intersectoral Action At Work

There was widespread agreement among conference participants that IAH has worked. There were many success stories at the global, national and local levels. These included food/nutrition (for example, the WHO/FAO collaboration Codex Alimentarius Commission), the environment (such as Agenda 21 - a global plan of action for measures to achieve human-centred sustainable development into the 21st century and beyond), tobacco reduction and control (for example, in Finland and Canada), immunization (for instance over 250 million children were immunized in December 1996 and January 1997 when Bangladesh, Bhutan, China, Myanmar, Nepal, Pakistan and Thailand synchronized their immunization programmes) and healthy cities and villages (for example, Healthy City Kuching, Malaysia, and "SHROUK". Egypt's national program for integrated rural development).

A Definition of IAH

There was little formal discussion of the definition of IAH although several of the conference working documents provided definitions. The following definition appeared to reflect the consensus of participants:

a recognized relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes, (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone.

National Centre for Health Promotion (4)

Conference background materials and discussion suggested that intersectoral action takes many different forms, such as coalitions and partnerships, and can be implemented through a myriad of activities, advocacy, legislation and regulation, policy and program action, and interventions in different settings that include schools, workplace, hospitals, cities/villages/communities/islands. Further, participants agreed that what is success in

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one situation may prove to be failure in another. There is a broad range of dynamics at play. Some of these, such as political commitment and leadership, social and cultural factors and timing, are intrinsic to relationships among key stakeholders and others to the environmental circumstances associated with action. The case studies and stories emphasized that all of these factors are critical to success. Strong political leadership and support were often paramount. During the meeting examples cited included the Ontario

Premier's Council, Canada, Healthy Kuching City, Beijing Healthy City.

Conditions for Effective Intersectoral Action

Effective intersectoral action requires sectors or organizations to

- ❖ identify the necessity to work together to achieve their goal;
- ❖ create opportunities for action within their working environments;
- ❖ develop the capacity to take action;
- ❖ develop a relationship to enable them to take action;
- ❖ plan, implement and evaluate the action to the satisfaction of each; and
- ❖ achieve sustainable outcomes.

National Centre for Health Promotion (4)

As well, there are inconsistencies and contradictions in IAH efforts: some suggested that progress has not been as successful as might have been expected, for example, concerning environmental issues. And although efforts to promote smoking reduction through legislation, taxation and prevention efforts have enjoyed some success in developed countries, consumption has been magnified "by the aggressive advertising methods of multinational tobacco conglomerates that have increasingly targeted women, adolescents, and developing country markets"(5).

There was agreement that while there are examples of IAH successes at all levels, IAH has worked best at the local level. The reasons were summarized by the WHO Regional Advisor, South East Asia Regional Office, in the observation that "the decentralized management process involving the delegation of authority, responsibility, and resources, concretely brings the sector-specific resources i.e. materials, technical advice and program interventions closer to the responsibility of local government"(6).

A Summary of IAH Successes and Achievements

- ❖ Broader approach to health
 - ❖ Better policies, plans, practices
 - ❖ Health more visible on the political agenda
 - ❖ Knowledge of organization structures and management strategies that work
 - ❖ Knowledge of practical requirements for implementation
- von Schirnding, Conference Plenary Presentation

Finally, there was a sense that although IAH has worked, there is still a lot to be learned and communicated more effectively both within and outside of the health sector. This was expressed as the need to reframe intersectoral action in the context of a new

understanding of sustainable health systems and human development.

2.3 Partnerships and Strategies

The conference materials and workshop discussions acknowledged the particular importance of organizational and institutional factors/dynamics in successful IAH at the national and local levels. They also recognized the importance of human resources (including strong leadership and commitment, and effective training), community involvement and the pacing of actions in a manner that is compatible with needs and priorities, opportunities and resources.

Partnerships were assessed at the global, regional and national levels as well as at the local level. In successful cases, a common thread or goal is the existence of a network of

“communities of organizations” working together to create new solutions. This calls for new players who are increasingly interdependent and work within boundaries or systems that are considerably more fluid than in the past.

Many of the examples of IAH suggested that as well as being part of all IAH efforts the health sector often provides a critical source of leadership for international efforts (e.g., Beijing Healthy City). Thus, the health sector generally, ministries of health and professionals are all essential players. However, in other cases, although there are clear health interests, plans call for broader multidisciplinary involvement (e.g., construction of dams, creation of agricultural credit systems). In one working group, it was stressed that the best example of IAH occurs when a non-health sector adapts its own programme. An example is school health programmes. In such cases, the health sector is involved to the extent that it retains the technical expertise. In sum, participants acknowledged that it was not essential for all IAH efforts that the health sector be a part of alliances/partnerships, but instead this depended on whether and where the health sector could provide “added value”.

One workshop proposed a categorization of potential partners on the basis of the challenges associated with establishing and maintaining working arrangements. This was depicted by concentric circles, with an outside ring of difficult or “hard” partners, including particularly the economic and financial sector, “easy” partners, such as the social services sector, and the health care sector as a central core, where collaboration among the health disciplines is often very difficult.

Several sectors were identified as being particularly important to future action and requiring more strategic attention. The first is the health sector itself. Without significant adjustments and improvements in intrasectoral action, participants felt that broader progress outside of the sector and at the macro levels could not be made. Two other important players or sectors are the private sector and voluntary, non-government organizations, where there is a need to increase both competencies and flexibility to work with these new partners effectively.

Discussion of strategies ranged from the conceptual, to the operational and tactical. Stakeholder analysis, along with more emphasis on outcomes as opposed to process, is required at all levels. At the global and national levels, the challenge is to achieve greater clarity about who does what, along with common frameworks in which IAH can take place within an expanded range of stakeholders, particularly those outside of the traditional health circle. The importance of regional efforts was also noted. Local partnership arrangements have been particularly successful in the “settings” context, where “social structures provide channels and mechanisms for reaching defined populations”(8). For example, in the Beijing Healthy City programme, settings approaches have been adapted in health-promoting schools, green and gardening workplaces and no smoking public places. Participants also noted very different partnership challenges between the rural and urban settings, frequently brought on by the complexity of organizational systems and multiple power arrangements in the urban populous areas.

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*“The forces of
change are
pushing all societal
systems toward
reorientation and
reorganization. . . .
It is essential to
realize this if we
want to build
partnerships.”*

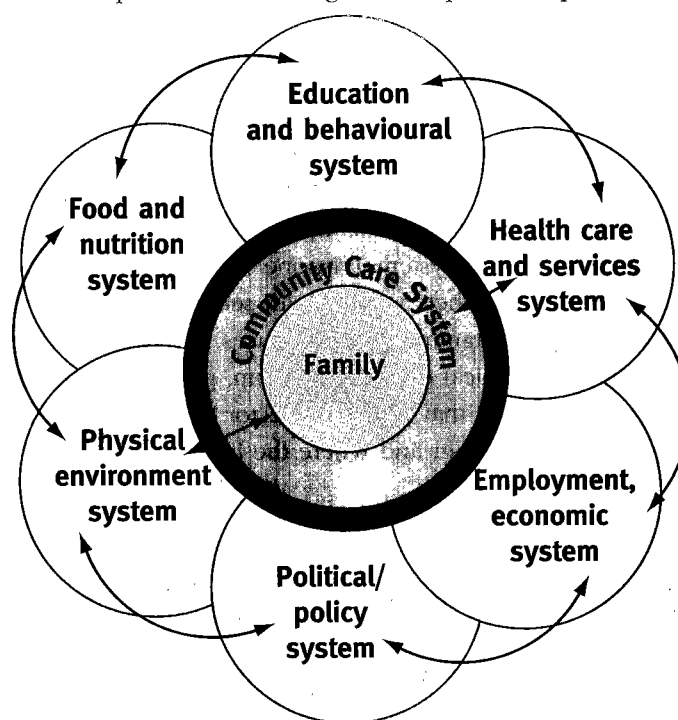
Kickbusch (7)

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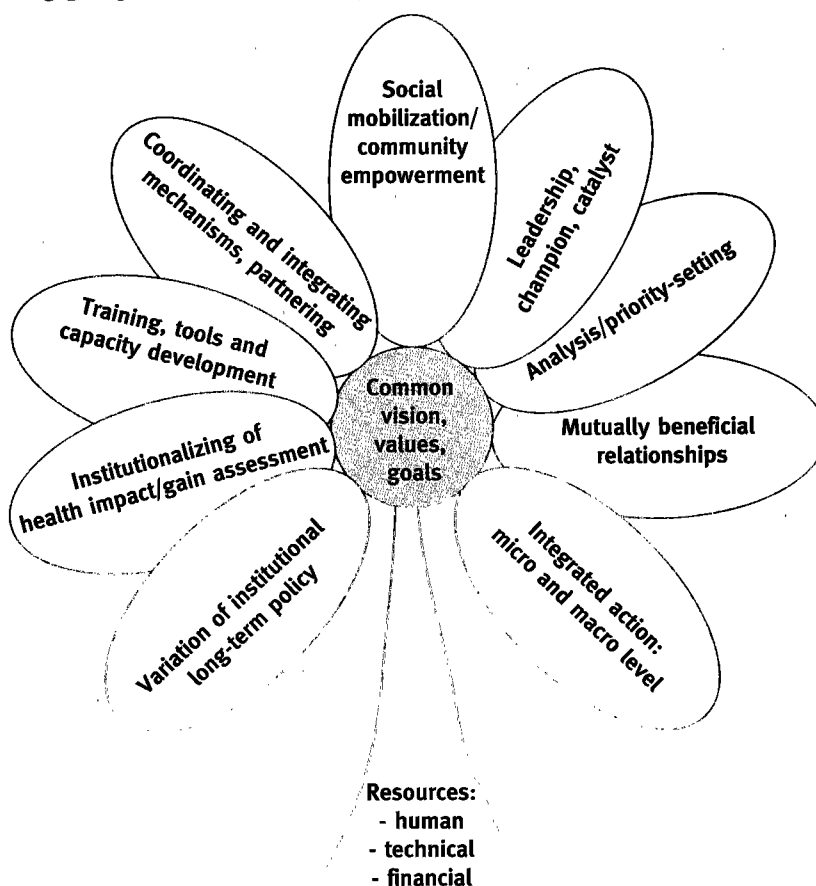
A Conceptual Framework of IAH

Dr. Rita Thapa, in a presentation on WHO South-East Asia Region experience in IAH, used a flower as a metaphor for describing sectoral partnerships:



Ingredients of Successful IAH

One working group extended the metaphor, to describe key ingredients of successful IAH:



2.4 Policy and Program Implications

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1. IAH is working: there are many excellent examples at the global, national and local levels of intersectoral action contributing to infrastructure development, institutional reform, sustainability of health actions, empowerment of lay people, health gains and the reduction of health inequities. Existing experience and research validate the partnership approach that is integral to health-for-all. Nevertheless, these successes must continue to be documented and analysed more systematically to determine what works under which political, social and cultural conditions, which intersectoral linkages work best, and on what geographical scales. In addition, benchmarks and best practices must be established (including measurement and evaluation models) and the results communicated better and more widely.
2. Concurrent with this, analytical frameworks and tools are needed to move the field beyond a heavy reliance on anecdotal, descriptive accounts to more quantitative indicators and results associated with health gains.
3. An assessment of the major determinants of health should be used to allocate resources among competing priorities and to focus efforts to improve the health of populations. It is clear, however, that the factors influencing health are highly contextual. Our understanding of their contribution to reducing the burden of disease will continue to evolve in the face of environmental, economic, biomedical and technological change. Policy, program and monitoring/accountability processes must remain open to incorporating an ever-changing mix and growth of factors that affect health.
4. Additional research is required to strengthen the knowledge base regarding the determinants, their interrelationships and how they affect health. In particular, a future research initiative should define in quantifiable terms the sectoral burden of disease as well as the sectoral potential for enhancing health. This analytical framework would assist policy-makers to select from among sectoral interventions those that will yield the greatest health gains.

A relevant current research approach involves a refinement of the data collected from the Global Burden of Disease studies (9). These data would allow for the development of a sectoral “balance sheet” showing the impact of each sector (positive or negative) on health and would facilitate dialogue between health and other sectors. They would also help to quantify the contribution of health services to the improvement of health status.

5. More analysis and work is required to better understand and build on factors in the policy and organizational environment that contribute to the success of IAH. Current organizational restructuring and downsizing efforts, combined with issues of governance and fiscal restraint, afford new opportunities as well as threats for IAH. Current knowledge of organizational change and adjustment may not be sufficient to inform and guide future IAH efforts.
6. The settings approach has been an important strategy in promoting and implementing IAH. This is particularly apparent in the areas of education and

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The private sector

*"It is important that
we improve our
capacity to mobilize
the private sector...
not just in a way
that looks to it to
commit additional
resources for health
but also to
demonstrate how
current—or
planned—activities
contribute directly
to health."*

environmental health services through the healthy schools movement and in the healthy/sustainable cities/villages communities/islands and Local Agenda 21 initiatives. These efforts should be maintained and strengthened. However, there is a concurrent need to explore and promote the start up of new pilots, models and initiatives, which will advance learning and gains in such areas as organizational support, financing and accountability systems, and incentive systems, which are the foundations for ongoing HFA progress.

7. Critical to future efforts is support for action at the local level, where power, resources, a capacity and need to act and a commitment to the democratic process most often converge. However, a capacity to act locally and to think globally is often facilitated by infrastructures and supports at the national and global levels, and the need to think and act globally. This is readily apparent in the case of the impacts of global trade on food and nutrition, water, chemical safety, tobacco and pharmaceuticals. Thus, there is a need for clear and effective strategic linkages across global, regional and national partnership and development efforts to support local action.
8. The increasing complexity and interconnectedness of issues and the blurring of geopolitical, disciplinary, organizational and functional boundaries call for the strengthening of partnerships in taking actions on health. Global alliances are a comparatively new dimension of IAH with very rapidly changing technologies and infrastructures, players, and ground rules. Here, current knowledge and skills may be least applicable to the challenges at hand and in need of considerable strengthening.

Non-government/ Community-based Organizations

Whatever the project and at whatever level it is aimed, the ultimate success will depend on the participation and commitment of individuals, families and communities. It is because of this . . . at whatever level a project was planned for, it has to go down to the levels of neighbourhood and community . . .

Kiyu and Hashim (10)

9. It will be important to improve partnerships with the private sector and volunteer, non-government organizations, including community-based organizations. The private sector can and frequently does contribute to health in the normal course of "doing business" — as is increasingly evident, for example, in the nutrition industry. Creative ways must be explored to extend these efforts as well as to extract the skills and practices that have applications to health (e.g., social marketing; cost-benefit research; strategic investment planning).

Non-government organizations are often

the impetus for many of the values that frame national health and social development policies. However, in many parts of the world they are fraught with cynicism about political leadership and public participation. Further, at the global level, NGOs often perceive themselves as underutilized by development agencies and undervalued by donor agencies. Thus, they must be reinvigorated and cultivated as important partners in development.

3. Global Change

A central theme of the conference was change: while all agreed that significant progress has been made since Alma Ata there was also agreement that significant gaps in health status persist. Further, unprecedented global and transnational changes are under way that pose new challenges to future health gains and suggest new partnerships and alliances. The solutions are often unique to each country, region and community and “determined by factors such as their resources, customs, institutions and values. This implies that a combination of global, national and local strategies need to be developed, which must be harmonized”(8).

The following global issues were raised over the course of discussion.

3.1 Globalization

Defined as the “process of increasing economic, political and social interdependence”, this phenomenon is characterized by the expansion of the global economy and the growth of transnational trade and investment. These changes in the world’s political economy were discussed around two issues in particular. One was the position of economic factors as the dominant value system and indicator for growth and development. Another was the diminishing autonomy of the state and its loss of freedom to set national policies (5). The adverse impacts on health systems, policies and outcomes were most often identified in relation to the globalization of infectious diseases, the trade and promotion of tobacco (particularly in relation to developing countries), work and employment/unemployment, nutrition and issues of food security, and the environment and chemical hazards.

3.2 Values

Participants called for the championing of a new value system founded on human rights, ethics, freedom from discrimination and sustainable development. (This system would replace the current free market values paradigm and its preoccupation with competition, productivity and economic growth.) The new system would also give health security equal status with economic and social security, thus strengthening world resolve to eliminate poverty and health inequities.

3.3 Decentralization

Throughout the world, many governments are assigning responsibility for the management, delivery and financing of health, social and infrastructure services to the local municipal level. This process has been welcomed as a commitment to more responsive and strengthened local empowerment and public participation. One region suggested that “effective decentralization within the context of good governance will provide an enabling environment for intersectoral action in health” (11). On the other hand, there were cautions that decentralization has also been associated with “offloading”, “downsizing” and/or “devolution” of fiscal and program delivery responsibilities from one level of government to another, often without full regard for impacts on populations or the quality of services that results. Further, it can mean the

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“The globalization of disease and health risks requires global intersectoral action to promote and protect human health.”

Bettcher (5)

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nation-state's giving up the responsibility for promoting values, norms and standards that respect and maintain principles of mobility, rights and equity.

3.4 Governance

"Governance is the system through which society organizes and manages the affairs of sectors and partners in order to achieve the goals of the people"(12).

New theories and models are emerging about the nature of relationships between and within nation-states. At the national, regional and local levels, governments are struggling to define what they do best. In many countries, this examination of roles and responsibilities has also extended to the private sector and the voluntary or civic sector. A central aspect of this rethinking includes articulating what governments need to ensure to promote long-term, sustainable improvements in health for all citizens.

Banks and Financial Partners

Health is central to development. Conversely poor health, inequalities in health status and lack of provision of essential health functions destabilize countries and retard or inhibit community development. Partnerships with new "economic" organizations that influence the broader determinants of health are essential. The World Bank is a central player, along with regional and local development banks and financial institutions. Their mandates, knowledge, skills and actions play a major role in effecting sustainable health gains in human populations.

3.5 Restraint/Structural Adjustment

A worldwide recession in the late 80's and early 90's, drastic deficit and debt reduction measures by both nation-states and lending authorities and structural adjustment measures have led to unprecedented restructuring initiatives across the public, private and voluntary sectors. In the case of public sector reform, where health is frequently a centre-piece, the changes have often been initiated by powerful finance and treasury ministries on the argument that these changes constitute improved quality and effectiveness in the public sector overall and a more cost-effective design and delivery of services. These changes and the partnership arrangements that result must be critically examined with a view to the real impacts on health gains. Intersectoral actions may be initiated and "implemented by default through sectoral adjustment to public sector reforms and diminishing resources" and not as a result of a clear articulation of, or commitment to, sustainable health values, goals, or outcomes/indicators (13).

3.6 Inequities

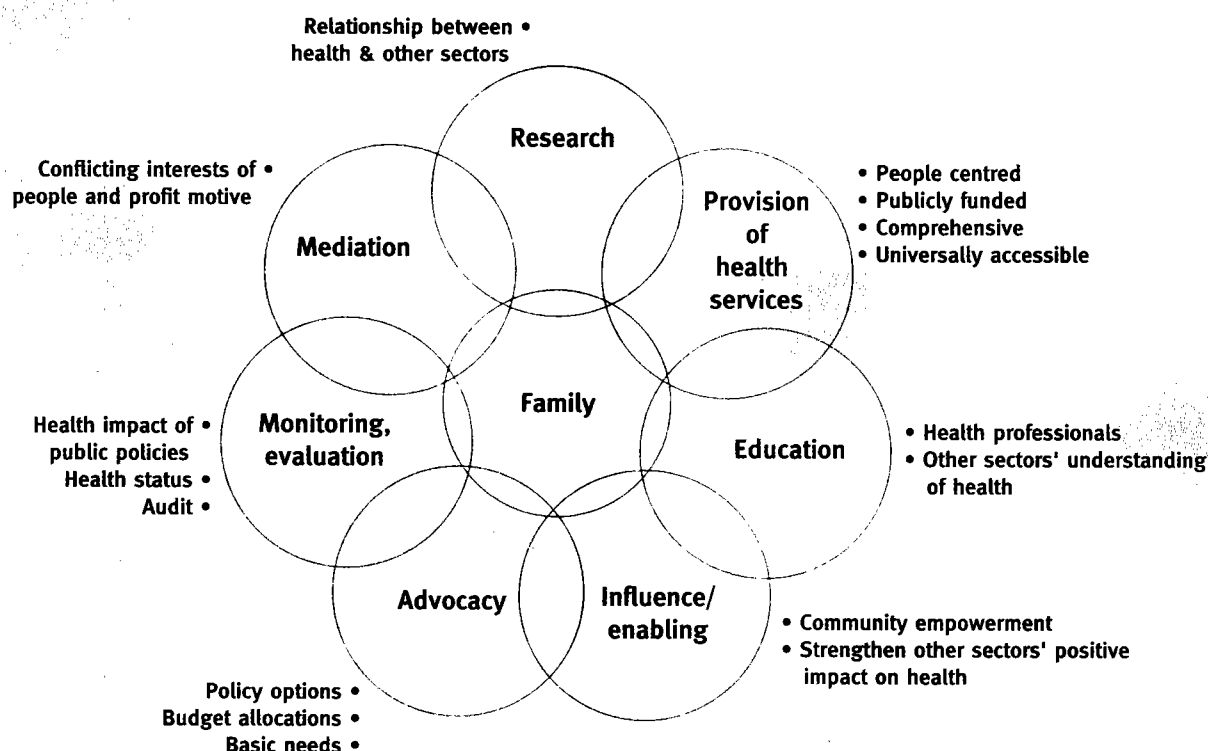
Inequities in access to both health care and incomes persist in both developing and developed parts of the world. Notwithstanding unprecedented gains for health for many, as we approach the 21st century there are "still almost six million deaths each year from undernutrition, and a further 2.7 million deaths caused by poor water supply, sanitation and lack of hygiene" (2). Equity of access to health care continues to be a major concern in many parts of the world. For example, in South East Asia, forty percent of the population of the region do not yet have effective access to health care, contributing to the unacceptably high maternal mortality rates, which are among the highest in the world (6). Since 1980 a surge in economic growth in a handful of countries (15) has brought rapidly rising incomes to their 1.5 billion inhabitants. However, over this same period, economic decline or stagnation has affected 100 countries, reducing the incomes of their

4. The Evolving Health Sector

4.1 Strengthening the Current Health System

Participants felt that the 21st century calls for a very different kind of health system from the one that has characterized the past 50 years. They felt that the system, as is, cannot perform in the current rapidly changing environment and that in the absence of change, it will become increasingly marginalized and possibly even redundant.

One Workshop's Depiction of The Role of the Health Sector in IAH



This does not suggest that efforts associated with Alma Ata and health for all have not been important or successful. Participants agreed that primary health care continues to be valid and acknowledged that the primary health care approach and philosophy has led to tangible improvements in health status around the world. Further, one of its primary components, intersectoral action, continues to guide many health efforts: from polio eradication and immunization in the Middle East and clean water and nutrition programs in Africa, through healthy cities programs across Asia, to the assessment and management of chemical risk through the Intergovernmental Forum on Chemical Safety at the global level.

Yet serious gaps in access to health services and inequities in health status persist. In many parts of the world, a lack of political will precludes directing resources towards the full spectrum of health determinants: instead resources are concentrated on comparatively costly, curative interventions that benefit only a few. There are also serious gaps in the concepts and practices associated with health, development and "growth". For example,

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the question was raised as to why, with all that we know about what contributes to health and the burden of disease, are we only now seriously examining the subject of development with a view to understanding economic growth as a means to human development rather than as an end in itself? Why is it that most of the international covenants and laws governing the free market, global trade and the interests of transnational corporations are enforceable but those pertaining to human rights and health are lacking in firm accountability mechanisms?

4.2 Health as Sustainable Human Development

The challenge is to continue to build on the accomplishments of the past, including continued support for primary health care, but also to move towards a different health system, which is proactive and oriented towards the health of total populations and is driven by broad partnerships. Within this new perspective, health would be repositioned as a benchmark for sustainable human development.

This reconceptualization of health is not new. Participants noted that it has been developed and successfully implemented in the “settings” approach of healthy communities, villages, cities, islands, market places, schools, hospitals and workplaces. Further, it is the underpinning of the 1992 Earth Summit in Rio and the resulting Agenda 21 strategy, which called for an anthropogenic approach to sustainable development that included health as an important component. From these experiences, participants felt that what is needed is a repositioning of health to “the centre of a culture” that values, invests in and measures health as sustainable human development (described as the sum total of social and economic efforts). Health becomes the outcome of the total societal investment in people (7).

大卫生

A theme that captured this idea was the “All for Health” Chinese notion of DA-WEI-SHENG, the national policy of health development. DA means “big, all and total” and WEI-SHENG means “health”. Thus, “total health”.

4.3 A New Health System

To achieve this new vision for health, participants agreed on the need for the development and implementation of sustainable health systems, with a new understanding of what a health “system” is. There was broad support for the view that this system must evolve through a balanced, cooperative approach to sustainable human development in which the health sector is one of a number of intersectoral players in an open systems or “web” configuration.

New models call for different kinds of leadership, skills, information and intelligence on the part of all players. This includes the health sector, but also governments, the private sector, voluntary non-government organizations, and the academic and research community. These models also call for new systems of governance to manage the partnerships and alliances. This may result in new roles and responsibilities, delivery and financing methods, and monitoring, accountability and outcome tools and measures.

*“The web that
holds the
intersectoral actions
together is
communication”*

There was discussion of the need to develop new capacities and infrastructures to support individuals and institutions to work in these areas. As well, participants stressed the importance of harnessing developments in information science and communication technology to both contribute directly to health gains (for example, in the area of human genome development) and “level the playing field” for research around the world. The latter ranges from creating new opportunities for remote and resource-poor researchers to participate more actively in research, to the creation of virtual, world class centres of excellence on research priorities.

4.4 Addressing Poverty

Poverty was seen as essentially a political issue, involving the presence or absence of will to address it, from the local to the state and global levels. Therefore, there was agreement that a conscious effort is required to promote and maintain a strong “values” base in future actions if important principles like equity are to be advanced and inequities in income and health reduced.

What we are . . . aiming for is a web/open systems model [where] . . . different parts of a wider system. . . constantly work together in short-term and long-term alliances. . . Such a web of health requires quite a different type of leadership, intelligence and accountability.

Kickbusch (7)

Discussion included the complexities of defining poverty, the newly poor and the growing phenomenon of the urban poor. There was also discussion of the kinds of initiatives that appear to have been most successful in addressing poverty, including local economic development efforts involving training, microcredit schemes and efforts to forge broader alliances with the private sector.

There was agreement that the health sector has a particularly important role to play in IAH initiatives relating to poverty. This includes the promotion of research into interrelationships among determinants/ causative factors; the mobilization of communities; institutional and personal capacity-building; the development of improved analytical techniques for impact assessment; and ongoing advocacy and networking at all levels. These efforts may be most important globally, where intersectoral connections are already established (e.g., children, food and nutrition), still evolving (e.g., AIDS) or still at the formative stage (e.g., world banking/development).

4.5 Impacts of IAH

There was discussion in all working groups of the need for improved evidence about the impacts of IAH and health interventions, generally, on outcomes. Discussion of indicators of successful interventions suggested a shortcoming in current efforts and a need for change: the range of acceptable indicators is too narrow and often skewed towards economic factors. There is also a need to strengthen understanding, acceptance and use of benchmarks and intermediate indicators as a basis for informing policy and program decisions. Current indicators of health outcomes need to capture health opportunities as well as health burdens, as measured by disability-adjusted life years (DALYs), morbidity and mortality data. There is also a need to make indicators more user friendly.

Participants supported an approach to indicators that looks at the issue of evidence along a continuum of actions/activities, including inputs (e.g., human and fiscal resources); process (e.g., the empowerment of lay people, the development of healthy public

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policy); impacts (e.g., infrastructure development, sustainability, cost-benefits); health outcomes (e.g., health gains, reductions in health inequalities); and monitoring and benchmarking. Overall, there was a sense that process indicators have tended to be undervalued and that there remains considerable work to be done to develop analytical frameworks to identify the contribution different sectors make to health, including the health services sector itself.

4.6 Research

New and different research is needed in the field of IAH, and health impacts and outcomes. In one of the conference background documents the comment is made that “policy must increasingly be informed by research on the epidemiology of health”, which is often found in different disciplines and sectors that have “very different construction of reality, and obviously, priorities” (14). There were many other areas where research was considered important, leading to a call for a new research agenda.

A brief presentation outlined what this agenda might look like: overall guiding principles included being needs-driven, value-based, holistic rather than reductionist, transdisciplinary and built on a model of complex webs of interaction. A lengthy listing of new areas/ kinds of research was also identified: intersectoral responses to emerging diseases and pathogens; norms and standard setting; analysis/best-practice for integrating multisectoral initiatives into national development efforts; models incorporating a transdisciplinary systems approach for working through integrated webs of causation and new opportunities for intervention; predictive and management models/tools and operations research for dealing with complex emergencies; legal analysis relating to the global health implications of multilateral and global environment and trade agreements.

4.7 Policy and Program Implications

1. Clearly the health sector cannot achieve health for all on its own. Further, while intersectoral action for health has contributed to concrete health gains, current paradigms for health and the present strategies for IAH are not likely to result in substantial progress in the future. Accordingly, a significant change in the conceptualization of health is called for, along with a change within the health system itself.
2. This change can only occur around a new vision of health as is being proposed in the draft WHO policy of the Renewed Health-For-All strategy in which health is central to sustainable human development. The strategy embraces a universal HFA value system, makes health the centre-piece of development by combating poverty and promoting health in all settings and within all sectors, incorporates health in sustainable development plans and actions and is predicated on governance systems that ensure that health is central to development. Within this framework, resources and efforts will be directed to the development and maintenance of sustainable health systems (17).

3. In order for the health sector to continue to be an active partner in this change, it will be necessary for the sector to put its own house in order. This calls for it to:
 - ❖ clarify and articulate investment goals, including inputs and outputs;
 - ❖ assume new roles, including leadership in development, by acting as catalyst, champion, advocate as well as partner;
 - ❖ ensure organizational readiness and build new planning and delivery structures;
 - ❖ build a wider understanding of disciplines, new professional profiles and competencies (e.g., public health lawyers) and a changing skills base;
 - ❖ develop new tools and mechanisms (e.g., legislative actions, regulatory measures, sanctions, new reward/incentive schemes);
 - ❖ implement new outcome and performance measures;
 - ❖ support new research initiatives including support for researchers/research centres engaged in cross-cutting work involving new agendas, model-building etc;
 - ❖ participate in and support new alliances that ensure that health plays a stronger role in financial plans and at economic and political decision-making tables.

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5. Emerging Roles and Responsibilities

5.1 WHO

The WHO Constitution mandated the organization to carry out its responsibilities as the “conscience for world health”. Participants were in agreement that the conscience role continues to be important but that significant change is now required in how the organization does business, in its approaches to health, member states and partners and in how it is structured. It will need to strengthen its emphasis on “steering, facilitating, analyzing, anticipating and advocating....” Its prime mandate should focus on building the intellectual and organizational infrastructure for a new human development order in cooperation with member-states and other sectors.

There was strong support for a more proactive role on the part of WHO in ensuring that the new HFA vision, including support for key values, be translated into transparent and enforceable international instruments. This would include a convention or charter on the right to health for all peoples of the world.

Key WHO functions would include leadership in building new models and approaches that are required for the 21st century, including support for new governance structures; strengthened partnerships in order to effect global health gains; analysis and direction in the development of normative functions and standards; strengthened global monitoring and surveillance; support for new performance goals, indicators, and research models and agendas; and continued technical cooperation and broadened communication, promotion and networking activities. This also would call for new kinds of leadership skills and disciplines within the organization.

At the regional level WHO should continue such activities as developing analytical tools to identify national/local priorities, providing technical support and training initiatives, and promoting interagency cooperation. There was

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Participants' Views of What Has to Change for IAH

Over the course of the conference, there were discussions of successful IAH experiences and indicators, of partnerships and strategies and how the health sector, WHO, national and local governments have promoted IAH. These were the stories of the “what” and the “why”. When it came to the “so what/what now”, the following suggestions came out of a brainstorming session:

- ♦ “WHO needs to construct well-argued cases for IAH as an investment in human development.”
- ♦ “WHO is in a position to take concerted intersectoral action and initiative, especially in relation to poverty, environment and economic development issues and must do so with a sense of urgency.”
- ♦ “Economic development has to be focused on healthy human development.”
- ♦ “The health sector can (and in many countries has) engaged many partners (especially in local government and the education sector) in programs such as healthy schools, dental health, healthy cities and villages.”
- ♦ “The health sector needs to embrace IAH within its own work framework; we need to ensure intrasectoral action within health as a key strategy for ensuring intersectoral action between health and other sectors (i.e., get our own house in order first).”
- ♦ “Intersectoral action is a *sine qua non* for solving the complex old and new challenges to achieving HFA in the 21st century.”
- ♦ “IAH needs to be adapted and applied in new ways, especially to new problems, e.g., sustainability, population growth, urbanization, poverty, conflict, all of which have prominent health components.”
- ♦ “We must move from descriptive talk about IAH based on anecdotal stories to achievable, evidence-based interventions at multiple levels.”
- ♦ “An important ‘new’ intersectoral problem with virtually no present health sector input is globalized trade, which has many impacts on the health of populations.”
- ♦ “WHO needs to encourage broad-based horizontal partnerships and alliances at the non-state, state, regional and international intergovernmental levels to address the challenges which threaten the livelihood and well-being of future generations.”

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also a view that regional offices should strengthen and/or take on new activities in relation to building increased political support and mobilizing resources, particularly within global and regional financial institutions and banks, promoting and safeguarding efforts to reduce inequities and ensuring better policy and strategic linkages between national and global efforts.

5.2 National Governments

One participant described national/state governments as being like the nut in a nutcracker, caught between having to manage pressures coming both from above and below (i.e., demands and expectations from global forces and from the local or municipal level).

Top-down / Bottom-up Approaches

A combination of the two approaches "is needed to ensure that health is fully incorporated into global, national and local sustainable development plans. The end point in a bottom-up strategy could be the development of a national strategy, whilst in a top-down approach the starting point could be the development of a national strategy and guidelines."

von Schirmding (8)

There was agreement that national governments continue to play a very important role in intersectoral action on health. They are critical in leading and setting a framework for health, in articulating and providing essential health functions, and in promoting solidarity of the vision, values and principles that address the unique characteristics of the country. Examples are found in the IAH experiences of Tanzania, Bhutan, Guinea, Egypt, Burkina Faso and so on.

National governments also make the major decisions regarding the allocation of resources for health and the trade-offs that must be made among competing interests and priorities. In addition, they manage health system reform, including the capacity to deliver and sustain services at the community level. They have the responsibility of integrating economic and social development at the policy and operational levels and to promote and ensure accountability for the total societal investment in its peoples. National governments also are responsible for ensuring effective decentralization "within the context of good governance" to guarantee a supportive environment for IAH (11).

5.3 Local Governments

One important element of IAH at the local level is political will. Case stories and examples pointed repeatedly to the importance of clear, strong and sustained support for initiatives by key political leaders in effecting action, followed by support from bureaucracy/administration. This was particularly evident in the Beijing and Kuching Healthy City programmes. Another important role is support for local infrastructures and resources to assess and prioritize local needs and to plan, finance and evaluate activities and projects. This is frequently represented by integrated health systems, which provide the structure within which broader action can proceed. These range from loosely knit village/area volunteer development committees to formal administrative entities such as community health services. These structures are most effective where there is a clear national policy of decentralized health services in place.

An environment of local support for public participation is also critical for success and sustainability. Local citizens are frequently called on to co-manage and co-finance efforts and, in communities lacking access to government services, to deliver essential health

services. It is at the community level that the “pooled services from all sectors, along with the people themselves” bring “local points of view along with local wisdom into the planning and problem-solving” (6).

Participants again noted that urban growth in both developing and developed countries presents particular challenges associated with inequities, environmental employment and health problems. These often demand of local governments that they assume roles and responsibilities more commonly associated with other levels of government.

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5.4 Policy and Program Implications

WHO

1. There is a need for a full-scale change in the vision, policies, structure, approaches and activities of WHO to enable it to move from rhetoric to action on an IAH strategy.
2. WHO must be the leader in formulating and marketing a vision for the new health system required for the 21st century. This vision should find expression in a world charter or convention, perhaps a Charter of Rights to Health, which could be crafted at a Global Summit where new partnerships and alliances could be promoted. Consideration should also be given to creating new vehicles like a Nobel prize for health gains/development.
3. WHO must build partnerships outside the health sector, particularly in international and regional banking, financial institutions and the private sector, and should strengthen NGO sector alliances both in planning and monitoring/auditing global development activities.
4. WHO must collect, analyse and make available new models and approaches to working intersectorally, including initiatives relating to organizational renewal/institutional change.
5. WHO has an important role to play in developing and undertaking normative functions and in developing critical policy assessment tools (e.g., “global report cards”).
6. WHO must promote new initiatives in the area of human resources development, including training both within the health sector and across sectors/disciplines, extending capacities critical to IAH such as information management, research and evaluation, organizational change and public policy development.
7. WHO must support a new global research strategy and agenda that complements the biomedical agenda and addresses policy action and health outcomes.
8. WHO must adopt a culture of change and reflect this in communications strategies; it should increase its communications, consulting and networking activities in more innovative and accessible ways.

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9. WHO must continue to support a range of partners and players with frameworks, tools and guidelines for implementation at the regional level through a broad range of activities and shaped by considerations such as
 - ❖ a focus on health determinants rather than disease, which also provides critical technical analysis;
 - ❖ the mobilization of political and partnership support, including financing, and development banks and a strengthening of regional and country capacity;
 - ❖ strengthening links between global and national development strategies to ensure relevance of local efforts.

At the National/State Level

Nation-states should

- ❖ establish national health frameworks and goals and lead the process of health reform, to the extent appropriate within specific constitutional mandates;
- ❖ develop and support a concept of growth that integrates social and economic development as sustainable human development, with transparent monitoring and accounting indicators;
- ❖ support the establishment of tools that promote priority-setting, including the development of related research agendas;
- ❖ ensure the maintenance of primary health care, along with other basic health functions required to improve the quality of life and reduce the incidence of disease;
- ❖ ensure monitoring and accountability functions;
- ❖ promote the development of reliable health information and research;
- ❖ promote and support local planning capabilities, including decentralization "within the context of good governance";
- ❖ create and support infrastructures that promote and support public participation in health and public policy.

At the Local Level

Governments should

- ❖ develop and support sustainable local economic development policies and initiatives as centre-pieces to alleviating poverty and relieving the burden of disease;
- ❖ operate the economic, social and environmental infrastructure;
- ❖ support community participation;
- ❖ promote comprehensive primary health care efforts implemented through functionally integrated health systems that reinforce community care approaches;
- ❖ support and strengthen equitable access to education, information and technology as central to sustainable community development.

6. HFA for 2020

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Over the course of the conference, participants articulated a policy framework for intersectoral action for health in which health is seen as “a global common” and in which there is a broad societal commitment to an investment in health and to accountability for action and positive outcomes (7).

Within this framework, there was consensus on the need to build on the many lessons learned about IAH over the past two decades and to continue to systematically strengthen future efforts. This calls for the health sector to work very differently with a wide range of both old and new players.

Globalization, technology and advances in health, among others, find us on the threshold of an unprecedented opportunity to address critical development issues at the levels of individuals, communities and society-at-large. We are moving ahead with modest success on many fronts, but too often on an issue-by-issue basis, with little real attention to or control over the impacts on equitable and lasting growth and well-being.

The work of this conference renews the challenge of connecting these efforts through a renewed commitment to IAH, rooted firmly in healthy public policy and sustainable human development.

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A Call for Dialogue and Trust

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A theme that ran throughout the conference was diversity and the importance of assessing and determining action in the context of different peoples and communities. Thus, interpersonal factors were recognized as being critical in the success of intersectoral efforts, including personal attitudes, skills, relationships, trust and respect. Participants also agreed that a critical challenge associated with IAH is change of attitude and behaviour within the health sector itself and strengthened intrasectoral action.

Acting on a commitment to participatory action research, WHO commissioned an analysis of the conference process “as intersectoral action in action”. At the outset, participants were invited to reflect on their diversities and how they “create a variety of voices, stimulating or hampering mutual understanding”. They were also invited to reflect on how these diversities influence group norms and can be a problem or opportunity for group interaction.

As a research project, the experiment was successful, if for no other reason than that it happened. It suggests the courage of conviction that will be needed for related research in future. Nevertheless, there were methodological challenges that could have been addressed through a more open, participatory conference planning process. As a consultation process, the conference debate strengthened over time. However, it was apparent that strong dialogue from the outset could have been facilitated through improved clarity of purpose and establishment of clear goals that better reflected more participants’ needs and expectations. Further, careful attention must be given to factors of position, gender, discipline, north/south axis, etc., to ensure a balance of power, participation rather than control, inclusion rather than exclusion and cooperation rather than cooption.

And as an exercise in IAH? We were reminded that we are always “living, playing, loving and working” within the context of one sector or another and that “all these sectors have their own kind of power, their own function, their own culture” (18). Accordingly, we were challenged to better trust the IAH process to which we all subscribe and to really walk the talk as we move toward 2020!

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Appendix A

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Appendix B

Conference Final Program

Sunday 20 April 1997

Intersectoral Action for Health

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9h-12h45 Morning Session

Purpose: To identify key components of Intersectoral Action for Health within the context of Health-for-All in the Twenty-First Century.

9h-10h45 Opening Session

Chairperson: Dr. Wilfred Kreisel, Executive Director, Health and Environment, World Health Organization

Greetings: Dr. Wilfred Kreisel, Executive Director, Health and Environment, WHO

The Honourable David Dingwall, Minister of Health, Health Canada

Sir George Alleyne, Regional Director, WHO Regional Office for the Americas (AMRO)/Pan American Health Organization (PAHO)

Mr. E.G. Cramm, Deputy Minister of Health, Nova Scotia

His Worship, Walter R. Fitzgerald, Mayor of Halifax Regional Municipality

Dr. John Hastings, President, Canadian Public Health Association

Children's choir of École Beaufort

Keynote Address **Emerging Directions in the New Global Health Policy: Health-for-All in the Twenty-first Century**

Dr. Fernando S. Antezana, Assistant Director General, WHO

10h45-11h Nutrition Break

11h-12h45 **Evolution of the IAH Approach Since Alma-Ata**

Moderator: Ms Margaret Hilson, Assistant Executive Director, International Programs, CPHA

Dr. Ilona Kickbusch, Director, Division of Health Promotion, Education and Communications, WHO

Dr. Rita Thapa, Regional Advisor, Community Health Services, South-East Asia Regional Office (SEARO), WHO

Dr. Edmundo Werna, University of São Paulo, Brazil

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12h45-14h	Lunch
14h-17h45	Afternoon Session
Purpose:	To present an integrated global analysis of experiences with intersectoral initiatives for health in the context of both developing and industrialized countries.
14h-15h15	Panel on Global, National and Local Intersectoral Action for Health
Moderator:	Dr. Bertha Mo, Research Scientist, International Development Research Centre
1.	Intersectoral Action for Health at the Local Level: Addressing Health and Environment Concerns in Sustainable Development Dr. Yasmin von Schirnding, Office of Global and Integrated Environmental Health, WHO
2.	Think and Act Globally and Intersectorally to Protect National Health Dr. Douglas Bettcher, Policy Action Coordination Team, WHO
3.	Healthy Public Policy: Roles of Governments and Health Partners in IAH: Country Case Studies Dr. Jamilah Hashim, Malaysia Ms Munu Thapa, Nepal
15h15-15h30	Nutrition Break
15h30-17h45	Healthy Public Policy (continued) Ms Nancy Kotani, Canada Dr. Meri Koivuusalo, Finland Questions and Open Discussion
Sunday Evening	Participants are free to make their own arrangements for dinner.

Monday 21 April 1997

**Intersectoral
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9h-12h45 Morning Session

9h-9h30 Overview of Day 2 and Directions for Working Groups
Chairperson: Dr. Wilfred Kreisel

Discussion in Working Groups

In three sessions on Monday and Tuesday, six working groups will focus on specific elements of an intersectoral strategy for health. In each working group session, two groups will deal with the local, national and global levels of analysis. After working group sessions 2 and 3, synthesized global, national and local reports will be presented to Plenary. Finally, on Wednesday the contributions of each of these groups will be integrated in order to provide an overview of the final conference report. Case studies will be used in each of the small group sessions to provide practical examples of intersectoral actions for health and situations in which good IAH policies are required.

**9h45-12h45 Working Groups Session One:
Health Determinants, Best Practices and Indicators**

Terms of Reference (Session One)

- Discuss determinants of health that lend themselves to intersectoral action for health initiatives.
- Define the strengths of intersectoral action for health initiatives. What does past experience suggest for future best practices?
- Define what constitutes success and elaborate determinants of success and failure at various levels.
- What are the critical benchmark measures/indicators of successful intersectoral action for health initiatives?

In Session One the working groups will need to address the following key questions:

- 1a. What are some of the key successful IAH experiences at the global, national, and local levels?
- 1b. What key benchmark indicators of IAH can be used to measure the success of IAH initiatives?

**12h45-14h Lunch — Delegates free to make their own lunch
arrangements**

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14h-17h45 Afternoon Session

Working Groups Session Two: Critical Partnerships and Strategies

Terms of Reference:

- Identify which partnerships and which intersectoral actions are most likely to lever tangible and sustainable health gains for populations (in typical settings from poor rural to affluent urban environments).
- Define actions that are most likely to address both relative and absolute levels of poverty through intersectoral action. In so doing, address the role of the health sector at various levels in contributing to poverty alleviation and in advancing equity.
- Identify strategies and actions within the health sector that are supportive of the attainment of the goals of sustainable development. This could include actions in specific settings and alignment of sectoral policies.

In Session Two the working groups will need to address the following key questions:

- 2a. What role does the health sector have to play within IAH initiatives, specifically related to addressing absolute poverty and reducing the burden of disease?
- 2b. What IAH linkages and partnerships have had the greatest impact on the health status of those groups living in absolute poverty?

Monday Evening Dinner and Ceilidh with the Honourable John Savage, Premier of Nova Scotia

Tuesday 22 April 1997

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9h-12h45 Morning Session

9h-10h30 Reports from Working Groups: Session One and Session Two
Discussion

10h30-10h45 Nutrition Break

10h45-12h45 Working Groups Session Three: Policy/Strategic Questions

Terms of Reference:

- Explore and define the emerging role of the state in ensuring that health gains are maintained and promoted for all. Explicitly, define the role of the Health Department in facilitating intersectoral action and national governance for health.
- Discuss the roles of the UN bodies, World Bank and World Trade Organization in achieving an integrated approach to the governance of health. Explicitly, define the role of WHO in relation to these bodies.
- Explore the roles of local government and other sub-national partners in policy and planning at the local level.
- Identify implications of the working groups outputs for capacity development and for research.
- Consider the policy/strategic linkages between the local, national and global levels.

In Session Three the working groups will need to address the following key questions:

- 3a. Which policies does WHO need to integrate into a global IAH strategy that will be relevant at the global, national and local levels?
- 3b. What is the role of the state and local governments in facilitating and promoting intersectoral initiatives for health?

12h45-14h Lunch

14h-17h45 Afternoon Session

14h00-15h30 Working Groups Session Three (continued)
Drafting of final synthesized local, national and global reports to Plenary

15h30-15h45 Nutrition Break

15h45-17h45 Report from Working Groups: Session Three
Discussion

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Wednesday 23 April, 1997

Purpose: To review the major discussions covered throughout the previous three days and to arrive at consensus regarding key points to be included in the IAH conference report and in the HFA policy for the twenty-first century.

9h-12h45 Morning Session
Elements to be Included in the
Health-for-All Policy in the Twenty-first Century

Moderator: Dr. Yves Bergevin, Senior Health Policy Advisor, Canadian International Development Agency

9h-9h20 Overview and Synthesis of Working Group Reports and
Identification of Key Elements for Intersectoral Action to
be Included in the HFA Policy in the Twenty-first Century
Presentation by Conference Rapporteur: Dr. I. Kickbusch

9h20-9h40 Implications of IAH Conference for Health-for-All in the
Twenty-first Century
Dr. Derek Yach, Chief, Policy Action Coordination Team, WHO

9h40-9h50 Implications of IAH Conference for Health-for-All in the
Twenty-first Century: WHO Regional Perspective
Dr. Luis Sambo, Director, Support to National Health Systems, AFRO

9h50-11h30 Open Discussion and Debate
Reaching Consensus

11h30-11h45 Nutrition Break

11h30-12h15 Closing Ceremony

Chairperson: Dr. Wilfred Kreisel, Executive Director, Health and Environment, World Health Organization

The Honourable Bernie Boudreau, Minister of Health, Nova Scotia

Dr. Yves Bergevin, Canadian International Development Agency

Appendix C

Conference Background Documents

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von Schirnding Y. *Intersectoral action for health: Addressing health and environment concerns in sustainable development*. Geneva, World Health Organization, 1997 (WHO/PPE/PAC/97.1).

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1.6 billion peoples, who represent more than a quarter of the world's population (14). Without a broad human development framework, countries continue to choose between greater income/economic growth and health equity as opposed to seeing them as complementary.

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3.7 Health Systems

Substantial achievements in global health have been made since Alma Ata. The Primary Health Care Strategy has been adopted in some form by the majority of countries worldwide, and the populations' access to PHC elements has steadily increased, albeit with great variation in coverage. Further, one of the most important achievements of the last two decades has been the growing acceptance of the concept of health for all as a unifying conceptual framework for improving global health (15). At the same time, there is consensus that further investments in the health systems alone will not substantially contribute to the improved health of the population. Suggestions for the future call for major shifts in the conceptualization and approaches to support IAH, including a more holistic approach to health development and health system reform within the context of socio-economic reform. Similarly, they call for new approaches to health investment based on prevention and promotion and population health approaches.

3.8 Migration/Urbanization

Economic and labour market adjustments, transitions and dislocations, demographic factors, boundary disputes and humanitarian relief efforts are all contributing to the changing settlement patterns between and within nations. Further, significant movement of populations from rural to urban areas contribute to both demands for human services and a growing incidence of crime and violence, income inequity and poverty.

3.9 Global Environmental Issues

Echoing the findings and recommendations of the United Nations Conference on Environment and Development (Rio de Janeiro, June 1992), the health repercussions associated with environmental degradation will require enhanced levels of intersectoral collaboration. For example, it was emphasized that cross-cutting subjects, such as the impact of global trade and environment issues on human health, will require that substantive trade and environment policies be elaborated in the future, and that agreements be reached on existing international conventions.

“The basic driving forces behind environmental health problems, such as population growth, economic development and non-sustainable consumption, need to be addressed if we are to secure a healthy environment and sustainable development.”

WHO (16)

3.10 Policy and Program Implications

1. In the face of global change, it will be important that the state maintain an effective capacity and competence to play a role in promoting and protecting the human development rights and diverse interests of citizens. For example, there is a need for state institutions to give greater emphasis to ensuring that essential public health functions are universally provided and are of adequate quality. New ways will have to be found to do so, within the context of changing governance structures and continued growth in the influence of transnational organizations. The health sector has an important contribution to make to this debate, particularly as it applies to addressing absolute poverty and reducing the burden of disease, but it must quickly develop the capacities, tools and strategies to participate credibly alongside the other major players.
2. There is a strong sense of urgency associated with the global changes under way and a need for WHO and all international governmental organizations (in cooperation with non-government organizations) to intervene quickly, and in a sustained fashion on a global basis.
3. There is a need for a new global order founded on sustainable human development, which explicitly acknowledges and monitors the contribution of health and social programmes to economic development and promotes complementarity of all development efforts.