INTERSECTORAL ACTION FOR HEALTH

Report of Working Group 11

Equity and Health
Introduction

The discussion began with addresses by M. Ripert, Deputy Director-General of the United Nations and Mrs Simone Veil, former Minister of Health, France and President of the European Parliament. Their introductory remarks covered the overall issues of Equity and Intersectoral Action and focused the following discussion on the operational issues to be considered.

The Health for All strategy was cited as the origin for the shift in global consideration of health goals. Its major concern for equity in health and its assertion of the need for intersectoral cooperation to achieve that objective were emphasized. It was also noted that commitment by political leaders to this major change in the thrust of national health and development planning was recognized as a priority at the time of Alma Ata and remains still today an essential requirement. Achieving equity in health requires adjusting priorities toward the most vulnerable social groups, greater concern by other sectors for health consequences and a targeting of health resources to assure greater attention to the health needs of those groups through the primary health care strategy. All of those steps involve fundamental institutional changes which cannot be accomplished without the political commitment of national leaders.

Summary of Issues:
1. Political Commitment

It was repeatedly emphasized that a prerequisite for creating a better situation for vulnerable groups is a strong political commitment to equity in health and development. Several speakers stressed the gap between the promise of intersectoral action and performance at the national and international levels. There is an overall need for creating greater awareness regarding inequities in health in the health sector as well as in other relevant sectors and in the general public.

2. Equity and Health

While the Alma-Ata declaration formalized political commitment to equity and health, the competing pressures faced by ministries of health often impede the fulfilment of this commitment. This commitment can generate unrealistic expectations regarding health care. Resources are expended for sophisticated equipment with imported components and for monumental projects serving a small but powerful part of the population at the expense of insuring full access to basic health care of the majority. While it is recognized by the PHC strategy that this pattern of expenditures leads to inequitable distribution of health care and inappropriate use of scarce resources, it remains a prevalent pattern in both developed and developing countries. It is clearly necessary to select priorities keeping in sharp focus the health conditions confronting the most vulnerable groups so as to ensure that the resources within the health sector are allocated where they will have the most beneficial effect for the largest number of people. Consequently, it is vital to define the concern for equity and health in the broader context of equity and development.
Various speakers noted the direct relationship between equity in health and equity in development. Therefore they emphasized that equity in health is a fundamental indicator of the quality of national socio-economic development. Achieving the goal of improving conditions of the population, particularly the vulnerable groups, is not only a test of the quality of development but an important factor in the development process itself. Examples were given indicating that regions in developing countries in which the population suffers from malnutrition are regions where the pace of economic development is inevitably retarded. In industrialized countries, the failure to undertake intersectoral actions to avoid industrial and other accidents presents society with growing disability costs.

Pursuing the goals of equity in health as the member countries have advocated in the adoption of the Health for All strategy, implies a fundamental concentration of national attention on the status of vulnerable groups within the society. In every nation the health status of those vulnerable groups, whether landless rural labourers, small and marginal farmers, mothers and children or the aged, measure the degree to which equity in health has been transformed from rhetoric to reality in the design and implementation of national development strategies. Speakers recognized the need for intersectoral actions which can raise the level of health and well-being of those groups. No single sector can do it alone, rather each in its own planning and programming must incorporate the goals of equity in health and recognize that its actions have a direct bearing on achieving progress toward the goal of equity in health.
4. Indicators - Monitoring of Progress

There is a need for developing indicators which define the situation of the most vulnerable groups that will give a more reliable basis for health and development policies. The health sector should collaborate with other sectors in defining the specific indicators which then can be used jointly in the monitoring of overall development, e.g., shed light on effects of food policy (such as subsidies), education policy (such as policies in primary education). How national economic policies and projects impact on those vulnerable groups, groups which also are undergoing change, should be one of the key guides for national planners.

5. Intersectoral Development Planning

Speakers noted the absence of machinery at the national and international level for the incorporation of health impact analyses into the design of the full range of national global economic policies and sectoral policies, programmes and projects, such as those of agriculture, industry and energy. Emphasizing the importance of those projects, such as dams or major agricultural investments, for expanding employment and other economic development objectives, the speakers nevertheless criticized the failure to examine, before the fact, the potential adverse impact such projects have on the health of the population affected and particularly on vulnerable population groups. The potential for complementary actions, incorporated into those projects and policies to protect the health of the population often has been lost. The absence of an inherent concern for the health consequences of other sectoral activities was noted by speakers who emphasized the essential need for the health ministry to be involved in the discussions of those economic policies and large public works
projects in order to provide information on their potential health impact. Similarly, there was the concern that multilateral financial institutions, such as the IMF, the World Bank, would need to incorporate greater concern for social development in order to avoid damage to health goals.

The incorporation of health equity into national development planning was viewed as a key area for generating greater intersectoral collaboration. By assuring that other sectors take into account the health impact of their policies, they too would be a part of a national intersectoral effort to pursue health goals. While allocation of national resources for health may remain limited, more efficient intersectoral targeting of health resources on the basis of a concern for advancing the health conditions of vulnerable groups could result in the most productive harnessing of national resources for national development.

Ultimately, inequalities will remain unless there is a greater allocation of national resources toward the vulnerable groups and thereby toward the promotion of equity in health.

6. Casualty of the Social Development Problem

The overall amount of resources available for health and equity related programmes depends very much on the economic environment and constraints that confront decision-makers at the national level.

The economic crisis and the enormous debt burden facing developing countries has led to the adoption of restrictive adjustment policies. By compressing effective demand and by allocating more resources to export-oriented sectors, such policies result in additional
pressures on central government. In many cases, no safeguard has been specified for social expenditures and the social sector becomes almost 'naturally' the first casualty of adjustment.

Concerted action is urgently needed at the international level in order to provide a more supportive environment to the efforts of developing countries in the area of social development. Adjustment decisions should not produce a negative impact on equity and health. The health status of the vulnerable groups should be a fundamental criterion in the analysis of alternative policies.
INTERSECTORAL ACTION FOR HEALTH

Report of Working Group 4:

Environment - Water and sanitation, habitat and industry
1.1 Two common focuses united all the discussion and the recommendations which arose out of this discussion.

1.1.1 The first was the recognition that the ultimate goal of development is improved quality of life or improved well-being for entire national populations. Growth in production or productivity is not an end in itself but merely a means of achieving a stronger economic base from which to promote improved quality of life or well-being. And there is little point in discussing 'intersectoral cooperation' in the abstract as the discussion of intersectoral cooperation is about intersectoral action to improve health.

1.1.2 The second focus was the need for governments and international agencies to give priority to meeting the needs of poorer groups. Within the poor, there are groups which are particularly vulnerable or whose needs conventional programmes often miss. These include women-headed households, abandoned children, older people and handicapped people. One should recall that around one billion people are living in absolute poverty, i.e. one person in five in the entire world. These are the ones with the poorest housing conditions, the worst access to piped water, sanitation, health care and education. An increasing proportion are living in urban areas. These also include people who are especially threatened by disasters. For instance, in many cities, squatter settlements grow up on lands subject to flooding or landslides because this is the only land close to the city from which they will not be immediately evicted. The worse the environmental quality of the land they build on, the less likely their forceful eviction.
1.2 But in discussing these two focuses, we must be realistic. Financial resources are limited, especially during the present economic recession and the decline in the availability of soft loans and untied aid. There are three areas of common concern with regard to constraints:

1.2.1 The first is the acknowledgement that a step-by-step approach with each step targeted to the poorer and more vulnerable groups is essential. Careful intersectoral coordination can increase the impact on health and well-being of limited resources.

1.2.2 The second is that governments support directly the efforts of people and the community groups they form with technical advice so people's own contributions and skills are used to the maximum. Government agencies, as the suppliers of information on how to improve the health and safety of houses, drainage and sanitation, can achieve far more than governments seeking to build 'houses' for the poor.

1.2.3 The third is that multilateral and bilateral agencies should devote a higher proportion of their aid to projects and programmes which directly reach lower income groups with improved housing and living conditions and access to basic social and physical services.
2.1 Issue 1 - Meeting essential needs

Actions by governments across a broad front, aimed at meeting the basic, essential needs of their populations can make a major contribution to health and well-being. The following are recommended as important approaches in implementing such actions.

2.1.1 Emphasis should be given to identifying the needs of the most disadvantaged groups and the formulation of strategies aimed at eliminating or reducing their most important health risks.

2.1.2 Voluntary non-government organizations should be involved in meeting essential needs because of their skills and experience in working at the interface between government and communities and their areas of involvement which often transcend many sectors.

2.1.3 Integrated rural development programmes which can combine employment creation, increased economic growth, establishment of infrastructure and improved living conditions are examples of successful approaches to intersectoral action for health.

2.2 Issue 2 - Shelter provision or improvement

2.2.1 Governments should accept responsibility for providing technical material and financial assistance to the most disadvantaged groups of the population in order to facilitate an acceleration in improvement of living accommodation.
2.2.2 Planning for increased provision of shelter should emphasize the use of safe materials and housing designs should incorporate safety features which will eliminate important health risks such as unguarded or smoke producing cooking stoves.

2.2.3 Simple, affordable, appropriate technologies for cooking, heating, water supply, waste disposal, etc., should be introduced whenever feasible.

2.2.4 In view of the high capital cost of developing a healthy physical environment, WHO should seek new sources of financial assistance, including the private sector.

2.3 Issue 3 - Management of natural resources

2.3.1 Decentralization of decision-making backed up with legal and technical support, as well as community mobilisation, is an important means of ensuring the safe and sustained utilisation of natural resources.

2.3.2 Methodologies which can assess and predict the impact of economic development activities on health and the environment should be developed as important levers both to minimize damaging effects as well as to assist in raising health and social well-being in the order or priorities for allocation of government budgets.
MECHANISMS FOR FACILITATING INTERSECTORAL ACTION ON ENVIRONMENT AND HEALTH

The Group recognized that there were several mechanisms for assuring that coordination between the different sectors involved was optimal and for minimizing the conflicts of interest, and of areas of jurisdiction, that were liable to occur. Some specific examples were cited of mechanisms that had proved both manageable and effective.

3.1 In certain countries, interministerial councils on the environment had been established. Such councils should consist of representatives of all ministers concerned with health and environmental issues (including housing, land use planning, local government, etc.). Voluntary, non-governmental organizations could also be represented. This approach could often provide a forum where health and/or environment ministers could seek discussion of projects liable to impact adversely on their sectors. The Group anticipated further discussion and elaboration of this key matter when Issue No. 6 was discussed on Thursday, 8 May.

3.2 At the local level, community participation was crucial. Such participation could be assured in several ways - one was for governments to display a positive outlook towards non-governmental, voluntary organizations. Their cooperation could help to ensure the appropriate mobilization of support for, and implementation of, government policies and measures at the sub-national level in particular.
3.3 The question of decentralization of decision-making and policy application was raised. It was pointed out that some decentralization of authority to the municipal/district level was often essential, since it was at this level that the problems of the poorest sectors of the population were often best perceived and tackled. Yet at the same time, key policies on the protection of health and the human environment had in most countries to be decided upon at the central level.

3.4 In one developing country a Green Campaign had been instituted whose primary purpose was to promote the establishment of "Green Councils" in each of the country's communities. Their purpose was essentially to make optimal use of all the economic resources of the community to provide health and other benefits. The programme was essentially designed to develop a different order of priorities - geared to real human needs - for investing human and material resources. The programme had legal support - all those involved were aware of their legal rights - and was also afforded appropriate technical support.

3.5 Government involvement alone was insufficient in many national contexts. Government efforts could be greatly strengthened by input from professional/scientific societies, whose collective experiences could also bring new insights into problem-solving in the health/environmental areas.
THIRTY-NINTH WORLD HEALTH ASSEMBLY

REPORT OF THE TECHNICAL DISCUSSIONS ON

THE ROLE OF INTERSECTORAL COOPERATION IN NATIONAL STRATEGIES FOR HEALTH FOR ALL

Co-sponsored by:

the United Nations Office for Development and International Economic Cooperation
the United Nations Environment Programme (UNEP)
the United Nations Centre for Human Settlement (Habitat) and the International Year of Shelter for the Homeless (IYSH)
the Food and Agriculture Organization of the United Nations (FAO)
the United Nations Educational, Scientific and Cultural Organization (UNESCO)
BACKGROUND

1. In the Health for All Strategy, the Member States of the WHO committed themselves to creating the conditions which will enable all people to enjoy a healthy life by the year 2000 A.D. Primary health care became the principal means of achieving this objective. This strategy reordered the priorities in the health sector and moved from a perspective which was dominantly disease-oriented and curative, to one in which the main focus was on the prevention of ill health, the maintenance and promotion of good health and the capacity to resist disease.

2. It has become evident, that health goals defined in these terms, cannot be realised through the services delivered by the health sector alone. They require the combined effort of several other sectors whose activities have a major impact on health. From the inception, the primary health care strategy therefore, recognised that intersectoral action is a vitally important condition for achieving its goals. It identified the main sectoral elements including food and nutrition, waste and sanitation, housing and education. In this approach, improvements in health are perceived as a multisectorial responsibility, in which the main development sectors would need to collaborate with the health sector.

3. The initiatives for intersectoral action that were promoted through the primary health care strategy have had their impact on many aspects of health. However, the experience that has been gained, points to the need for more effective strategies of intersectoral cooperation. While specific programmes and projects for control of diseases as well as community health projects have demonstrated some success in the coordination of sectors for achieving particular goals, it has not yet been possible to develop systems of intersectoral collaboration which effectively take account of and deal with many of the important linkages between health and the programmes and policies of other sectors. There is ample evidence that the neglect of the intersectoral dimension in health can seriously jeopardise the HFA strategy and the realisation of its objectives. Some important constraints to effective intersectoral action for health included the high degree of compartmentalization and separatism in existing governmental structures; tendency of different sectors to compete with each other; the mistaken notion that development is economic growth, resulting in the neglect of the social aspects of development. Intersectoral action can often best be initiated at the grass-roots level where limitations of bureaucratic processes and vested interest are minimal and where the people who are directly affected would be able to mobilize the resources of sectors relevant to their problems.
Preparations for the Technical Discussions

4. The role of intersectoral cooperation in national strategies of Health for All was selected as the subject for Technical Discussions by the Executive Board in May 1984, in order that Member States might address themselves to some of these crucial issues and consider how best they could respond to the challenges that were posed.

5. WHO had already initiated in 1981 a series of studies and research projects designed to enhance the understanding of the interrelationships between development activities and major changes in the health status of the population. These studies analysed the developments in health in several countries and examined how the policies in various sectors interacted and combined to produce significant improvements in the health of the population, in varying socio-economic conditions and at different levels of per capita income. The insights gathered in these studies provided a useful starting point for the preparations that had to be made for the Technical Discussions.

6. Preparatory work included several meetings that were held in developed and developing countries. At these meetings participants from health and other sectors identified important issues for consideration at the Technical Discussions, reviewed some of the past experiences of intersectoral action which contributed to health, and helped to develop the agenda and structure of the Discussions. The background document entitled 'Intersectoral Action for Health' benefitted from all these activities.

7. The preparations for the Technical Discussions also provided a unique opportunity to both enhance the level as well as strengthen the process of intersectoral cooperation. What enhanced the process even more was the co-sponsorship provided by the United Nations Office of the Director-General for Development and International Economic Cooperation, UNEP, UNCHS (Habitat), and IYSH, FAO and UNESCO for the appropriate working groups. This co-sponsorship has involved collaboration with WHO in the preparation of background material, the joint preparation of the operational issues to be discussed, and finally securing the participation of Ministers and high level policy makers representing relevant development sectors. As a result, the Technical Discussions themselves have been organized as a genuine intersectoral dialogue for defining the multi-sectoral responsibility for health, for formulating action-oriented recommendations and for affirming the international, national and sectoral commitments that go with them.

Summary of Discussions and Recommendations

8. The Technical Discussions were held on three mornings of the 7th, 8th and 9th of May. More than 500 people participated, among which were a large number of Ministers of Health and over 40 Ministers and high level decision-makers from areas of critical importance to health and well-being. The meeting commenced with a plenary session. President Léopold Senghor
delivered the key note address. The President spoke at length about the importance of the Alma-Ata Declaration on Primary Health Care and its real meaning in relation to development strategy; its focus on the most vulnerable groups, and its implications for making necessary but difficult choices especially in relation to resource distribution. The President said that, "the strategy for health has acquired new dimensions and brought new promise of deliverance from ill-health and relief from suffering for the disinherited on earth ..... In many ways [it is] one of the richest expressions of efforts made during the '70s to enhance the meaning of development, to take it beyond the exclusive concern with economic growth, and enview it with a deep concern for human well-being in its fullest sense .... Thus, development acquires a human face ....". Thereafter, the background documents were introduced and arrangements for the meeting and the sessions of the working groups described. The plenary was followed by two sessions each of the four working groups. The discussions and recommendations of the groups are summarized below.

**Equity and Health**

**Introduction**

9. The goal of Health for All implies that the resources essential for satisfying health needs should be within the reach of everyone. Equity has therefore to be an overriding concern of the national strategies of Health for All and that requires a strong political commitment. Equity in health however requires equity in development as a whole. Equity-oriented strategies of development have demonstrated remarkable success in improving the health of the population and raising the quality of their life within the constraints and low levels of per capita income. They contain many important lessons. National development strategies need to include elements in all important sectors, which are directed towards the goals of equity and the amelioration of the living conditions of the disadvantaged and poorer social groups. The equity-oriented elements in food and agriculture, health, education, and the development of the physical environment mutually reinforce each other to produce substantial improvements in the health and well-being of the people.

10. These strategies have also to avoid the excessive urban biases that are common to most development strategies. Consequently resources for the social and economic infrastructure and investments in development would be more equitably distributed, without intensifying disparities between the rural and urban living conditions. The political processes should be able to articulate the demands at the community level as well as respond to them. Economic development programmes directed at raising productivity and income in the parts of the economy which contain the poor majority have to receive priority. In most of the equity-oriented strategies that have been implemented, the state and public agencies have assumed an important role in satisfying the basic needs of the people. The national strategies of health for all would have to be an integral part of a development strategy which contains most of this compound of equity-oriented elements and these national and
sectoral commitments to equity. The systems of national planning and decision-making must also enable the health sector to participate actively and play an effective role in the formulation and implementation of the equity oriented development strategy, particularly the health-related components in the development strategies of other sectors.

11. To achieve the goal of Health for All it is essential to reduce the existing inequities in health. One of the principal objectives of the health strategies is the improvement of the health status of the groups which are disadvantaged in terms of health. Both the Alma-Ata Conference and the Strategy for Health for All have given high priority to the needs of those who are most vulnerable and are at greatest risk. Most often these are the groups which are by-passed in the larger processes of social and economic development. In the developing countries these groups include the small farmers with inadequate resources, the landless labour with limited employment opportunities, the illiterate, and the urban poor living in slums and shanties in a poorly served environment. In developed countries the disadvantaged are among the lower social classes, migrants, unemployed, the various categories of the working population exposed to occupational health risks, those at high risk of accident and injury, adolescent victims of lifestyles which intensify health hazards, the ageing populations subject to physical and mental ill-health which seriously degrades the quality of life.

12. These disadvantaged and vulnerable groups are the weak mal-developed parts of the total system available in a society for the care and well-being of its people. They clearly manifest the strengths and weaknesses of existing strategies and policies. It is in these parts that the importance of simultaneous action to satisfy a range of interrelated needs whether they be food and nutrition, water and sanitation, education adn housing are thrown up in sharp relief. For the disadvantaged and vulnerable groups the achievement of health goals depend vitally on the capacity of sectoral programmes, whether they be agriculture, housing, water and sanitation or education, to achieve the goals of equity in their own different spheres. The linkage and interaction of these components of other sectors with health, in a concerned effort at the improvement of the well-being of the disadvantaged become the prime mover in intersectoral action for health.

13. The changes in the health status of these vulnerable groups can then be one of the best criteria for evaluating the effectiveness of health strategies. How the strategies, policies, programmes and activities of the other sectors affect the well-being and health of these groups, is also an important indicator of the quality of the development resulting from the efforts of these sectors. Although the concern for vulnerable groups as the main target of health policies has been forcefully expressed in the HFA strategy, the health problems have been seldom approached through the systematic identification of these groups and the conditions of risk in which they live. Such identification is essential if health strategies are to take account of and deal with the major health risks that originate in other sectors and mobilize the potential of other sectors for the promotion of health.
14. Relevant health-related goals have therefore to be incorporated in the development goals of other sectors, and the health-related components of their policies clearly articulated. This is not only essential at the national level but also must be reflected at the local level. Equity in health can only be fully attained when there is decentralization of power and decision-making. The local community should play a key role in the allocation of resources to meet the goal of equity in health and development and concentrate effort where it is most needed.

15. This approach calls on the health sector to link with other sectors and collaborate with them in incorporating health goals and health criteria into their strategies, policies and programmes. The health sector has to assist other development sectors in monitoring and evaluating the health impact of projects and policies so that negative health effects are anticipated and countered and the positive impact on health is strengthened and improved. Under all circumstances it is important that decisions are taken with full knowledge of any short-term trade-offs between health and other goals and that compensatory action needed is clearly stated. In all these actions, the impact on vulnerable groups must receive specific attention. The implementation of such a strategy would require changes in institutional arrangements and training and reorientation of relevant cadres, especially as a resource which is critically scarce is the skill for coordination and administration of intersectoral action.

16. While the Alma-Ata declaration formalized political commitment to equity and health, the competing pressures within ministries of health have often impeded the fulfilment of this commitment. Resources are expended for sophisticated equipment with imported components and for projects serving a small but powerful part of the population at the expense of insuring full access to basic health care of the majority. While it is recognized by the PHC strategy that this pattern of expenditures leads to inequitable distribution of health care and inappropriate use of scarce resources, it remains a prevalent pattern in many of the developed and developing countries. It is clearly necessary to have a balanced allocation of resources so as to ensure that those resources are used where they will have the most beneficial effect for the largest number of people at the lowest cost. Equitable and cost-effective use of resources within the health sector is a necessary condition for equity and health in the broader context of social development.

17. The overall amount of resources available for health and equity related programmes depends very much on the economic environment and constraints that confront decision-makers at the national level. The economic crisis and the enormous debt burden facing developing countries have led to the adoption of restrictive adjustment policies. By compressing effective demand and by allocating more resources to export-oriented sectors, such policies result in additional pressures on central government. In many cases, no safeguard has been specified for social expenditures and the social sector becomes almost 'naturally' the first
casualty of adjustment. Adjustment decisions should not produce a negative impact on equity and health. The health status of the vulnerable groups should be a fundamental criterion in the analysis of alternative policies.

18. Concerted action is urgently needed at the international level in order to provide a more supportive environment to the efforts of developing countries in the area of social development. When designing adjustment policies there has to be a clear recognition of their effect on the health and nutrition of children and other vulnerable groups, particularly the poor. The burdens of adjustment would have to be distributed equitably within countries. This requires a thorough analysis of the different components of adjustment policies such as those which have an impact on the pricing and imports of goods which are related to health needs, or budgetary cuts on the health sector and health-related services. The response to the austerities of adjustment has to be two-fold. First the goals of adjustment policy should incorporate a specific concern and commitment to the protection of minimum levels of health and nutrition for the most vulnerable social groups. Policy-makers would have to examine how these special considerations could be taken into account without jeopardising the main objectives of economic recovery. Second, in the face of severe financial constraints, the health sector can pursue the optimal cost-effective strategies in which there is a further strengthening of the PHC approach, and in which the health-related resources and contributions by other sectors are fully mobilized through effective intersectoral cooperation.

Recommendations

19. To realize these goals, the following recommendations are put forth. They reflect the need for action at different levels and of differing scope. Actions are recommended at the local and national levels focusing on management and training requirements. Actions are also recommended for reorientation within the health sector and between sectors, and special attention is given to actions required by the international community.

The country level

1. Member governments should ensure that economic adjustment policies, and macroeconomic policies generally take into account their implications for the health and nutritional conditions of the population and incorporate a specific concern for and commitment to the protection of minimum levels of health and nutrition of the most vulnerable social groups. Such a commitment should include principles which guide the allocation of sufficient resources to the social sectors so as not to erode the social base for development.
2. Member governments should develop and strengthen the institutional mechanisms and decision-making processes to ensure that health and other sectors collaborate in identifying how the policies of those other sectors impact on health, in identifying health goals and health criteria into their policies and programmes, and in undertaking a systematic health impact analysis and monitoring of the major development projects of those sectors.

3. Member countries should take action to ensure that the national strategies of Health for All are developed and implemented as an integral part of an equity-oriented development strategy in which all main development sectors identify and define their equity-oriented components. The systems of planning and decision-making should enable the health sector to collaborate with other sectors in formulating and implementing such strategies, and in carrying out the necessary institutional improvements at the national, sectoral, and local levels for that purpose.

4. Member governments should clearly identify the vulnerable groups in their societies based on a profile of the existing disparities in health between those groups and the general population. Countries should seek to identify the social and economic conditions which relate to the greater health risk of those groups. Health and other sectors jointly should set targets for improving the health and well-being of those groups. Progress in achieving these targets should be monitored by the health and other sectors and such progress should be used as an indicator in evaluating the quality of national development.

5. Member governments should undertake the reorientation and training of planners, professionals and workers at the appropriate levels with the participation of the health sector to develop the methodologies and skills to assess the implications of their actions on health goals. Member governments should ensure as well that the training of health workers at all levels includes knowledge and skills for coordination and administration of intersectoral action for the realization of health goals.

6. Member governments also should seek to ensure that the training of health professions includes a population-based epidemiological approach and that the planning of health workers be aimed at producing the numbers and kinds of health workers which reflect the needs of a health care system based on PHC and the Health for All goals.

7. Member governments, in pursuit of equity in health, should emphasize, through the PHC strategy, access of all of the population to the health service system and the structuring of that system to ensure that the highest possible care is available to the largest number of beneficiaries at the lowest possible cost. Governments should
make a greater effort at reducing resource allocation to high-cost technologies which serve small segments of the population, particularly during the current economic crisis.

8. Member governments should give greater attention to the decentralization of the health effort including planning, staffing, managing and, where possible without impinging on the goal of equity, funding at the local level. They should seek the involvement of the community in the entire process shifting to a concentration on basic sanitation, education, preventive medicine and environmental protection, along with a balanced system of health services.

The International Community

1. In the design and implementation of adjustment policies, international financial agencies should recognize the health and nutritional status of the population as an important factor and should ensure the protection of minimum levels of health and nutrition of the most vulnerable social groups.

2. Multilateral and bilateral donor agencies should support countries undergoing severe adjustments to their economies in order to avoid adverse impact on the health conditions of the population and particularly to support programmes designed to protect the minimum levels of health and nutrition of vulnerable social groups.

3. Multilateral and bilateral donor agencies should provide direct support to countries for studies of the intersectoral linkages to health for training of personnel in the process of analysing intersectoral impact on health and for intersectoral projects themselves aimed at improving the health and well-being of the population.

4. Multilateral and bilateral donor agencies should incorporate health impact analyses into their feasibility studies of industrial, agriculture, public works and other projects and undertake the necessary adjustments based on the results of those studies to avoid adverse health impact or include the funding necessary for complementary actions to avoid the potential adverse health impact.

5. Multilateral and bilateral donor agencies should support the strengthening of national development planning mechanisms to ensure more adequate consideration of the health impact of global economic, industrial, agricultural, public works and other sectoral policies and projects.
World Health Organization

1. WHO should ensure that the component of equity is included where appropriate in all its programmes. Intersectoral action efforts should be based on these Technical Discussions and experiences already available in WHO and member countries. Collected information should be analysed and lessons drawn and widely disseminated. Moreover special studies should be undertaken on the essential linkages between the social sectors and the rest of the economy. The process of allocation of resources should be particularly analysed in relation to intersectoral action for equity in health.

2. WHO, at all levels, and other sponsoring agencies of the Technical Discussions, should support collaborative actions by health and other sectors in member countries to study intersectoral linkages to health, to train personnel in the various sectors of government in the intersectoral aspect of health, and to carry out intersectoral cooperative efforts aimed at improving the health of the population, with specific concern for the vulnerable groups.

3. WHO, at all levels, and other sponsoring agencies of the Technical Discussions, should support efforts to identify vulnerable groups in the population based on indicators of their health status and support countries in their monitoring of changes in those conditions over time.

4. The Director-General, and other sponsoring agencies, should communicate to the International Monetary Fund and other international financial institutions the conclusions and recommendations of the Technical Discussions, particularly with respect to the need for economic adjustment policies to take into account their potential impact on the health of the population and for those policies to incorporate a specific concern for and commitment to the protection of minimum levels of health and nutrition for vulnerable groups.

5. The Director-General, and other sponsoring agencies, should communicate to the World Bank and other multilateral development financing institutions the conclusions and recommendations of the Technical Discussions, particularly with respect to the inclusion of health impact analyses in all feasibility studies accompanying agricultural, industrial, public works and other projects.

6. The Director-General, and other sponsoring agencies, should strengthen relations with other international organizations for the promotion of intersectoral actions to improve equity in health.
7. The Regional Directors of WHO should communicate to the respective multilateral development financing institutions within each region the conclusions and recommendations of the Technical Discussions, urge support for intersectoral action at the country level, and urge the inclusion of health impact analyses by those institutions in the feasibility studies of their industrial, agricultural, public works and other projects.

Agriculture - Food and Nutrition

Introduction

20. Today's world is characterized by huge food surpluses in some areas, while many needy countries are not in a position either to produce or to buy the food their populations need. At the same time, developing countries, whose income is mostly from agriculture, cannot find the markets they need to sell their own produce. The result is that poverty continues to affect large masses of rural populations who are deprived of basic services, thus contributing to the unplanned exodus towards cities, and increasing illness, malnutrition and misery. However, some developing countries are providing evidence that development with equity is possible through examples of successful intersectoral cooperation in the pursuit of social goals. Developed countries are also improving intersectoral coordination between health, agriculture and consumers.

21. Various types of institutions at central and peripheral levels are active in trying to ensure that due attention is given to the nutritional and, ultimately, health needs of populations. Special attention should be paid to meeting the needs of vulnerable groups, especially those of women and children under five years of age, the former representing 50-60% of the total agricultural labour force. Suitable technologies should be made available to small farmers in order to increase productivity and income. To this end, however, agricultural development strategies should ensure that the energy needs of the entire labour force, male and female, are fully met.

Policy and situational analysis

22. Logically, one should proceed with policy analysis and planning in health and agriculture in an integrated manner in advance of discussing the promotion of economic growth and the promotion of health through agriculture.

23. A joint diagnosis of the global, regional and national food and nutrition situation should be undertaken by the health and agriculture sectors. Particular emphasis should be placed on the local level with the involvement and participation of the population concerned. Such analyses are too often undertaken, if at all, from the perspective of only one of the two sectors.
24. Monitoring of the food and nutrition situation should be a continuing endeavour based on a permanent, effective interaction between the agriculture and health sectors. In this context, the relationship between dietary intake and disease should be assessed on a national and local basis for different socioeconomic groups.

Equity-oriented strategies

25. Policy makers should routinely take into consideration the interaction between agriculture and health, especially during the planning process. Health and nutrition goals should be stated explicitly as part of the objectives of the plans drawn up for both sectors.

26. In considering the interaction between agriculture and health, a number of basic principles should be borne in mind:

(a) equity and the fair distribution of goods and services, especially to targeted groups;

(b) the effects of different agricultural and other development policies on vulnerable groups, for example, women, children, the rural poor, refugees, etc., should be given primary attention. Landless farm labourers form a group at greatest risk; labour-saving techniques, by increasing productivity could also increase their number. Agricultural development strategies should, therefore, promote employment as well as food availability and security;

(c) the incorporation of food and nutrition activities in the implementation of the Strategy for Health for All by the Year 2000 through the primary health care approach.

Building national capability

27. Mechanisms, organs and frameworks, through which intersectoral action for health can take place, should be defined and organized. There should be political support for these at the highest level, and involvement and responsibility of the populations concerned at the local level of operations.

28. Government institutions and technical mechanisms are required that will enable health to influence agricultural policy making, especially on the basis of equity-oriented criteria, and to assess the health outcomes of agricultural strategies. Those countries that do have intersectoral mechanisms bringing together health and agriculture, e.g. national food and nutrition councils, can build on these to extend their policy mandate to cover the broader intersectoral issues identified in this report. Specifically, they could ensure the incorporation of a health impact analysis into the agricultural planning and policy development process, as well as in the allocation of resources.
29. Appropriate methodology and expertise are required to permit the systematic assessment of the nutritional and health impact of national agricultural policies. This includes improving approaches to nutritional surveillance, surveys of health and agricultural conditions, and making use of more relevant data collection schemes and analysis procedures. This will require an enhancement of the skills and knowledge of the responsible staff from the two sectors.

30. Decentralization is an essential feature of improved planning, coordination and implementation at intermediate and local levels. In developing countries, the focus of action could be an agricultural-based rural development strategy which would bring together related concerns such as increased employment opportunity, food security, delivery of services and occupational work safety. This would facilitate constructive dialogue, the sharing of information, and the preparation and coordinated execution of a common plan.

31. The identification of problems at the grass-roots level, with priority given to vulnerable groups and areas, is critical to the process of integrated planning and action. It is important that those persons who work at the periphery representing their respective sectors are able to identify problems and understand how they interrelate. Their training and supervision will have to be oriented accordingly.

32. An essential feature of the process outlined above is education of the public to improve awareness of health matters and to enhance their individual and collective abilities to participate actively in problem analysis and the design and implementation of interventions. Particular emphasis should be given to extending communication, education and information to the rural poor in a form which proves practical and understandable to them. Front-line health and agricultural workers should be involved in this process, through the use of low-cost non-formal educational techniques.

A. Recommendations - National level

1. Governments should formulate comprehensive agriculture and health policies, covering all aspects of human and natural resources development, which are actively supported by coherent strategies that have been prepared in this light by each relevant sector:

   (a) undertaking joint diagnosis of food and nutrition from agricultural and health points of view;
   (b) explicitly stating health goals in agricultural development plans, particularly in instances of economic difficulties;
   (c) keeping in mind issues of equity and the needs of identified target groups, particularly women;
   (d) paying special attention to the specific areas identified in the technical discussions, as they may be relevant in particular country situations.
2. Setting up the mechanism/forum for effecting intersectoral action for health on a continuing day-to-day basis:

(a) designing the overall mechanism (citing roles of governments and relevant professional, commercial/industrial systems and structures);
(b) designing the integrated framework for viewing the relationship between the various sectors and health;
(c) setting up the specialized entity to serve as centre (deciding where it should be located, e.g. in central planning, health or agriculture;
(d) rallying support at all levels.

3. Building up national technical capability:

(a) data base development, setting up monitoring systems;
(b) analytical tools to better appreciate impact on health of various actions in agriculture;
(c) training, both at the policy analysis and extension worker level;
(d) research.

4. Agriculture priority actions

In order for agriculture to contribute more effectively to health and welfare, particular consideration should be given to:

(a) improving access to land and essential inputs and services, especially health and education;
(b) maximizing land use and improving product mix;
(c) promoting production and use of traditional crops for ensuring food security and generating income;
(d) pursuing equitable farm price policies as well as producer subsidies in order to bring about an increase in food production and income. Consumer subsidies could be useful in encouraging increased demand, especially in urban areas, but their unbridled use could be counterproductive by serving as a disincentive for local production;
(e) selecting technology that is appropriate for particular sociocultural and economic environments;
(f) developing and using crops that can be grown on marginal lands and improved strains of plants, especially through transfer to developing countries of biotechnology and genetic engineering under appropriate, internationally agreed guidelines;
(g) striking a balance between food- and cash-crop production and production for local vs. export markets. Farmers should be guided in this regard by appropriate extension services;
(h) reducing food losses due to spoilage, contamination and rodents;
(i) increasing food safety, which should be considered in the context of food processing in all countries;
(j) routine fortification of suitable foods, which merits consideration as an important means of avoiding subclinical nutritional deficiencies;
(k) continued development of international food quality standards, which contribute not only to improved nutrition but facilitate the movement of commodities between and among countries;
(l) the positive impact on development for and by the rural poor, and on their nutritional status, of carefully planned and executed food aid programmes.

5. Monitoring nutritional status

Systems for monitoring nutritional status should be established in all countries as a reliable basis for policy- and decision-making. The systems should have the technical and administrative capacity, in addition to the political visibility, that will enable them to stimulate prompt policy and programme responses to nutrition situations as they are being diagnosed.

The relationship between dietary intake and disease should be assessed at national, regional and local levels according to socioeconomic group.

6. The impact of food aid

The role of food aid programmes should be carefully analysed at individual country and project levels in order to assess more accurately the positive and negative effects of this aid on socioeconomic development, human welfare, food production, and possible changes in dietary practices that may be introduced as a result.

A world nutrition map, which accurately defines and positions dietary traditions, patterns and needs, should be prepared as a means to guide those who provide food aid in the choice of appropriate commodities for a given country or region.

B. Recommendations - International level

Economic adjustment policies:

The world economic recession has had a particularly negative impact on health and nutrition in a number of ways, including through a reduction in health sector budgets and a reduction, if not outright suppression, of consumer food subsidies in
many developing countries. At this most critical of times for the health and nutritional status of much of the world's poor, therefore, international lending institutions should also be guided by explicit health and nutrition concerns in the formulation and application of their economic adjustment policies on behalf of debtor nations.

**International intersectoral action:**

Intersectoral action should lead to fully integrated approaches where the activities of international multilateral and bilateral development agencies are concerned in order to minimize for countries those difficulties often associated with absorbing the varying types and amounts of technical and financial support that is being made available to them.

Governments, on the other hand, should exchange information and know-how on agriculture-related health development, in the spirit of TCDC.

**International information exchange:**

(a) inter-country sharing of experiences and technical resources;
(b) international forum/network for sharing country experiences as well as specialized research studies done by, or available to, international organizations;
(c) provision by such international/specialized agencies such as FAO and WHO of:
   (i) checklist of critical data needs for better understanding of impact of agriculture on health;
   (ii) copies of simple analytical tools/quantitative methods which can be easily applied, given current data availabilities (i.e., anticipated data gaps).

**Education - Culture, Information and Life Patterns**

33. Education is a decisive factor in health improvement. Even a few years of school provide basic skills and capacities that can make a vital difference to the continuing acquisition of knowledge, and an individual's ability to deal with life situations and respond to a changing environment. Poor countries which have given priority to investments in education have lowered mortality levels far below those of countries with higher per capita incomes but less educated populations. In situations where survival is a major health problem and where female literacy is low, female education both formal and non-formal have lead to substantial improvements in the health of the population.
34. The educational goals accepted throughout the world of universalization of primary education and the eradication of illiteracy directly support Health for All. It is now well documented that there is a direct correlation between educational achievement and health status.

**Recommendation 1**

Universal primary education should be recognized as an essential ingredient to the achievement of health for all. Educational personnel should be aware that their effort to expand access to education will have a long lasting benefit on the health of the community. Conversely, efforts of health personnel to improve community health status will lead to increases in educational efficiency.

35. In view of the fact that primary education often by-passes a considerable proportion of the adult population who have had no schooling and are illiterate, a number of countries are making intensive efforts at expanding and improving the quality of functional literacy and other non-formal educational programmes. Many of these programmes provide scope for imparting knowledge, information and skills vital for the improvement of nutrition, health and the quality of life.

**Recommendation 2**

The health sector should support other sectors in their efforts to integrate education for health with non-formal education programmes. Particular emphasis should be placed on literacy programmes for vulnerable groups. Functional literacy can be thought at the same time as health and nutrition thereby creating more effective educational systems.

36. The school could assure a place of prime importance in health promotion and service delivery.
Recommendation 3

Education and health personnel should act jointly to strengthen the school as a focal point for health education and health service delivery. Such joint action should include teacher training, the incorporation of locally relevant health teaching/learning in school curricula, school meals and the strengthening of school health services and health monitoring systems.

37. If schools are to be used successfully as vehicles for health promotion, supportive activities need to be carried out by families and community organizations i.e., women and religious groups.

38. Those in the education sector should make available the state of the art education and communication technologies that can be utilized to promote health.

39. A prerequisite for effective intersectoral co-operation for health is an adequately and motivated professional cadre in all health-related sectors who have acquired the necessary interdisciplinary skills and knowledge to identify the links between health and other development sectors. The manpower development and training required for intrasectoral cooperation emphasized call for new perspectives and reorientations in education and training at all levels. In the field of professional training and higher learning the educational sector has an important role to play in adapting the curricula and imparting a core of interdisciplinary knowledge which enhances the understanding of the intersectoral linkages in development and the capacity of specialties to communicate with each other. Knowledge, training and skill which are specific to intersectoral action must be imparted to workers at all the appropriate levels in the health sector and other health related sectors with inputs from each of the relevant sectors.

Recommendation 4

Countries should develop the programmes of education and training to produce the professional and other cadres at all appropriate levels, who will have the necessary interdisciplinary approaches, knowledge and skills which are required for the formulation and implementation of intersectoral strategies and programmes for development. These programmes should include curricula changes and innovations at the level of higher education, as well as training and reorientation of workers in health and health-related sectors.
40. Intersectoral programme committees composed of education and health decision-makers could be organized to plan joint activities. Such committees could begin by analysing existing efforts in education and health in terms of their relevance for joint programming. Collaboration at the programme level need to be reinforced with collaboration at the levels of training, implementation and evaluation.

41. Health professions' student organizations are also important to health promotion. Today's students are the decision-makers of tomorrow and thus their early involvement in their education which should be community-oriented. Non-governmental organizations and consumer groups can also be vehicles for promoting health. Many such groups have been able to spread health-related messages in a forceful manner.

42. Some important constraints to effective intersectoral action for health included the high degree of compartmentalization and separatism in existing governmental structures; tendency of different sectors to compete with each other; the mistaken notion that development is economic growth, resulting in the neglect of the social aspects of development. Intersectoral action can often best be initiated at the grass roots level where limitations of bureaucratic processes and vested interest are minimal and where the people who are directly affected would be able to mobilize the resources of sectors relevant to their problems.

43. Socio-cultural factors have a pervasive and far-reaching impact on health. Health programmes often fail to realise their objectives when these factors are neglected or ignored. In developing countries, traditional knowledge, beliefs, values and cultural practices concerning health and especially nutrition continuously interact with modern health services. The health sector needs to develop approaches which can draw on the health protective and health promoting elements of the traditional culture and value systems; while removing cultural practices that are harmful to health. In the developed countries, health and ill-health are closely linked with individual behaviour, life-styles and continuous changes in social institutions such as the family and value systems governing them. Major health risks stem from overconsumption of certain foods, the stresses of work and life styles, family situations, sexual permissiveness, addictions to alcohol, tobacco and drugs.

44. In regard to culture-related health problems, vulnerable groups requiring special attention are the adolescents, women and the elderly. These health problems require strategies which combine the wide dissemination of knowledge and information on health hazards. Such strategies require intersectoral action on a wide front, with education and information playing a major role and all the major representatives from the relevant sectors collaborating in the effort. Using situations and processes which touch people's lives, health messages can produce the necessary impact by enhancing knowledge and changing attitudes and values. These educational efforts must be linked with the non-formal and functional education programmes discussed earlier.
45. Human rights, ethics and cultural dimensions of health are neglected areas and when included in the training programmes of health providers ensure better understanding and services.

46. Overcoming cultural barriers need a strong political will and for this the support of willing opinion leaders, such as older people, traditional healers, religious and political leaders is important.

**Recommendation 5**

Health strategies in both developed and developing countries should take account of the pervasive impact of the socio-cultural factors affecting health, identify the major culture-related health problems, and strengthen the efforts at information retention of positive cultural values, education and value formation needed to promote the required changes in health behaviour, values and life styles. Special attention has to be paid to the groups which are vulnerable to these culture-linked health hazards, such as the adolescents, the elderly, the illiterate, the disadvantaged groups especially women and the culturally isolated groups.

47. The mass media are playing an increasingly important role in disseminating knowledge and information influencing health behaviour and promoting life-styles which have both positive as well as negative implications for health. Printed media and television while effective have their limitations in terms of outreach in developing countries. There are however other forms of communications which are practical, affordable, and generally appreciated such as creative arts, folk songs, dances, mime, travelling theatres, puppetry and community focused discussions which can be equally effective in conveying health messages. The health sector will need to make fuller use of this immense potential of the media to communicate health messages and influence health-related behaviour. The media will have to become more conscious of their responsibility for raising awareness, increasing health knowledge, and articulating public needs in the field of health and social development. Basic to the promotion of such partnership between the media and the health sector is a strong political will which fosters equity in information dissemination and a mutual appreciation of each others role.

48. Communities are being flooded with information from different development sectors sometimes with conflicting and competing messages usually couched in technical and bureaucrat jargon rarely understood by the public. Some countries have attempted to bridge this problem through the creation of mechanisms such as "listener-viewer-reader groups" which serve as fora for discussions and disgestion of information received and for follow-up actions as needed.
49. Health as a subject matter for media is not attractive and not sensational. The media therefore will have to be more innovative and imaginative in communicating health messages. In this respect, there is a need for both media and health personnel to learn to work harmoniously with each other based on the mutual appreciation of each others' concerns and problems. This would need familiarization of media personnel on health matters, and for the orientation of health personnel in the use of media and in communicating to them their ideas.

Recommendation 6

A close and systematic collaboration and partnership between the health sector and mass media should be promoted to make full use of the potential of the media for increasing public awareness concerning health and promoting desired changes in health-related behaviour. Health and media personnel should be oriented and trained for such collaboration. Communications experts should ensure that mass media health messages effectively reach the local community and vulnerable groups.

Water and sanitation, habitat and industry

50. Two common focuses united all the discussion and the recommendations which arose out of these discussion.

51. The first was the recognition that the ultimate goal of development is improved quality of life and improved well-being for entire national populations. Growth in production and productivity which requires the rational use of natural resources is not an end in itself but rather a means of achieving a stronger economic base from which to promote improved quality of life and well-being. And there is little point in discussing 'intersectoral cooperation' in the abstract as the discussion of this is about intersectoral action to improve health.

52. The working group recognized the need to develop a quality of life index which would help bind together the sectoral inputs of the different agencies and ministries in seeking to improve health and well-being.
Recommendation

The UN agencies are requested to further develop a quality of life index and to ensure that it takes account not only of classical biostatistical indicators but also of elements such as environment, habitat, educational status, employment/income, food supply and other aspects within the competence of the various agencies. Indicators can be included to measure the degree of people's access to social and physical services. Efforts should be made first to produce a provisional index, test its use and utility in selected countries, and then produce a revised version in the light of field testing.

53. The second focus was the need for governments and international agencies to give priority to meeting the needs of poorer groups. Within the poor, there are groups which are particularly vulnerable or whose needs conventional programmes often miss. These include women-headed households, abandoned children, older people and handicapped people. One should recall that around one billion people are living in absolute poverty, i.e. one person in five in the entire world. These are the ones with the poorest housing conditions, the worst access to piped water, sanitation, health care and education. An increasing proportion are living in urban areas. These also include people who are especially threatened by disasters. For instance, in many cities, squatter settlements grow up on lands subject to flooding or landslides because this is the only land close to the city from which they will not be immediately evicted. The worse the environmental quality of the land they build on, the less likely their forceful eviction.

54. But in discussing these two focuses, we must be realistic. Financial resources allocated to health and environment have been limited, especially during the present economic recession and the decline in the availability of soft loans and untied aid. There are three areas of common concern with regard to constraints:

55. The first is the acknowledgement that a step-by-step approach with each step targeted to the poorer and more vulnerable groups is essential. Careful intersectoral coordination can increase the impact on health and well-being of limited resources.

56. The second is the lack of skills and trained personnel, especially at local government level and in the area of intersectoral action and collaboration.

57. The third is the small proportion of funds devoted by national governments and international agencies to projects and programmes which directly reach lower income groups with improved housing and living conditions and access to basic social and physical services.
58. The plans and programmes of all important government ministries and agencies impact on the environment - including people's living and working environment. As such, they frequently have a major impact on people's health status. Ministries or agencies concerned with housing, public works, urban and regional planning and environmental protection all have important roles to play in helping to improve people's health status, especially the health status of the poorer and more vulnerable groups. Yet most countries have to develop first the understanding among each sectoral agency or ministry as to their role in improving health status and secondly the planning and administrative systems for managing inter-ministry or inter-agency cooperation in implementation. International agencies also often lack an understanding of the need for intersectoral action to improve health and of how to operationalize it.

**Recommendation**

Countries should identify the role of each sectoral ministry or agency in improving health, and seek the most appropriate institutional mechanism for coordinating sectoral action. International agencies have a major role both to advise and support national intersectoral action and to support regional and national discussions as to how best this is achieved. International agencies must also improve their own intersectoral coordination.

59. The environmental and health problems of the poorer groups demand special attention. Special mention should be made of landless labourers and the poorest farmers in rural areas and those living in rundown tenements or shanty towns in urban areas. The poorest groups usually face the most critical environmental problems in terms of impact on health since they have no alternative but to live in the most dangerous areas and exploit the more dangerous income earning opportunities. It is the poorer groups which are disadvantaged in terms of water and sanitation. In cities, the poorer groups are disadvantaged in terms of garbage disposal. The effort to design and implement cost effective services for rural and urban poor must be further strengthened and intensified. Technologies which make best use of local resources and are adapted for conditions of scarcity should be further developed and applied.
Recommendation

Governments should renew and strengthen the collaboration between the health sector and both national and local authorities responsible for air and water quality, sanitation and the disposal of domestic and industrial waste. This is a critical part of achieving targets set by the International Drinking Water Supply and Sanitation Decade, recognizing that 'water and sanitation' for all must form a critical part of the strategy of 'Health for all'. Three elements should be given special attention: the socio-cultural factors related to the use and maintenance of these services; the provision of services to groups most vulnerable to health risks among the rural and urban poor; and the development and application of appropriate cost-effective technologies and systems to manage them which maximize local control and local resource use and promote equitable access to these services.

60. The physical environment for health begins with the house and its immediate surrounds; it is here where health risks are manifold. In the housing of the rural and urban poor in Third World nations, these health hazards stem from factors relating to the poor quality of the structure and materials, unsatisfactory design and inadequate space, and poor quality sites which are often subject to natural disasters (for example floods or landslides) and are frequently poorly drained. Among the health hazards associated with housing of poor quality are vector borne diseases, respiratory infections (especially those relating to indoor air pollution from fires or stoves) and diarrhoeal diseases. Health problems linked to housing are also prevalent in different forms in developed countries. Examples of unhealthy housing can be found in rich industrial countries of Europe and North America and include housing that is both old and new. New technologies in housing also seem to generate new health risks.
Recommendation

The health agencies and agencies responsible for housing, public works and physical planning should collaborate in identifying the health related component of programmes to upgrade housing, especially those of lower income groups, and then formulate and implement intersectoral programmes to address health needs. The housing of the rural poor and urban poor living in tenements, cheap boarding houses and squatter settlements are especially disadvantaged and their health problems related to their physical environment deserve special attention. Governments should pay special attention to the problems of indoor air pollution arising from stoves and open fires: these problems impinge most heavily on women and children. For those living in illegal settlements, secure tenure must be considered since insecure tenure means little motivation on the part of the inhabitants to improve their own housing quality and work together to improve the neighbourhood.

61. The norms and codes which set standards for land use planning, building, air and water quality, and infrastructure often have adverse effects on health because they demand what is unrealistic or unattainable or what is impossible to monitor. But they can be more effective in their task of promoting health and safety if they are implemented as much through the provision of advice and technical assistance as through enforcement.

Recommendation

Countries should review existing codes and regulations on the built environment to see how their emphasis can be changed to give advice, support and technical assistance to lower income groups managing the construction of their own houses to ensure basic health and safety standards are met. In addition, governments should assess the extent to which improved health and safety standards in other areas might be raised through educational material, technical advice and incentives.

62. Most new housing units and most improvements to housing in the Third World are organized by the people themselves. They do so at little or no cost to governments. And in doing so, they contribute considerably to capital formation and their activities have many multiplier links with the other areas of production. But individuals and the community groups through
which they often work cannot solve many of their health problems, especially those related to the provision of infrastructure and services and the acquisition of legal, safe, affordable land sites in cities.

**Recommendation**

Countries should note the beneficial impact on health and on improving housing conditions achieved by governments who move their housing policies from those which seek to 'build houses for the poor' to one which supports the efforts of people and their community groups to build for themselves. Within this, governments role is more to ensure resources for building such as land, building materials and credit are cheap and easily available and that infrastructure and services are available to the houses and neighbourhoods that the poor build for themselves. This should be undertaken in both rural and urban areas with programmes and projects formulated, implemented and monitored with the full collaboration of representatives of local inhabitants. The enormous potential of community groups and of the NGOs or Private Voluntary Organizations who work with them should also be enhanced.

63. Although a considerable amount can be achieved in improving health through well focused sectoral action and inter-sectoral cooperation, sustained improvements demand both more resources and more effective implementation. The critical role of local government both as the articulator and representative of local needs, as a possible mobilizer of local resource and as a coordinator of sectoral inputs is given too little attention.

**Recommendation**

Governments should review the extent to which local government has the power, resources and trained personnel to allow it to play a major developmental role as articulator of local needs up to higher levels of government, as mobilizer of local resources, as coordinator of the inputs of the many sectoral agencies seeking to improve health, and as manager of much newly installed equipment and services. Councils of experts can provide much needed technical advice.
64. Both governments and international agencies give a relatively low priority to projects and programmes such as water supply, sanitation, upgrading of slums and shanty towns, primary health care and the supply of cheap resources for housing construction or improvement. Yet these are the projects and programmes which collectively can have the most dramatic impact on the health status of the population, especially the poorer and more vulnerable groups. The international agencies have a responsibility both to seek to increase the proportion of aid and technical assistance to all sectoral agencies and ministries whose work impinges on improving health status, especially for the lower income groups, and to helping with the integration of their actions into well coordinated intersectoral programmes and projects.

**Recommendation**

Governments and international agencies should give a higher priority to sectoral projects and programmes and to their coordination which seek directly to improve health status, especially for poorer and more vulnerable groups. International aid agencies should also be encouraged to incorporate the quality of life index - revised and improved as experience with its use is gained - in their project appraisal criteria, so that health benefits are incorporated into cost benefit analyses and other cost effectiveness or pre-investment analyses.

65. Since we lack an understanding of the most effective interventions by different sectoral agencies and ministries in improving health status and of the best combinations with coordinated action between these different agencies and ministries, monitoring systems should be set up. This would serve the double function first of assessing the effectiveness of new initiatives and secondly of monitoring the impact of existing projects and programmes on health and the environment.
Recommendation

Projects and policies for development and management of natural resources should be subject to systematic appraisal. These initiatives should be organized to create a sustained 'watch' on the environment-health linkage both to appraise new initiatives to improve health and to monitor health impacts of programmes and projects with potentially high health risks.

This meeting calls on WHO, UNEP, Habitat and other related organizations to cooperate to develop simple, easy to apply cost benefit and cost effectiveness methodologies to evaluate the positive role of health and environmental protection in strategies, policies and programmes to promote growth in productivity and production.

The meeting invites a limited number of countries - who are prepared and willing to do so - to test such methodologies in their ongoing and/or planned health and environmental protection activities.

66. In most nations, intersectoral action has already contributed to the protection of the health of workers through occupational health programmes in which the state and trade unions each play a role. However, there is abundant evidence to show that many people, including women and children, work without that protection in a working environment which can be seriously detrimental to health. This is particularly true of unregistered industries or home-based enterprises which comprise what has been described as the informal sector.

67. The approach to improving health conditions in these kinds of enterprises has to be through working with the people running them - perhaps through local business organizations or through informal discussions between local social and environmental health workers. Training and technical advice to these small, informal enterprises will have a more beneficial impact than any attempt to impose standards through factory inspectorates.
Recommendation

Countries should promote systematic collaboration between local government health and social workers and those working in the informal sector to see how health and safety standards can be improved through collaboration between employers, employees and local government. Such efforts should combine education in occupational health, training, extension services, and appropriate supervisory and regulatory measures, and bring together representatives of trade unions, employers' associations and local government.

68. A critical part of training is the training of local health workers - at village or sub-district level. These are the people who can most clearly assess needs and advise on the best means of addressing these needs - with appropriate technical advice from central agency staff. They are also a critical part of the monitoring process to see whether implementation actually succeeds in meeting the most urgent needs and improving health.

Recommendation

Governments can better understand grassroots needs and better support grassroots efforts if health workers and social workers are located within the villages and sub-districts in cities. In addition, the work of professionals is made much easier if local community leaders' help and support are elicited in formulation, implementation and monitoring of projects and programmes.

69. Carefully designed and implemented public works programmes maximizing use of local labour and local resources and minimizing capital equipment can create much needed jobs, promote environmental management (for instance through watershed management or reforestation being included in such programmes) and promote improvements in health.
Recommendation

Governments should aid local authorities in coming up with public works programmes to promote health, increase production and safeguard environment with capital costs minimized and use of local labour and local resources maximized. When integrated with wider social and economic development programmes and projects, these can help retain rural population in rural areas and slow the exodus to the cities, particularly of young persons.

Approaches

Issue 1 - Meeting essential needs

Actions by governments across a broad front, aimed at meeting the basic, essential needs of their populations can make a major contribution to health and well-being. The following are recommended as important approaches in implementing such actions.

- Emphasis should be given to identifying the needs of the most disadvantaged groups and the formulation of strategies aimed at eliminating or reducing their most important health and environmental risks.

- Voluntary non-government organizations should be involved in meeting essential needs because of their skills and experience in working at the interface between government and communities and their areas of involvement which often transcend many sectors.

- Integrated rural development programmes which can combine employment creation, increased economic growth, establishment of infrastructure and improved living conditions are examples of successful approaches to intersectoral action for health.

Issue 2 - Shelter provision or improvement

- Governments should carry out reforms in land use planning and provide land with secure tenure, as well as technical, material and financial assistance to the most disadvantaged groups of the population in order to facilitate an acceleration in improvement of living accommodation.
Planning for increased provision of shelter should emphasize the use of safe, locally available materials, and housing designs, whilst within the reach of the underprivileged, should incorporate safety features which will eliminate important health risks such as unguarded or smoke producing cooking stoves. Low quality housing is often correlated with the prevalence of serious endemic conditions, e.g., Chagas' disease.

- Simple, affordable, appropriate technologies for cooking, heating, water supply, waste disposal, etc., should be introduced whenever feasible.

- In view of the high capital cost of developing a healthy physical environment, WHO should seek new sources of financial assistance, including the private sector.

**Issue 3 - Management of natural resources**

- Decentralization of decision-making backed up with legal and technical support, as well as community mobilisation, is an important means of ensuring the safe and sustained utilisation of natural resources.

- Methodologies and mechanisms for the integrated assessment, prediction and monitoring of the impact of economic development activities on health and the environment should be developed and used as important levers both to minimize damaging effects as well as to assist in raising health, environment and social well-being in the order of priorities for allocation of government budgets.

- Intensified intersectoral cooperation at bilateral and multilateral levels should promote the sustainable use of natural resources contributing to locally self-sufficient production of food, water and energy.

- Development of non-polluting, non-waste and low-waste technologies, safe and non-hazardous methods and materials, are essential for sustainable use of natural resources.

**Mechanisms for facilitating intersectoral action on environmental health**

70. The Group recognized that there were several mechanisms for assuring that coordination between the different sectors involved was optimal and for minimizing the conflicts of interest, and of areas of jurisdiction, that were liable to occur. Some specific examples were cited of mechanisms that had proved both manageable and effective.
71. In certain countries, interministerial councils on the environment had been established. Such councils should consist of representatives of all ministries concerned with health and environmental issues (including housing, land use planning, local government, etc.), as well as scientific and technical experts from public health, industrial and educational institutions. Voluntary, non-governmental organizations could also be represented. This approach could provide a forum where health and/or environment ministers could seek discussion of and influence projects liable to have an adverse impact on their sectors. In some countries such intersectoral councils had also worked effectively at the district and local levels.

72. At the local level, community participation was crucial. Such participation could be assured in several ways - one was for governments to display a positive outlook towards non-governmental, voluntary organizations. Their cooperation could help to ensure the appropriate mobilization of support for, and implementation of, national policies and measures at all levels, particularly the crucial district level.

73. The question of decentralization of decision-making and policy application was raised. It was pointed out that some decentralization of authority to the municipal/district level was often essential, since it was at this level that the problems of the poorest sectors of the population were often best perceived and tackled. Yet at the same time, key policies on the protection of health and the human environment had in most countries to be decided upon at the central level.

74. In one developing country a 'Green Campaign' had been instituted by the Government whose primary purpose was to promote the establishment of "Green Councils" in each of the country's communities. Such councils are essentially political bodies, under the direct jurisdiction of the mayor and municipal council. Their purpose was essentially to make optimal use of all the economic resources of the community to provide health and other benefits. The programme was essentially designed to develop a different order of priorities - geared to real human needs - for investing human and material resources. The programme had legal support - all those involved were aware of their legal rights - and was also afforded appropriate technical support.

75. A developed country is now establishing Environmental Committees at the municipal level supported by the necessary administrative machinery - including those of the health services of the municipalities.

76. Government involvement alone was insufficient in many national contexts. Government efforts could be greatly strengthened by input from professional/scientific societies, whose collective experiences could also bring new insights into problem-solving in the health/environmental areas.
77. Improved intersectoral cooperation among international as well as national agencies in the design and implementation of national, regional and local projects is conducive to more effective improvements in health and environmental conditions.

78. The human resources element should not be neglected. In many developing countries there was a great need to increase the knowledge and skills of health and environmental personnel, and to improve the coordination of their activities so as to assure optimal utilization of the manpower resources.

The role of legislation

79. Legislation could be an important tool in improving health and the human environment. But legal texts per se were not enough - they had to be implemented and their effectiveness monitored. No legislation could succeed unless the population was convinced that it was for their benefit.

80. Some developing countries still had a veritable plethora of legislative instruments (sometimes several decades old) dealing with various components of the environment. It was important that these be consolidated and harmonized, a task which had already been undertaken successfully in certain countries.

81. Legislative texts were insufficient unless they were accompanied by quantitative and qualitative standards. The point was made that the standards elaborated for the affluent industrialized countries were in some instances irrelevant to the needs of developing countries, and efforts had to be made to formulate appropriate standards to meet their particular conditions.

82. The occupational health and safety legislation existing in most countries tended to apply and be implemented only in medium-sized and large industries. Laws were also needed to protect workers in small and home-based industries where workers could often be exposed to serious health hazards. The dissemination of information on constraints in implementing occupational health and safety legislation would be most useful.

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REPORT OF THE TECHNICAL DISCUSSIONS ON
THE ROLE OF INTERSECTORAL COOPERATION IN NATIONAL STRATEGIES
FOR HEALTH FOR ALL

Co-sponsored by: the United Nations Office for Development and
International Economic Cooperation
the United Nations Environment Programme (UNEP)
the United Nations Centre for Human Settlement (Habitat) and the
International Year of Shelter for the Homeless (IYSH)
the Food and Agriculture Organization of the United Nations (FAO)
the United Nations Educational, Scientific and Cultural Organization
(UNESCO)
BACKGROUND

1. In the Health for All Strategy, the Member States of the WHO committed themselves to creating the conditions which will enable all people to enjoy a healthy life by the year 2000 A.D. Primary health care became the principal means of achieving this objective. This strategy reordered the priorities in the health sector and moved from a perspective which was dominantly disease-oriented and curative, to one in which the main focus was on the prevention of ill health, the maintenance and promotion of good health and the capacity to resist disease.

2. It has become evident, that health goals defined in these terms, cannot be realised through the services delivered by the health sector alone. They require the combined effort of several other sectors whose activities have a major impact on health. From the inception, the primary health care strategy therefore, recognised that intersectoral action is a vitally important condition for achieving its goals. It identified the main sectoral elements including food and nutrition, water and sanitation, housing and education. In this approach, improvements in health are perceived as a multisectoral responsibility, in which the main development sectors would need to collaborate with the health sector.

3. The initiatives for intersectoral action that were promoted through the primary health care strategy have had their impact on many aspects of health. However, the experience that has been gained, points to the need for more effective strategies of intersectoral cooperation. There is ample evidence that the neglect of the intersectoral dimension in health can seriously jeopardise the HFA strategy and the realisation of its objectives. While specific programmes and projects for control of diseases as well as community health projects have demonstrated some success in the coordination of sectors for achieving particular goals, it has not yet been possible to develop systems of intersectoral collaboration which effectively take account of and deal with many of the important linkages between health and the programmes and policies of other sectors. This lack of success stems first of all from development strategies in which development is perceived predominantly in terms of economic growth resulting in the neglect of sectors which are essential to social well-being. Other major constraints are the compartmentalization of existing governmental structures, the resulting competition among different sectors in their pursuit of various sectoral goals and excessive centralization of decision making which stifles grass-roots' initiative and the participation of the people. Intersectoral action can often best be promoted at the grass roots level where the need for it is most clearly perceived and where the people who are directly affected are able to mobilize the efforts of the relevant sectors for the solution of interrelated problems.

Preparations for the Technical Discussions

4. The role of intersectoral cooperation in national strategies of Health for All was selected as the subject for Technical Discussions by the Executive Board in May 1984, in order that Member States might address themselves to some of these crucial issues and consider how best they could respond to the challenges that were posed.

5. WHO had already initiated in 1981 a series of studies and research projects designed to enhance the understanding of the interrelationships between development activities and major changes in the health status of the population. These studies analysed the developments in health in several countries and examined how the policies in various sectors interacted and combined to produce significant improvements in the health of the population, in varying socio-economic conditions and at different levels of per capita income. The insights gathered in these studies provided a useful starting point for the preparations that had to be made for the Technical Discussions.

6. Preparatory work included several meetings that were held in developed and developing countries. At these meetings participants from health and other sectors identified important issues for consideration at the Technical Discussions, reviewed some of the past experiences of intersectoral action which contributed to health, and helped to develop the agenda and structure of the Discussions. The background document entitled 'Intersectoral Action for Health' benefitted from all these activities.
7. The preparations for the Technical Discussions also provided a unique opportunity to both enhance the level as well as strengthen the process of intersectoral cooperation. An initiative of special importance to this process was the co-sponsorship provided by the United Nations Office of the Director-General for Development and International Economic Cooperation, UNEP, UNCHS (Habitat), and IYSH, FAO and UNESCO for the appropriate working groups. This co-sponsorship has involved collaboration with WHO in the preparation of background material, the joint preparation of the operational issues discussed, and arrangements for the participation of Ministers and high level policy makers representing relevant development sectors. As a result, the Technical Discussions themselves have been organized as a genuine intersectoral dialogue for defining the multi-sectoral responsibility for health, for formulating action-oriented recommendations and for affirming the international, national and sectoral commitments that go with them.

Summary of Discussions and Recommendations

8. The Technical Discussions were held on three mornings of the 7th, 8th and 9th of May. More than 500 persons participated, among whom were a large number of Ministers of Health and over 40 Ministers and high level decision-makers from areas of critical importance to health. The meeting commenced with a plenary session. President Léopold Senghor delivered the key note address. Speaking at length on the importance of the Alma-Ata Declaration on Primary Health Care and its far reaching implications for national development strategies, the President said that, "the strategy for health has acquired new dimensions and brought new promise of deliverance from ill-health and relief from suffering for the disinheriteds on earth ...... In many ways [it is] one of the richest expressions of efforts made during the 70s to enhance the meaning of development, to take it beyond the exclusive concern with economic growth, and imbue it with a deep concern for human well-being in its fullest sense .... Thus, development acquires a human face ....". The first plenary was followed by two sessions each of the four working groups which met separately on 7 and 8 May. The moderators of each group presented the group report to the final plenary meeting on 9 May. Each presentation was followed by a brief discussion and dialogue among participants, after which the report as a whole was adopted. In their concluding remarks the heads and representatives of the co-sponsoring agencies expressed their support for the ideas that had emerged, their intention to collaborate with each other to give effect to the recommendations of the Technical Discussions and to support their implementation at the national level.

Some stated that the Report of the Discussions would be presented to their governing bodies during the course of this year. Both co-sponsors and participants were particularly concerned that the momentum towards intersectoral action for health should be sustained.

The discussion and recommendations of the groups are summarized below.

EQUITY AND HEALTH

Equity in Development

9. The goal of Health for All implies that the resources essential for satisfying health needs should be within the reach of everyone. Equity has therefore to be an overriding concern of the national strategies of Health for All and this requires a strong political commitment. Equity in health however requires equity in development as a whole. Equity-oriented strategies of development have demonstrated remarkable success in improving the health of the population and raising the quality of their life within the constraints and low levels of per capita income. They contain many important lessons. National development strategies need to include elements in all important sectors, which are directed towards the goals of equity and the amelioration of the living conditions of the disadvantaged and poorer social groups. The equity-oriented elements in food and agriculture, health, education, and the development of the physical environment should mutually reinforce each other to produce substantial improvements in the health and well-being of the people.

10. These strategies have also to avoid the excessive urban biases that are common to most development strategies. Consequently resources for the social and economic infrastructure and investments in development would be more equitably distributed reducing the disparities between the rural and urban living conditions. The political processes should be able to articulate the demands at the community level as well as respond to them. Economic development programmes directed at raising productivity and income in the parts of the
economy which contain the poor majority have to receive priority. In most of the
equity-oriented strategies that have been implemented, the state and public agencies have
assumed an important role in satisfying the basic needs of the people. The national
strategies of health for all would have to be an integral part of a development strategy
which contains most of this compound of equity-oriented elements and these national and
sectoral commitments to equity. The systems of national planning and decision-making must
also enable the health sector to participate actively and play an effective role in the
formulation and implementation of the equity oriented development strategy, particularly the
health-related components in the development strategies of other sectors.

RECOMMENDATIONS

Country level

Member States should take action to ensure that the national strategies of Health for All
are developed and implemented as an integral part of an equity-oriented development
strategy in which all main development sectors identify and define their equity-oriented
components. The systems of planning and decision-making should enable the health sector
to collaborate with other sectors in formulating and implementing such strategies, and in
carrying out the necessary institutional improvements at the national, sectoral, and
local levels for that purpose.

World Health Organization

WHO should ensure that the component of equity is included where appropriate in all its
programmes. Intersectoral action efforts should be based on these Technical Discussions
and experiences already available in WHO and member countries. Collected information,
including information from other health-related sectors, should be analysed and lessons
drawn and widely disseminated. Moreover special studies should be undertaken on the
essential linkages between the social sectors and the rest of the economy. In particular
the process of allocation of resources should be analysed in relation to intersectoral
action for equity in health.

The Health Status of Vulnerable Groups as a Development Indicator

11. To achieve the goal of Health for All it is essential to reduce the existing inequities
in health. One of the principal objectives of the health strategies is the improvement of
the health status of the groups which are disadvantaged in terms of health. Both the
Alma-Ata Conference and the Strategy for Health for All have given high priority to the needs
of those who are most vulnerable and are at greatest risk. Most often these are the groups
which are by-passed in the larger processes of social and economic development. In the
developing countries these groups include the small farmers with inadequate resources, the
landless agricultural labour with limited employment opportunities, the illiterate, and the
urban poor living in slums and shanties in a poorly served environment. In developed
countries the disadvantaged are among the lower social classes, migrants, unemployed, the
various categories of the working population exposed to occupational health risks, those at
high risk of accident and injury, adolescent victims of lifestyles which intensify health
hazards, the ageing populations subject to physical and mental ill-health which seriously
degrades the quality of life.

12. In these disadvantaged and vulnerable groups the weakness and inadequacies in the total
system available in a society for the care and well-being of its people, are clearly
manifest. It is in relation to these groups that the importance of simultaneous action to
satisfy a range of interrelated needs whether they be food and nutrition, water and
sanitation, education and housing is thrown up in sharp relief. For the disadvantaged and
vulnerable groups the achievement of health goals depend vitally on the capacity of sectoral
programmes, whether they be agriculture, housing, water and sanitation or education, to
achieve the goals of equity in their own different spheres. The linkage and interaction of
these components of other sectors with health, in a concerted effort at the improvement of
the well-being of the disadvantaged become the prime mover in intersectoral action for health.
13. The changes in the health status of these vulnerable groups can then be one of the best criteria for evaluating the effectiveness of health strategies. How the strategies, policies, programmes and activities of the other sectors affect the well-being and health of these groups, is also an important indicator of the quality of the development resulting from the efforts of these sectors. Although the concern for vulnerable groups as the main target of health policies has been forcefully expressed in the IHPA strategy, the health problems have been seldom approached through the systematic identification of these groups and the conditions of risk in which they live. Such identification is essential if health strategies are to take account of and deal with the major health risks that originate in other sectors and if they are to mobilize the potential of other sectors for the promotion of health.

**RECOMMENDATIONS**

**Country level**

Member States should clearly identify the vulnerable groups in their societies based on a profile of the existing disparities in health between these groups and the general population. In developing countries, these groups include small farmers with inadequate resources, landless agricultural labour, the urban poor in slums and shanties and in developed countries, the unemployed, the migrants and workers in high risk occupations. Countries should seek to identify the social and economic conditions which relate to the greater health risk of these groups. Health and other sectors jointly should set targets for improving the health and well-being of these groups. Progress in achieving these targets should be monitored by the health and other sectors and such progress should be used as an indicator in evaluating the quality of national development.

**World Health Organization**

WHO, at all levels, and other sponsoring agencies of the Technical Discussions, should support efforts to identify vulnerable groups in the population based on indicators of their health status. They should support countries in monitoring changes in their health situation over time.

**Institutional Improvements and Training for Intersectoral Action**

14. Relevant health-related goals have therefore to be incorporated in the development goals of other sectors, and the health-related components of their policies clearly articulated. This is not only essential at the national level but also must be reflected at the local level. Equity in health can only be fully attained when there is decentralization of power and decision-making. The local community should play a key role in the allocation of resources to meet the goal of equity in health and development and concentrate effort where it is most needed.

15. This approach calls on the health sector to forge linkages with other sectors and collaborate with them in incorporating health goals and health criteria into their strategies, policies and programmes. The health sector has to assist other development sectors in monitoring and evaluating the health impact of projects and policies so that negative health effects are anticipated and countered and the positive impact on health is strengthened and improved. Under all circumstances it is important that decisions are taken with full knowledge of any short-term trade-offs between health and other goals and that compensatory action needed is clearly stated. In all these actions, the impact on vulnerable groups must receive specific attention. The implementation of such a strategy would require changes in institutional arrangements and training and reorientation of relevant cadres, especially as the skills and knowledge for coordination and administration of intersectoral action are resources which are critically scarce.
RECOMMENDATIONS

Country level

Member States should:

develop and strengthen the institutional mechanisms and decision-making processes to ensure that health and other sectors collaborate in identifying how the policies of those sectors impact on health, in incorporating health goals and health criteria into their policies and programmes, and in undertaking a systematic health impact analysis and monitoring of the major development projects of those sectors;

strengthen and promote institutions and processes which decentralize decision-making, so as to enable local communities, particularly the vulnerable groups to participate effectively in the formulation and implementation of intersectoral programmes for the improvement of their health and well-being;

promote and support the reorientation and training of planners, professionals and workers at the appropriate levels with the participation of the health sector to develop the methodologies and skills to assess the implications of their actions on health goals. Member States should ensure as well that the training of health workers at all levels includes knowledge and skills for coordination and administration of intersectoral action for the realization of health goals;

seek to ensure that the training of health professionals includes a population-based epidemiological approach and that health manpower planning is aimed at producing the numbers and kinds of health workers which reflect the needs of a health care system based on PHC and the Health for All goals.

International level

Multilateral and bilateral donor agencies should:

support the strengthening of national development planning mechanisms to ensure more adequate consideration of the health impact of global economic, industrial, agricultural, public works and other sectoral policies and projects.

should incorporate health impact analysis into their feasibility studies of industrial, agriculture, public works and other projects, based on the results of these studies, undertake the necessary adjustments to avoid adverse health impact and include the funding for complementary actions.

provide direct support to countries for intersectoral projects aimed at improving the health and well-being of the population, for studies of the intersectoral linkages to health and for training of personnel in the process of analysing intersectoral impact on health.

World Health Organization

The WHO should communicate to the World Bank and other multilateral development financing institutions the conclusions and recommendations of the Technical Discussions, particularly with respect to the inclusion of health impact analyses in all feasibility studies accompanying agricultural, industrial, public works and other projects.

WHO, at all levels, and other sponsoring agencies of the Technical Discussions, should support collaborative actions by health and other sectors in member countries to study intersectoral linkages to health, to train personnel in the various sectors of government in the intersectoral aspect of health, and to carry out intersectoral cooperative efforts aimed at improving the health of the population, with specific concern for the vulnerable groups.
The Regional Offices of WHO should communicate to the respective multilateral development financing institutions within each region the conclusions and recommendations of the Technical Discussions, urge support for intersectoral action at the country level and the inclusion of health impact analyses by those institutions in the feasibility studies of their industrial, agricultural, public works and other projects.

WHO and other sponsoring agencies, should strengthen relations among themselves as well as with other international organizations for the promotion of intersectoral actions to improve equity in health. WHO and the co-sponsoring agencies should consider the feasibility of promoting intersectoral strategies on the lines recommended by the Technical Discussions in selected countries with the necessary political commitment to such strategies.

Equity within the Health Sector

16. While the Alma-Ata declaration affirmed political commitment to equity and health, the competing pressures within ministries of health have often impeded the fulfilment of this commitment. Resources are expended for sophisticated equipment with imported components and for projects serving a small but powerful part of the population at the expense of ensuring full access to basic health care of the majority. While it is recognized by the PHC strategy that this pattern of expenditures leads to inequitable distribution of health care and inappropriate use of scarce resources, this pattern persists in many of the developed and developing countries. It is clearly necessary to have a balanced allocation of resources so as to ensure that those resources are used where they will have the most beneficial effect for the largest number of people at the lowest cost. Equitable and cost-effective use of resources within the health sector, regardless of the health financing systems chosen, is a necessary condition for equity and health in the broader context of social development.

RECOMMENDATION

Member States, in pursuit of equity in health, should emphasize, through the PHC strategy, access of all of the population to the health service system and the structuring of that system to ensure that the best possible care is available to the largest number of beneficiaries with the most cost effective use of available resources. Governments should make a greater effort at reducing resource allocation to high-cost technologies which serve small segments of the population.

Member States should give greater attention to the decentralization of the health effort including planning, staffing, managing and, where possible without impinging on the goal of equity, funding at the local level. They should seek the involvement of the community in the entire process shifting to a concentration on basic sanitation, education, preventive medicine and environmental protection, along with a balanced system of health services.

Adjustment Policies and their Impact on Health

17. The overall amount of resources available for health and equity related programmes depends very much on the economic environment and constraints that confront decision-makers at the national level. The economic crisis and the enormous debt burden facing developing countries have led to the adoption of restrictive adjustment policies. By compressing effective demand and by allocating more resources to export-oriented sectors, such policies result in additional pressures on central government budgets. In many cases, no safeguard has been specified for social expenditures and the social sector becomes almost automatically the first casualty of adjustment.

18. Adjustment decisions should not produce a negative impact on equity and health. When designing adjustment policies there has to be a clear recognition of their effect on the health and nutrition of children and other vulnerable groups. The health status of these groups should be a fundamental criterion in the analysis of alternative policy options. The
burdens of adjustment would have to be distributed equitably within countries. This requires a thorough analysis of the different components of adjustment policies such as those which have an impact on the pricing and imports of goods which are related to health needs, budgetary cuts on the health sector and health-related services or the reduction or removal of consumer food subsidies.

19. The response to the austerities of adjustment has to be two-fold. First the goals of adjustment policy should incorporate a specific concern and commitment to the protection of minimum levels of health and nutrition of the population with special attention to the most vulnerable social groups. Policy-makers would have to ensure that these elements are included in the policy package without jeopardizing the main objectives of economic recovery. These considerations have to be taken into account fully by the international financial agencies when framing policies and defining conditions for adjustment at the country level. The same criteria should also play an important part in the decisions of donors regarding their priorities for development. Concerted action is urgently needed at the international level in order to provide a more supportive environment for the efforts of developing countries in the area of social development. Second, in the face of severe financial constraints, the health sector can pursue the optimal cost-effective strategies in which there is a further strengthening of the PHC approach, and in which the health-related resources and contributions by other sectors are fully mobilized through effective intersectoral cooperation.

RECOMMENDATIONS

Country level

Member States should ensure that economic adjustment policies, and macroeconomic policies generally take into account their implications for the health and nutritional conditions of the population and incorporate a specific concern for and commitment to the protection of minimum levels of health and nutrition of the entire population with special attention to the most vulnerable groups. Such a commitment should include principles which guide the allocation of sufficient resources to the social sectors so as not to erode the social base for development.

The International Community

In the design and implementation of adjustment policies, international financial agencies should recognize the health and nutritional status of the population as an important factor and should ensure the protection of minimum levels of health and nutrition of vulnerable groups.

Multilateral and bilateral donor agencies should support countries undergoing severe adjustments to their economies in order to avoid adverse impact on the health conditions of the population and particularly support programmes designed to protect the minimum levels of health and nutrition of vulnerable groups.

World Health Organization

The WHO should communicate to the International Monetary Fund and other international financial institutions the conclusions and recommendations of the Technical Discussions, particularly with respect to the need for economic adjustment policies to take into account their potential impact on the health of the population and for those policies to incorporate a specific concern for and commitment to the protection of minimum levels of health and nutrition for vulnerable groups.
Agriculture as a determinant of health

20. Today's world is characterized by huge food surpluses in some areas, while many needy countries are not in a position either to produce or to buy the food their populations need. At the same time, the conditions in the international markets remain unfavourable for many of the products of developing countries which depend heavily on agriculture. More than two thirds of the population in developing countries derive their livelihood from agriculture. Poverty continues to affect large masses of rural populations who are deprived of basic services. This in turn contributes to the unplanned exodus towards cities, and to increasing ill-health, malnutrition and misery among the urban poor.

21. The experience of some developing countries demonstrates that development with equity can achieve a substantial improvement of health and well-being in predominantly rural economies at low levels of income. In these countries agricultural strategies have combined with the strategies of other sectors to produce this outcome. Policy makers should systematically examine and take in to consideration the interaction between agriculture and health, especially during the planning process. Health and nutrition goals should be stated explicitly as part of the objectives of the plans drawn up for both sectors.

22. Logically, policy analysis and planning in health and agriculture should proceed in an integrated manner in examining the links between the promotion of economic growth and the promotion of health through agriculture. A joint diagnosis of the national food and nutrition situation should be undertaken by the health and agriculture sectors. Particular emphasis should be placed on the local level with the involvement and participation of the population concerned. Such analyses are too often undertaken, if at all, from the perspective of only one of the two sectors.

Agricultural policies and actions related to health

23. The processes of agricultural development affect health in diverse ways. Increases in agricultural output will raise household income and improve the well-being of the rural poor who comprise the majority and those who are most exposed to the risk of ill-health. On the other hand the crop mix in the increases of output may cause new health hazards or reduce the capacity for food self-sufficiency of vulnerable groups without correspondingly increasing their purchasing power. Policies relating to land ownership can have either positive or negative impact on the capacity of households to satisfy their basic needs and their nutritional health needs in particular. The changes in agricultural technology both for their impact on energy use, as well as the new health hazards they bring, have important health consequences. Agricultural pricing policies, subsidies, taxes and incentives can influence patterns of production and consumption in ways which have a significant impact on health.

24. To enhance the contribution of agriculture to health and welfare, the actions which command high priority are:

(a) improving access to land and essential inputs and services, especially health and education;
(b) maximizing land use including protection of prime agricultural land from non-agricultural uses and improving product mix;
(c) promoting production and use of traditional crops for ensuring food security and generating income;
(d) avoiding production of crops dangerous to health such as tobacco, and addictive drugs; in the case of existing cultivation, promoting substitution with alternative crops through appropriate policies and incentives;
(e) pursuing equitable farm price policies as well as producer subsidies in order to bring about an increase in food production and income. Consumer subsidies could also be useful in encouraging increased demand for local production, especially in urban areas, but their unbridled use could be counterproductive by serving as a disincentive for local production;
(f) selecting technology that is appropriate for particular sociocultural and economic environments;

(g) developing and using crops that can be grown on marginal lands and improved strains of plants, especially through transfer to developing countries of biotechnology and genetic engineering under appropriate, internationally agreed guidelines;

(h) striking a balance between food- and cash-crop production and production for local vs. export markets. Farmers should be guided in this regard by appropriate extension services;

(i) reducing food losses due to spoilage, contamination and rodents;

(j) increasing food safety, which should be considered in the context of food processing in all countries;

(k) routine fortification of suitable foods, which merits consideration as an important means of avoiding subclinical nutritional deficiencies;

(l) continued development of international food quality standards, which contribute not only to improved nutrition but facilitate the movement of commodities between and among countries;

(m) the positive impact of carefully planned and executed food aid programmes on development for and by the rural poor, and on their nutritional status.

**RECOMMENDATION**

Governments should formulate comprehensive agriculture and health policies, covering all aspects of human and natural resources development, which are actively supported by coherent strategies which include:

- undertaking joint diagnosis of the food and nutrition situation from agricultural and health points of view;
- explicitly stating health goals in agricultural development plans and programmes, particularly when there is likely to be a conflict between health and production objectives;
- making a systematic analysis and assessment of the nutritional and health impact of agricultural policies and projects as well as the process of resource allocation.

The main health-related agricultural actions which have high priority should be incorporated in such a strategy.

**Equity in agriculture**

25. The goals of the agricultural sector are usually identified in terms of crops and output targets. In defining the health-related component, the costs and benefits of agricultural development have to be related to different population groups of agricultural workers, families and households, and special attention paid to the vulnerable groups. This would mean that the health sector would be most concerned with the equity-oriented component of agriculture. This component would include crop improvements within reach of the poor; a system of agricultural extension services and supplies providing equitable access; agrarian reforms which increase access to agricultural resources, land and employment; investments in agricultural infrastructure such as small-scale irrigation works or storage and marketing facilities, and specific measures to reduce seasonal fluctuations in income and employment.
RECOMMENDATION

Member States should recognise the special importance of the equity-oriented component in agriculture for achieving health goals, and in formulating and implementing the national strategy of health for all, identify and strengthen the links between health and this component in agriculture.

Towards this objective, a number of basic principles should be borne in mind:

- equity and the fair distribution of goods and services, especially to targeted groups;
- the effects of different agricultural and other development policies on vulnerable groups, for example, women, children, the rural poor, refugees, should be given primary attention. Landless farm labourers form a group at greatest risk;
- labour-saving techniques, by increasing productivity could also increase their number. Agricultural development strategies should, therefore, promote employment as well as food availability and security;
- the incorporation of food and nutrition activities in the implementation of the Strategy for Health for All by the Year 2000 through the primary health care approach.

26. Monitoring of the food and nutrition situation should be a continuing endeavour based on a permanent, effective interaction between the agriculture and health sectors. In this context, the relationship between dietary intake and disease should be assessed on a national and local basis for different socio-economic groups.

RECOMMENDATION

Systems for monitoring the nutritional status and assessing the relationship between dietary intake and disease should be established in all countries as a reliable basis for policy-and decision-making. This should be done at national, regional and local levels according to socio-economic groups. The systems should have the technical and administrative capacity, in addition to the political visibility, that will enable them to stimulate prompt policy and programme responses to nutrition situations as they are being diagnosed.

27. The impact of food aid on nutrition and agricultural production needs to be carefully assessed and assistance programmes designed to secure maximum benefits for both.

RECOMMENDATIONS

Country level

The role of food aid programmes should be carefully analysed by member countries at individual country and project levels in order to assess more accurately the positive and negative effects of this aid on socio-economic development, human welfare, food production, and possible changes in dietary practices that may be introduced as a result. Donors should collaborate with and support national governments in this task.
A world nutrition map, which accurately defines and positions dietary traditions, patterns and needs, should be prepared as a means to guide those who provide food aid in the choice of appropriate commodities for a given country or region. Efforts should be made to utilise surplus commodities from neighbouring developing countries.

The institutional framework for intersectoral action

28. Mechanisms and frameworks, through which intersectoral action for health can take place, should be defined and organized. There should be political support for these at the highest level, and involvement and responsibility of the populations concerned at the local level of operations.

29. Government institutions and technical mechanisms are required that will enable health to influence agricultural policy making, especially on the basis of equity-oriented criteria, and to assess the health outcomes of agricultural strategies. Those countries that do have intersectoral mechanisms bringing together health and agriculture, e.g. national food and nutrition councils, can build on these to extend their policy mandate to cover the broader intersectoral issues identified in this report.

30. Appropriate methodology and expertise are required to permit the systematic assessment of the nutritional and health impact of national agricultural policies. This includes improving approaches to nutritional surveillance, surveys of health and agricultural conditions, and making use of more relevant data collection schemes and analysis procedures. This will require an enhancement of the skills and knowledge of the responsible staff from the two sectors.

RECOMMENDATIONS

Country level

For intersectoral action to be effective member countries should strengthen and/or develop the overall institutional framework and the substantive skills for viewing the relationship between the various sectors and health. The analytical tools for appreciating the impact of agricultural policies and actions on health would have to be improved. Appropriate training would have to be imparted for both policy analysis and implementation at the various levels. These efforts should be supported by further research into the linkages between agriculture and health and the development of an adequate data and information base on agriculture health linkages.

International level

The international multilateral and bilateral development agencies should as far as possible adopt fully integrated approaches in order to promote intersectoral action and minimize for countries those difficulties often associated with absorbing the varying types and amounts of technical and financial support that are being made available to them.

Governments should exchange information and know-how on agriculture-related health development, in the spirit of TCDC.

The World Health Organization and the Food and Agriculture Organization

WHO and FAO should promote intercountry sharing of experiences and technical resources in the field of intersectoral action relating to health and agriculture. WHO and FAO should collaborate in providing checklists of critical data needs for better understanding the impact of agriculture on health, as well as simple analytical tools and quantitative methods which can be easily applied given the current availability of data.
31. Decentralization is an essential feature of improved planning, coordination and implementation at intermediate and local levels. In developing countries, the focus of action could be an agricultural-based rural development strategy which would bring together related concerns such as increased employment opportunity, food security, delivery of services related to basic needs, and occupational work safety. This would facilitate constructive dialogue, the sharing of information, and the preparation and coordinated execution of a common plan.

32. The identification of problems at the grass-roots level, with priority given to vulnerable groups and areas, is critical to the process of integrated planning and action. It is important that those persons who work at the periphery representing their respective sectors are able to identify problems and understand how they interrelate. Their training and supervision will have to be oriented accordingly.

33. An essential feature of the process outlined above is education of the public to improve awareness of health matters and to enhance their individual and collective abilities to participate actively in problem analysis and the design and implementation of interventions. Particular emphasis should be given to extending communication, education and information to the rural poor in a form which proves practical and understandable to them. Front-line health and agricultural workers should be involved in this process, through the use of low-cost non-formal educational techniques.

**EDUCATION - CULTURE, INFORMATION AND LIFE PATTERNS**

**Education as a decisive factor in health improvement**

34. Education is a decisive factor in health improvement. Even a few years of school provide basic skills and capacities that can make a vital difference to the continuing acquisition of knowledge, and an individual's ability to deal with life situations and respond to a changing environment. Low income countries which have given priority to investments in education have lowered mortality levels far below those of countries with higher per capita incomes but less educated populations. In situations where survival is a major health problem and where female literacy is low, female education both formal and non-formal can lead to substantial improvements in the health of the population.

35. The educational goals of universal primary education and the eradication of illiteracy directly support Health for All. It is now well documented that there is a direct correlation between educational achievement and health status.

**RECOMMENDATION**

Universal primary education should be recognized as an essential ingredient to the achievement of health for all. Educational personnel should be aware that their effort to expand access to education, particularly female participation in schooling, will have a long lasting benefit on the health of the community. Policy makers and field workers in the two sectors should collaborate to promote female participation in education, reducing drop out rates in the early years of school and improving the health environment in schools and home. Efforts of health personnel to improve community health status will lead to increases in educational efficiency.

36. In view of the fact that primary education often by-passes a considerable proportion of the adult population who have had no schooling and are illiterate, a number of countries are making intensive efforts at expanding and improving the quality of functional literacy and other non-formal education programmes. Many of these programmes provide scope for imparting knowledge, information and skills vital for the improvement of nutrition, health and the quality of life.
RECOMMENDATION

The health sector should collaborate with and support other sectors in integrating education for health with non-formal education and programmes of functional literacy. Particular emphasis should be placed on literacy programmes for vulnerable groups.

The school as a focal point for health improvement

37. The school could assume a place of prime importance in health promotion and service delivery.

RECOMMENDATION

Education and health personnel should act jointly to strengthen the school as a focal point for health education and health service delivery. Such joint action should include teacher training, the incorporation of locally relevant health teaching/learning in school curricula, school meals and the strengthening of school health services and health monitoring systems.

38. If schools are to be used successfully as vehicles for health promotion, supportive activities need to be carried out by families and community organizations, for example, women and religious groups. The education sector should make available the relevant education and communication technologies that can be utilized to promote health.

Education and skill formation for intersectoral action

39. A prerequisite for effective intersectoral co-operation for health is an adequately and motivated professional cadre in all health-related sectors who have acquired the necessary interdisciplinary skills and knowledge to identify the links between health and other development sectors. The manpower development and training required for intersectoral cooperation emphasizes the need for new perspectives and reorientations in education and training at all levels. In the field of professional training and higher learning the educational sector has an important role to play in evolving and developing educational structures, adapting the curricula and imparting a core of interdisciplinary knowledge which enhances the understanding of the intersectoral linkages in development and the capacity of specialities to communicate with each other. Knowledge, training and skill which are specific to intersectoral action must be imparted to workers at all the appropriate levels in the health and health-related sectors with inputs from each of the relevant sectors.

RECOMMENDATION

Countries should develop programmes of education and training to produce the professional and other cadres at all appropriate levels, who will have the necessary interdisciplinary approaches, knowledge and skills which are required for the formulation and implementation of intersectoral strategies and programmes for development. These programmes should include the development of educational structures, curricula changes and innovations at the level of higher education, as well as training and reorientation of workers in health and health-related sectors.
40. Intersectoral programme committees composed of education and health decision-makers could be organized to plan joint activities. Such committees could begin by analysing existing efforts in education and health in terms of their relevance for joint programming. Collaboration at the programme level needs to be reinforced with collaboration at the levels of training, implementation and evaluation.

41. Student organizations are important resources to be utilized in health promotion. Today's students are the decision-makers of tomorrow and thus their early involvement in their education which should be community-oriented is essential. Non-governmental organizations and consumer groups can also be vehicles for promoting health. Many such groups have been able to spread health-related messages in a forceful manner.

Culture-related health problems

42. Socio-cultural factors have a pervasive and far-reaching impact on health. Health programmes often fail to realise their objectives when these factors are neglected or ignored. In developing countries, traditional knowledge, beliefs, values and cultural practices concerning health and especially nutrition continuously interact with modern health services. The health sector needs to develop approaches which can draw on the health protective and health promoting elements of the traditional culture and value systems, while removing cultural practices that are harmful to health. In the developed countries, health and ill-health are closely linked with individual behaviour, and continuous changes in social institutions such as the family and value systems governing them. Major health risks stem from overconsumption of certain foods, the stresses of work and life patterns, family situations, sexual permissiveness, addictions to alcohol, tobacco and drugs.

43. In regard to culture-related health problems, some of the vulnerable groups requiring special attention are the adolescents, women, the elderly, migrants and minority ethnic groups. These health problems require strategies which combine the wide dissemination of knowledge and information on health hazards. Such strategies require intersectoral action on a wide front, with education and information playing a major role and all the major representatives from the relevant sectors collaborating in the effort. Using situations and processes which touch people's lives, health messages can produce the necessary impact by enhancing knowledge and changing attitudes and values. These educational efforts must be linked with the non-formal and functional education programmes discussed earlier.

44. Human rights, ethics and cultural dimensions of health are neglected areas and when included in the training programmes of health providers ensure better understanding and services. Overcoming cultural barriers needs a strong political will and for this the support of willing opinion leaders, such as older people, traditional healers, religious and political leaders is important.

RECOMMENDATION

Health strategies in both developed and developing countries should take account of the pervasive impact of the socio-cultural factors affecting health, identify the major culture-related health problems, and strengthen the efforts at information, retention of positive cultural values, education and value formation needed to promote the required changes in health behaviour, values and life patterns. Special attention has to be paid to the groups which are at risk such as the adolescents, the elderly, the illiterate, the disadvantaged groups especially women and the culturally displaced or isolated groups such as migrants.

Mass media and health

45. The mass media are playing an increasingly important role in disseminating knowledge and information influencing health behaviour and promoting life-styles which have both positive as well as negative implications for health. Printed media and television while effective
have their limitations in terms of outreach in developing countries. There are, however, other forms of communications which are practical, affordable, and generally appreciated such as creative arts, folk songs, dances, mime, travelling theatres, puppetry and community focused discussions which can be equally effective in conveying health messages. The health sector will need to make fuller use of this immense potential of the media to communicate health messages and influence health-related behaviour. The media will have to become more conscious of their responsibility for raising awareness, increasing health knowledge, and articulating public needs in the field of health and social development. Basic to the promotion of such partnership between the media and the health sector is a strong political will which fosters equity in information dissemination and a mutual appreciation of each others role.

46. Communities are being flooded with information from different development sectors sometimes with conflicting and competing messages usually couched in technical and bureaucratic jargon rarely understood by the public. Some countries have attempted to bridge this problem through the creation of mechanisms such as "listener-viewer-reader groups" which serve as fora for discussions and digestion of information received and for follow-up actions as needed.

47. Health as a subject matter for media is not attractive and not sensational. The media therefore will have to be more innovative and imaginative in communicating health messages. In this respect, there is a need for both media and health personnel to learn to work harmoniously with each other based on the mutual appreciation of each others' concerns and problems. This would need familiarization of media personnel on health matters, and for the orientation of health personnel in the use of media and in communicating to them their ideas.

RECOMMENDATION

A close and systematic collaboration and partnership between the health sector and mass media should be promoted to make full use of the potential of the media for increasing public awareness concerning health and promoting desired changes in health-related behaviour. Health and media personnel should be oriented and trained for such collaboration. Communications experts should ensure that mass media health messages effectively reach the local community and vulnerable groups. An international symposium on these issues to promote collaboration and understanding between the health sector and mass media could be jointly organized by WHO and UNESCO.

HEALTH AND ENVIRONMENT - WATER, SANITATION, HABITAT AND INDUSTRY

Quality of Life as the Goal of Development

48. Intersectoral action in health and environment has to be based on the recognition that the ultimate goal of development is improved quality of life and well-being for entire national populations. Growth in production and productivity which requires the rational use of natural resources is not an end in itself but rather a means of achieving a stronger economic base from which to promote improved quality of life and well-being.

49. In this context there is need for governments and international agencies to give priority to meeting the needs of poorer groups. Within the poor, there are groups which are particularly vulnerable or who are bypassed in conventional programmes. Nearly one billion people in the world are living in absolute poverty. These are the ones with the poorest housing conditions, the least access to potable water, sanitation, health care and education. An increasing proportion are living in urban areas. These also include people who are especially threatened by disasters. For instance, in many cities, squatter settlements grow up on lands subject to flooding or landslides because this is the only land close to the city from which they will not be immediately evicted.
50. However, the financial resources allocated to health and environment have been limited, especially during the present economic recession and the decline in the availability of soft loans and untied aid. Only a small proportion of funds is devoted by national governments and international agencies to projects and programmes which directly reach lower income groups with improved housing and living conditions and access to basic social and physical services. This is compounded by the lack of skills and trained personnel, especially at local government level and in the area of intersectoral action and collaboration. This situation calls for clearly conceived priorities and a step-by-step approach with each step targeted to the poorer and more vulnerable groups. Best and most cost effective use of the limited resources available can be made through intersectoral cooperation, and the impact on health and well being can be enhanced.

51. The plans and programmes of all important government ministries and agencies impact on the environment - including people's living and working environment. As such, they frequently have a major impact on people's health status. Ministries or agencies concerned with housing, public works, urban and regional planning and environmental protection all have important roles to play in helping to improve people's health status, especially the health status of the poorer and more vulnerable groups. Yet most countries have to develop first the understanding among each sectoral agency or ministry as to their role in improving health status and secondly the planning and administrative systems for managing inter-ministry or inter-agency cooperation in implementation. International agencies also often lack an understanding of the need for intersectoral action to improve health and how to operationalize it.

RECOMMENDATIONS

Country level

Countries should identify the role of each sectoral ministry or agency in improving health, and seek the most appropriate institutional mechanism for coordinating sectoral action.

International level

International agencies have a major role both to advise and support national intersectoral action and to support regional and national discussions as to how best this is achieved. International agencies must also improve their own intersectoral coordination.

52. In order to improve intersectoral coordination and direct sectoral strategies towards the achievement of the common goal of improving the quality of life and well-being of people, it is necessary to develop methodologies and indicators which both define and unify the contributions of the different sectors, in the realization of this common goal. These should assist policy makers in their decisions affecting choices and priorities among sectors.

RECOMMENDATIONS

Country level

Methodologies and mechanisms for the integrated assessment, prediction and monitoring of the impact of economic development activities on health and the environment should be developed and used as important levers to minimize damaging effects as well as to assist in raising health, environment and social well-being in the order of priorities for allocation of government budgets.
International level

The UN agencies should collaborate in developing methodologies of composite indicators of the quality of life to take into account not only the classical biostatistical indicators but also the elements such as environment, habitat, educational status, employment/income, food supply and other aspects within the competence of the various agencies. Indicators can be included to measure the degree of people's access to social and physical services.

Equity in the Management of Environment and Health

53. The environmental and health problems of the poorer groups demand special attention. Special mention should be made of landless labourers and the poorest farmers in rural areas and those living in rundown tenements or shanty towns in urban areas. The poorest groups usually face the most critical environmental problems in terms of impact on health since they have no alternative but to live in the most dangerous areas and exploit the more dangerous income earning opportunities. It is the poorer groups which are disadvantaged in terms of water and sanitation. In cities, the poorer groups are disadvantaged in terms of garbage disposal. The effort to design and implement cost effective services for rural and urban poor must be further strengthened and intensified. Technologies which make best use of local resources and are adapted for conditions of scarcity should be further developed and applied. Development of non-polluting, non-waste and low-waste technologies, safe and non-hazardous methods and materials, are essential for sustainable use of natural resources. They are also the technologies which can best protect and promote health.

RECOMMENDATION

Governments should renew and strengthen the collaboration between the health sector and both national and local authorities responsible for the quality of air, soil and water, sanitation and the disposal of domestic and industrial waste. This is a critical part of achieving targets set by the International Drinking Water Supply and Sanitation Decade, recognizing that 'water and sanitation for all' must form an essential part of the strategy of 'Health for all'. Three elements should be given special attention: the socio-cultural factors related to the use and maintenance of these services; the provision of services to groups most vulnerable to health risks among the rural and urban poor; and the development and application of appropriate cost-effective non-polluting, non-waste or low waste technologies and systems which maximize local control and local resource use and promote equitable access to these services.

The Contribution of Housing to Health

54. The physical environment for health begins with the house and its immediate surroundings. It is here that health risks are manifold. In the housing of the rural and urban poor in developing countries, these health hazards stem from factors relating to the poor quality of the structure and materials, unsatisfactory design and inadequate space, and poor quality sites which are often subject to natural disasters (for example, floods or landslides) and are frequently poorly drained. Associated with housing of poor quality are vector borne diseases, respiratory infections (especially those relating to indoor air pollution from fires or stoves) and diarrhoeal diseases. Health problems linked to housing are also prevalent in different forms in developed countries. Examples of unhealthy housing can be found in rich industrial countries of Europe and North America and include housing that is both old and new. New technologies in housing also seem to generate new health risks.
RECOMMENDATION

The health agencies and agencies responsible for housing, public works and physical planning should collaborate in identifying the health related component of programmes to upgrade housing, especially those of lower income groups, and then formulate and implement intersectoral programmes to address health needs. The housing of the rural and urban poor living in tenements, cheap boarding houses and squatter settlements is especially disadvantaged and health problems related to the physical environment deserve special attention. Governments should pay special attention to the problems of indoor air pollution arising from stoves, open fires or modern unhealthy building materials; these problems impinge most heavily on women and children. For those living in illegal settlements, secure tenure must be considered since insecure tenure means little motivation on the part of the inhabitants to improve their own housing quality and work together to improve the neighbourhood.

55. The norms and codes which set standards for land use planning, building, air and water quality, and infrastructure often demand what is unrealistic or unattainable or what is impossible to monitor. They can be rendered more effective in promoting health and safety if they are adapted to local conditions and implemented as much through the provision of advice and technical assistance as through enforcement.

RECOMMENDATION

Countries should review existing codes and regulations on the built environment to see how their emphasis can be changed to give advice, support and technical assistance to lower income groups managing the construction of their own houses to ensure that basic health and safety standards are met. In addition, governments should assess the extent to which improved health and safety standards in other areas might be raised through educational material, technical advice and incentives.

Governments should carry out reforms in land use planning and provide land with secure tenure, as well as technical, material and financial assistance to the most disadvantaged groups of the population in order to facilitate an acceleration in improvement of living accommodation.

The Role of Communities and Local Government

56. Most new housing units and most improvements to housing in developing countries are organized by the people themselves. They do so at little or no cost to governments. And in doing so, they contribute considerably to capital formation and their activities have many multiplier links with the other areas of production. But individuals and the community groups through which they often work cannot solve many of their health problems, especially those related to the provision of infrastructure and services and the acquisition of legal, safe, affordable land sites in cities.

RECOMMENDATION

Planning for increased provision of shelter should emphasize the use of safe, locally available materials. Housing designs, whilst within the reach of the underprivileged, should incorporate safety features which will eliminate important health risks such as unvented or smoke producing cooking stoves. Simple, affordable, appropriate technologies for cooking, heating, water supply, waste disposal, etc., should be introduced whenever feasible.
57. Countries should note the beneficial impact on health and on improved housing conditions achieved by governments who move their housing policies from those which seek to 'build houses for the poor' to one which supports the efforts of people and their community groups to build for themselves. Within this, the role of governments is more to ensure that resources for building such as land, building materials and credit are cheap and easily provided and that infrastructure and services are available to the houses and neighbourhoods that the poor build for themselves. This should be undertaken in both rural and urban areas with programmes and projects formulated, implemented and monitored with the full collaboration of representatives of the local community. The enormous potential of community groups and of the NGOs or Private Voluntary Organizations who work with them should also be mobilized.

**RECOMMENDATION**

Cooperation of community-based voluntary organizations must be sought to ensure effective community participation in formulation and implementation of solutions to local environmental and health problems.

58. Although much can be achieved in improving health through well focused sectoral action and inter-sectoral cooperation, sustained improvements demand both more resources and more effective implementation. The critical role of local government both as the articulator and representative of local needs, as a possible mobilizer of local resource and as a coordinator of sectoral inputs is given too little attention.

**RECOMMENDATION**

Countries should review the extent to which local authorities have the power, resources and trained personnel enabling them to play a major developmental role as articulator of local needs up to higher levels of government, as mobilizer of local resources, as coordinator of the inputs of the many sectoral agencies seeking to improve health, and as manager of much newly installed equipment and services. Councils of experts can provide much needed technical advice.

International Agencies and Intersectoral Programmes

59. Both governments and international agencies give a relatively low priority to projects and programmes such as water supply, sanitation, upgrading of slums and shanty towns, primary health care and the supply of cheap resources for housing construction or improvement. Yet these are the projects and programmes which collectively can have the most dramatic impact on the health status of the population, especially the poorer and more vulnerable groups. The international agencies have a responsibility both to seek to increase the proportion of aid and technical support to all sectoral agencies and ministries whose work impinges on health. It is also for them to integrate their own actions into well coordinated intersectoral programmes and projects.

**RECOMMENDATIONS**

Country level

Governments and international agencies should give a higher priority to those projects and programmes which seek directly to improve health status, especially for poorer and more vulnerable groups. Integrated rural development programmes which can combine employment creation, increased economic growth, establishment of infrastructure and improved living conditions are examples of successful approaches to intersectoral action for health.
International level

International aid agencies should also be encouraged to incorporate criteria and impact analysis in their project appraisal in order to take into account health benefits in cost benefit, cost effectiveness or pre-investment analyses.

Monitoring the Environment-Health Link

60. Since there is a lack of understanding of the impact of various factors on health and environment, of the most effective interventions by different sectors in improving health status, and of the best combinations of coordinated action between them, monitoring systems should be set up. This would serve the double function first of assessing the effectiveness of new initiatives and secondly of monitoring the impact of existing projects and programmes on health and the environment.

RECOMMENDATIONS

Projects and policies for economic and social development and management of natural resources should be subject to systematic appraisal to analyse their impact on natural resources. A sustained 'watch' on the environment-health linkage should be organized to assess the impact of new initiatives on health as well as to monitor health impacts of programmes and projects with potentially high health risks.

WHO, UNEP, Habitat and other related organizations should cooperate to develop simple, easy to apply cost benefit and cost effectiveness methodologies to evaluate the positive role of health and environmental protection in strategies, policies and programmes to promote growth in productivity and production.

A limited number of countries - who are prepared and willing to do so - should be invited to test such methodologies in their ongoing and/or planned health and environmental protection activities.

Health and the Working Environment

61. In most nations, intersectoral action has already contributed to the protection of the health of workers through occupational health programmes in which the state employees and trade unions each play a role. However, there is abundant evidence to show that many people, including women and children, work without that protection in an environment which can be seriously detrimental to health. This is particularly true of unregistered industries or home-based enterprises which comprise what has been described as the informal sector.

62. The approach to improving health conditions in these kinds of enterprises has to be through working with the people running them - perhaps through local business organizations or through informal discussions between local social and environmental health workers. Training and technical advice to these small, informal enterprises will have a more beneficial impact than any attempt to impose standards through factory inspectorates.

RECOMMENDATION

Countries should promote systematic collaboration between local government health and social workers and those working in the informal sector to see how health and safety standards can be improved through collaboration between employers, employees and local government. Such efforts should combine education in occupational health, training, extension services, and appropriate supervisory and regulatory measures, and bring together representatives of trade unions, employers' associations and local government.
The Role of Public Works Programmes

63. Carefully designed and implemented public works programmes maximizing use of local labour and local resources and minimizing capital equipment can create much needed jobs, promote environmental management (for instance through watershed management or reforestation being included in such programmes) and contribute to improvements in health.

RECOMMENDATION

Governments should aid local authorities in coming up with public works programmes to promote health, increase production and safeguard environment with capital costs minimized and use of local labour and local resources maximized. When integrated with wider social and economic development programmes and projects, these can help rural populations in rural areas and slow the exodus to the cities, particularly of young persons.

Mechanisms for facilitating intersectoral action on environmental health

64. Countries have developed various mechanisms for ensuring that coordination between the different sectors involved is optimal and for minimizing the conflicts of interest, and of areas of jurisdiction, that are liable to occur.

65. In certain countries, interministerial councils on the environment have been established. Such councils should consist of representatives of all ministries concerned with health and environmental issues (including housing, land use planning, local government), as well as scientific and technical experts from public health, industrial and educational institutions. Voluntary, non-governmental organizations could also be represented. This approach could provide a forum where health and/or environment ministers could consider and influence projects liable to have an adverse impact. In some countries such intersectoral councils have also worked effectively at the district and local levels.

66. At the local level, community participation is crucial. Community participation could be assured in several ways - one is for governments to display a positive outlook towards non-governmental, voluntary organizations. Their cooperation could help to ensure the appropriate mobilization of support for, and implementation of, national policies and measures at all levels, particularly the crucial district level.

67. Decentralization of decision-making backed up with legal and technical support, as well as community mobilization, is an important means of securing intersectoral coordination between health and environment and at the same time ensuring the safe and sustained utilization of natural resources. Decentralization of authority to the municipal/district level is often essential, since it is at this level that the problems of the poorest sectors of the population are often best perceived and tackled. Yet in most countries, key policies on the protection of health and the human environment are decided upon at the central level. An example of decentralization and community participation is the 'Green Campaign' instituted by the Government of one developing country. Its primary purpose is to promote the establishment of "Green Councils" in each of the country's communities, under the direct jurisdiction of the mayor and municipal council. Their objective is essentially to make optimal use of all the economic resources of the community to provide health and other benefits. One developed country is now establishing Environmental Committees at the municipal level supported by the necessary administrative machinery - including those of the health services of the municipalities.

RECOMMENDATION

Governments should give priority to training their technical staff to enhance their understanding and knowledge of the intersectoral nature of environment and health for systematic application in their work.
68. A critical part of training is the training of local health workers and social workers — at village or sub-district level. These are the people who can most clearly assess needs and advise on the best means of addressing these needs — with appropriate technical advice from central agency staff. They are also a critical part of the monitoring process to see whether implementation actually succeeds in meeting the most urgent needs and improving health.

**RECOMMENDATION**

Governments can better understand grassroots needs and better support grassroots efforts if trained health workers and social workers are located within the villages and sub-districts in cities. In addition, the work of professionals is made much easier if local community leaders' help and support are elicited in formulation, implementation and monitoring of projects and programmes.

69. Legislation could be an important tool in improving health and the human environment. But legal texts per se are not enough — they have to be implemented and their effectiveness monitored. No legislation can succeed unless the population is convinced that it is for their benefit.

70. Some developing countries still have a veritable plethora of legislative instruments (sometimes several decades old) dealing with various components of the environment. It is important that these be consolidated and harmonized, a task which has already been undertaken successfully in certain countries.

71. Legislative texts are insufficient unless they are accompanied by quantitative and qualitative standards. But the standards elaborated for the affluent industrialized countries are in some instances irrelevant to the needs of developing countries, and efforts need to be made to formulate appropriate standards to meet their particular conditions.

**RECOMMENDATION**

Appropriate implementable legislations should be established or consolidated by governments to ensure their most appropriate use as an important tool for improving health and human environment.
The WHA 39th Technical Discussions were conducted as follows:

General Chairman: Mr Goran Dahlgren
Secretary: Dr A. El Bindari Hammad

There were four working groups, namely:

**Group 1  Equity and Health**

Co-sponsor: Mr J. Ripert
Director General Mr Y. Berthelot
Moderator: Mme Simone Veil
Co-moderator: Mr G. Gunatilleke
Secretary: Dr P. Rosenfield
Co-secretary: Mr B. Lanvin

**Group 2  Agriculture, Food and Nutrition**

Co-sponsor: Mr Nurul Islam
Assistant Director General
Moderator: Mr G. Dissanayake
Co-moderator: Dr A. Horwitz
Secretary: Dr G. Quincke
Co-secretary: Dr P. Lunven

**Group 3  Education, culture information and life patterns**

Co-sponsor: Dr S. Spaulding
Director, IBE
Moderator: Dr A. Fakhro
Co-moderator: Dr Maureen Law
Secretary: Dr Amelia Mangay Maglacas
Co-secretary: Mrs Susan Van der Vynckt

**Group 4  Environment - water and sanitation, habitat and industry**

Co-sponsor: Dr M.K. Tolba
Executive Director
Moderator: Dr Emil Selim
Co-moderator: Sir John Reid
Secretary: Mr L. Laugeri
Co-secretary: Dr F. Sella
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Dr J. Bland  Dr H. Hellberg  Dr Farouk Partow
Dr B. Cooper  Miss P. Hunt  Miss M. Pasquet
Dr Claire Chollat-Traquet  Dr Henriette Jansen  Dr L. Philip
Miss L. Daniels  Dr H.M. Kahssay  Mrs A. Pollinger
Dr M. El Batawi  Dr E. Lefranc  Dr A. Pradilla
Mr S. Ewart  Mr J. Ling  Mme S. Ray-Tabona
Dr D. Flahault  Dr S. Litsios  Miss S. Rose
Mr T. Farkas  Dr I. Luculesco  Miss J. Sikkens
Mr S.S. Fluss  Dr J. Martin  Dr E. Tarimo
Dr H.G. Gorchev  Dr R. Mercado  Mr H. Tomyska
Mrs K. Metwalli  Mme A.-M.-Mutschler  Dr O.I.H. Omer
Dr Farouk Partow  Miss M. Pasquet  Dr L. Philip
Mrs A. Pollinger  Dr A. Pradilla  Mme S. Ray-Tabona
Miss S. Rose  Miss J. Sikkens  Dr E. Tarimo
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Dr P. Svensson  
Dr E. Tarimo  
Mr H. Tomyska  
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Volunteers

Miss H. Aly  
Miss F. Assaad  
Mrs M. Cabral De Mello  
Miss J. D' souza  
Mrs F. El Assra  
Miss J. Ferguson  
Miss R. Hammad  
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INTERSECTORAL ACTION FOR HEALTH

Report of Working Group 2: Agriculture - Food and Nutrition

1. INTRODUCTION

Today's world is characterized by huge food surpluses in some areas, while many needy countries are not in a position to produce or buy the food their populations need. At the same time, developing countries, whose income is mostly from agriculture cannot find the markets they need for selling their own produce. The result is that poverty continues to affect large masses of rural populations who do not receive basic services, thus contributing to the unplanned exodus towards cities, and increasing illness, malnutrition and misery. However, some developing countries are providing evidence that development with equity is possible. There are examples of successful intersectoral cooperation in pursuing social goals. Developed countries are also improving intersectoral coordination between health, agriculture and consumers.

Various types of institutions at central and peripheral levels are active in trying to ensure that due attention is given to the nutritional, and ultimately, health needs of populations. Special attention should be paid to meeting the needs of vulnerable groups and especially those of women, who represent 50-60% of the total agricultural labour force. Suitable technologies should be made available to small farmers in order to increase productivity and income. Producer subsidies are also needed to encourage food production and this, together with the provision of health services, safe water and environmental sanitation, are the most efficient ways of slowing down massive migration. However, agricultural development strategies have to ensure that the energy needs of the whole population, both male and female, are fully met.

Consumer subsidies could be useful in encouraging increased demand, especially in urban areas, but their unbridled use could be counterproductive by serving as a disincentive for local production.
2. POLICY AND SITUATIONAL ANALYSIS

Logically, one should proceed with policy analysis and planning in health and agriculture in advance of discussing the promotion of economic growth and the promotion of health through agriculture.

A joint diagnosis of the food and nutrition situation should be undertaken by the health and agriculture sectors globally, regionally and nationally. This is too often undertaken, if at all, from the perspective of only one of the two.

Monitoring of the food and nutrition situation should be a continuing endeavour based on a permanent, effective interaction between the agriculture and health sectors.

In affluent societies, the relationship between dietary intake and disease should be assessed on a regional basis.

3. EQUITY-ORIENTED STRATEGIES

Policy makers must take into consideration the impact of agriculture on health. Health goals should be stated explicitly as part of the objectives of the plans drawn up by the agriculture sector.

In considering the interaction between agriculture and health, a number of basic principles should be borne in mind:

(a) equity and the fair distribution of goods and services, especially to targeted groups;

(b) the special needs of vulnerable groups, for example women, children, refugees, etc.
The role of food aid programmes in areas of undernutrition and starvation was not considered in the background document. It is necessary to consider the effects on populations and the food, nutrition and health links of rapid changes in dietary practices that are introduced via food aid. A world nutrition map should be drawn which will serve to guide those who are involved in providing food aid in the choice of appropriate commodities for a given region or country.

4. BUILDING NATIONAL CAPABILITY

Mechanisms, organs and frameworks have to be defined and organized through which intersectoral action for health can take place. There must be political support for these at the highest level, and involvement and responsibility of the populations concerned at the local level of operations.

In focusing on a world free from hunger, consideration should be given to:

(a) the development and use of crops that can be grown on marginal lands and improved strains of plants, especially through transfer to developing countries of biotechnology and genetic engineering under appropriate, internationally agreed guidelines;

(b) striking a balance between food and cash crop production and production for local versus export markets, farmers must be guided by appropriate extension services;

(c) reducing food losses due to spoilage, contamination and rodents;

(d) food safety, which should be considered in the context of food processing in all countries; the routine fortification of suitable foods, which merits consideration as an important means of avoiding subclinical nutritional deficiencies; and the continued development of international food quality standards, which contribute not only to improved nutrition but facilitate the movement of commodities between and among countries.
INTERSECTORAL ACTION FOR HEALTH

Report of Working Group 3:

Education - Culture, information and life patterns

The session started with Dr Spaulding of UNESCO stating the importance his agency attached to the subject of the discussion. He then introduced his colleagues at the head table.

Dr Ali Fakhro, Minister of Education of Bahrain, and the moderator of the group discussion, urged participants to exchange freely their thoughts, information, and experience on the subject. Dr Ali Fakhro pointed out that the importance of intersectoral coordination has often been emphasized, but for the most part very little has been done about it. He went on to stress that the goal of Health for All goes hand in hand with the goal of Education for All. Both are equity-oriented, related to the values of development and lead to social justice. The promotion of intersectoral action for health will depend to a great extent on the Ministries of Health which must constantly remind the leaders of other sectors of the need for their cooperation. Finally Dr Ali Fakhro reviewed the five sets of issues contained in the background document, and expressed the hope that participants would eventually provide the basis for the drafting of action-oriented recommendations.

2. The discussion was started by President L. Senghor who stated that a substantial proportion of the national budget should go to the education sector to ensure effective overall development. He also called attention to the importance of indigenous medicine.

The participants focused their discussions on the first three of five issues, i.e., health promotion, formal education, non-formal education, and higher learning institutions and health. Twenty-eight participants shared their experiences and ideas with regard to education and health.

3. Education is seen as a decisive factor in health improvement. Even a few years of schooling provide the basic skills and capacities which make a vital difference to the continuing acquisition of knowledge, and the individual's abilities to manage life situations and respond to a changing environment. Poor countries which have given priority to investments in education have lowered mortality levels far below those of countries with higher per capita incomes but less educated populations. In situations where survival is the major health problem and where female literacy is low, female education, both formal and non-formal has led to substantial improvement in the health of the population. A number of participants emphasized that health for all and universal primary education are vitally interlinked.

4. In view of the fact that primary education often by-passes a considerable proportion of the adult population who have had no schooling and are illiterate, a number of countries are making intensive efforts at expanding and improving the quality of functional literacy and other non-formal educational programmes. Many of these programmes deal with concrete life situations provide scope for imparting knowledge, information and skills which are vital for the improvement of nutrition, health and the quality of life as a whole, particularly among disadvantaged groups. The health sector has scope to participate actively in activities in this field.
5. Several participants talked about how the school assumes a place of prime importance for health promotion, particularly as primary education expands, and an increasing proportion of the child population becomes accessible to school. The school can play a major role as a centre for organizing and providing health care for the young, for educating them in healthy living and as a focal point for community health.

The role of teachers in strengthening the relationship between education and health was highlighted as was the necessity of improving their training in health so that in addition to teaching about health, they can provide leadership and facilitate the use of schools as centres for community action for health.

While much importance is attached to schools as focal points for health promotion, it was pointed out that families and communities should reinforce on a continuing basis teaching-learning and other health promoting activities organized by schools.

6. Participants pointed out that a prerequisite for effective intersectoral co-operation for achieving health goals is an adequately trained and motivated professional cadre in all health-related sectors who have acquired the necessary interdisciplinary skills and knowledge to identify the links between health and other development sectors. The manpower development and training required for intrasectoral cooperation emphasized call for new perspectives and reorientations in education and training at all levels. In the field of professional training and higher learning the educational sector has an important role to play in adapting the curricula and imparting a core of interdisciplinary knowledge which enhances the understanding of the intersectoral linkages in development and the capacity of specialities to communicate with each other. Knowledge, training and skill which are specific to intersectoral action must be imparted to workers at all the appropriate levels in the health sector and other health related sectors with inputs from each of the relevant sectors.

The student organizations are also important to the health for all goal. Todays' students are the decision-makers of tomorrow and thus their early involvement in national health development should be assured.

The importance of involving different consumer groups in educating people on health matters was also emphasized and several examples cited where such groups were able to spread health-related messages in a forceful manner.

7. Some important constraints to effective intersectoral action for health mentioned included the high degree of compartmentalization and separatism in the existing governmental structure; tendency of different sectors to compete with each other; the mistaken notion that development is economic growth, resulting in the neglect of the social aspects of development. It was further pointed out, that intersectoral action could best be initiated at the grass roots level where limitations of bureaucratic processes and vested interest are minimal and where the people who are directly affected would be able to mobilize the resources of sectors relevant to their problems.

In dealing with the national level, formal mechanisms for intersectoral action are needed. It was pointed out, however, that where such mechanisms existed, in some instances ministries of health failed to use them effectively. It is hoped that this technical discussion on intersectoral action for health would lead to the revitalization and more effective use of such mechanisms.