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Good health is, by definition, an integral part of social development. The Constitution of the World Health Organization defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. The need to protect this right and ensure adherence to the responsibilities it imposes are recognized in the concepts of “health security” and “health accountability”. Health security demands equity, while health accountability implies obligation on the part of states and health professionals as well as a wider societal responsibility to take account of the impact of development and other policies on health. Although a better understanding is now emerging of the crucial contribution that good health makes to economic activity, enabling individuals to lead a socially and economically productive life, the dimension of health in social development has been neglected. Investment in health is essential for economic growth based on a productive workforce. To achieve this, growth needs to be accompanied by more equitable access to the benefits of development, as inequities have severe health consequences and pose an unacceptable threat to human well-being and security.

The World Summit for Social Development reflects a recognition that, in addition to promoting economic growth, the development process must be human-centred, leading to improved quality of life for all. It is hoped that political leaders meeting in Copenhagen will endorse the need for new approaches to social development based on equality, cooperation, mutual respect and solidarity.

The Summit is being held against a background of profound social, economic, political and technological change which has a strong impact on health and quality of life. Globalization of the economic system is accompanied by trends towards privatization and market economies. In many countries, social disintegration related to poverty and unemployment has led to a deterioration in health. This has affected family health in general and the health of children, women and the elderly in particular. The health and well-being of children, women and men can be most effectively addressed through intersectoral collaboration focused inter alia on capacity-building to support empowerment leading to families characterized by gender equity, constructive reduction of conflict and genuine mutual support.

The capacity of the private sector as a driving force both for human and economic development is sometimes overestimated. Human development, including health, is a social responsibility which involves both private and public sectors. Equity must be ensured through financing of services that benefit the poorest and most vulnerable segments.
of society. Likewise health care cannot be freely commercialized and sold to the highest bidder or dispensed according to the ability to pay.

I The relation of health to poverty, unemployment and social disintegration is examined in depth.

One of the most serious consequences of poverty is ill-health. Poverty exacerbates the spread of disease but, equally importantly, the impact of ill-health has the capacity to intensify poverty or push groups and societies below the poverty line. Among the many examples of this are malnutrition, cholera and tuberculosis. Malnutrition is one of the most serious health hazards, leading to wasting. Cholera, which is directly associated with lack of adequate housing, clean water and sanitation, has increased dramatically over the last decade.

Tuberculosis is re-emerging as a major disease in poor areas in both industrialized and developing countries. In some areas, the spread of tuberculosis is being exacerbated by its association with HIV/AIDS, especially amongst the most vulnerable populations.

Overwhelming evidence from a large body of research in many countries indicates that high levels of unemployment and economic instability can cause significant mental and physical ill-health, not only among the unemployed but also within their families and in the community in general. A special case is the emergence of youth unemployment which, as a widespread and deep-seated structural problem, is a stark manifestation of the failure of development.

Social disintegration related to poverty and unemployment is shown by indicators such as the harmful use of alcohol and drugs, and violence. These are major public health issues, particularly with regard to children's and women's health.

Conflict and war, have incalculable health costs in terms of mortality and disability. As the current situation in Rwanda so tragically illustrates, conflict not only leads to death and mutilation but also to the vulnerability of populations to the spread of epidemics. A close association exists between violence and inequity, finding concrete expression in disparities in health conditions between different segments of the population.

These disparities are an obstacle to the development of a productive, healthy and competitive workforce. They stimulate social unrest and prevent the optimum use of economic resources.

Ill-health has a cost to development. In one society, direct health care costs alone due to violent injury were estimated at $5.7 billion per year. And for every death from violence, there are more than 100 times as many nonfatal injuries. To this must be added the costs associated with the atmosphere of insecurity and fear that arises from an environment of violence.

The costs of health-related problems like the harmful use of substances are also vast. Of special concern is the rapid increase in the consumption and commercial promotion of alcoholic beverages and tobacco in developing countries.

Diseases, including endemic tropical diseases or HIV/AIDS and conditions in specific population groups such as those affecting women, illustrate the destructive repercussions of ill-health on development. Women, more than any other single group, illustrate the combined impact of poverty, unemployment and social disintegration on health and the quality of life. While there is no doubt that, with democratization and technological advances, women's overall health has improved, these gains are offset by the social disadvantages women suffer.

In many countries the democratization process, which would allow equal opportunity for men and women, has not begun. Worldwide, over 60% of those currently unemployed are women. The ranks of the poor are disproportionately filled with women facing high health risks or prostitution. In many societies drug dependence, drug dealing and prostitution are closely connected. These women are at high risk of being infected with HIV and other sexually transmitted diseases.

Women are sociologically, culturally and economically vulnerable to disease. Every two minutes a woman dies from AIDS. Substance abuse by mothers has serious consequences. Women are particularly affected in situations of conflict and war. Technological innovations have not responded to the entire range of women's health needs.
Addressing health can be a practical approach to the alleviation of the devastating force of poverty. Great gains can be made in poverty alleviation through projects which provide access to health through credit, encouraging functional literacy or basic training in income-generating ventures.

The role of health in conflict reduction as a “bridge to peace” or a “corridor of tranquillity” has been documented. Health investment may also be a form of insurance for the prevention of conflict and the maintenance of social and civil peace.

Health indicators measure the outcomes of development and have a monitoring role as a basis for health accountability. Health goals and targets are necessary and are available. The goals and targets of the WHO Ninth General Programme of Work are set as an expression of commitment by WHO and its Member States to support countries in achieving improvements in health status and greater equity in health.

This report is an illustration of WHO’s profound commitment to human development. It expresses a concern for the protection and enrichment of the quality of life. And it stresses that this quality of life is inseparably linked with health status. It calls for a multisectoral and multilateral approach to ensure that health is addressed from the outset in all efforts for development.
REVEALING FACTS ON HEALTH

THE FACE OF POVERTY

- 76 years for developed market economies
- 54 years for least developed countries

Maternal mortality rate (1993 estimates)
- 11 per 100,000 live births for developed market countries
- 735 per 100,000 live births for least developed countries

- 7 per 1000 live births for developed market economies
- 112 per 1000 live births for least developed countries

- 172 per 1000 live births for least developed countries

Children under five years of age suffering from malnutrition (1993 estimates)
- 192.5 million or one in three children in the developing world
- one in four children in Africa
- two in five children in Asia
- one in 10 children in Latin America

- 20 percent of newborns weigh less than 2500 gr at birth in least developed countries

Number of deaths in 1993 due to:
- Infectious and parasitic diseases:
  - 16310 thousand in the developing world
  - 135 thousand in the developed world
- Perinatal causes:
  - 3097 thousand in the developing world
  - 83 thousand in the developed world
- Maternal causes:
  - 508 thousand in the developing world

Children's condition
- In the developing world, some 80 million children between the ages of 10 and 14 are employed in work that interferes with their normal development; some 30 million of them live in city streets.

SYMPTOMS OF SOCIAL DISINTEGRATION

Suicide
- In many countries, the suicide rate has risen dramatically since the 1950s, even doubling or tripling in some cases.

- A large proportion of people committing suicide show high blood levels of alcohol.
- Many suicides have taken place among adolescents and young adults.

Prevalence of HIV infections among adult men and women, estimated end of 1994
- 18 million globally
- 11 million in Sub-Saharan Africa

THE FACE OF INEQUITY

Access to safe water in rural areas (1992)
- 63% of population in the developing world
- 29% of population in the developing countries of the WHO African Region
- 52% of population in the developing countries of the WHO Region for the Americas
- 50% of population in the developing countries of the WHO Eastern Mediterranean Region
- 72% of population in the developing countries of the WHO Region for South-East Asia
- 73% of population in the developing countries of the WHO Region for the Western Pacific

Access to safe excreta-disposal facilities in rural areas (1992)
- 62% of population in the developing world
- 25% of population in the developing countries of the WHO African Region
- 34% of population in the developing countries of the WHO Region for the Americas
- 29% of population in the developing countries of the WHO Eastern Mediterranean Region
- 22% of population in the developing countries of the WHO Region for South-East Asia
- 82% of population in the developing countries of the WHO Region for the Western Pacific

THE FACE OF SOCIAL EXCLUSION

Women's condition
- Working women in all regions of the world receive lower pay than men; women's earnings vary from about 50–90 percent of men's earnings in the developing world.
- 30 million suffer from diseases derived from alcohol intake
- 300,000 deaths per year due to alcohol cirrhosis
- 50,000 deaths by car accident or related to alcohol
- 1 billion women use pharmaceutical hypnotics
- 20 million street girls inhale volatile solvents.
INTRODUCTION

Health is, by definition, an integral part of social development. The Constitution of the World Health Organization (WHO) defines health as:

A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Those who prepared WHO's Constitution had the foresight to envision health within the context of human rights, peace and security. The Constitution affirms:

The enjoyment of the highest attainable standard of health is one of the fundamental human rights of every human being without distinction of race, religion, political belief, economic or social condition.

The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and states.

The Health for All movement launched at the Thirtieth World Health Assembly in 1977 was based on recognition of the link between health and development. Health for All promulgates, as a primary goal of all societies, universal attainment by the year 2000 of a level of health that permits all people to lead socially and economically productive lives. The fundamental conditions for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity.

The right of everyone to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control; as well as the right to special care and assistance to mothers and children who should benefit from the same social protection, has been emphasized in the Universal Declaration of Human Rights and given legal protection in the Convention on the Rights of the Child and the International Covenant on Economic, Social and Cultural Rights.

The need to protect these rights and ensure adherence to the responsibilities they incur is more relevant today than ever before and is reflected in the concepts of "health security" and "health accountability". Health security is founded on equity. It represents the principle of universality in health promotion and care, with the aim that all human beings may live free from the risk of preventable illness and injury and may have equal access to quality health care that is both affordable and relevant.

Health security means more than a system of processes and schemes which guarantee access to health care. It includes the right to food in sufficient quantity and of good quality, the information necessary for self-reliance, and a working and living environment where known health risks are controlled and where the respect and protection of each person's physical and moral integrity are ensured. It also means empowering people, to make the right choices in health, enabling them to cope with changing patterns of vulnerability, and building their capacity to keep themselves and their families healthy. This calls for various forms of social and economic support, and for fuller knowledge and awareness. Intersectoral collaboration is indispensable in this regard.

Health accountability begins with the obligations of states and the responsibilities of health professionals to provide health services to all. It also includes states' acceptance of responsibility for the impact on health of their development and other policies.
PART I

HEALTH:
A NEGLECTED
INDICATOR OF
DEVELOPMENT

There is wide belief that economic growth is the central aim of development. Without economic growth, societies could not build the resource base that is required for all development activities, including the implementation of social programmes such as health and education. However, the pursuit of development in the economic sphere alone may obscure the purpose of development as a whole, which is to improve the quality of life of all people.

In the past century, enormous progress has been made in human welfare - the ultimate goal of development. Advances have usually gone hand in hand with economic growth. Even where growth lagged, however, quality of life improved. Governments have played a leading role in this. Public spending on classrooms and textbooks, safe drinking-water and sanitation, nutrition and immunization programmes and family planning clinics has been of critical importance, especially for the world's poor. But the demands of the future will require better targeting of services, new and more efficient methods of delivery, fewer regressive subsidies, and closer partnership with the private sector in the provision of certain services. During times of economic hardship, tough choices must be made and shorter gains in economic growth must be weighed against long-term threats to human development and the quality of life.

Greater wealth - whether for countries, communities or individuals - is not a sufficient guarantee of better health. Policies that have narrowly focused on economic development have frequently had adverse effects on health and social status, particularly of the most vulnerable groups such as disadvantaged women, girl children, the elderly, the unemployed, the disabled, the hungry or homeless, migrants, refugees and those living in poverty. When economies are badly managed, investments in people may go to waste.

Better diet, housing and control of communicable diseases have raised the quality of life everywhere. By reducing illness, these improvements have increased people's alertness, capacity for learning, and ability to cope with and enjoy life. By prolonging life, they have made investments in knowledge and skills even more worthwhile. And the benefits of good health reach into the future; a mother's good health strongly influences the early physical and mental development of her children.

Development policies that have not incorporated social policies have often increased people's vulnerability through degradation of the environment, greater unemployment, global recession with its consequent reduced social benefits and poorer chances of education, inadequate nutrition and clean water, poor waste disposal, unsafe housing, and lack of essential services. New pockets of deprivation have emerged, even in areas with high levels of gross national product (GNP) per
capita. New vulnerable groups and forms of exclusion may have been created. These inequities have severe health consequences and pose an unacceptable threat to human well-being and security. In societies where health is endangered and health services are denied, the situation becomes volatile and may lead to conflict.

On the other hand, development policies and economic strategies that have incorporated social policies on health and education have contributed to improvement in health status, leading invariably to progress, as measured in terms of overall quality-of-life indicators such as life expectancy and infant mortality rates.

The health status of a population, especially when disaggregated by sector, age and economic and social status, provides an indicator of the human outcomes of development and highlights disparities between different members of society. Health reflects people's living conditions, it may point to inequity, and it provides an early warning of emerging social problems.

The convening of the World Summit for Social Development reflects a recognition by the international community that, in addition to promoting economic growth, the development process must be people-centred and must incorporate non-material and social dimensions that contribute to improved quality of life for all. It is revealing that it is the failure of development that has largely defined the agenda of the Summit — poverty, high unemployment and social disintegration. These issues are perceived as the most urgent manifestations of a deep-seated social crisis which almost all societies face today. There is also the awareness that not only do unsatisfied social needs get worse but the remedial action they call for gets more costly.

The gathering of political leaders in Copenhagen is not called to celebrate what has been achieved, but to sound the alarm that growing poverty, unemployment and social disintegration is both dangerous and unacceptable. It will test our commitment to fostering the creation both of new societies based on equity and cooperation, rather than inequity and destructive competition, and of interpersonal relationships based on mutual respect and solidarity.

Beneficial links between health and development should emerge from the summit, and should be identified and reinforced. This is particularly true for vulnerable and disadvantaged groups where deprivation in health and economic resources exist together, reinforcing each other, and where integrated strategies are needed to break the vicious circle of poverty, illiteracy and ill-health. Strategies that combine health and development must be at the core of action to prevent poverty, unemployment and social disintegration. Health cuts across the core issues of the Summit and unifies them in a single holistic concept of the human condition.

This vision of health needs to be brought home to the policy-makers who have tended to treat health benefits brought about by economic development in the same way as they would treat economic benefits brought about by improvements in health. They generally assume that these benefits flow automatically from the interaction of the health and development processes, and they seldom see the need for special interventions. The Summit will make clear that this is not the case. Health must be consciously built into the development process and it must be consciously protected.

WHO's efforts to improve health and quality of life and to advance development further are grounded in the certainty that, in order to bring about the necessary changes, health policies must reach beyond the health sector while remaining rooted in the principles of primary health care. Perhaps the most important task of WHO is to impress upon the international community the need for political commitment to place health at the centre of development goals. International agreement on the importance of health for reaching economic and social development targets must be translated into political commitment at national level. Top decision-makers should adopt policies which assume responsibility for health, clearly define the role of the health sector and earmark adequate financial resources for health. This commitment necessarily will emphasize the improvement of the health of the most vulnerable population groups and will specify action that must be taken by all health-related sectors. WHO's concept of health also embraces legislative and regulatory measures for health protection and promotion. Both are urgently needed in view of the threats to health from the effects of macroeconomic, agricultural, industrial, energy and trade policies.
Health system development, reform and management are further elements of WHO's vision for propagating a greater degree of overall development. Health education and promotion that involves the encouragement of healthy lifestyles is also critical; personal responsibility for fostering and maintaining health is as important as action taken by government leaders. There is a need for community involvement in health system development, improved training, employment conditions and distribution of health care workers, and integration of specific programmes into health systems at appropriate levels as indicated by epidemiological data.

Health has a potentially important role at the Summit. Health can be the basis for consensus on the desired outcomes of the Summit; it can provide focus in drawing up specific commitments, programmes of action and policies to be adopted; and it can provide the common language for political agreement on ensuring the achievement of the Summit's goals.

Privatization and market mechanisms

The "democratic" ideal is gaining universal acceptance and is reshaping political systems the world over. The dismantling of old structures and the reaffirmation of human rights and freedoms are releasing both creative and disruptive energies. Most societies, although in various stages of political transition, are seeking and evolving new forms of civic participation and decentralization to enable communities, households and individuals to assume an increasing share of responsibility for the decisions that affect their lives. In many cases, however, efforts to decentralize have proved insufficient since the function of decision-making on many key issues is still retained by the central government.

An increasing number of countries are going through radical adaptation, progressively becoming part of larger and more integrated regional entities. The worldwide trend towards an open market economy has led to the emergence of a global model for organizing production and the distribution of services. The driving forces of the world we now live in put governments under pressure to liberalize trade and adopt free market mechanisms. Greater economic efficiency is sought through modernization, often bringing with it greater inequity and inequality of opportunity. In many countries the transition from state-administered forms to market mechanisms has involved high social and human costs that have intensified poverty and unemployment and have often led to a deterioration in health.

The increasing materialism of our age and the focus on economic growth have led to the assumption that the only "goods" of a society are material goods. These attitudes have ignored or denigrated social and cultural values and have led to movements for self-determination based on ethnic, religious and cultural identities that are creating deep conflicts within some nation States. It is necessary to move on from this limited view and recognize health as a social good, and not merely as a means to economic development.

This is especially relevant when we consider that the change from a centrally planned to a market economy in many countries has implied a diminishing role of the state and greater leeway for the market to act as a regulatory mechanism. Where the democratic process is in its early stages, the danger lies in the state relinquishing responsibility for establishing norms and standards leading to a weakening or total absence of mechanisms for
control and supervision. This affects all sectors, but has a particular impact on health standards and quality of care.

In the increasing trend towards privatization in some countries, the capacity of the private sector to become the engine that drives economic and human development is sometimes overestimated. The private sector may be too impoverished to provide the necessary momentum for all sectors of the economy.

In such situations, the role of government is crucial in ensuring equity by providing services that benefit the poorest and most vulnerable segments of society, who are the hardest hit during periods of economic transition. Even in full-fledged market economies it is the government that ensures equality of opportunity. There is often a positive correlation between economic development and public financing of health services.

At this time of change, it is more important than ever to come to a better understanding of what can be achieved by the complementary actions of governments and the private sector.

Health is a social responsibility. Maintaining the right balance between the market and the protection of the public good through the state is proving to be a difficult and complex task. There is conflict between, on the one hand, the forces pushing for free market economies in the name of efficiency and, on the other, the need to ensure equity and social justice in the provision of health care services. Contrary to the common belief, it has been shown that investment in health by the state can often be the driving force for modernization.

Human rights are not available for profit. Health care cannot be freely commercialized and sold to the highest bidder or dispensed according to the ability to pay. The experience of health care vividly demonstrates that what is profitable is not always what is good, and that those who need health care most are often those who cannot pay for it.

Who are those who cannot pay? We all know them: they are the marginalized, the disadvantaged and the vulnerable who do not fully participate in the social process. It is in the area of health that their vulnerability is most apparent.

Even within poverty there are disparities and inequalities that are reflected in aspects of health status that need to be addressed. In poor households, women suffer from special conditions of deprivation. A very revealing indicator of poverty is the gender differential in life expectancy. In normal conditions, the average life span of a woman exceeds that of a man by three to four years. In poor countries or communities, the average life span of women tends to be the same or even lower than that of men, mainly as a result of the higher health hazards associated with high fertility, poor nutrition and the burdens of household work.

One of the most serious consequences of poverty is malnutrition which can cause wasting, blindness from vitamin A deficiency, mental retardation from iodine deficiency and widespread iron deficiency. This means that even where educational services are available, some children cannot see, cannot hear and cannot develop to their full potential.

How much would a society save by investing in preventive measures to address poor nutritional status? Savings would be gained not only from reduction of institutional care but also in terms of costs that cannot be measured in figures, such as the suffering of the individual affected, the family, care-takers and the community as a whole.

The failure of macroeconomic policies and the free market system to ensure equitable distribution of wealth has led to an active process of poverty creation. The vulnerable population in urban areas has continued to increase. The share of the urban population in the total population of the poorest countries, excluding China and India, rose from
14% to 25% during the period 1965–1989. This was not an orderly process in which the superior amenities available in the urban sector became available to the expanding population as a whole. Rapid urban growth has produced pockets of deprivation and subhuman living conditions that are at times more severe than those in rural areas. The poor have been portrayed as a net burden on the process of growth. Not only have poor people remained poor, but so have large numbers of poor nations. Part of the debt crisis of the 1980s arose from an inability to mobilize domestic assets and from systematic resort to external resources. The instability of this kind of development has been amply demonstrated. In many cases it is difficult to envisage national growth without strong economic development among the poor themselves—not as the objects, but as the subjects of development.

The poor, particularly those living in slums and squatter settlements on the fringes of major cities, have experienced little benefit from the progress made during the International Drinking Water Supply and Sanitation Decade (1981–1990). Despite the achievements of the Decade, an estimated 1000 million people in the world’s developing regions remain without access to safe drinking water and about twice that number lack the means for sanitary excreta disposal. In 1990, in 44 developing countries with the lowest indicators of health development, the share of the rural population with access to health services, safe water and sanitation was 37%, 38%, and 6% respectively. The comparable figures for the urban population in the same countries were 81%, 74%, and 39%.

Insanitary living conditions are associated with very high rates of parasitic and diarrhoeal diseases, and with a rise in communicable diseases. In some parts of the world, increasing impoverishment over the past decade has been reflected in the re-emergence of major diseases previously thought to have been brought under effective control or eradicated.

Cholera, for example, with its direct association with lack of adequate housing, clean water and sanitation, has increased dramatically in the past 10 years. In the year 1991 alone, cholera was reported in 14 countries of Latin America in which the disease had not been reported for several decades.

Tuberculosis is re-emerging as a major disease in areas of poverty in industrialized and developing countries alike. In some areas, the spread of tuberculosis is being exacerbated by the acquired immunodeficiency syndrome (AIDS). People infected with the human immunodeficiency virus (HIV) are more susceptible to tuberculosis infection as a result of their depressed immune status. WHO estimates that in Africa in 1990, 24% of all cases of tuberculosis were attributable to HIV infection. It is estimated that this figure will increase to 40% by the year 2000. This is an alarming projection, especially in the light of the particularly virulent form of tuberculosis that is associated with HIV/AIDS.

In the drive for profit by industry or employers, minimum standards of safety are often ignored with disastrous consequences for employees and the community. The poor are particularly vulnerable to these occupational and environmental health risks, whether as agricultural workers in contact with new agrochemicals, urban dwellers exposed to environmental pollution, or child labourers. Accidents and manmade disasters have grown in scale and intensity and have become one of the leading causes of death and disability. Some 120 million occupational accidents with 200 000 fatalities are estimated to occur annually, as are 700 000 fatalities in traffic accidents and more than a million in domestic accidents.
The social, economic and technological changes engendered by development can create new health risks and new forms of health insecurity, as well as new opportunities to promote positive health. Many of these changes originate in sectors and in activities that have no direct concern with, or responsibility for, health.

Few systems are capable of identifying and dealing with the health implications of development strategies and macroeconomic policies, whether these are manifested as development projects, new technologies, international trade, the activities of transnational enterprises, or changes in value systems and lifestyles.

**Unemployment**

There are 35 million people out of work in the leading industrialized countries and many more in developing countries. Unemployment has become not only an economic problem and a problem of personal deprivation, but also a major public health concern. There is overwhelming evidence from a large body of research in many countries that high levels of unemployment and economic instability cause a significant increase in the levels of mental ill-health and also have adverse effects on physical health, not only of the unemployed, but also of their families and the community in general.

The opportunity of participating in work and productive activity is a prerequisite for physical and mental health. Unemployment can produce a deep sense of worthlessness and loss of purpose, leading to psychological impairment and various states of ill-health. It is a form of social exclusion. The health problems of the unemployed acquire a chronic and more complex character when unemployment coexists with poverty.

The emergence of youth unemployment as a widespread and deep-seated structural problem is a stark manifestation of the failure of development. Economic conditions in many countries have deteriorated while the skills needed for employment have become more sophisticated. These trends increase the stress young people experience in their search for education, training and jobs, and lead to conditions of alienation and health-damaging behaviours, such as dependence on drugs and alcohol, which also have negative moral consequences.

However, it should also be noted that young people are generally less vulnerable than the very young or the very old, since the young are at a time of life of great energy, creativity and enthusiasm. Given the right degree of support and opportunity they are a great resource for the present and future of all societies.

**Breakdown in values**

Measurement of success in materialistic terms and lack of human solidarity are often seen as prevailing characteristics in societies in many regions of the world. The pursuit of materialism at the cost of traditional values of sharing and caring is considered by many to be having a marked impact on human behaviour globally. The breakdown of value systems has had far-reaching and all too often tragic consequences for social cohesion and health. Economic development is reflected in changes in lifestyles, attitude and health behaviour.

In many countries the institution of the family is undergoing unprecedented change. The extended multigeneration family of traditional societies is giving way to the nuclear family which is in turn giving way increasingly to single-parent families and the no-parent families of street children. Armed conflict and natural disasters result in tens of thousands of “unaccompanied” refugee children who are often separated permanently from their families. The health burden of changing lifestyles and family patterns has been particularly heavy for the young and the elderly, and a family health perspective offers a way of assessing how these demands can be most effectively addressed over the life course of families.

High levels of profit have encouraged drug trafficking and property crimes. The need to ensure essential foreign currency through tourism
has led some governments to turn a blind eye to the risk that prostitution poses to the lives and health of their women and girls.

Trafficking in illegal drugs and their source materials, together with trade in weapons, has created the overwhelming temptation of quick and easy access to huge fortunes through violence. In places this has led to the corruption of social values and even of institutions such as the judicial system. A violent culture transmits the values that sustain it — in the family, at school, in the arts or in each other’s effects on behaviour and well-being. Behaviour is seldom simply a matter of individual choice; it is strongly constrained by local, financial and sociocultural realities. The more vulnerable and weaker members of society are at most risk but, in a society that is further polarized by inequality of opportunity and of access to the benefits of scientific and technological progress, the vulnerable are at higher risk still.

Urbanization and modernization of rural cultures have often been accompanied by the breakdown of social support systems. Urbanization that outstrips the capacity of the infrastructure affects the social environment in the most direct way. Adverse effects include increase in crime, violence and rates of alcoholism, drug abuse and suicide. Urban overcrowding and poor working conditions can lead to anxiety, depression and chronic stress, and have detrimental effects on the quality of life of families and communities.

Changes in family structure and living arrangements have significant impact on people’s health and their capacity to cope with health and social problems.

Doubts are raised increasingly about the quality of life of old or disabled persons living in extended family structures. There can be no doubt, however, that the breakdown of traditional living arrangements and, in particular, the dramatic increase in divorce rates and single-parent families, as well as the increase in people living alone, will present a major challenge to health and other social services.

The increase in violence is one of the most glaring results of social disintegration related to poverty and unemployment. Violence is a public health issue. Indeed it is one of the most complex problems that the public health field has ever addressed for there is no single cause nor any one solution. Violence may erupt as a result of structural factors, such as

Social disintegration

Poverty, unemployment and social disintegration have both direct and indirect impacts on the social and mental well-being of individuals, communities and countries. In general, mental, social and behavioural health problems represent overlapping clusters of problems that, against a background of global change, interact so as to intensify

the mass communication media. Is it surprising that young people become victims of drug dependence at a scale never witnessed before? Is it surprising to find death from violence reaching such alarming proportions in everyday life?

Extreme and widespread poverty, persistent high unemployment and the forces leading to social disintegration are perceived as the most evident sign of the deep-seated social crisis that almost all societies face today.
patterns of economic, political and social domination. Or it may express the anguish of those who see no future reward for their efforts, or of those for whom the future seems bleaker than the present. Or it may be due to traumatic experiences suffered in the home or community, or to any situation marked by cruelty, discrimination, rejection, or forcible and arbitrary domination. The association of violence with drug or alcohol use should also be recognized.

In recent decades humanity has been able to avoid wars on the scale of World Wars I and II, but smaller and more persistent military conflicts and civil wars have become endemic in many parts of the world. As a result, there has been a more pervasive militarization of societies which, while in some instances necessary, jeopardizes the democratic process. With relatively easy access to more sophisticated weapons of extinction, the levels of violence in societies have escalated. New structures of violence have emerged, such as transnational criminal organizations engaged in illegal trade of narcotics, arms and other goods. International terrorist networks have grown and pose major threats to the security of states and to the lives of civilians.

Violence associated with gender, ethnicity, family relationships or sexual preference may invade areas of privacy that could otherwise provide a safe haven from outside aggression, turning them into settings for domination and cruelty.

Violence towards children, and the degree to which violent images are permitted to permeate film and other media, can be regarded as a reflection of the level of violence tolerated by a society. Gratuitous violence on television is on the increase at a time when television is, in some societies, being used increasingly as a baby-sitter. In some countries, it has been estimated that by the time a child leaves elementary school he or she will have witnessed 8,000 murders and 100,000 acts of violence on film. As a result, violence is becoming regarded as normal.

The stark reality of the effect of seeing and experiencing violence on television is the increase in crime carried out by younger and younger children. While parents are invariably concerned about what is going into their children's mouths, they may be less concerned about what is feeding their minds.

Although it is widely accepted today that there is no single direct relationship between poverty and violence, a close association does indeed exist between inequity and violence. It is not that poor people are intrinsically more violent than other members of society, but, rather, that the inequities they suffer, combined with the disempowerment, fear, insecurity, frustration and depression these cause, are contributing factors to violent behaviour.

It is not enough, therefore, solely to condemn the one who kills his neighbour, for this action is often dependent on a series of events. A chain can only be as strong as its weakest link and society is only as rich as its poorest member.

Violence threatens the health care systems of all nations. It draws off resources urgently needed for other health problems. For example, in one industrialized country medical costs due to firearm injuries exceed $1 billion per year. In addition, in the same country domestic violence results in almost 100,000 days of hospitalization, almost 30,000 emergency department visits, and almost 40,000 visits to physicians each year. Nearly three out of four personal crimes result in economic loss, with 10% of all victims of violent crime losing time from work. Direct health care costs alone due to violent injury are estimated at $5.7 billion per year. And for every death from violence, there are over 100 times as many non-fatal injuries.

To this must be added the costs associated with the atmosphere of insecurity and fear that arises from a violent environment. Demands for more and better law enforcement, police, military forces, order and repression divert resources from more socially oriented strategies. The costs of private surveillance and weaponry and of buildings with security systems all have an impact on a country's economy and syphon off funds that could have been used for preventive programmes. Studies are currently underway to analyse the correlation between cuts in health budgets and increases in policing, security and prisons. Processes of social disintegration are often at the root of political conflicts and find their most acute manifestations in collective group violence of various types and civil war.

The health costs of such conflict and aggression are incalculable in terms of mortality and disabil-
ity. The injuries inflicted by modern weapons demand resources of equipment and skilled personnel which are far beyond the capacity of many countries, exhausting precious national resources. The use of landmines has consequences that extend beyond warfare, with devastating impact on the life of the civilian community and on the economy. In situations such as guerrilla warfare, combatants have very limited access to health care. As the current conflict in Rwanda illustrates so tragically, conflict not only leads to death and mutilation in fighting but also to vulnerability to the spread of epidemics among people fleeing the fighting and among the communities that grant them refuge. This does not take into consideration the destruction of the health infrastructure, or the pollution of waters that leads to epidemics which are difficult to contain in situations of war and conflicts.

The rehabilitation of war victims is an additional burden. Many war victims may never recover, as reflected in the numbers of those who are unable to resettle in their communities. Many will be permanently handicapped. The total health cost of these mental and physical dramas may never be measured.

Local wars and human rights abuses have fuelled the refugee crisis. The United Nations High Commissioner for Refugees estimates the total current number of refugees and displaced persons in the world at 20–30 million. Given that the total number of people forcibly uprooted during the entire 20th century, including the two world wars, is estimated to be around 140 million, the trend of the past decade seems to be unprecedented. The health consequences of the refugee crisis are likely to be long-term and may pass from one generation to the next.

The price of inequity

For health, equity is not an abstract term. Inequity is firmly anchored in disparities in health conditions between different segments of the population. If we look at morbidity and mortality patterns of different groups, it is clearly not the wealthy who consistently contract diseases such as cholera, schistosomiasis or guinea worm. The poor also suffer more from non-communicable diseases.

Inequities in access to health care which persist both between and within countries are manifested in, for example, the high rates of maternal, perinatal and infant mortality that continue to be reported from developing countries. Taken together in 1995, the 47 least developed countries, with a population of 575 million people, are estimated to have an average life expectancy of 52 years and an infant mortality rate of 106 per thousand live births. Disadvantaged groups within developed countries with high levels of GNP per capita also have poor health status. Ill-health represents a huge economic cost that can retard and reverse economic development. It is an obstacle to the development of a productive, healthy and competitive workforce. It also prevents the optimum use of economic resources.

Three specific examples of the complex relationship between ill-health, poverty, social disintegration and unemployment are parasitic diseases, HIV/AIDS and women’s health.

The prevalence of a parasitic disease like guinea worm prevents the use of potentially productive land and undermines people’s income-earning activities. Other diseases such as malaria and onchocerciasis have become the dominant cause of poverty in specific regions. In one country, a major rice import substitution programme could not proceed until malaria had been effectively controlled.

The AIDS pandemic illustrates the interrelatedness of the three Summit themes. HIV infection underscores the already existing faultlines in society. The destructive repercussions of ill-health for development are illustrated by the tragic example of the HIV/AIDS pandemic. AIDS kills
individuals and destroys families, communities and economies. As young and middle-aged adults, men and women, who are the mainstay of the family, the backbone of the workforce and the key to development, die from AIDS, the profile of the workforce will drastically change. In many cases improvements in child survival will be reversed.

Through its effects on savings and productivity, AIDS poses a severe threat to economic growth in countries already in distress. WHO estimates a cumulative total of 30–40 million HIV-infected cases by the year 2000.

What hope is there in those parts of the world where the creativity and productivity of the younger generation, upon which all economic progress depends, is being destroyed?

Poverty exacerbates the spread of HIV, particularly where women and men, girls and boys, are forced into prostitution through economic necessity. Similarly, economic and social pressures all too often lead to the use of drugs and the consequent risk of HIV infection from the use of contaminated needles. Children forced through poverty and family breakdown to make a precarious living on city streets are particularly vulnerable to these risks.

There is a two-way relationship between AIDS and social issues. Like poverty, social exclusion creates additional vulnerability to the risk of HIV infection as those groups in society who suffer prejudice and discrimination are harder to reach with AIDS education and other preventive efforts. Similarly, as a result of the fact that HIV is transmitted more easily to those already infected with another sexually transmitted disease (STD), the disadvantage suffered by these groups in gaining access to STD treatment leads to their increased vulnerability to the risk of HIV infection. Alcohol and drug use among young people may further enhance unsafe sexual behaviour, increasing the risk of the transmission of HIV and other STDs as well as giving rise to unwanted pregnancies.

AIDS also leads to social exclusion. AIDS combines some of the worst aspects of a range of other diseases, all of which have led, and continue to lead, to social isolation. Like syphilis, HIV infection can be passed from mother to child. Unlike many other diseases, it hits those in the prime of their life, just when they are ready to give to society their youth, creativity and vitality.

The combination of these characteristics has caused an unprecedented degree of prejudice and discrimination against people with HIV and AIDS. Such discrimination results in immense suffering to those concerned. In addition, it impedes public health efforts to control the spread of HIV, as the fear associated with identification of HIV status inhibits individuals from coming forward for HIV testing and health treatment.

The case of women

There is perhaps no single group that illustrates better the combined impact of poverty, unemployment and social disintegration on health and quality of life than women. The poor health status of women has disastrous repercussions for economic development. It is estimated that women are the sole bread-winners in one quarter to one third of the world’s households, and in many parts of the world women are an integral and essential part of the labour force. Women account for more than 70% of the agricultural workforce in many parts of Africa. In these situations, the economic cost of the relatively low health status of women in terms of lost productivity is particularly high, not to mention the diminished ability of those who are mothers to provide adequate care and support for their children.
There is no doubt that women's overall health has improved. This is illustrated by generally increased life expectancy among women. But has there been a corresponding improvement in the quality of women's lives? Women who reach old age must frequently contend with loneliness, alienation, disability and poverty.

Girls are born with a biological advantage over boys, but this is often cancelled out by the social disadvantages they suffer. Differential feeding practices, additional burdens of work and lack of basic schooling for girls put them at greater risk of malnutrition and disease. Early pregnancies before girls are physically and socially mature set a pattern for repeated pregnancies and pose a major risk for their lives.

One of the tragedies of 1995 is the persistent denial of education to many women, and the relationship this has to disease and health conditions that affect women. Illiteracy in all its forms—not only the inability to read and write, but the denial of information pertinent to an understanding by women of how their body functions, and how they can prevent diseases and protect themselves—is one of the most pernicious factors leading to harmful practices perpetuated by women themselves. Some of these health-damaging behaviours span from childhood to old age and include food taboos at various stages in the life of a girl or woman, harmful practices during pregnancy, delivery and care of the newborn, introduction of harmful substances into the vagina, female genital mutilation, and many more.

Street children who have no family ties and no place to live are an increasingly familiar sight in some developing countries. Many of the young girls living on the streets are easy prey for criminal prostitution rings and drug trafficking. These girls suffer terrible health consequences.

The unprecedented scale at which political, economic, social and technological changes are occurring affects the health status and quality of life of both men and women, but it has particular health consequences for women because of their biological, social, physiological and gender specificities.

In many political arenas democratization has opened new avenues for women's advancement and contributed to political and legal gains. Women's empowerment has opened the door to active participation at all levels of decision-making—including a greater say in the restructuring of society and in efforts to eliminate discrimination, foster equality and enhance health. The exclusion of women is apparent in countries where democratization has not begun. Also in many countries where democracy is nascent or established there may still be fundamental contradictions. While democracy opens up prospects for equal opportunity for men and women, it does not necessarily provide the mechanisms for effective expression of this equality, nor does it address the underlying roots of discrimination that continue to flourish in democratic systems. In these situations women have very little say in decisions regarding their health needs and the type of health services they require. Such services must be economically and culturally acceptable.

The forms of adjustment that are most conducive to growth and protection of human needs will not emerge by accident. They have to be encouraged by an appropriate set of incentives and policies and will also require political courage. In spite of broad recognition of this imperative, the most vulnerable women still find that their needs remain unmet and that little has been done to mitigate the social costs of adjustment on their lives.

In a highly competitive climate where there is emphasis on the production of cheap tradeable goods, many companies seek to produce at the lowest cost by increasing working hours, by sacrificing costly safety standards and by cutting wages. Women fill the ranks of these low-paid workers. The health consequences can be seen when scores of workers lose their jobs in massive lay-offs, or suffer acute or chronic ill-health due to poor working conditions.
A recent study in Central and Eastern Europe has shown that, prior to economic restructuring, female participation in the labour market was as high as 50%. The percentage of women currently unemployeed exceeds 60%.

Today, the ranks of the poor are disproportionately filled by single women-headed households.

Poor women increasingly resort to strategies for coping that include accepting work with high health risks, including prostitution.

Is it any surprise that, worldwide, every minute of the day and every day of the year, two women become infected with HIV and every two minutes a woman dies from AIDS? It is estimated that more than 1 million women became HIV-infected in 1993 alone.

Women appear to be biologically more vulnerable to HIV infection. Transmission of HIV from men to women is as much as 2–10 times more efficient than transmission from women to men.

More than 20 million women are chronically infected with either herpes or human papilloma virus, both of which increase their vulnerability to HIV infection.

Problems that regularly occur in society are aggravated during conflict and war. While men, women and children all suffer during war, civil strife and other conflicts, women in particular are affected.

When war strikes, women suffer the bombardments in silence, make do when the electricity and water supplies have been destroyed, and seek food when there is no longer any food available.

Throughout the history of war, women have been subject to the most degrading treatment, torture, plunder and rape at the hands of aggressors.

It is estimated that 75% of the world’s 30 million refugees are women and girls. Most of them are exposed to poor nutrition and illness, and many of them to violence, including rape.


Technological innovations have not benefited all people equally. Available technologies may be inappropriate or may not respond fully to women’s health needs. Consequently, women receive fewer intensive diagnostic and treatment interventions than men – especially in the case of cardiovascular conditions. Women have not been sufficiently involved in technology development.

The tools and equipment used by women farmers are designed for use by men. They have been found to have serious health repercussions on women which may appear much later in life. Women may also be given insufficient access to existing technologies. For example, women often lack the means to protect themselves independently against STDs and other conditions.

Amniocentesis, ultrasound and chorionic villus sampling are but three examples of technologies which have been developed to detect and treat potential health-damaging conditions and diseases in their earliest stages. Guidelines should be elaborated and enforced so as to protect against misuse of such new technologies whose misapplication may raise serious moral and ethical questions.

Reckless behaviour patterns characteristic of disillusioned youth may, in the case of girls, be passed on from mother to child. The use of alcohol, drugs and tobacco during pregnancy can have serious consequences for foetuses and infants, ranging from low birth weight to a variety of physical and mental disorders.

Women must cope with social stress and pressure in a personal way but, as mothers, wives, daughters, sisters and caregivers, they bear the burden of coping with the unemployment of a husband or a child, the drug abuse of a brother or the rape of a daughter.

It has been stressed that while adequate nutritional intake is important for all human beings and is closely linked to patterns of morbidity and mortality, it is particularly important for girls and women. This is because of intergenerational and cumulative effects which permeate different phases of a woman’s life.
• Discriminatory feeding practices in childhood sometimes lead to protein-energy malnutrition, anaemia and other micronutrient deficiencies in young girls.

• Stunting caused by protein-energy malnutrition in girls is responsible for subsequent problems in childbirth leading to increased incidence of obstructed labour, and vesicovaginal fistulae, birth asphyxia and other conditions.

• Globally, 51% of pregnant women and one-third of women of reproductive age who are not pregnant suffer from anaemia. In developing countries, 56% of pregnant women are anaemic. Up to 7% of pregnant women suffer from severe anaemia in Southern Asia.

• The adolescent girl requires, but rarely gets, 18% more iron per kg body weight than male adolescents. Virtually all adolescent girls in developing countries suffer from iron deficiency.

• In the girl child, without other sources of vitamin D, the pelvic bones are apt to become deformed, leading to future complications such as death in childbirth from obstructed labour.

• Iodine deficiency is the commonest preventable cause of mental retardation. At least 25% of adolescent girls in developing countries are affected by iodine deficiency and this seriously affects the next generation. Iodine deficiency leads not only to goitre but also to brain damage in the fetus and infant, resulting in irreversible retarded psychomotor development. In severe cases it causes cretinism, deaf-mutism, squint, spastic diplegia and other serious defects. It also affects a woman's reproductive function leading to increased rates of abortion, stillbirth, congenital anomalies, low birth weight and infant and young child mortality. Mild to moderate deficiency causes loss of 5–10 IQ points.

• The effects of the socially disadvantaged position of women and girls are often cumulative, the most severe consequence being death in childbirth. Maternal mortality rates in resource-poor countries are as high as 100 times the rates in industrialized countries.

• The death of a mother has dramatic consequences on the family, and especially on children. When a mother dies it doubles the death rate of her surviving sons and quadruples that of her daughters. In high maternal mortality settings, there may be as many as 175,000 motherless children for every million families.

• Pregnancies that come too early, too often and too closely spaced present a serious danger to women’s health. Maternal mortality rates are higher among teenage mothers.

• Children of malnourished mothers are at increased risk of low birth weight which leads to infant death and conditions such as cerebral palsy, autism and learning disabilities.

• Cancer of the cervix is a disease found disproportionately in women in developing countries and is one of the leading causes of death among women in these countries. There is a clear socioeconomic gradient in the incidence, linking it with poverty.

• It is estimated that more than 1000 newborns die every day as a complication of unsafe handling of the cord after delivery, and an equal number suffer health risks when early breastfeeding is purposely withheld during the first days after birth.

• Globally, at least 2 million girls a year suffer genital mutilation, approximately 6000 new cases every day – five girls every minute. An estimated 85–114 million girls and women in the world are genitally mutilated.

Although grossly underreported, *violence against women* is now reaching alarming proportions in developed and developing countries alike. Domestic violence and rape have only recently been viewed as a public health problem yet they are a significant cause of female morbidity and mortality. Violence against women leads to psychological trauma, depression, substance abuse, injuries, STDs and HIV infection, suicide, and death. Male substance abuse is recognized as one of the causes of domestic violence.

On a per capita basis the health burden of domestic violence and rape on women of reproductive age is roughly the same in industrial and developing countries, but because the overall health burden is greater in developing countries the percentage attributable to gender-based victimization is smaller (roughly 5%).

Based on the limited data available, the World Bank estimates that, in industrialized countries, rape and domestic violence account for almost one in every five healthy years of life lost to women aged between 15 and 44. In these countries, abused women have significantly worse physical and mental health when measured by standardized health status questionnaires.

Women who are the victims of violence rarely receive rehabilitative care. They usually lack insurance coverage, particularly for the mental health consequences of violence, and do not receive the compensation that victims of other injury-causing traumas receive.

As life expectancy increases in most countries, it is estimated that the number of women over the age of 65 will increase from 188 million in 1990 to 326 million in 2015. Many of these older women will have experienced poor nutrition, reproductive ill-health, dangerous working conditions, violence and lifestyle-related diseases, all of which exacerbate the post-menopausal phenomena of increased likelihood of breast and cervical cancers and osteoporosis. Poverty, loneliness and alienation are common among the elderly. Little is known of the health conditions of elderly females except in industrialized countries. Data on the health of the elderly female population has to be extrapolated from findings in these countries.
While it is useful to treat the themes of poverty, unemployment and social development as separate issues in terms of analysis, this approach is inadequate when it comes to addressing the solutions. Experiences over the last few decades have established that strategies designed to alleviate poverty, relieve the suffering caused by unemployment, generate full employment and foster social cohesion, are least likely to succeed when they address these issues in isolation. They are most likely to succeed when a multifaceted, multisectional and integrated approach is pursued.

Rather than treating the symptoms of poverty, unemployment and social disintegration, should we not aim to eradicate the structural causes of inequity? This means focusing on empowerment and equal access to all that society has to offer, including health.

Research has consistently pointed to the importance of families in the maintenance of health, the prevention of illness and the curing of disease. Greater emphasis needs to be given to understanding the strengths of families in all their forms, and the role of social networks and formal health services in supporting the well-being of individuals, families and communities.

In most integrated strategies, health is approached as an element to be added in the form of improvement and expansion of health services rather than as an integral part of the process of transformation of deprived, underprivileged and socially marginalized people. Changes in health status of vulnerable and marginalized groups should be indispensable criteria both in formulating national development policies and strategies and in evaluating their outcomes.

**Health can alleviate the most devastating forms of poverty**

Medical ethics provide a moral imperative for addressing the health needs of all people without distinction. This orientation
of primary health care to equity also establishes health as a vehicle of poverty alleviation. For the lower strata of society, health is a survival issue. We have seen that ill-health is a cause of poverty, and poverty is a cause of ill-health. By investing in health, we empower the individual to escape from the vicious downward spiral of ill-health and poverty and instead to climb the ladder of increased health and capacity that leads to greater social and economic productivity.

The flow of costs and benefits from health to economic growth and other processes of development are frequently identifiable and interventions which strengthen the link between health and development are easy to design and implement. This is the case when an endemic disease acts as a serious impediment to growth. One example of a solution to a health problem that has led to economic benefits was seen when a programme of agricultural settlement was launched in a malaria-ridden dry zone, where it was necessary to control malaria first. Another example is the onchocerciasis control programme which liberated productive land to be used for economic development.

It has also been shown that investment in the health of the poorest segments of society, or the marginalized that exhibit serious symptoms of ill-health, is a preconditions for enabling these individuals and population groups to move out of their difficult situation and increase their prospects of engaging in productive activity. Eliminating inequity and ensuring access to health for the groups most in need requires the development of health systems that are well designed and well managed.

Great gains can be made in alleviating poverty through projects that provide access to credit for women and encourage functional literacy or basic training in an income-generating venture. Such projects are even more effective when they are linked directly to the promotion of health. Integrated programmes directed at the improvement of women’s health in poor communities demonstrate that improvements in health give women more time for income-generating activities and contribute to the economic and social well-being of the household. In one African country, for example, the virtual eradication of guinea worm in some districts was achieved by a combination of health education and the provision of safe drinking-water. This has released energies in the farming sector, resulting in substantial increases in production which have, in turn, meant more income for rural families and have led to better nutrition.

The latter has had an impact on school attendance and performance since children are more alert and miss fewer days of school through sickness.

By helping to diminish social differentials and inequities, health helps to foster social cohesion and development. The health sector is not alone in this struggle, but in its pivotal role it can do much
to integrate the work of the various sectors and to foster a multisectoral approach. In this way, health can lay the groundwork for a sustained, integrated and holistic approach to human development.

The emphasis of health on prevention

Primary health care and Health for All advocate the priority order of national health strategies from the curative to the preventive and proactive. This means moving the emphasis from treating disease to limiting health risks and fostering health-promotive behaviours. This is the emphasis behind the tremendous strides made in preventive programmes for children such as expanded immunization, diarrhoeal disease control, safe motherhood, tropical disease control, nutrition programmes and many more. All take place within the context of primary health care and are rooted in a family and community-based infrastructure that provides care and services to all, irrespective of race, sex or religion. This type of infrastructure applies to both rural and urban areas, in both developed and developing countries. The community-based approach is a good example of health becoming a powerful means of social integration that fosters group cohesion.

Many diseases and conditions of ill-health that are widespread in both developing and developed countries can be prevented by relevant actions for health promotion. Many health problems have their roots largely in environmental and socioeconomic factors, in lifestyles and in behaviour that human beings can influence by their own actions. The promotion of health and improvement of socioeconomic status require healthy public policy, advocacy for health, supportive environments for health development and sustained coordinated actions by all concerned sectors, institutions, groups and social organizations. With appropriate education and training, and with sustained technical, financial, administrative and moral support, communities can be empowered to participate actively in improving their health and overall socioeconomic conditions.

The health sector, a major employer

The health sector is one of the major employers in the job market and includes both service provision
and manufacturing. The multidisciplinary skills required in the health sector have led to the employment of a range of professionals, semi-professionals and lay workers in many institutions of the health system. In developing countries, employment in the health sector carries with it additional fringe benefits that are not always provided by other sectors of the economy. They include housing, health care benefits, transport, uniforms and even meals. These benefits are related to the type of services which the health professional performs in health institutions. Furthermore, recent years have witnessed a dramatic increase in health-related industries that are bound to grow even further. Their production ranges from pharmaceuticals to equipment and hi-tech materials.

**Health in conflict reduction**

Health is valued by everyone. It provides a basis for bringing people together to analyse, to discuss and to arrive at a consensus acceptable to all. The potential for using health as a mechanism for dialogue, and even peace, has been demonstrated in situations of conflict. Concern about health may diffuse political confrontation and place problems in a humanitarian perspective that is more acceptable to all parties.

Experiences from around the world show that, even in wars and armed conflicts, health can act as “a bridge for peace” and a “corridor of tranquility”, providing the neutral space in which mutual respect and consensus can grow. As recently as November 1994, the WHO Regional Office for the Eastern Mediterranean was successful in convincing the main factions in the conflict in Afghanistan to stop fighting during a vaccination campaign launched by WHO. As a result, millions of children in Afghanistan have been vaccinated against poliomyelitis and measles during a week of tranquillity when hostilities were halted. This illustrates how health can become a common objective and can evoke a binding commitment that is shared by warring parties.

Health investment is also a form of insurance for the prevention of conflict and maintenance of social and civil peace. Investing in the health education and skill formation of young people reduces the possibility that they will be recruited into criminal activities and substance misuse, restricts the potential for many social ills, and leads to greater security.

Health was again used as a rallying cry to gain consensus in one country on how to reduce the exposure of children to violent images on television. Treating violence as a public health issue provides a bridge between the principle of freedom of expression on the one hand and the potentially destructive effect of images of gratuitous violence on the other. By examining television violence from a medical perspective and seeing it in terms of a mental health problem of children rather than censoring what adults can watch, and by approaching the issue through cooperation and consensus rather than confrontation, all those with an interest in the problem were able to come to a reasonable and collective decision.

The value system that is implicit in health care makes health central to development. Responsibilities and activities for the protection and promotion of health are embedded in humanitarian concerns, professional ethics and human values. Health thus provides a major ethical and spiritual basis for influencing the behaviour of individuals and of society as a whole.
PART III
MEASURING THE EFFECTS OF DEVELOPMENT

We have seen that health status is a reflection of the successes and failures of development. Health could also be used to measure progress towards overcoming inequities. Good health indicators show the outcome of a combination of biological, genetic, environmental and socioeconomic factors. For example, the enjoyment of a health status that enables an individual to lead an economically and socially productive life means that this individual has not only benefited from the availability of goods and services, but has also acquired the information and behaviour patterns to improve and protect his or her health.

A wide range of indicators of health status can be used to measure both the outcomes and the processes of development. A first group of indicators relates directly to disease – to types of disease, their incidence and the rates of morbidity. The increasing incidence of cardiovascular diseases and cancers, for instance, may point to underlying causes relating to food, nutrition, smoking and alcohol use, trade policies, changes in lifestyles or the environment.

A second group of health indicators relates to health risk factors. Examples include all forms of malnutrition: obesity, low birth weight, protein deficiency and others. Further examples are birth spacing and fertility rates, levels of immunization, smoking, and alcohol and drug abuse. A third set of indicators relates to mortality. These are the most revealing indicators of extreme vulnerability. They include infant and child mortality, maternal mortality, and deaths as a result of traffic accidents, violence and other causes.

Finally, a fourth set of indicators relates to processes that contribute to human development. These include the quality of health services, access to and utilization of services, education, housing, water and sanitation, the work environment, income and purchasing power. The health impact of policies and activities in all relevant areas of development should be under continuous surveillance and monitoring. The state of health of the population must be used constantly as a measure of the degree and quality of the development that is taking place and of the effectiveness of the development strategies that are being implemented.

A system of accountability must be developed for all sectors to enable them to identify and deal with the health implications of their strategies and policies. These systems of accountability would identify the health risks of various activities, introduce surveillance and monitoring, define health rights and responsibilities, design and implement a health accounting system and promote the free flow of health knowledge and information.

The Summit may consider some of the goals and targets listed below to be particularly useful as a benchmark for measuring progress made in social development in general and in the
The following goals and targets serve to ensure the survival and healthy development of special groups of the population.

| Goal: | To increase the span of healthy life for all people in such a way that health disparities between social groups are reduced |
|-------|
| Target: | Life expectancy at birth will not be less than 60 years in any country |
| Target: | For all population groups, the difference between the highest and the lowest values for life expectancy at birth will be reduced by at least 50% |

Goal: To ensure universal access to an agreed set of essential health care and services of acceptable quality, comprising at least the eight essential elements of primary health care

Target: At least 85% of the world's population will have access (within an hour's walk or travel) to treatment of common diseases and to essential drugs and vaccines, biological products and blood products of good quality

Goal: To ensure continued improvements in nutritional status for all population groups

Target: The prevalence rate for severe and moderate malnutrition in children under five will be reduced by 50%

Target: Micronutrient deficiencies from vitamin A and iodine will be eliminated (no longer of public health significance in terms of prevalence)

Goal: To enable all people to adopt and maintain healthy lifestyles and healthy behaviour

Target: All people will have access to information and opportunities to promote health-enhancing lifestyles and decrease health-damaging behaviour

Goal: To ensure survival and healthy development of children

Target: The infant mortality rate will not exceed 50 per 1000 live births

Target: The mortality rate among children under five years of age will not exceed 70 per 1000 live births

Target: The proportion of low birth weight (less than 2.5 kg) will be reduced to less than 10%

Target: At least 90% of the children under one year of age will be immunized against these six diseases: diphtheria, pertussis, tetanus, measles, poliomyelitis and tuberculosis

Goal: To improve the health and well-being of women

Target: The maternal mortality rate will be reduced by 50%

Target: All pregnant women will have protection with tetanus toxoid, access to prenatal care, trained attendants during childbirth and referral facilities for high-risk pregnancies and obstetrical emergencies

Target: Disability-free life expectancy at birth will increase by 15% in all populations

Target: The prevalence rate from iron deficiency anaemia in women (aged 15–49 years) will be reduced by 33%

Goal: To improve the health and well-being of the elderly

Target: All countries will have launched initiatives for health gaining and will have appropriate preventive, curative and rehabilitative services for the elderly

Goal: To ensure healthy population development

Target: All individuals and couples will have access to information and services to prevent pregnancies that are too early, too closely spaced, too late or too many
Goals that strive to eradicate, eliminate and control diseases and conditions that particularly affect the poor, unemployed and the socially excluded preventing them contributing to social and economic development, include the following:

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<tbody>
<tr>
<td>To eradicate, eliminate or control major diseases constituting global health problems</td>
<td>Poliomyelitis and dracunculiasis (guinea worm) will be eradicated.</td>
</tr>
</tbody>
</table>

The above goals and targets are extracted from WHO’s Ninth General Programme of Work, which covers the period from 1996 to 2001. They reflect a commitment from WHO and the world community. If the goals may be understood as aspirational, the targets must be seen as operational. They are interrelated and interlinked with the main themes of the Social Summit. Inasmuch as one or all the themes of the Summit may influence the level of attainment of these targets, achieving the targets will also have impact upon the Summit themes, individually or collectively.

Countries in all parts of the world are manifesting a crisis in health status. Many people are subject to persistent ill-health and unnecessary suffering. It is a crisis reflected in new conditions of sickness and vulnerability that are an outcome of the present modes of development.

The alleviation of this tremendous human suffering demands a multipronged approach that can deal simultaneously with conditions of poor health, low income and productivity, and lack of access to relevant services and required knowledge and skills. Such an approach will aim to empower the most disadvantaged groups, remove beggars from the streets, provide surrogate parents for orphans, and address the needs of the homeless, the unemployed and the forgotten elderly. It will aim to create a society which offers hope to all who are disadvantaged. This cannot be achieved without taking into account health as a life giving force. But health must not be conceived simply as a series of services. Above all the development process will have to break the cycle of poverty and inequity and must aim towards a meaningful prolongation of life, a guarantee of child survival and development, elimination of maternal
mortality, reduction in substance abuse and violence, and promotion of a sense of well-being and wholesomeness throughout people’s lives.

The family unit, whatever its particular structure, plays a critical role in ensuring and maintaining the health of its members. Families often respond to challenge with surprising resilience and the essential functions of family life often survive the most intense assaults. At the same time, economic and legal protection, support services and family-friendly policies can buttress the function of families in critically important ways.

If the Social Summit is to move beyond rhetoric and relate issues and concerns to measurable targets, political commitment must be backed by goals that are achievable. In addition, goals must be adaptable to various national settings and cultures as well as to countries at various stages of development.

When a multifaceted, multisectoral and integrated approach to social development is pursued, health status provides the best assessment of vulnerability, social deprivation and development needs. Improvement in health status is the best indicator that development processes are having a positive impact on disadvantaged groups.

A clear commitment to overcoming economic and social inequities in all their manifestations is essential if the World Summit is to play an effective role in promoting equitable social development in a world of justice, harmony and peace. Health must figure largely in this commitment. Equally, a health-focused approach to development provides a pragmatic means to honour such a commitment.

"The eight elements of primary health care are:

- education concerning prevailing health problems and the methods of preventing and controlling them
- promotion of food supply and proper nutrition
- an adequate supply of safe water and basic sanitation
- material and child health care including family planning
- immunization against the major infectious diseases
- prevention and control of locally endemic diseases
- appropriate treatment of common diseases and injuries and mental health care
- provision of essential drugs

Additional issues that countries address will broaden the scope of primary health care. Targets for the other elements of primary health care are included under the other goals. Indicators to determine access to all elements of primary health care should be developed as a complement to information about access to individual elements."
A STRATEGY FOR WORLD ACTION

The World Summit for Social Development offers a great challenge to the world community to seek new approaches based on equality, cooperation, mutual respect and solidarity. Health is at the centre of such a development approach whose outcomes can be measured in improved health and better life.

The critical issues under consideration at the Social Summit are global and multisectoral; the response must be equally global and multisectoral. It is clear that the Social Summit can be a driving force for progress in development only if all agencies and governments work in a concerted way. Disparate approaches have little lasting effect, but unified efforts hold the potential to maximize benefits to those who are most in need.

The World Health Organization has a mandate to direct and coordinate international efforts for health, and to provide technical support to countries. In striving to fulfil this mandate, the Organization looks forward to continuing close and constructive cooperation with other agencies, institutions and non-governmental organizations for the purpose of ensuring the centrality of health in all development policies and strategies.

In WHO's Ninth General Programme of Work which defines the global health policy framework for the Organization in cooperation with countries and international partners in development, both the technical cooperation and directing and coordinating functions of WHO are focused on enhancing the capacity of countries to define and implement their own priorities for health development and public health action, disease prevention and health promotion, and to establish sustainable health infrastructure.

Four interrelated policy orientations have been established as a focus for action by the world community, including WHO, to attain the goals and targets set in the Ninth General Programme of Work, some of which appear in this document. They are:

a) integrating health and human development in public policy;
b) ensuring equitable access to health services;
c) promoting and protecting health;
d) preventing and controlling specific health problems.

WHO's directing and coordinating functions include the search for international consensus on health problems of global priority and the most effective ways of assisting countries to solve them. In pursuing this, WHO will advocate for the use of all measures to mobilize international resources and action for health, including humanitarian assistance.

WHO has a singular role to play in ensuring greater accountability for health through the Organization's normative function. This includes monitoring the health situation and trends throughout the world; proposing conventions, regulations, norms, standards and guidelines related to health.

This position paper has argued that the pursuit of development in the economic, educational or health sphere alone may obscure the purpose of development as a whole which is to improve the quality of life of all people. Work undertaken since the early 1980's by WHO and a number of sister agencies of the United Nations system has demonstrated that social and economic gains can be pursued simultaneously. Of particular value is the technical assistance WHO provides to countries to strengthen initiatives aimed at protecting and promoting the health and well-being of the most disadvantaged groups in society.

WHO can provide numerous examples of successful initiatives in which the priority needs of people are addressed by and with the people themselves thereby fostering a level of self-reliance which ensures that gains made in economic and social development, including health, are protected and enhanced, even during conflict situations. Countries adopting such approaches reap multiple benefits by alleviating the health problems that contribute to poverty, and by using innovative methods to address the multidimensional poverty which often leads to deprivation, exclusion, violence and, ultimately, poor health. Above all the self-reliance which is created releases the energy of people and encourages further development.

WHO is not only concerned with identifying and working with countries and partners to improve the health status of disadvantaged groups in societies, but in using such innovative approaches to ensure that such groups come to a position
where they can enjoy their full rights and move out of a situation of poverty and inequity.

In responding to the challenges set by the World Summit for Social Development, WHO welcomes the opportunity to work with countries, development partners, non-governmental organizations, and others. The results of such concerted world action will be seen in the following outcomes:

- strengthened partnerships for health development by gaining political commitment and intersectoral cooperation to improve both the socioeconomic determinants of health and the health benefits of social and economic development;
- improved capability in all countries to analyse the health effects of development projects and to influence public policy relating to development and decisions on resources for health;
- use of health status within the population, and in particular its changes over time among disadvantaged groups, as an indicator for assessing the quality of development and its impact on the environment;
- expanded and improved functioning of health infrastructure in countries in order to ensure and maintain access for all communities and groups to appropriate services for health promotion, and preventive, curative and rehabilitative care, including the essential elements of primary health care and the appropriate supporting hospital services;
- enhanced capabilities and opportunities for communities in health development and in the management of their health systems;
- better information and transfer of knowledge on proven, affordable, cost-effective technology and its appropriate application;
- implementation of strategies for all sectors of human activity in countries to protect, promote and improve health and enhance human development, particularly by reducing and controlling health risks and encouraging healthy lifestyles;
- implementation of strategies to combat the spread of violence, particularly against such vulnerable groups as children, women and the elderly;
- implementation of strategies and methods for public participation including multisectoral community involvement in health promotion and protection.

The challenge we face as a new millennium dawns is more urgent than ever – to use the coming decades to build consistent improvement into the lives of those who are suffering and to strengthen the capacity of future generations to make sure that improvement continues.

Health is not just a worthy investment; it is vital to our very survival. Since health is the foundation on which all human endeavour rests, it is the business of all sectors of society to strive actively to preserve it. If there is one message that should stem from this Social Summit, it is that health – the basis of human life – must be addressed from the very outset in all efforts for development.
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Note
The following additional documents (listed here in alphabetical order), delivered to or distributed at the Inter-American Conference on Society, Violence and Health (Washington, DC, 16–17 November 1994), were consulted in the preparation of this document:

- AMNESTY INTERNATIONAL (LONDON). "The continent in which we want to live: a message from Amnesty International to the people of the Americas". Document AMR 01/01/94.

- BOGDONOFF, P. & SMITH, J. "On-line resources pertaining to society, violence & health". Contribution to the Conference


- CENTER FOR VICTIMS OF TORTURE (MINNEAPOLIS). Unpublished letter to the Director of the Pan American Health Organization.

- DEPARTMENT OF HEALTH AND SOCIAL SERVICES & QUEBEC PUBLIC HEALTH NETWORK. “From injury prevention to promoting safe environments and behaviour: basics of the approach in Quebec”.


- DINSMORE, P. Notes for an address to the Conference (on behalf of the Canadian Radio-television and Telecommunications Commission).


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