Intersectoral cooperation in primary health care

"The role of intersectoral cooperation in national strategies for Health for all." World Health this month examines the theme chosen for the Technical Discussions which will take place during the World Health Assembly, to be held in May in Geneva

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Improvements in the health status of a population cannot be achieved simply by expanding and developing the health services. The prevention and control of disease and the promotion of health require a concerted effort for the improvement of human well-being as a whole. In this task, what has been defined as "health care" has to be supported by improvements in the social and economic infrastructure, and contributions from various sectors other than health.

Certainly there has been a broad understanding of the linkages between health development and development in other sectors. The health experience of the industrialised countries has contributed significantly to this understanding. We know that the major causes of sickness and death arising out of a large cluster of diseases associated with poor sanitation, illiteracy and low levels of income were effectively controlled in these countries well before the discovery of antibiotics and other spectacular curative "breakthroughs". The control of diarrhoeal diseases, tuberculosis and a wide range of communicable diseases was primarily achieved through far-reaching improvements in the urban infrastructure, housing and environmental sanitation, through the changes in health behaviour which accompanied higher levels of education and literacy, and through the improvement in nutritional status as incomes and living standards steadily rose. The positive outcome in health was therefore the result of an intersectoral effort.

Higher levels of education result in improved levels of health.

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The more recent experiences of a few developing countries illustrate even more dramatically the way in which health forms part of an integrated process of development. These countries have been able to achieve high levels of life expectancy and have shown remarkable progress in reducing infant and maternal mortality at comparatively low levels of income. The state of Kerala, with per capita incomes well below the average for India as a whole, enjoys a health status— as measured by life expectancy, infant mortality and other health indicators—which is well above the rest of India.

Similarly Sri Lanka, with a per capita income in the region of US$ 300, has within a time span of 35 years raised life expectancy from 46 years to nearly 70 years and reduced mortality from 22 per thousand to six per thousand. Costa Rica, which is in the middle-income category of developing countries, has over a time span of 30 years achieved a spectacular reduction in infant mortality and improvements in other health indicators.

In all these cases, studies have shown that the efforts in the health field were simultaneously reinforced by developments in other sectors. In Sri Lanka, health was part of a welfare system which provided mass free education and guaranteed a subsidised ration of food to all households. This was combined with economic development policies which improved the productivity and income levels of the rural poor through a coordinated programme for food production in the peasant sector.

The programme for the control of malaria in Sri Lanka during the 1940s
and 1950s is a striking example of intersectoral action. The control of malaria formed one component of a socio-economic programme aimed at resettling the malaria-stricken zone in the country, and at achieving self-sufficiency in rice, the staple food. Consequently, the health programme formed part of a larger economic and political commitment as a result of which malaria control received the highest priority. The socio-economic programme also meant developing the social and economic infrastructure of the areas where malaria was endemic. The rural peasantry engaged in rice cultivation, a severely disadvantaged segment, became the target of a variety of government programmes which increased productivity and income, improved their nutritional status and raised the educational levels. The malaria programme was an integral part of these developments.

In Kerala, India, long-standing programmes directed at social welfare raised the educational levels of the population and developed a social infrastructure, including a transport network which provided easy access to services. An effective programme of land reform had given poor people access to land resources for food production at the household level and this had far-reaching effects on the availability of food for the poor.

In Costa Rica, social and economic reforms and educational improvements helped to change the health situation dramatically in three decades. During the 1970s particularly, a National Health Plan and a General Health Law took account of important intersectoral and national requirements for achieving the planned objectives. The health programme itself was part of a larger programme of social welfare which had the effect of redistributing income through services. Within the health programme itself an important place was given to rural and community programmes of primary health care. Community level institutions were promoted to involve the community more closely. The remarkable decline in infant mortality from 67 per 1,000 live births in 1970 to 21 in 1980 is attributed mainly to this community health programme.

In all three territories, education (and female literacy in particular) has played a key role in improving the health situation. It enabled the health programmes to focus on the mother, on enhancing her knowledge of and capability for child care, on improving the immediate health environment of the infant and child, and on reducing the numbers of people at highest risk.

The importance of intersectoral action in health development can also be very forcefully illustrated in a case where the lack of it had a negative outcome. The resident plantation workers in Sri Lanka, descended from Indian immigrant labour during the colonial period, had at the time of independence marginally higher health indicators, such as crude death rate and infant mortality, than the rest of the Sri Lankan population. During the 30 years that followed, the plantation workers were unable to participate fully in the welfare system of the rest of the country. Educational levels and especially female literacy continued to remain low. Housing conditions remained poor. Even though basic health services were provided, and the nutritional intake and income levels were marginally higher than those of the rural Sri Lankan peasantry in the surrounding area, health indicators for the population quickly fell below the national average and by the 1970s lagged far behind. Whereas, in the rest of the country, health development was an integral part of social development which raised educational levels and improved the quality of the habitat as a whole, the plantation workers were confined within an enclave which did not form part of this integrated process.

Despite all that has happened in the past in the developed world, and despite the many experiences in developing countries that prove the value of intersectoral action, few countries consciously incorporate such action in their national health strategies. This is partly because the health services already face the daunting problem of extending their coverage to reach all the people. In addition, there is the technical complexity of the problems that require intersectoral action. The challenge is for all sectors to explore relationships about which useful data are scarce and for which most sectors are technically unprepared. Finally, what is needed is political leadership which is oriented towards social development, and not just to economic development.

The Alma-Ata Declaration of 1978 and WHO's Strategy for Health for all, with their emphasis on prevention of disease and promotion of health, have
identified intersectoral action as a key element in health policies and action programmes, and one of the most important guiding principles in formulating and implementing national health strategies.

In the initiatives embodied in WHO's Health for All strategy, intersectoral action has been emphasised and articulated as part of the entire health strategy, mainly because of the basic re-ordering of health priorities. Today the major emphasis is on the prevention and control of disease and the promotion of health through primary health care. This shift in priorities has immediately highlighted the intersectoral character of health care. Agriculture and nutrition, housing, sanitation, water supply, literacy, health education and greater self-reliance in health care all are integrated in the current primary health care strategies.

Achievement of the Health for All goals will depend vitally on sound intersectoral action directed at specific health goals. On the one hand, eliminating the major causes of prevalent sickness and preventing any specific cluster of diseases will require action in all those areas outside the health sector which currently contribute to the incidence of those diseases. And on the other, the broader aim of increasing well-being and resistance to disease as a whole while promoting and maintaining good health will require the combined efforts of many sectors not immediately related to health.

Neither the individual nor the household perceives well-being as fragmented into sectors—even if that well-being stems from a specific economic sector, or from education, or from health, or from employment. Well-being is a single unified condition. The same is equally true of the well-being of a community. It is with this perception in mind that health planners and health workers need to act when drawing up strategies or putting primary health care into practice. This will ensure that the health component is placed in the context of social development as a whole, and that other sectors are mobilised and motivated to lend their support towards achieving health goals.

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The community health worker can help to identify community problems and people at risk or in need; he or she has a bridging function, putting the community in touch with health and other services.

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