GUIDELINES
FOR
POLICIES AND PROGRAMMES
ON
INTERSECTORAL ACTION
FOR
HEALTH

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POLICY GUIDELINES FOR INTERSECTORAL AND INTRASECTORAL ACTION FOR HEALTH

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PREFACE

The formulation of these outlines for programming at the national level intersectoral and intrasectoral action to raise levels of health among different communities was undertaken by the Marga Institute for the World Health Organisation. They are intended to assist policy planners in determining the broad outlines of action oriented programmes for raising health levels in the context of the health situation prevailing in the country and, more pertinently, among different communities within the country where vulnerability gives rise for concern. As vulnerability is often the results of complex interactions between activities in various sectors, the guidelines draw attention to particular areas of sectoral activity which tend to have a marked influence on the health outcome.

The report was prepared by Mr Eardley Fernando, Consultant, Human Resources and Social Studies Division of the Institute in close consultation with Mr Godfrey Gunatillake, Vice Chairman and Dr P. D. A. Perera, Director.
Guidelines for policy Formulation for Health-related
Inter-sectoral Intervention at District level in Sri Lanka

Although with the Alma Ata Conference there has been a fundamental change in the approach to health which has given much greater emphasis to the multi-sectoral character of health development, it cannot be said that the new strategy has as yet led to a comprehensive intersectoral approach which takes adequate account of the impact which sectors other than health are continuously making on the well-being of communities - especially of rural population segments, as is clearly the case in Sri Lanka. The new strategy requires the health sector to collaborate with these sectors to restructure their health-related components towards a positive outcome in health. However, as the recent study (1986) on Seasonality and Health in the Matale District of Sri Lanka has disclosed, the new multi-sectoral approach has still far to go before the advances in health envisaged reach a satisfactory level of realisation.

There are several reasons why integrated multi-sectoral efforts have not advanced far enough in Sri Lanka:

(i) Health planning for the most part continues to be carried out in relative isolation from other sectors though, in a crisis, intensive multi-sectoral collaboration has achieved much under the purposeful direction of the Government Agent and his assistants.

(ii) Other sectors have been slow to incorporate health goals as part of their own sectoral goals and to articulate clearly the health related components in their programmes.

(iii) Insufficient appreciation that articulating the health-related policy component of health-related sector activities is a collective responsibility in which the relevant sectors must work closely together with the health sector.

(iv) Due to the lack of national mechanisms for intersectoral co-ordination for health promotion, the development planning system tends to neglect
horizontal linkages with major impacts on health.

(v) Intersectoral efforts require the health sector to collaborate with other sectors in incorporating health goals into the programmes of these other sectors rather than, as is often the case, merely seeking inputs from these sectors into its own health care programmes and services.

(vi) The failure to find feasible solutions that reconcile health goals with other sectoral goals when these are in conflict; in such instances decisions must be taken in the full knowledge of the trade-offs between health goals and other goals and with the compensatory actions which might be needed clearly stated and understood.

Despite the existence of a national plan headed by a National Health Council under the Prime Minister with mechanisms down to the village level for health-related sectors to collaborate in overcoming health problems at the source by planned intersectoral efforts, it became clear during the study on Seasonality and Health that inter-sectoral programmes have still some way to go before an acceptable level of success can be considered to have been achieved. During the course of the study it became apparent that aspects of the shortcomings (i) to (vi) listed above were present to a lesser or greater extent. In particular it appeared that the principal problems confronting the action oriented intersectoral efforts at village level were:

1. clear identification of the health problems

2. correct identification of the cause or causes contributing to them

3. effective co-ordination and integration of the activities at the action-oriented levels

4. lack of appropriate resources and manpower.

5. insufficient commitment at all implementation levels to achieve the best outcome in the shortest time with the resources available.
The chart below depicts the network of mechanism for the development of health in Sri Lanka.

1. NATIONAL COUNCIL OF HEALTH (NCH) presided over by the Prime Minister and attended by Ministers in charge of health-related sectors. Political direction flows from this body.

2. NATIONAL HEALTH DEVELOPMENT COMMITTEE (NHDC) presided over by the Secretary, (Health) and attended by the Secretaries and Departmental Heads of all the health-related Ministries and Departments. The NHDC has set up the following Standing Committees
   i. Primary Health Care
   ii. Manpower
   iii. Drugs
   iv. Health Research
   v. Indigenous Medicine

3. DISTRICT HEALTH DEVELOPMENT COMMITTEES (DHDC) (one for each Health Region) Presided over by the District Minister and attended by the District Heads of all health-related Departments.

4. HEALTH DEVELOPMENT COMMITTEES in each of 259 Assistant Government Agent (AGA) Divisions presided over by the AGA and attended by Divisional Health Officers and Divisional Officers of health-related Departments.

5. VILLAGE HEALTH DEVELOPMENT COMMITTEES for each predetermined cluster of villages, attended by Public Health Inspectors, Public Health Midwives, Health Volunteers, health-oriented NGO representatives
In the movement from political direction at NHC level to the final stage of action for health at village level, the health sector has seemingly failed to develop adequately effective interrelations with other sectors with health-related elements - for example agriculture, education, water supply, etc., apparently due to weaknesses in clearly identifying the sources or causes contributing to particular aspects of ill-health as well as the exact nature of the intersectoral linkages that should be employed in overcoming them. In essence, the all important task of the Health Development Committees at Districts Level is to identify health problems at the source and develop the intersectoral linkages necessary at District, Divisional and village levels to overcome them. At this point in the chain when identification of causes, the intersectoral linkages to combat them, and designing action oriented programmes is the prime need, the key to successful intersectoral interaction lies with the RDHS, District Heads, the Medical Officers of Health (MOHS) PH1S and PHMS. It is a task for these officials to facilitate the movement away from a perspective of health which is primarily disease-oriented and curative in nature, to one which emphasises the prevention of ill-health, the removal of risks to health and the promotion of well-being of the various population groups they serve.

It follows that in designing action-oriented health strategies to serve the various population groups in districts, the RDHS and MOHS must be in a position where it becomes possible by acting through the Government and AGAs and the appropriate Health Development Committees, to undertake health planning by mobilising all available resources of health and health-related sectors for simultaneous joint action on each of several identified fronts. This means that resources and manpower available in the relevant health-related sectors are mustered and channelled into specific health programmes and so co-ordinated that, while these resources and manpower are engaged in their own sectoral fields, they would also automatically contribute to the total health outcome of the communities they have been organised to serve. This would help in achieving the best outcome in health at the lowest cost.

In the institutional structure 1 - 5 the Village Health Development Committee is a grassroot level group of the Department of Health Services dealing primarily with intra-department problems and functions under the Divisional Health
Officer. Matters which require intersectoral action are placed before the Health Department Committee of the Division functioning under the AGA who is also responsible for the agenda. Unless matters of policy or higher level administration decisions are involved, it is possible to resolve most other issues at this level. In the former case, reference is made to the District Health Development Committee (DHDC) presided over by the District Minister. At this level it is possible to resolve most agenda items administratively through the District Heads of the Department of Health and other Departments with related activities. The DHDC is thus able to play a key role in the District in most unresolved intrasectoral and intersectoral issues which fall within its purview. Any matters left unresolved at this stage are usually matters requiring a higher level of policy or administrative decision by the Secretaries and Heads of all health related Departments constituting the National Health Development Committee (NHDC). The NHDC is required to resolve such matters as lies within its sphere of competence. What finally filters through to the National Health Council (NHC) comprising of all health related Ministers are therefore largely matters needing high level policy decisions and political direction. The agenda and working papers outlining issues needing to be resolved either by changes to administrative procedures or by policy decisions is prepared by the Secretary Health who is in attendance at meetings of the NHC and functions as its Secretary.

**Study on Seasonality and Health, Matale District**

The principal outcome of the above study was that it provided a thoroughly researched empirical base for formulating intersectoral programmes of action for health at community level. It took as its starting point the strategy of Health for All with the emphasis placed on primary health care. It was based on the hypothesis that effective health care strategies need to identify the intersectoral linkages in health. For identification of these linkages in concrete health situations, it took into account the socio-economic determinants of health and their varying socio-economic and environmental conditions. Many of the linkages which the health sector must have with non-health sectors were disclosed in the conditions and a proper understanding of the relationships essential for intersectoral action in the field of health emerged.
Matale District was selected after examining other district alternatives as it was considered as being most representative of:

(i) the main agroclimatic zones - wet, dry, intermediate

(ii) the principal population groups in Sri Lanka:
- a rural sector (approximately 80%) which included a significant segment of:

(a) economically depressed dry zone village households

(b) recent dry zone settlements embodying both economically depressed households with less than a hectare of agricultural land as well as relatively more favourable placed households farming approximately 3 hectares of land

(c) wet zone villages
- a plantation sector
- an urban sector

and hence also representative of most health situation in the Island. The Matale District was selected, after a comparative evaluation, as likely to represent the various health situations best through an exhaustive health survey of over a thousand households.

**Vulnerability, vulnerable households and population segments at risk**

The study facilitated the identification of the population segments most at risk as well as the principal reasons leading to their exposure to health hazards by an indepth analysis of morbidity rates in the background of their seasonal variations. The vulnerable segments as revealed by the research study are listed below, classified by their principal health related needs.

Key to locations:  
DZV : Dry Zone Village  
DZS : Dry Zone Settlement  
WZV : Wet Zone Village
1. Income, employment, food and nutrition

<table>
<thead>
<tr>
<th>Vulnerable segment</th>
<th>Locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Farm households with insufficient land</td>
<td>DZVs; DZSs; WZVs</td>
</tr>
<tr>
<td>(ii) Households with a family size exceeding the desirable norm of, say, 5 to 6 members</td>
<td>DZVs; DZSs; WZVs</td>
</tr>
<tr>
<td>(iii) Households with unacceptable poor levels of income (cut-off point Rs.750p/m)</td>
<td>DZVs; DZSs; WZVs</td>
</tr>
<tr>
<td>(iv) Households supplying periodical agricultural labour and /or lacking employment opportunities</td>
<td>DZVs: WZVs</td>
</tr>
<tr>
<td>(v) Households with low nutrition levels and inadequate food intake</td>
<td>DZVs; DZSs; WZVs</td>
</tr>
<tr>
<td>(vi) Households with members prone to multiple episodes of illness usually of increasing incidence during the monsoonal periods</td>
<td>DZVs; DZSs; WZVs</td>
</tr>
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</table>

2. Water supply

   | (i) Households with unprotected water supply subject to pollution - shallow wells, ponds, streams and irrigation channels; health risks tend to increase in incidence during wet seasons | DZVs; DZSs; WZVs |

3. Housing and Sanitation

   | (i) Households in temporary houses | DZVs; DZSs; WZVs; |
   | (ii) Households in houses with mud floors | DZVs; DZSs; WZVs; Plantations |
   | (iii) Households in houses with temporary (usually thatched) roof or roofing of metal sheets | DZVs; DZVs; DZSs; Plantation |
   | (iv) Households with pit latrines and households with no toilet facilities | DZVs; DZSs; WZVs; Plantation |
4. Education, Knowledge, Information and Behavioural Patterns

(i) Households where the home-maker's level of education is below average

(ii) Households with 2 or more children in the 0-50 months age segment

(iii) Households where parents opt for or have 4 or more children

(iv) Mothers whose actual birth spacing falls short or the preferred interval which, in the majority of cases, is a gap of 2 to 3 years

5. Other health-related shortcomings

(i) Households with children who have not been fully immunised (Diphtheria, Pertussis, Tetanus, Poliomyelitis and Measles) by the age of 60 months (BCG is routine)

(ii) The frequent shortages in essential drugs and medicines at peripheral health institutions as well as under-manning of these institutions

(iii) Lack of easy accessibility to health care centres further compounded by seasonal disruption of public transport during the wet seasons and often by irregularity at other times.

Community Development and Intersectoral action

The selection of Matale District for study ensures that specific identified areas where the need for an intersectoral effort for raising the level of well-being and the policy guidelines for doing so effectively, would automatically have relevance and applicability for the various population groups in rural areas throughout Sri Lanka. Urban areas are dealt with
separately as in such cases the majority of identified shortcomings are of much less significance being generally confined to urban poverty, housing in slums and shanties and overcrowding. Sri Lanka, in common with most developing countries, has adopted programmes of integrated rural development which provide considerable scope for incorporation of health and for mobilisation of intersectoral effort for achieving health goals. Illustrations of effective integration of health into socio-economic development at the local level for particular population groups are available in many developing countries which have adopted equity oriented strategies - China, Kerala, Thailand. Thailand’s "basic minimum needs" strategy for instance incorporates health goals in a wider social development strategy which reaches down to the community level to improve the quality of life of the less privileged, by attempting to correct the imbalance in past development policies that tended to emphasise growth and neglected equity. These provide useful guidelines for adapting the experience of these other countries to the Sri Lanka situation. It should, however, be mentioned that Sri Lanka has, particularly since achieving Independence in 1948, made vast progress in raising the health status of her population to a level where it compares favourably with most developing countries in the world, very largely by the almost unaided efforts of the health sector. However, the pace of improvement has slackened during the last decade or so as, on the one hand, the health sector is encountering difficulties in penetrating into hard-core diseases which have their roots in poverty and, on the other, the gradual change in disease patterns which is embedded in the development process. To overcome these obstacles it has become increasingly clear that the health sector must promote committed intersectoral efforts on a wide front with different health-related sectors collaborating closely for an onslaught on the root causes of disease and infection. The response to the new situations has been the creation of the National Health Council to give the political impetus to the intersectoral mechanisms for action that have been set up.

**National Development Strategies**

What has been demonstrated in Costa Rica, Cuba, Kerala, Thailand as well as Sri Lanka, is that a health strategy to be effective must form part of a total development strategy in which all sectors give prime importance to health and the well-being of
people. A national development strategy must however be expected to have a multiple impact on health, both positive and negative. Health policy makers and planners must hence have the capacity to identify at least the major health-related components of development strategy and to play an effective lead role in shaping such strategies towards health promotive goals. It will be the responsibility of these health officials and teams to identify the main elements of the intersectoral strategy for health in the context of the specific development characteristics and the health situation in Sri Lanka. In this task attention would need to be paid to following major issues which are critical for planning intersectoral action.

(i) a thorough understanding of the stage in regard to the transition in health; this would imply a deep national consciousness and understanding of the inequalities and wide disparities in health which exist and a singleminded commitment to removing such inequalities and disparities, accepting that every individual, particularly the disadvantaged and the vulnerable through whatever cause, is entitled to a healthy life and that the resources to satisfy health needs are accessible to everyone.

(ii) at the national level, identification of those health-related policy components of other sectors which call for higher priority action;

(iii) at project level, the health impact analysis of all major projects and continuous monitoring to be regular feature of planning and implementation in all sectors with health related activities;

(iv) at the local level, incorporation of these health components in integrated development projects which are determined, formulated and implemented at this level;

(v) identification of the disadvantaged or vulnerable groups whose health status will be one of the most revealing indicators of the capacity of this total system to achieve Health for All;

(iv) continuous monitoring of the health impact of on-going projects to correct unforeseen adverse contingencies.
that may be revealed during implementation and time to
time review thereafter in the medium and long terms.
The chart below endeavours to depict in broad terms the
relationship between national development and health:

<table>
<thead>
<tr>
<th>Impact of National Development Strategies &amp; Sectoral Strategies on health</th>
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</thead>
<tbody>
<tr>
<td>Main Characteristics &amp; goals</td>
</tr>
<tr>
<td>1. National development strategies and Macro-economic policies have an impact on health.</td>
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<tr>
<td>- Is the strategy growth-oriented neglecting distribution and reduction of poverty?</td>
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<tr>
<td>- Is it export-oriented with possible adverse impact on production for domestic market, food, essential goods?</td>
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<tr>
<td>- Does it have an urban bias with high priority for industrialisation that can increase urban migration and neglect the rural poor?</td>
</tr>
<tr>
<td>- What is the mix of market and state in the strategies - the relative priority of public service and welfare systems and state's responsibility for services such as health, education?</td>
</tr>
<tr>
<td>- Is it equity-oriented and directed at satisfying basic needs, raising incomes and quality of life of the poor?</td>
</tr>
</tbody>
</table>

2. These are reflected in sectoral development goals which have impact on health.
Changes and developments in each of the clusters above have varying health impacts on population according to social class, age, genders, occupation, geographical location. This interaction leads to -

National Health outcome and is best reflected in the health status of vulnerable groups

Guidelines for action oriented strategies specific to the health sector

As in any health-related intersectoral policy the health sector is required to play the lead role, it becomes incumbent on the health sector to undertake specific action related tasks of identification of health problems, co-ordination of intersectoral effort and transforming them to successful implementation. The following responsibilities devolve on the sector and policies must be designed to meet them:

- How successful have local level health officials been in identifying health problems in their totality and isolating the causes giving rise to them?
- To what extent have the officials succeeded in motivating local level teams to meet the challenges posed by health and if below expectation -

- How could the teams be made to act with greater purpose by training? by infusion of management skills?, by strengthening teams bringing in more knowledge from without?, by inspiring beneficiary enthusiasm and keen local participation?

- To what extent has it been practically possible for the RDHS or MOH to keep a close watch on team activities and if inadequate could MOs from local hospitals step in to close the gap?

- What steps must be taken to ensure that peripheral institutions do not run short of essential drugs and medicine and are kept competently manned at all times so as to increase the confidence - now rapidly decreasing, in these institutions.

- To what extent is provision made to ensure intrasectoral collaboration - e.g. a joint effort by the Anti-Filaria Campaign and the Anti Malaria Campaign to combat a threat of, say, an outbreak of malaria.

- To what extent are the bacteriologists and microscopists of the health sector also assisting in testing the quality of water supply - especially in rural areas?

- In instances where the local (village) level teams appear either incompetent or inadequate to implement a developed intersectoral programme, has supplementary assistances in manpower and other resources from contiguous areas in the same District been sought through the G.A. and to what extent?

- To what extent has attention been paid to vulnerable groups in relation to their specific health hazards?

- To what extent has the health sector worked in tandem with health volunteers and concerned NGOs to keep the nutritional status of the young - particularly the school going population, the pre-school children and
pregnant and lactating mothers under constant surveillance?

- To what extent has the health sector, assisted by other groups like health volunteers and NGOs, endeavoured to assist mothers in achieving their general desire to adopt birth spacing of two or more years by providing them with an acceptable level of knowledge on safe reliable temporary family planning methods and ready access to the necessary requirements that may be the users' choice?

- To what extent has special attention been paid by the health sector to improve the health status of families with over 4 children and households subsisting on incomes below Rs.750 a month?

- In siting peripheral health institutions, what is the extent or concern paid to easy accessibility to the wider community they are expected to serve, rather than the convenience of the relatively small staff manning such institutions, thereby aggravating accessibility and increasing household health expenditure of poor rural households?

- To what extent, apart from the curative, has the health sector actively involved itself with State authorities in preventing the degenerating influences of tourism and the emergence of a culture completely alien to our Sri Lanka culture and the religious beliefs of whatever religion?

- Should not mobile multipurpose services be provided to the less accessible rural areas for immunisation, health education and propaganda.
Guidelines for policy determination relevant to the principal health-related sectors in the context of intersectoral activity in moving towards health for All

1. Education

(a) Formal

- How far is primary education (at the very least) accessible to the population as a whole and particularly to those segments of the rural poor living in isolated communities?

- As the level of education of females is a decisive factor in health improvement, how far has health and education, as prime movers in a broader intersectoral programme, collaborated in promoting female literacy and female participation in education?

- To what extent do school curricula disseminate basic health education in such areas as personal hygiene, sanitation and preventive health habits relating to the spread of contagious diseases?

- Have teachers been trained to participate in school health programmes to influence health behaviour, monitor pupils' health, recognise common ailments and deal with them?

- To what extent have health and education authorities collaborated to make school buildings and their precincts a model for health thus promoting a spiralling effect among a wider community?

- How can the school dropout in the early stages of education be controlled?

(b) Higher learning institutions and health

- Are health professionals being re-oriented to be health educators as well?
- Have teaching professionals an understanding of interaction of different sectors in achieving health goals, so that they will possess the ability to promote interdisciplinary knowledge of health?

- Is the student population being taught to cope with the health risks in their vulnerable years of early adulthood?

- To what extent do these institutions provide health leadership and participation in health-related programmes which require motivation of a wider public?

- How much has the health sector and education authorities appreciated the appalling conditions present in the lodging of the majority of undergraduates where it is not unusual for 4 to 6 students to be herded into one room of 12 x 12 square feet at best, living, studying and cooking in the room often without even a desk and the extent to which absence of even minimum accommodation contributes to the rebellious spirit that frequently erupts?

(c) Non-formal education and functional literacy

- Has attention been paid towards imparting functional literacy and non-formal education which includes health in concrete life situations of illiterate women — resource management in conditions of scarcity, lack of skills in family care, nutrition and diet in conditions of poverty, importance of child education, child immunisation and family planning?

(d) Culture and health

- To what extent does health and education attempt to wean the population away from cultural practices which have traditionally had a beneficial influence on health?
- Has an effort been made through intersectoral collaboration to alleviate the harmful effects on health through changing life-styles patterns of consumption and addiction and stress acquired during development?

2. Environment

(a) Housing

- In improving the quality of housing what is the attention paid to eliminate health hazards through water borne diseases, diarrhoeal diseases, respiratory diseases and communicable diseases which together contribute significantly to morbidity by

(i) replacement of mud floors with cement floors?

(ii) replacement of thatched or metal sheeting roofs with tiles or asbestos?

(iii) prevention of overcrowding

(iv) other preventive measures - better ventilation, reducing pollutive effects of cooking, etc all of which carry health risks?

- To what extent have policy changes and reorientation been undertaken to:

(i) provide advice on safety standards - bottle lamps, food storage, etc?

(ii) make it obligatory for local and municipal authorities to be receptive to problems, especially of the poor, and to involve these institutions in housing development?

(iii) revise public health laws and standards to be relevant to current situations and within reach of the poor?
(iv) grant legal rights of tenure in some form to squatters?

(v) revise building codes appropriate to the very limited resources of the poor?

How far have intersectoral linkages in improving physical infrastructure taken into account the radical transformation taking place in the human habitat including shifts in the geographical distribution of population as a result of development?

(b) Water supply

- To what extent has health information and education stressed the importance of making domestic water safe - boiling, filtering, safe hygienic storage etc?

- How far has health information and education been incorporated as an essential constituent of water and sanitation programmes to ensure close community involvement from the planning stage onwards and motivating behavioural changes through enhanced knowledge and skills in the proper usage and maintenance of the facilities provided?

- To what extent have health services in collaboration with other sectors made efforts to control the cumulative effects of pollution and disease transmission, poor maintenance and problems of seepage which facilitates proliferation of disease vectors?

- How far have intersectoral efforts been directed to control health hazards that exist outside development programmes relating to swamps, husk pits, river pollution, etc. which are known to originate from demographic and socio-economic changes in the entire region?

- How much attention has been devoted intersectorally to provide proper, safe drainage of waste and storm
water to minimise health risks?

- How regularly have known sources of domestic water supply been tested by bacteriologists to ensure their fitness for daily use?

- What if any has been the action taken to prevent fluoridation of water beyond the safety limit and thereby remove health hazards flowing as a direct consequence, of over-fluoridation - e.g. Dental Fluorosis in Anuradhapura.

(c) Sanitation

- What action has been taken to replace bucket latrines, pit latrines and cess pits which contribute significantly to disease, with more sanitary toilet facilities?

- How far has a concerted effort been made to provide sanitary toilets to households having no toilet facilities whatever compelling defaecation in the open?

- To what extent have householders been instructed in the proper maintenance and correct use or toilets?

- How far has health education been directed at maintaining in a sanitary condition sheds and enclosures for cattle, goats and other domestic animals to offset the tendency of these structures becoming sources of infection?

- To what extent has attention been paid to proper domestic hygiene in such areas as household cleanliness, garbage disposal, spraying, etc.

Agriculture and Health

(a) Product mix

- What is the relative priority given to the
production of staple food items on the one hand
other non-food commodities on the other?

- Is the emphasis on high yielding agricultural
  production or on robust products more acclimatised
to local conditions with lower production costs?

- Does advice to farmers, particularly "smallholders,
  extend to priorities as between more expensive
  products rich in nutrients which are beyond their
  purchasing power and low-priced high quality food
  from which the poor get their proteins, usually
  adequately - cereals, pulses rather than animal
  products?

- What production policies are followed in relation
to cropping issues around seasonal considerations
dependent on post harvest losses, storability,
credit and market movements?

- To what extent is the focus on cash-cropping with
its possible capacity for generating employment
and raising incomes but with probable adverse
impacts on nutrition, which traditional farming
for food production usually offsets?

- To what extent does agricultural policy neglect
traditional crops (roots, melons, plantain, non-
staple gathered fruits, etc.) thus reducing energy
for the rural poor, particularly during pre-
harvest periods, in times of drought and famine?

- How far does policy go to encourage home gardens
with its capacity to raise the nutrient level of
meals?

- What advice is given when confronted with a
situation where cheap staples replace foods richer
in nutrients - e.g. the replacement of high
protein cereals and pulses with root crops?
(b) Crops harmful to health

- Is there an awareness of health risks from harmful production (e.g. tobacco, narcotics) and are meaningful efforts being made to deal with this menace which may however be lucrative?

- To what extent do public policies take action to deal with the problems by propaganda, information and education so as to protect health by reducing the demand for them?

(c) Land land ownership and tenure

- What water resources are available to smallholders with less than one hectare of land for intensive multi-cropping of this limited extent and if adequate, water is not available, what are the policies that should be adopted to provide them with their water requirements?

- If reservoir irrigation is brought to them, how will supply be priced so as to be affordable for subsistence farmer households?

- What is the capacity of these smallholders to purchase essential agrochemicals to increase yields by intensive multicropping?

- What are the agricultural policies aimed at improving the access of poor farmers and landless to land and other productive resources?

(d) Pricing and food security

- How do agricultural policies relating to pricing take into account food and nutrition issues, specifically in regard to food prices?

- What is the impact of guaranteed prices and food subsidies on food production and also in relation to food consumption and food security
- To what extent are food security schemes and state assistance (e.g. food stamps, supplementary feeding schemes) being kept under constant review.

(e) **Investment in agriculture**

- To what extent is investment at national level concentrated in areas where returns are highest at the expense of areas where the need is greatest?

(f) **Technology**

- How are technological changes affecting labour, employment and use of human energy particularly of women and how appropriate are they in the socio-economic context of Sri Lanka?

- What are the policy initiatives and safeguards adopted in regard to health hazards of agrochemicals, pesticides, etc?

- Is scientific research directed at problems which can improve the conditions of poor, smallholder farmers, especially those farming marginal land - variety improvements and crop mixes, problems of seasonality and seasonal fluctuations, post-harvest losses, exploitation by intermediaries in the marketing chain, drought, floods, shift towards traditional fertiliser and compost rather than agrochemicals etc.?

(g) **Miscellaneous**

- Incorporating non-formal education into extension programmes of the Agricultural Department especially into extension programmes designed to manage farm budgets and resource flows to minimise seasonal troughs and lean periods; how far is this being done?

- To what extent is emphasis laid on food stocking and prevention of post harvest losses?
4. Industrialisation

- Has action been taken by the health sector in association with other concerned sectors - e.g. labour, environment, social services, rural development, industries, etc. to minimise, if not eliminate, hazards to workers?

- To what extent have meaningful measures been taken by the health sector in collaboration with these other sectors to protect communities who, due to industrial activity in their midst live in a disadvantaged socio-economic environment, with special attention being paid to groups at greater risk than others as for instance women and children? (cement factories, tanneries, the FTZ are examples).

- Have measures been taken and with what degree of success against conditions of worsening pollution which pose serious health hazards and economic problems (reduced paddy yields, fisheries) resulting from policies for attracting foreign enterprise with minimum controls and the import of technologies far in advance of the technical know-how and scientific infrastructure of Sri Lanka and the ability to neutralise or otherwise render harmless pollutive waste and industrial effluents (a responsibility of the industry itself) dumped indiscriminately into waterways and agricultural land?

- Has attention been paid by the health and agricultural sectors to the health hazards resulting from the widespread use in agriculture of toxic chemicals and pesticides which, though improving overall agricultural production, can be, as seen in Sri Lanka, highly costly to life and human health in respect of consumers as well as agricultural operators?

- How far has the health sector succeeded in approaching through legislation and continuous monitoring, as well as with collaboration with
other sectors concerned with food safety, problems arising from the indiscriminate use of such substances as hormones and other additives to fatten farm animals and poultry for increasing producer profits but at the expense of consumer health?

- Has sufficient attention been paid by the health sector in collaboration with agencies responsible for controlling industrial production, to promote national policies which provide for adequate systems and safeguards and surveillance for greater security against errors or failures in systems of control of industrial plants which could result in catastrophic consequences?

- How much attention has the health and other concerned sectors devoted to evaluating the long term consequence of pollution in respect of human beings and of the environment and if so what steps have been taken to promote legislation and other action to promote standards which would remove such dangers.

Urbanisation

- To what extent is there a movement away from development strategies which favour industrial and commercial complexes in and around large cities and in locations where the middle and upper income groups usually reside and how far is development being equity oriented by locating them where the majority of people are, rather than adopting processes which draw people to urban centres at great cost to themselves both in terms of expenditure as well as in terms of health?

- To what extent has there been a conscious effort incorporated in the development process to provide transportation two way loads as a means of countering the urban drift with all its attendant adverse effects on health and expenditure,
forgetting that transportation which was a basic instrument in creating towns and cities is now threatening to destroy them as seen in numerous example in the developed west and is increasingly being observed in Colombo.

6. Credit and Finance

To what extents are intersectoral efforts being directed towards facilitating the availability of rural credit and loans from banking institutions to deal with

(a) minimising the adverse effects of seasonal troughs and lean periods?

(b) capital requirements needed for dairying and home gardens to increase the nutrition content of food intake?

(c) the tendency to divert consumption expenditure to working capital during lean periods?

To what extent have efforts been made to make rural agricultural credit easier to negotiate in terms of collateral requirements and how far have such efforts been successful?

7. Supplementary income earning small industries

To what extent have small industries been converted to a valuable income earning resource by

(a) providing training, especially to school dropouts and the disabled?

(b) providing common facilities centres (for plating, buffing polishing etc.) toll craft villages?
(c) providing up-to-date design centres for a group of craft villages to up-date designs, provide market information and as a means of quality control?

(d) providing advice on the need to provide continuity in production by planned exploitation or vegetable raw matter and continuous replanting so avoiding past disasters - e.g. ñana, wetakeiya, gaïsha, batta etc?

(e) providing simple modernised tools on easy terms?

(f) providing marketing avenues on mutually acceptable financial terms?

(g) placing orders for state requirements - e.g. school furnature, hospital cloth and furniture, office equipment, etc?

Transportation

Despite current thinking in Sri Lanka that bus routes must pay their way without cross subsidisation, it is a fact that rural transport services, whatever the means - road or rail, in any part of the world do not show an operating surplus. On the other hand if benefits are quantified they will be found to be enormous; they arise from, to refer to a few, continuous appreciation of land values, wider marketing opportunities, less dependence on marketing intermediaries and hence higher surpluses, improved accessibility at lower cost to medical care and education, better employment opportunities, reducing the urban drift and repopulating depopulated villages, better opportunities for travel, recreation and other pastimes, giving purpose to life and others too numerous to mention. It is, therefore, considered current thinking is narrow and despite a near 80% rural population only around 40% of the bus milage operates in purely rural areas thus resulting in severe hardship to rural folk as well as negating to some extent the
benefit of the development process. As regards health costs, the expenditure on transport varies from about 25% in more accessible rural areas to over 50% in the less accessible areas. In this context the following issues emerge:

- to what extent if any has the health sector endeavoured to influence the Central Transport Board thinking in favour of an intensification of rural services by emphasising that the primary objectives of a state transport service is to further the social, economic, developmental and political goals of the government in power - profitability being of low priority.

- to what extent have concerned agencies endeavoured to have the road network carrying vehicular traffic expanded to provide at least a skeletal service to more remote areas?

- what efforts have been made to stress that high priority must be accorded to rural bus services because an operational failure means usually no service, sometimes for several days?

- what public works (which will to some extent help to offset the worst effects of seasonality) been suggested to raise road platforms, widen culverts etc, to reduce to a minimum disruption of transport through floods.

9. The Large Scale Project

- The cumulative impact some large scale projects have on health requires interventions of a different nature in which the health sector needs to be actively involved. For instance, large scale water development projects, as for instance Sri Lanka's Mahaweli Project, has the potential to cause disturbances to the ecosystems, disturbances involving parasitic and infectious diseases which can be seriously harmful to the population in the
vicinity. It is, however, possible through appropriate intersectoral planning to offset such adverse impacts on health. This raises a number of issues

- What intersectoral measures have been taken in the early stages to prevent parasitic and infectious diseases being transmitted to the people?

- What action has been taken to combat other health hazards from unsatisfactory temporary housing, drowning, malnutrition and other diseases of poverty among the displaced population?

- Has timely action been taken to prevent an upsurge of Malaria among unplanned colonies of people growing around such projects?

10. Small Scale Projects

The cumulative effects of small scale water projects are also significant. The issues arising in their case are:

- Since these water sources have multiple uses - drinking and bathing (both humans and animals), irrigation, flood control, fishing etc. contamination must be expected leading to a high rate of disease transmission; what steps have been taken to free such water sourcws of the ability to transmit disease?

- Many small impoundments constructed by local initiative suffer from poor maintenance and problems such as seepage favouring important diseases vectors and hence the question arises as to how conscious have the authorities been of this danger and what steps have been taken to mitigate the adverse effects of possible disease proliferation?
11. Local bodies

To what extent do local bodies satisfactorily discharge their health-related functions:

(a) garbage disposal?

(b) construction of drains, their maintenance and daily cleaning?

(c) provision of medical care through free health centres both ayurveda and western?

(d) provision of preschools?

(e) provision of recreation facilities, grounds and children's parks?

(f) income support for the needy?

(g) monitoring water supply?

(h) slum clearance and housing projects?

(i) provision of ambulance and fire fighting services?

(j) provision of access roads?

Vulnerable Groups as the main target in the strategy for Health for all

The Alma Ata Declaration specifically emphasised its concern for vulnerable groups in the coverage of health care services. The limited character of the response hitherto evoked in respect of intersectoral co-operation could be partly attributed to the fact that while the health sector in Sri Lanka has recognised the importance or groups at risk, it has seldom identified the groups at risk relating their vulnerability to the socio-economic and environmental conditions in which they live and work. An approach of this nature would immediately confront the health sector with health risks originating in other sectors and the health-related concerns of those sectors.
Hard-core ill-health rooted in extreme poverty clearly demonstrates that their eradication must lean heavily on the health-related contributions of other sectors. The Health for All strategy is primarily equity oriented. Thus the strategy compels planners to focus on and clearly define disparities in health between various population groups and thereafter identify the vulnerability and factors contributing to their vulnerability. This is of fundamental importance when designing the framework of equity oriented health strategies for each identified vulnerable group.

Equity in health must be seen as equity in development as a whole. Thus, as seen in the foregoing policy guidelines, equity-related components of a total health strategy which emphasises primary health care must be linked to the equity-oriented components in the development strategies and areas of responsibility of the other sectors and form part of such strategies and areas of responsibility.

In conclusion, quality of life for users on people and their experience of the interactions between those processes considered by them vital to living or being alive. If people or social groups are to have any influence on directing their own destinies, they must be informed of the options available to them and of the consequences which flow from their choice. This is where participation in decision making becomes all-important in affording an opportunity for communicating their views to the agencies involved. If the opportunity is not afforded, as is usual in top down processes, the group preferences are not reflected in the decision and the decision will not be sensitive to the collective choice of the social group it is intended to benefit. The outcome must inevitably be a loss in the effectiveness of the interventions and a lack of sustainability in the long term.