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RECOMMENDATIONS OF THE EXPERT GROUP ON MORTALITY AND HEALTH POLICY

Report of the Secretary-General

SUMMARY

In response to Economic and Social Council resolution 1981/87, the Expert Group on Mortality and Health Policy was convened at Rome, Italy, from 30 May to 3 June 1983, as part of the preparations for the International Conference on Population to be convened in Mexico from 6 to 13 August 1984. The findings of the Expert Group are summarized in the present document as part of the background documentation to be submitted to the Population Commission acting as the Preparatory Committee for the Conference.

The Expert Group examined factors affecting mortality and health and their consequences for and their relationships with development. The discussions involved progress and prospects for mortality reduction, interactions between health, mortality and development, health policies and their effects on mortality, and implementation of health policies. The deliberations had as an essential perspective the goals of the World Population Plan of Action and specific policy measures that would promote the achievement of those goals. The recommendations covered: (a) general considerations; (b) goals; (c) health and development; (d) health and social policies and programmes; (e) mortality and reproductive behaviour; (f) data collection and research; and (g) technical co-operation.

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INTRODUCTION

1. The Economic and Social Council, in its resolution 1981/87 of 25 November 1981, decided to convene an international conference on population, under the auspices of the United Nations. The Conference would be devoted to the discussion of selected issues of the highest priority, giving full recognition to the relationships between population and social and economic development, with the aim of contributing to the process of review and appraisal of the World Population Plan of Action 1/ and to its further implementation. The Council also authorized the Secretary-General to convene four expert groups as part of the preparatory activities.

2. Pursuant to that resolution, the Secretary-General convened the Expert Group on Mortality and Health Policy from 30 May to 3 June 1983. At the invitation of the Government of Italy, the Expert Group meeting was held at Rome. The participants included 15 experts, invited by the Secretary-General in their individual capacity; representatives of the five regional commissions; the World Health Organization; the United Nations Children's Fund; the International Bank for Reconstruction and Development; the Food and Agriculture Organization of the United Nations; and representatives of 10 intergovernmental or non-governmental organizations. The latter were the Organisation for Economic Co-operation and Development, the International Planned Parenthood Federation, the International Statistical Institute/World Fertility Survey, the Population Council, the Population Institute, the International Social Security Association, the International Union for the Scientific Study of Population, the Institute of the Sahel, the Committee for International Co-operation in National Research in Demography, and the Opera Pia International. There were three observers. The participants represented a broad range of geographic regions, scientific disciplines and institutions concerned with questions of mortality and health policy.

3. To provide a basis for discussion, a background document was prepared by the Department of International Economic and Social Affairs of the United Nations Secretariat. That document, entitled "Mortality and health policy: highlights of the issues in the context of the World Population Plan of Action", provided an overview of the topics for discussion corresponding to the substantive items of the agenda as follows: (a) progress and prospects for mortality reduction; (b) interactions between health, mortality, and development; (c) health policies and their effects on mortality; and (d) implementation of health policies. Other background papers were provided by the Department of Technical Co-operation for Development of the United Nations Secretariat, the United Nations Fund for Population Activities, several regional commissions and specialized agencies, the Committee for International Co-operation in National Research in Demography, the International Social Security Association, and the International Statistical Institute/World Fertility Survey.

4. Special acknowledgement is due to the International Union for the Scientific Study of Population and to its Committee on Factors Affecting Mortality and the Length of Life for allowing the United Nations to reproduce several papers and draw

on the discussions of the Seminar on Social Policy, Health Policy and Mortality Prospects, held in Paris in March 1983.

5. Welcoming remarks were made by Aldo Aiello, Member of the Italian Parliament, Sergio Silvio Balanzino, representing the Italian Ministry of Foreign Affairs, and Giovanni Spinelli, on behalf of the Mayor of Rome. Rafael M. Salas, Secretary-General of the International Conference on Population, 1984, and Executive Director of the United Nations Fund for Population Activities, in his statement, noted that reduction of premature mortality should be a primary concern of Governments and that it was essential to find ways of translating such government concern into effective action. He further emphasized that the reduction of premature mortality was both a humanitarian concern and an important aspect of the question whether and how development is to be achieved. In his introductory remarks, Léon Tabah, Deputy Secretary-General of the International Conference and Director of the Population Division of the Department of International Economic and Social Affairs, indicated that the objective of all government policy was improvement of the length of life and its quality. He also emphasized that health policy must be considered part and parcel of development policy as health was not the affair of the health sector alone.

6. The central task of the Expert Group Meeting was to examine critical, high priority issues relevant to mortality and health and, on the basis of the deliberations, to make recommendations for action by Governments and international and non-governmental agencies that would enhance the effectiveness of the World Population Plan of Action and compliance with it. The views expressed by the experts at the meeting were made in their individual capacities and did not represent the views of the Governments of their countries.

I. PROGRESS AND PROSPECTS FOR MORTALITY REDUCTION

7. The World Population Plan of Action set as a target for the countries with the highest mortality rates the achievement of an expectation of life at birth of at least 50 years and an infant mortality rate of less than 120 infant deaths per 1,000 live births by 1985. It also noted the progress necessary for each region - and hence the world as a whole - to attain an average life expectancy of 62 years by 1985 and 74 years by 2000. The Expert Group noted the progress towards the latter figures made in the past decade. For 1985 life expectancy at birth is expected to be about 60 years world-wide, still two below the figure indicated in the Plan of Action. However, this aggregate figure disguised the fact that a number of individual countries, in addition to the major regions of Africa and South Asia, would fail to attain this figure. The participants stressed the mixed progress of the highest mortality countries in reaching the established minimum targets. By 1985, the goals for life expectancy will not have been reached by 22 countries and for infant mortality by 26 countries. All of these countries are in the regions of Africa or South Asia and have a combined population of 150 million.

8. The discussion indicated the many factors restraining mortality decline in the highest mortality countries, including development strategies that de-emphasize the production of basic foodstuffs; structures of health services not suitably adapted

to local conditions; low priority for health issues within development plans and budgets; absence of significant international aid for health; urban-biased styles of development; absence of appropriate health technologies; and high debt service burdens that prevent the importation of needed medical supplies.

9. The continuing high mortality in many developing countries emphasized to the participants the necessity of restating mortality goals for developing countries in revision of the Plan of Action. There was general consensus that targets should be set not only for the higher mortality countries but also for countries which have achieved intermediate or lower levels of mortality: such goals would add impetus to their mortality reduction programmes. The Expert Group stated that targets should also be considered for child mortality, maternal mortality, or for specific regions. The participants agreed that all targets should be measurable and feasible.

10. The participants noted that the developed countries have also followed divergent paths in mortality. In most but not in all countries mortality declines in the past decade have probably exceeded expectations, as unanticipated declines in cardiovascular mortality have often occurred among adults, and infant mortality has been reduced below a level that until recently was thought to be an irreducible minimum. Several countries, however, have witnessed a deterioration in mortality conditions, especially for males. Deleterious personal health habits may be implicated in this trend.

11. The discussion returned several times to the question of significant differential mortality, in both developing and developed countries. The desirability of setting goals for reduction of differentials, as well as for overall mortality levels, was discussed since, when some population groups suffer much higher mortality, the mortality condition of the country as a whole cannot be considered satisfactory, even if national targets have been achieved. Mortality improvement was seen as the responsibility of international as well as national authorities.

12. Many participants noted that mortality data in their countries or regions were seriously inadequate for formulating programmes. The ability to develop policies to achieve goals is thus hampered. It was observed that accurate mortality data were required not only to establish levels and trends in mortality and monitoring progress towards goals but also for identifying causal factors that could aid in programme formulation.

II. INTERACTIONS BETWEEN HEALTH, MORTALITY AND DEVELOPMENT

13. The goal of development is to advance the welfare and well-being of populations and improved levels of health and longevity are probably the single most highly valued components of this goal. Therefore the Expert Group expressed the opinion that viewpoints which separate the concepts of health and development are artificial and perhaps even dangerous in that they may have been responsible for reductions in international aid in the area of health and may have imposed a serious distortion in the setting of developmental priorities.

14. The relations between health and mortality and other components of the development process were discussed. There are several important routes by which health improvement and mortality decline can foster other features of the development process. Economists have found that among the most important sources of economic growth are improvements in labour quality and in the stock of knowledge and technology. Clearly, improved levels of health contribute to improved quality of labour and increase incentives to make human investments.

15. The improved longevity and health achieved by the developing countries was not considered as necessarily permanent. It was noted that developing countries are particularly vulnerable to climatic changes that alter the production of crops and to the vagaries of the international political and economic climate. The Sahelian drought and Bangladesh famine of the early 1970s stood as vivid reminders of the possibility of serious setbacks on the road to improved health.

16. At the same time it was recognized that mortality declines in developed countries are now contributing to the aging of populations and such a trend has consequences for health patterns and social support systems. Nevertheless, aging is positive in the sense that it reflects attainment of a universally valued goal. Concurring with the International Plan of Action on Aging, 2/ the participants noted the important contributions to society made by the elderly and expressed the view that Governments should anticipate and strive to accomodate, in a timely and humane fashion, the changes induced by population aging.

17. Economic development and socio-cultural modernization were not seen as bringing only benefits to the health of a society. Changes in life styles, environmental deterioration and hazardous industrial working conditions, often concomitant with development, have negative consequences; these consequences should be anticipated and attempts made to counteract them.

18. All peoples' endeavours to improve the length and quality of their lives are hampered by wars and allocation of resources towards armaments and away from social needs. The participants stressed the importance of peaceful relations among countries.

19. The Expert Group noted the persistence of significant mortality differentials and their relationship to social and economic inequalities. The Group further indicated that mortality differentials sometimes simply reflect the ability of one group to escape the very poor conditions of society and that those differentials therefore point the way towards progress that may be possible for all. It was concluded that a policy explicitly aimed at upgrading the conditions of the very poorest groups has proved to be a development strategy with very beneficial effects on health for those groups and for the population as a whole.

20. The Expert Group considered the effects of other components of the development process on health and mortality. Levels of per capita national income are strongly associated with mortality levels, pointing out the role of general economic advance in mortality improvement. However, at a given level of economic affluence, a considerable scope to influence mortality through policies in the social and health arena was indicated. Some countries are "super-achievers" in the health domain,

far outpacing the typical performance of other countries at their income levels. All of these super-achievers have stimulated widespread popular participation in the health sector and in the development process.

21. Among the social policies with greatest effects on health and mortality are those related to education. Evidence was reviewed showing that the level of maternal education in developing countries is a decisive determinant of child mortality levels. The evidence draws attention away from strictly economic factors to the important role of child care and distribution of resources within the family. When women are the first-level health care providers, their activities and attitudes influence the health of all family members. The mechanism through which maternal education may affect mortality includes a heightened perception of health problems and an increased sense of one's capacity to resolve the problem. Better maternal education may also create better knowledge of positive health and sanitary practices and change the relative status of women in the household. The provision of education may also stimulate the expectations for better health. Finally, it was noted that improved maternal education may reduce child mortality by changing patterns of childbearing. Whatever the mechanism of the relation, the close connection between maternal schooling and child mortality affords one of the most promising means for influencing child mortality. This is an area where programmes in one sector almost certainly produce major advances in another sector.

22. Women's own health can also be directly advanced through programmes to reduce maternal mortality. The Expert Group expressed the conviction that female circumcision is a health-threatening operation that should be ended where it exists.

23. In the light of the importance of overall social and economic development for health improvement, an effective effort to improve health status will require the co-operation of a wide range of international organizations. It is no longer satisfactory to reserve health concerns to the international organizations traditionally involved. Efforts will be needed to induce other organizations to adopt a more active concern for the health implications of their activities.

III. HEALTH AND SOCIAL POLICIES AND THEIR EFFECTS ON MORTALITY: DEVELOPING COUNTRIES

24. Central to the attainment of good health and long life is the adoption and implementation of health policies and the promotion of healthy conditions. A healthy milieu is necessarily characterized by high national levels of life expectancy and low levels of morbidity. Important intermediate goals are affordable access to health care for all segments of the population, active community participation, and the realization by individuals that early death and ill health is not inevitable but that a long and healthy life is within the individual and family's ability to attain and human right to demand.

25. The Expert Group identified five major themes to be considered when establishing health policies in developing countries: having the necessary data upon which to determine the appropriate health policy; establishing a conceptual framework to set health priorities and to allocate resources; ascertaining

appropriate health and social interventions; considering the financial, administrative and cultural context in which health policies must be implemented; and activating the political will of Governments to focus scarce resources and attention on health matters.

A. Data bases

26. Among the most fundamental requirements for the planning, implementation, and evaluation of a successful programme of health and social interventions are an understanding of the structure and distribution of morbidity and mortality within the country, information on the economic and social context and cultural patterns which underlie the mortality structure, knowledge of the potential efficacy of various health and social intervention strategies, and an understanding of the community cultural and behaviour patterns which may condition acceptance of the interventions. The Expert Group regretted that this data base of necessary background material for establishing health policies is non-existent in many developing countries.

27. It was the consensus of the Expert Group that the widespread need for information on three levels - small group anthropological studies of acceptance of health practices, national studies of mortality and morbidity patterns, and regional studies of the efficacy of health and social strategies - points to the advantages of a co-ordinated world-wide programme to study mortality and morbidity. Such a programme would provide a clearing house for information exchange and, more importantly, a central organization through which technical survey and substantive expertise could be exchanged, assistance provided for national research and data collection activities and international research organized. Such a programme would encourage efficient use of the small amount of resources often available for health and mortality issues.

28. The overriding importance of effective programme evaluation was repeatedly stressed, for which good data are obviously essential. Too often administrators view success in programmatic terms, for example, services delivered, rather than in terms of their impact on the ultimate targets of disease and death. Furthermore, a well-evaluated programme has benefits that extend far beyond the project area. The Expert Group emphasized the importance of including the necessary resources and expertise for data processing in evaluation activities.

B. Conceptual framework for setting health priorities

29. The Group indicated that the design, selection, and execution of health policies required the existence of an explicit and comprehensive conceptual framework reflecting the various mechanisms affecting health conditions and mortality. Such a framework should exhibit the role of the numerous proximate and background determinants and individual and community characteristics in health and mortality. The chain of events leading from healthy status to disease and eventual recovery or death may be quite lengthy and complicated, and the participants concurred that the framework must therefore recognize both social and biological

synergisms with health and mortality. In many cases, a sustained health improvement or mortality reduction may only be attained by attacking the underlying factors at their source, a source which at first glance may seem to have little relevance to health sector activities. For example, storage of water in pottery jars large enough for mosquitoes to set their eggs in may lead to malaria transmission even far from the usual river beds or lakes. Introduction of piped water or a change in water storage practices may be a more efficient means for malaria control under these circumstances than prophylaxis or spraying.

C. Efficacy of health and social interventions

30. The Expert Group recognized the interdependence and mutually-supportive role of advances in different sectors for reducing mortality. Participants endorsed the primary health care movement and the Declaration of Alma-Ata. 3/ Basic to this concept is the adaptation of health services to people's needs.

31. Primary health care stresses the importance of simple preventive measures spread throughout the population. Vaccination against specific diseases represents one of the most effective available disease prevention techniques. Neonatal tetanus, pertussis, and measles often contribute significantly to infant and child mortality and can be largely prevented by immunization. In most developing countries these diseases remain serious problems because of the low coverage of the population by vaccines. Oral rehydration therapies (a combination of treatment and prevention) also appear effective in containing the damage done by diarrhoeal disease with minimum demands on health personnel and facilities required for other tasks. However, the evidence is inconclusive on the population effectiveness of oral rehydration in large populations where intensive instruction is not possible. Encouragement in good feeding practices, especially regarding breast-feeding, is a promising component of primary health care programmes. Nutritional supplementation campaigns are also sometimes added to these programmes, although their effectiveness among large population groups, and among other than the most malnourished populations, remains to be established. Pre-natal and post-natal care, including family planning, can improve the health of mother and child as well as provide a setting for instruction on healthy child-rearing practices and on the recognition of diseases and procedures for dealing with them. Primary health care programmes can also include an important curative element, such as the administration of antibiotics. An unsanitary environment is an enormously important cause of ill-health and premature death in most developing countries. The burden of infection resulting from such an environment is one of the major reasons for poor physical growth of children, which in turn has very serious mortality implications. Clean water and satisfactory sewage disposal are important ingredients in the development process and should be phased in at the earliest stage permitted by economic considerations.

32. An additional important health measure is anti-malarial activities. Especially in Africa, malaria remains an extremely serious contributor to morbidity and to mortality from many causes.

33. The Expert Group noted that primary health care programmes have often been carried out in ways discordant with the provisions of the Declaration of Alma-Ata. There has often been insufficient attention to the need for community support and participation in launching, maintaining and upgrading such programmes. The medical community, when oriented towards expensive urban-based curative services based on the western model, may also prove a stumbling block.

34. Approaches that rely on technological measures without adequate attention to the need for personal behavioural changes were sharply criticized. It was also argued that there is a need for relevant, simple, appropriate technologies to support behavioural changes.

D. Context of health and social interventions

35. Appropriate health policies are specific to a population group's cultural and social setting and must be established within national contexts and national constraints. The design of social and health policies ought to take into consideration two sets of constraints: first, that isolated interventions may prevent certain morbid conditions without supressing other equally or more deleterious ones. Second, social and health programmes take place within a social context that imposes restrictions not only of an economic but also and perhaps more importantly of a cultural order. Beliefs and behaviours may impair the efficient implementation of interventions. More importance has to be given to tailoring specific interventions to specific cultural contexts.

36. It was repeatedly stressed that health programmes should not be exclusively focused on the use of therapeutic agents but should recognize the social/cultural and economic context of disease and premature death. Sometimes these social causes are much more susceptible to change than are biochemical balances. On a larger scale, it was stressed that health programmes such as primary health care should not be seen as a substitute for social and economic development but rather as working in concert with these to achieve valued social objectives.

E. Political will

37. The Group reviewed the experience of some countries which, in spite of critical constraints, have achieved considerable improvements in the health conditions of their population. In this regard, the Group recognized that such notable successes were due mainly to a strong political commitment. In fact, the implementation of social and health policies requires the mobilization of political action and political will. Whether or not such mobilization takes place efficiently will be a function of several conditions. One of these is the particular positions, alliances and strategies of the élites of the countries and the degree to which they are influenced by the population as a whole. Another, more obvious condition, is the share of available resources allocated for social needs in these countries. These limitations are very much influenced by the particular position of the country vis-à-vis the international system.

IV. HEALTH AND SOCIAL POLICIES AND THEIR EFFECTS ON MORTALITY: DEVELOPED COUNTRIES

38. The participants indicated that the conditions in developed countries differ from those in developing countries in several respects. Because populations are much older and mortality from communicable diseases very low, the chronic degenerative diseases are the principal concern. The latter are very serious sources of morbidity as well as of mortality; in fact, problems associated with prolonged chronic illnesses have become of major importance. Despite these distinctions, many of the problems are shared by developing countries, at least in urban areas, and will become more commonplace in some developing countries over the next decade.

39. The likelihood that many of the most serious health problems in developed countries could be reduced by changes in personal health practices was recognized throughout the discussion. These include such life style characteristics as cigarette smoking, lack of exercise, excessive alcohol consumption, and poor dietary practice. They also include driving after alcohol consumption and failure to take simple precautionary measures such as the use of seat belts. It must be recognized that life style behaviour often has an important socio-psychological basis that is usually poorly understood. Studies of these relations are necessary in order to construct effective interventions. At a minimum, according to the participants, it is necessary to disseminate widely information about the very serious consequences of such behaviour patterns so that people can act on the basis of full information. Campaigns of persuasion might also be mounted. Aggressive promotion of healthy life styles is clearly a high priority for health programmes.

40. Participants also discussed the value of early detection of chronic diseases. Mass screening programmes to detect preclinical disease are believed to be useful for several chronic diseases. Early detection may improve survival in certain types of cancer and reduce the costs of treatment. There have been very few appropriate studies to see whether mortality in the screened is lower than in the unscreened. Mass screening for lung, colon and bladder cancer is very expensive and of dubious value.

41. It was noted that in some countries, where measures have been taken to make available widespread health care, marked differentials persist by social strata. Evidence on time trends in such differentials is limited to a few countries; in those countries, relative differentials have not narrowed. The causes of this trend are unclear and deserve study. For example, carefully crafted comparative studies of health care systems - for example, private versus public - could shed light on the most efficient means to extend quality and coverage of programmes and as a result to reduce levels and differentials in mortality. However, the Group recognized that mortality levels and differentials are largely determined by policies and programmes that are not directly the responsibility of the health sector. They are determined by many social, economic, and cultural influences, thus underlining the importance of intersectoral collaboration and the development of mutually supportive and coherent strategies. The way of dealing with long-term illness, for example, can influence and be influenced by the availability of housing for the elderly, an issue complicated by radical changes in family patterns

and family support systems. The participants were alarmed by the widening sex differentials in mortality in more developed countries and indicated that life style behaviours, industrial hazards and pollution may all be taking a large toll on the male sex.

42. New approaches for studying mortality differentials are also needed, the participants indicated. In several countries, ingenious schemes for following up samples of the population have been introduced so that life histories can be reconstructed. This approach offers promising avenues not only for mortality research but also for a wide spectrum of social policy. Such an approach contains, inter alia, an essential step towards overcoming some of the major methodological obstacles to assessing the evolution of differential mortality over a period of time. They also provide possibilities for understanding the underlying reasons for deleterious individual-level behaviour patterns, particularly in relation to mental stress and emotional disturbances in everyday life. The Group noted that this approach would be also useful for studying differentials by sex.

V. IMPLEMENTATION OF MORTALITY REDUCTION AND HEALTH PROGRAMMES AND INTERNATIONAL CO-OPERATION

43. The Expert Group considered the factors which facilitate or hamper the implementation of health policies and indicated that knowledge is limited owing to the insufficient research and evaluation efforts built into health programmes. However, on the basis of the limited evidence available, the participants emphasized the following points in their discussions.

44. The successful implementation of health programmes is contingent upon the degree of commitment to the value of health improvement by those who hold and influence power and determine the allocation of resources. The achievement of health improvement will depend not only upon the commitment of those persons and national bodies but also upon the willingness of the international community to accept its full share of responsibility for supporting and encouraging efforts to lower mortality.

45. A health programme is more likely to be successfully implemented if it is considered in the context of other development programmes. Planners must be conversant with, sensitive to, and in contact with those working in other sectors. In that way conflict and superfluous action can be avoided and the health implications of development programmes can be considered and perhaps incorporated into development projects.

46. The Expert Group emphasized the importance of programme commitment by the personnel who carry out the programme and by the population whom it serves. This in turn suggested the possibility and value of the overlapping of personnel and clients. Commitment is likely to be enhanced when they are the same persons or members of the same group or community.

47. The Group noted that policy formulation without regard to limitation of resources can be self-defeating. When it is clear that resources in political support, material, funds, personnel or infrastructure will not be available, the first stage should be to marshal those resources before executing the project. The participants emphasized that that does not mean that health planners should not question the overall allocation of resources and seek support throughout the society for increased allocation to health.

48. Even when the necessary commitment, co-ordination and resources are available, the Expert Group noted that successful implementation of mortality reduction and health programmes was often hampered by mistakes in their very formulation. Often the appropriateness of the programme and its cost-benefit implications have not been clearly studied, interim and long-range targets have not been specified, nor necessary monitoring devices built in. Programmes have often been begun without the knowledge that in another country the very same programme was undertaken and failed (or succeeded). Internal and international communication and familiarity with accumulated research and knowledge is essential at the planning stage.

49. The participants also noted that past programme formulation has often been dominated by what was termed the "blueprint" approach. Detailed, long-range blueprints are formulated, often by international organizations and top-level experts distant from the local scenes in which the project is to be carried out and unfamiliar with and untrained in the realities of the field. This approach dispenses with grass-roots involvement in planning and implementation; such lack of community participation is often followed by lack of local commitment. The blueprint may lead to inflexibility. Even when interim evaluation is built in - not always the case - it may be difficult to make significant changes, particularly if they affect vested interests. The Experts emphasized that the programme formulation should take a "learning process approach". Overall goals are determined and resources specified in co-operation with the local community; such an approach includes local monitoring and builds in the possibility of change. Even with the learning process approach it is necessary a priori to prepare relatively detailed plans. The major advantage is that local commitment is enhanced and, through continuous monitoring and evaluation, the operational structure allows the flexibility to alter the plans, correct mistakes, incorporate new techniques, and respond to altered circumstances.

50. Programmes are often formulated within the mould of curative medicine and run by those who have long lived within that mould, very often physicians. Curative care is provided through capital investment structures in urban centres. High-level technology, highly skilled personnel and grand-scale building form the nucleus of health policies and, not surprisingly, the systems comprised have little measurable impact upon the mortality levels and health status of populations. When planning does not include community participation and is undertaken by capital city residents trained in developed country situations, the formation of a technology-based philosophy can be expected. It is the philosophy that corresponds to their experiences and environment: well-to-do, urban civil servants whose illnesses and disease patterns are best served by the hospital-based, doctor-intensive health framework. But the participants stressed that this approach often serves very poorly the bulk of the population, who live in rural areas and in environments necessitating a preventive health care emphasis.

51. The Expert Group recognized the impeding role sometimes played by vested interests on the international level. The pharmaceutical industry and other multinational corporations have abetted the turning of scarce resources away from community needs and towards purchase of their own products, which may have minimum relevance to the needs of the less developed countries. Ironically, the basic technological knowledge and techniques - drugs, nutrition, electronics, etc. - that they offer have great potential value for improving the health of the population of those countries as a supplement to a community-based health programme. The Expert Group indicated that international organizations have an important function for providing explicit standards, proposing codes of conduct and monitoring compliance in marketing and distribution of products.

52. It was noted that many health programmes have been bedevilled by elementary mismanagement, sheer inefficiency and, unfortunately, corruption. These are universal problems and vary only in their intensity. What can keep them in check is the integration of monitoring and evaluation procedures.

53. The participants discussed the important role of international co-operation in mortality reduction programmes, pointing out the moral responsibility of the international community to encourage and support countries in improving health and lengthening life among all population groups. The Group indicated that international organizations should strive to better co-ordinate projects in their fields of activity to ensure that health aspects are fully considered in their projects and in all aspects of development progress in a balanced manner. Specifically, the Group emphasized that the international organizations and donor countries and agencies should ensure that adequate resources are available for research and action programmes to formulate, implement and monitor appropriate and cost-effective health programmes.

54. Finally, the Expert Group stressed the fundamental value of a social climate in which large numbers of people recognize their human right to be well-informed about health matters and have the power to demand that their health needs be met. In situations where such a social climate has prevailed, considerable advances have occurred in the health and well-being of people throughout the society.

VI. RECOMMENDATIONS

55. The Expert Group reiterated the full validity of the principles and objectives of the World Population Plan of Action. Following intensive discussions of the state of knowledge about progress and prospects for mortality reduction, interactions between health, mortality and development, health and social policies and their effects on mortality, and implementation of health policies and technical co-operation, the Expert Group recommended a variety of actions that, in its view, would lead towards the further implementation of the objectives specified in the Plan of Action.

Preamble

(P.1) The improvement of health and the reduction of mortality is a central goal of development, since a long and healthy life is the single greatest gift that an individual can have. It also facilitates other aspects of development because ill-health and volatile mortality at younger ages disrupt all other development activities. High levels of morbidity and mortality underlie low work inputs, limited planning horizons and many other characteristics usually described under the rubric of underdevelopment.

(P.2) The ultimate goal of population activities is to improve the well-being of individuals and their families. High levels of mortality threaten the survival of many families because of the considerable chance of losing one or more children or a primary provider. A reduction of mortality speeds completion of the demographic transition since reduced infant and childhood mortality is likely to have a moderating effect on fertility levels. The attainment of low levels of fertility and of population growth may not be possible without the investment of greatly increased efforts and funding for the reduction of mortality.

(P.3) The Expert Group endorses the goal of health for all by the year 2000 as adopted in 1977 by the Thirtieth World Health Assembly and endorses the concept of primary health care as expressed in the Declaration of Alma-Ata 3/ in 1978.

A. General

(1) Since Governments have indicated in international forums, through resolutions of the General Assembly, and through United Nations population inquiries that at the national and sub-national levels mortality and health conditions are not acceptable, efforts to bring about more rapid declines in mortality and more rapid improvements in health should be greatly intensified and accorded a much higher priority than at present.

(2) In view of the central role of personal behaviour in health improvement, individuals and families should be provided, as a basic human right, with all information and resources necessary for them to control their own health situations.

(3) Noting that the goal of health for all by the year 2000 would be seriously hampered by wars and by the high expenditures on arms, national and international organizations should accord the highest priority to fostering improved international relations and so allowing reallocation of funds from military expenditures to programmes in the social and economic spheres.

B. Goals

(4) The International Conference on Population should set new goals for mortality reduction. The revised targets should be feasible, verifiable and consistent with current levels and prospective trends of mortality. Achievement of such goals is not only the responsibility of individual countries, but a collective

responsibility of the international community. Targets should be explicit and quantitative, stated in terms such as an expectation of life at birth of at least 60 years and an infant mortality rate of less than 70 infant deaths per 1,000 live births by the year 2000 for the countries with the highest mortality rates.

(5) It is recommended that the International Conference on Population should consider setting targets specific to separate regions or specific to groups of countries that are currently at higher, intermediate or lower levels of mortality. In addition, consideration should be given to goals for childhood and maternal mortality.

(6) It is recommended that the United Nations, the World Health Organization and other international organizations should continue to monitor levels, trends and differentials in mortality, as appropriate to their respective mandates, as an aid to countries for evaluating the success of programmes in achieving their goals for mortality reduction.

C. Health and development

(7) Since national and international policies relating to all sectors of society can influence health, and since improved health, especially through the mechanism of improved physical and mental capabilities, affects the success of development projects, it is recommended that:

(a) The promotion and preservation of good health should be the explicit concern of all levels and branches of government, according to their main functions;

(b) Government actions in the area of mortality and health should be co-ordinated with actions in other development and social sectors and, as part of that co-ordination, development programmes should be monitored and analysed to assess their health impact;

(c) Special attention should be paid to health on the agenda of national and international development agencies; they should not be limited merely to the programmes of those agencies traditionally concerned.

(8) In planning development strategies, Governments should strive towards initiating projects which equitably enhance health.

(9) In order to contribute most effectively to health improvement as well as general well-being, government programmes should be oriented increasingly towards the development of "human resources".

(10) Because formal maternal education influences family health and community development and because of the demonstrable link between maternal education and the survival of children, schooling for all girls should be a top priority in social development. Moreover, as there is usually a time-lag between the end of school attendance and motherhood, and as many women are now illiterate, a supplementary effort should be made to extend adult female mass education programmes, including, for example, emphasis on basic literacy and good hygiene and nutrition practices.

(11) In order to attain the objective of health for all by the year 2000, Governments, as a first priority, are urged to direct available health resources, on a multi-sectorial basis, towards the most vulnerable groups, especially those in the most impoverished social categories.

(12) Noting that progress to reduce mortality rates and improve health in many developing countries is impeded by the dependent economic relationship of many developing countries with the developed countries, as well as by the lack of necessary political will within the developing countries themselves, the Expert Group recommended that a firm assertion should be made in all appropriate international forums of the high price, in terms of human lives, of such unjust and inequitable international relations and of inadequate governmental commitment to improving the health of populations.

(13) Noting that the period 1981-1990 is the International Drinking Water Supply and Sanitation Decade, and in view of the known health and mortality effects of poor water supply and inadequate drainage, the Group recommended that provision of clean potable water and regulated waste disposal should be an urgent priority of all Governments.

(14) Because of the evidence linking inadequate housing with poor health and high mortality, it is recommended that efforts should be made to improve urban and rural housing as soon as possible.

(15) Because of their effects on health and mortality, every effort should be made to reduce pollution and other environmental damages.

(16) As the characteristics of many occupations in the modern sector of economies have negative consequences for mortality and morbidity, owing to stress and other hazardous working conditions, necessary preventive actions should be taken. Because these conditions not only affect the health of women participating in the labour force but also indirectly that of their children, particular attention should be given to the working conditions of women.

D. Health and social policies and programmes

(17) It is recommended that those Governments whose economic and social development plans and national budgets currently give relatively little emphasis to the health sector should give higher priority to health programmes in both budgets and development plans.

(18) National health systems should be oriented towards the goal of improving the health of all population groups within a country. The Expert Group confirms the Declaration of Alma-Ata as a means of carrying out this goal, especially through the development and delivery of appropriate technologies that cover all the population and that effectively involve all of the people concerned.

(19) During education and training of personnel for implementation of health programmes, the importance of humane attitudes and behaviour should be emphasized.

(20) Noting that many life-style characteristics, such as tobacco, alcohol and drug consumption, inadequate or inappropriate diet and lack of exercise, have detrimental effects on health and lead to premature death, it is recommended that countries should initiate or strengthen preventive action programmes to influence life styles, especially through education and mass media.

(21) For both infectious and non-infectious diseases, medical practice should be more oriented towards prevention. A reorientation towards preventive programmes would also allow substantial economies in health expenditure.

(22) As evaluation greatly enhances the value of a programme not only for future activities in the country but also for other countries, it is recommended that special attention should be given to the evaluation of the impacts of specific health, social and other interventions for reducing mortality and morbidity, as well as to determining the cost-effectiveness of such interventions.

(23) Efforts should be made to promote and support breast-feeding and to disseminate throughout the population information on its role in reducing infant morbidity and mortality. Emphasis should also be placed upon providing clean and nutritious supplementary feeding in a timely fashion.

(24) Because of the strong relationship within the most malnourished populations between maternal malnutrition and low birth weight of infants - with subsequent high neo-natal mortality - special emphasis should be given to maternal nutrition programmes for those populations.

(25) Countries that have not already done so are urged to establish a national list of essential drugs and to ensure the permanent availability of those drugs at all levels of the health care system.

(26) It is recommended that appropriate United Nations agencies should provide support to the Governments of those countries where circumcision of young girls is a continuing practice, as part of national efforts to prevent practices that lead to illness and death.

E. Mortality and reproductive behaviour

(27) Because fertility regulation is one of the most effective ways of preventing high-risk pregnancies, and hence of reducing perinatal, infant and maternal mortality and morbidity, family planning should be promoted as an important health measure in all maternal and child health programmes. The recommendations of the Expert Group on Fertility and Family (see E/CONF.76/PC.6) should be considered in conjunction with the recommendations of the Expert Group on Mortality and Health Policy.

(28) Possible short-term and long-term health risks associated with methods of fertility regulation should be carefully monitored, assessed and evaluated within each country's special context.

(29) It is recommended that relevant national and international agencies should make special efforts to reduce involuntary infertility and sub-fertility, as well as unwanted births with the attendant risks of illegal abortion.

(30) It is recommended that all efforts should be made to reduce maternal mortality and morbidity with the least possible delay. When culturally acceptable, every woman should be attended during pregnancy and during labour by a trained practitioner.

F. Data collection and research

(31) Because information on levels, trends and differentials in mortality, causes of death, and morbidity is necessary for the formulation, implementation and evaluation of health and social development policies, it is recommended that national Governments should create new, or strengthen existing, systems of data collection and processing and make use of and improve the quality of all available sources of information.

(32) As the regular reporting to the World Health Organization and other bodies by all countries of information on selected diseases of major concern is essential for disease control within and among countries, measures should be taken to ensure accuracy and continuity in such reports.

(33) Noting that information on levels, trends and differentials in mortality among adults is much less abundant than that concerning infants and children, it is recommended that special emphasis should be given to data collection and research for adult ages.

(34) It is recommended that a co-ordinated international data collection and research programme on health and mortality should be established. The programme should have a substantial degree of independence from existing institutions in order to maximize its adaptability and ability to undertake initiatives. The focus of the programme's work should be on the levels and trends of health, morbidity and mortality, the determinants of morbidity and mortality levels, mortality differentials, and the causes of changes in those levels, with particular emphasis on policy interventions which might stimulate desired change. The programme should attempt to foster standardization of concepts and should provide upon request guidance on data collection, processing and analysis.

(35) Research is recommended on the effectiveness and efficiency of different national health systems and development strategies for reducing mortality and morbidity in the context of the various social contexts found in developing countries.

(36) Studies are recommended to identify strategies to strengthen government action for more rapid reduction of levels and inequalities in mortality. Such studies should include identifying better strategies to implement policies.

(37) Owing to the persistence and even increase of differences in mortality between the sexes and among different socio-economic groups in more developed countries, follow-up or follow-back surveys should be organized in selected countries to further document such morbidity and mortality differentials and to study the sources of such differentials.

(38) In order to respond more effectively to the effects on health and survivorship of many life-style characteristics, epidemiological, demographic and clinical research on the health effects of life-style characteristics should be intensified.

(39) Since new declines in mortality in countries that have already achieved low levels will result in an accelerated aging of the population, the consequences of which include increased rates of morbidity, it is recommended that the United Nations, its specialized agencies, and other research institutes should undertake further studies on the problems associated with aging, and that Governments should adopt appropriate measures to anticipate and successfully prepare for its consequences.

G. Technical co-operation

(40) Technical co-operation provided by international agencies to developing countries should be better co-ordinated so that the progress in each field of activity may be complementary and a balanced growth achieved. Different international agencies operating in the same country should share all information and their activities should be co-ordinated with those of the approriate national office.

(41) It is recommended that the United Nations system should stimulate activities and provide all necessary assistance to countries to encourage the health programmes that will be the most adequate and cost-effective for that country, and to assist in the training of personnel appropriate to the situation and with the necessary commitment to human service.

(42) Since there is a need for concerted national and international effort to improve strategies for ensuring health throughout the developing world, it is strongly urged that donor agencies should increase resources for the formulation, implementation and evaluation of health programmes.

(43) In addition to supporting health programmes, donor agencies should allocate increased resources for health information, health education and communication programmes; exchange of health information, technology and skills among developing countries; and mortality data collection, processing and analysis.

Notes

1/ Report of the United Nations World Population Conference, Bucharest, 19-30 August 1974 (United Nations publication, Sales No. E.75.XIII.3), chap. I.

2/ Report of the World Assembly on Aging, Vienna, 26 July-6 August 1982 (United Nations publication, Sales No. E.82.I.16), chap. VI, sect. A.

3/ See World Health Organization, Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, Union of Soviet Socialist Republics, 6-12 September 1978 (Geneva, 1978).
