WHO/SDE/HDE/02.7
Original: English
Distr.: Limited

Health and Sustainable Development

Meeting of Senior Officials and Ministers of Health

Summary Report

Johannesburg, South Africa
19-22 January 2002

Department of Health
Republic of South Africa

Southern African Development Community

World Health Organization

Health and Sustainable Development

Meeting of Senior Officials and Ministers of Health

Summary Report

Johannesburg, South Africa
19-22 January 2002

Department of Health
Republic of South Africa

Southern African Development Community

World Health Organization

Table of Contents

1 Meeting synopsis

The Ministry of Health of South Africa, supported by the World Health Organization (Department of Health and Development), organized and hosted a ministerial meeting on "Health and Sustainable Development" in Johannesburg, South Africa, from 19-22 January 2002. The meeting was one of a series to plan the health agenda for the upcoming World Summit on Sustainable Development (WSSD). It was preceded by a WHO meeting, hosted by the Government of Norway, from 29 November to 1 December 2001 in Oslo, Norway on the theme "Making Health Central to Sustainable Development – Planning the Health Agenda for the World Summit on Sustainable Development".

The present meeting brought together ministers of health, senior officials and other representatives from countries of the Southern African Development Community (SADC), from China, India, Indonesia, Norway and the United States*, as well as representatives from other ministries, international organizations, and non-governmental organizations. The objective of the meeting was to help further define issues and strategies of relevance to the health agenda for the World Summit on Sustainable Development (WSSD). The meeting was organized in two parts: a senior officials' meeting which took place on 19 January, followed by a ministerial segment which took place from 20 to 22 January 2002.

During the meeting of senior officials, a background paper, and a paper outlining ideas for inclusion in a declaration on health and sustainable development, were considered. The deliberations were informed by presentations on "Poverty, Disease Burden and Development" given by Professor Eric Buch of the University of Pretoria, "Globalization, Trade and Health" presented by Mr Nhlanhla Masuku of USK International (Pvt.) Ltd., "Environment and Health Implications of Urbanization, with Special Reference to Johannesburg" given by Ms Angela Mathee of the Medical Research Council of South Africa, and "Strengthening the Role of Health in Sustainable Development: from Rio to Johannesburg" presented by Dr Yasmin von Schirnding of the World Health Organization.

During the ministerial segment of the meeting, addresses were given by Dr Andrew Cassels, Director, Department of Health and Development, World Health Organization, the Honourable Mr Ronnie Kasrils, Minister of Water Affairs and Forestry, Republic of South Africa, and the Honourable Ms Mathabiso Lepono, Minister of Environment, Gender and Youth Affairs, Kingdom of Lesotho. The keynote address was given by the Honourable Dr Manto Tshabalala-Msimang, Minister of Health, Republic of South Africa.

In the sessions which followed, further deliberations took place on the background paper, and the draft declaration. Inputs and modifications were discussed and agreed, subsequent to which the "Johannesburg Declaration on Health and Sustainable Development", and the background paper were adopted.

* The United States was not present on the second day when the Declaration was finalized.

2 Senior officials' meeting

The senior officials' meeting was officially opened by the Director-General of Health of South Africa, Dr Ayanda Ntsaluba.

Dr Ntsaluba welcomed all to the meeting. He highlighted the importance of this meeting in developing a health sector position for the World Summit on Sustainable Development, and briefly outlined the key issues of relevance in this regard. He explained the organization of the meeting and emphasised the importance of working constructively together to present a suitable set of proposals to the ministerial segment of the meeting taking place from 21 to 22 January 2002.

In order to inform the discussions during the course of the meeting, presentations were given in three theme areas:

- **Poverty, Disease Burden and Sustainable Development** – Professor E. Buch.
- **Globalization, Trade and Health** - Mr N. Masuku.
- **Environment and Health Implications of Urbanization, with Special Reference to Johannesburg** - Ms A. Mathee.

The background to work on health and sustainable development, and the context to the meeting, was given by Dr Yasmin von Schirnding, Focal Point: Agenda 21, World Health Organization, in a presentation on "Strengthening the Role of Health in Sustainable Development: From Rio to Johannesburg".

These presentations are summarized below.

Poverty, Disease Burden and Sustainable Development

Professor Buch began his talk with an overview of the global disease burden. He emphasized the fact that, while there had been improvements in some indicators, the disease burden, for both communicable and non-communicable diseases, still remained high and the poor carried a disproportionate burden of disease. Global development goals and targets were unlikely to be met unless efforts to achieve them were dramatically and rapidly scaled up, he said.

In looking at the linkages between poverty and ill-health, it could be seen that poverty was at the root of much ill-health, and this poverty was multi-dimensional. At the same time, poor health could lead to poverty, both at the national, and household levels. Conversely, good health could add billions of dollars to gross domestic product, and Professor Buch outlined some of the pathways through which this would happen.

He asserted that sustainable development was the key to improved health, since the poverty driving ill-health was interconnected with factors such as poor economic growth, inequity, globalization, environmental degradation and weak health services. Health services had an

important role to play in sustainable development by reducing the disease burden. However, this role was being undermined by the insecurity of health services in many developing countries, as well as under-funding and stunted technological development.

In considering ideas for a declaration on health and sustainable development, Professor Buch said that this should be aimed at reinvigorating sustainable development, and focusing on ways to bequeath a healthy life for present and future generations. Efforts should focus on the poor and marginalized in all countries as they bear the greatest health burden. He outlined the following as being fundamental in achieving healthy sustainable development:

- Reaffirmation of the global development goals and targets for reduction of disease burden;
- Rapidly moving disease programmes to scale;
- Implementation of sustainable poverty reduction strategies and ensuring that health concerns were addressed in these strategies;
- Renewed commitment to achieving the target of 0.7% of GNP for development aid, and earmarking funds within this for spending on poverty related ill-health;
- Bringing health into global environment concerns;
- Wider use of health impact assessments.

In examining ways to meet the critical need to strengthen and secure health systems, Professor Buch outlined the following as being important for consideration in the declaration:

- A call for global commitment to strengthening health systems;
- Commitment by countries to invest a greater proportion of their own resources to health services alongside vastly increased external funding;
- Fair financing mechanisms to cover the costs of health care;
- An agreement on ethical strategies to enable the retention of human resources in the developing world;
- More research on the diseases of the poor;
- A worldwide campaign for global health literacy.

Globalization, Trade and Health

Mr Masuku looked at the complexity of the relationship between globalization, trade and health, and referred to empirical evidence to date that suggests that trade liberalization-led globalization has largely disadvantaged developing economies in trade and health indicators.

He reviewed the structural adjustment programmes of the international financial institutions which had left many developing countries with unsustainable balance of trade deficits, depleted foreign exchange reserves and subsequent shortages of essential medicines and drugs. These same failed policies have been discarded, or are being pushed through discussions in OECD countries and the World Trade Organization.

Mr Masuku said that what was required was a resource-based sustainable development agenda, with strong anti-poverty policies. Mr Masuku concluded that, in order for globalization to benefit trade and health:

- Sustainable development policies must take precedence over trade liberalization and other market-oriented policies;
- National governments must allocate at least 5 % of GDP to the health sector;
- Equity in health policies must be pursued.

Environment and Health Implications of Urbanization, with Special Reference to Johannesburg

Ms Mathee looked at urbanization as a driving force which ultimately led to pressures on the environment through the emission of pollutants into the air, water and soil. This in turn led to:

- a deterioration in the state of the environment, and;
- the exposure of people to pollutants and toxics, often synergistically or cumulatively;
- a range of effects on health, ultimately requiring;
- various actions, especially preventative actions, to address all of the above (policies, programmes, projects).

She illustrated these with pictures and graphic examples of settings of environmental degradation and health risk from the Johannesburg area. The example of inner city "shack farms" in Johannesburg was drawn on to show how rapid unplanned urbanisation could lead to people living in settings in which shelter was insecure, air quality was poor, access to water and sanitation was limited, income was minimal. In addition, residents of the "shack farms" constantly had to deal with high levels of noise, a lack of adequate ventilation, limited privacy and the threat of violence. In these highly marginalized communities, health status, especially that of known high-risk groups such as young children, was particularly poor, leading to a situation of unsustainable development.

Ms Mathee's presentation also focussed on widespread environmental lead exposure in Johannesburg. Data was presented which indicated that 78% of children attending schools in low-income settings in the city have blood lead levels equalling, or higher than, the international action level of 10 µg/dl. The use of coal, wood and paraffin (kerosene) for domestic purposes in peri-urban and inner city informal settlements, and its implications for high levels of exposure to indoor (and ambient) air pollution and poor respiratory health, was another concern highlighted.

Ms Mathee highlighted aspects in relation to urbanization, environment and health, which were important to consider in discussions around the declaration. These included:

- Mechanisms to address the range of environmental concerns and health risks in settings of extreme under-development ("shack farms", squatter settlements);
- The role of HIV/AIDS in increasing vulnerability to environmental hazards (such as indoor air pollution and inadequate water and sanitation facilities);

- The need for public health responses to be pro-active, innovative and build on the initiatives of communities;
- Removal of barriers to social inclusion of marginalised communities in urban areas;
- Support for the promotion of good governance;
- The role of international networks and agreements;
- The use of tools to promote sustainable development and protect health needs (e.g. health impact assessments, national/regional environment and health action planning, local environment and health auditing).

Strengthening the Role of Health in Sustainable Development: From Rio to Johannesburg

Dr von Schirnding highlighted that this meeting was a key milestone in planning the health and sustainable development agenda for the World Summit on Sustainable Development. In order to set the scene for this meeting, Dr von Schirnding traced briefly the history and origins of the term "sustainable development". While noting that the definition is as appropriate today as it was nearly 15 years ago, Dr von Schirnding called attention to the importance of focusing on *development* within the concept of sustainable development. The economic, social and environmental dimensions of sustainable development needed to be viewed in a holistic and integrated way, and could not be addressed in isolation, she said.

Dr von Schirnding then looked at the key role that health plays in integrating across these three elements, as well as within each of the elements. She highlighted the fact that there was increasing evidence of strong two-way linkages between health and each of the three dimensions of sustainable development. She reminded participants that, irrespective of these linkages, health was also a key issue in its own right.

The 1992 United Nations Conference on Environment and Development (UNCED), was discussed in relation to the Rio Declaration, which enshrined the importance of health in the first principle, as well as in regard to Chapter 6 of Agenda 21, which was devoted to health. Dr von Schirnding outlined the "Rio Legacy" in terms of health, and also pointed out the gaps in this legacy. These included inadequate attention to: health and poverty alleviation; health risks and determinants beyond communicable diseases; health impacts of development policies and practices; and globalization and health.

The WSSD, therefore, provided an unprecedented opportunity to show why health needs to be central to the development process. Dr von Schirnding shared with participants some theme areas/messages of importance in relation to WSSD:

- Ill-health hampers poverty alleviation and socio-economic development;
- Environmental degradation, mismanagement of natural resources and unhealthy consumption patterns/lifestyles impact on health, particularly of the poor;
- Development policies and practices need to take into account current and future impacts on health;
- New partnerships and reform measures are needed both inside and outside the health sector.

The key elements of WHO's strategy for the WSSD revolved around:

- Assessing the evidence and tracking progress;
- Defining the issues and policy positions in dialogue with key partners in health;
- Carrying out advocacy and awareness-raising.

Dr von Schirnding highlighted some key outcomes that WHO would like to see from the WSSD. These included:

- Health issues featuring centrally in the final conference documentation and declaration;
- Renewed commitment to the implementation of the health aspects of Agenda 21;
- Concrete plan of action put in place on identified priorities for health and sustainable development;
- Agreement on mechanisms to improve intersectoral action, including institutional strengthening for health impact assessment;
- New partnerships and alliances put in place for health and sustainable development.

3 Ministerial segment

Opening banquet

Welcoming Address by the Honourable Dr Manto Tshabalala-Msimang, Minister of Health, Republic of South Africa

Participants were welcomed to South Africa in an opening banquet held on Sunday 20 January 2002. The Honourable Dr Manto Tshabalala-Msimang, Minister of Health of the Republic of South Africa, extended greetings and words of welcome to all participants. She pointed out that a number of major international conferences had been held recently in South Africa, from which much had been learned for the organization of the upcoming World Summit on Sustainable Development.

The Honourable Minister recalled that the United Nations Conference on Environment and Development (UNCED) had been revolutionary in moving from the relatively straightforward concept of environmental protection, towards the vision of sustainable development. Broad participation and the involvement of civil society had been instrumental in the success of UNCED. It was of prime importance to balance all three dimensions of sustainable development, including the need to find sustainable ways to ensure that people's basic needs were met, whilst preserving environmental capital.

Dr Tshabalala-Msimang challenged participants to translate the first principle of the Rio Declaration into action, and outlined a vision of how this might be done. She emphasized that there was a need:

- for policies and programmes that reach and involve poor people in both developed and developing countries;
- to tap into the potential role of health in poverty reduction and sustainable development;
- to invest in health as a key tool in poverty alleviation;
- to address the linkages between human beings, the economy and the environment.

In her final remarks, Dr Tshabalala-Msimang drew attention to the preparations for this meeting that had begun during the WHO meeting held in Oslo, Norway, from 29 November to 1 December 2001. This meeting had generated a wealth of challenging ideas on health and sustainable development, and provided fertile ground as preparation for the meeting here, she said. She extended her thanks to the Norwegian Government and to the World Health Organization, in particular to the Director-General, Dr Gro Harlem Brundtland, for supporting the meeting in South Africa.

Ministerial Segment

The ministerial segment of the meeting was officially opened on Monday 21 January 2002. Mr Sello Moloto, Member of Executive Council, Northern Province, South Africa, acted as programme director for the opening session.

Opening Remarks by Dr Welile Shasha, WHO Liaison Officer, South Africa

In his opening remarks, Dr Welile Shasha thanked the Government of South Africa for hosting the meeting, which was seen as an important milestone in preparations for the World Summit on Sustainable Development. Dr Shasha called attention to the importance of health and sustainable development in WHO activities at regional and global levels. He highlighted the personal commitment to sustainable development of Dr Ebrahim Samba, WHO Regional Director for Africa, who had been instrumental in raising the awareness of WHO representatives in the African region to the complexities of health, sustainable development and poverty.

Dr Shasha referred to the New Partnership for African Development (NEPAD) which was a truly African initiative and represented an imaginative and logical framework for sustainable development. He called the initiative an historical breakthrough and highlighted that the major challenge now is the implementation gap.

Address by Dr Andrew Cassels, Director, Department of Health and Development, World Health Organization

Dr Andrew Cassels addressed participants on behalf of WHO. He highlighted the fact that sustainable development was about mutually supportive strategies, about integration, and about putting people squarely in the centre of the frame. He referred to the complexity of the sustainable development agenda which posed a challenge for governments to find mutually supportive strategies, seek coherence across sectors, ensure complementarity of policies, handle trade-offs, and maximise the impact that can be achieved by an ever wider group of institutional actors.

In addressing this complexity, Dr Cassels outlined the following six key themes or challenges which must be responded to in addressing this complexity.

1. Put health higher on the international political and development agenda;
2. Move from targets to strategies;
3. Think about a new financial realism to achieve the targets;
4. Capitalize on the impetus for global action;
5. Look at health in a more holistic way;
6. Establish an enabling international environment.

Dr Cassels shared with participants some thoughts on framing the health agenda and messages for the World Summit on Sustainable Development. The WHO approach was two-pronged, with the first thrust showing how investment in people's health was important in terms of sustainable development in general, having a major payoff in terms of all three dimensions of sustainable development. The second thrust of the message would look at the role of health in greater depth in relation to the specific issues that will form the agenda for the WSSD. Dr Cassels emphasized that, in framing the messages, key factors from the

analysis of the context for health and sustainable development would be essential. He closed by saying that the work undertaken during this meeting to refine the health and sustainable development agenda would be crucial to the collective success of the meeting.

Address by the Honourable Mr Ronnie Kasrils, Minister of Water Affairs and Forestry, Republic of South Africa

In his opening address, the Honourable Mr Ronnie Kasrils highlighted aspects of South Africa's approach to the World Summit on Sustainable Development, which was first and foremost about development. South Africa, along with the rest of Africa, had put poverty at the forefront of the sustainable development agenda. For development to occur and be meaningful, it was essential to attack poverty, he said.

This perspective must be kept at the forefront as different sectors prepare for the WSSD, he said. He shared the following messages and examples from the water sector.

- Water had been used as a good example to show how development needs to be approached, in order to ensure that it is effective and sustainable;
- The key to achieving water goals did not lie within the water sector alone, but also in improving the international environment;
- This required new global frameworks such as the New Partnership for African Development which stresses the need to create conditions in which communities and countries are able to provide for themselves. There was also a need to link processes, such as negotiations in the World Trade Organization and Financing for Development, to the WSSD;
- There was a need for global environmental governance to meet the challenges of managing in an international context.

The Honourable Minister emphasized the importance of sanitation, which should not take a second seat to water supply. In this light, he outlined a programme comprised of three key elements:

- Advocate for the addition of a sanitation target among the Millennium Development Goals;
- Ensure that there is a truly global campaign to promote sanitation improvement;
- Promote the message that goals will not be achieved unless improved hygiene practices accompany improved water supply and sanitation.

Mr Kasrils closed by asking participants for their support in this effort and extended best wishes on behalf of Mr Valli Moosa, Minister of Environmental Affairs and Tourism.

Address by the Honourable Ms Mathabiso Lepono, Minister of Environment, Gender and Youth Affairs, Kingdom of Lesotho, and Chairperson of the SADC Environmental and Land Management Sector

Quoting from the SADC Special Report to UNCED in 1992, Ms Lepono reminded participants that the quest for integrated policies for sustainable development aimed at eradicating poverty and improving the livelihoods of millions of SADC citizens should continue to guide and drive efforts. The Honourable Minister highlighted some of the factors which continued to plague the SADC region, including poverty, HIV/AIDS and other communicable diseases, unplanned settlements with the attendant pollution, civil conflict leading to internal migration from rural to urban areas, and poor air quality, particularly in urban and peri-urban centres.

Ms Lepono informed participants that the SADC Council of Ministers had created a distinct SADC Environment and Land Management Sector in 1999 to address issues of environment and sustainable development. The SADC Committee of Ministers of Environment was spearheading both national, and SADC sub-regional, preparations for the WSSD. Their biggest challenge would be to bring together all stakeholders' views into a single development agenda.

The Honourable Minister welcomed the meeting as a clear sign of commitment to the principles of sustainable development, and emphasized the collective responsibility between sectors to make sure that the WSSD would make a difference to the health status of SADC citizens. In addition, Ms Lepono highlighted the opportunity that the meeting provided to enhance and strengthen understanding between health and environmental sectors. She shared her hopes that the meeting would come up with focused priority issues on health and sustainable development that would find their way onto the agenda of the World Summit on Sustainable Development.

Keynote address by the Honourable Dr Manto Tshabalala-Msimang, Minister of Health, Republic of South Africa

The Honourable Minister highlighted the fact that the task of participants at this meeting was to spell out very clearly the relationship between health and sustainable development, and to place the relevant issues high on the agenda of the World Summit on Sustainable Development.

Dr Tshabalala-Msimang noted that understanding of the link between health and development – and the role of health systems in modifying that relationship – had grown and matured in the last decade. She referred to the recently released report of the WHO Commission on Macroeconomics and Health, which she called a valuable asset for those arguing that health is not an appendage of development, but rather a key driving force.

The Honourable Minister noted that conditions were ripe for mobilizing support for health to be treated as a priority within the global development agenda. These included:

- The new sensitivity to the suffering of people in the developing world which had developed as a result of the HIV/AIDS catastrophe;
- The advances that had been made at the WTO meeting in Doha on patent protection of essential medicines;
- The birth of the Global Fund to Fight HIV/AIDS, TB and Malaria as a totally new international assistance vehicle;
- The growing recognition that health cannot be relegated exclusively to health professionals.

Dr Tshabalala-Msimang sketched some of the social and economic dynamics, and the health patterns associated with these, that would need to be taken into account in formulating a collective position in the declaration under consideration at the meeting, including:

- Poverty in a world of plenty as a fundamental determinant of disease;
- The effect of globalization on health, particularly concerns regarding its impact on specific regions, nations and classes within nations;
- The process of urbanization with the attendant disease and health conditions, as well as the negative impact on the environment;
- The health implications of social instability.

In closing, the Honourable Minister stated that, as advocates for health, they were approaching the World Summit seeking linkages. As health specialists, the participants had a particular and dynamic contribution to make to development. At the same time, they had an equally serious expectation that specialists in other areas would underpin health by striving for development in its broadest sense.

Working Sessions

Following the opening addresses, the ministers heard presentations from the technical experts present in the areas of: "Poverty, Disease Burden and Sustainable Development" (Professor E. Buch), "Globalization, Trade and Health" (Hon. Dr D. Parirenyatwa on behalf of Mr. N. Masuku), "Environment and Health Implications of Urbanization, with Special Reference to Johannesburg" (Ms A. Mathee). These presentations are summarized in section 2 of this report.

The Ministers discussed each of the presentations before proceeding to a consideration of the background paper and draft declaration. The remainder of the meeting was devoted to finalizing the background paper (see Annex 3), and to finalizing and officially adopting the "Johannesburg Declaration on Health and Sustainable Development". The full text of the Declaration is given in an accompanying document, available on request.

As follow up to the meeting, and in order to continue to strengthen and advocate for the health and sustainable development agenda, the ministers agreed that the "Johannesburg Declaration on Health and Sustainable Development" should be widely disseminated at national level to inform discussions and preparations underway for the WSSD in countries, as well as at sub-regional, regional and international level where the Declaration would be fed into the official preparatory process for the WSSD through the Preparatory Committees (Prepcoms) which would be taking place in the coming months.

The Honourable Minister of Health of South Africa informed participants that the World Summit on Sustainable Development would be on the agenda of the World Health Assembly in May of this year and that a resolution on the subject would be proposed to Member States at the governing body for consideration.

The meeting was officially closed by the Honourable Dr Manto Tshabalala-Msimang and was followed by an international press conference during which the Declaration was presented.

Annex 1 - Programme

Saturday 19 January

09.00 - 09.15	Opening remarks *Dr. Ayanda Ntsaluba,* Director-General, Ministry of Health, South Africa
09.15 - 09.30	**"Poverty, Disease Burden and Development"** *Professor Eric Buch,* Professor of Health Policy and Management, School of Health Systems and Public Health, University of Pretoria, South Africa
09.30 - 09.35	Questions
09.35 - 09.50	**"Globalization, Trade and Health"** *Mr Nhlanhla Masuku,* Managing Director of USK International (Pvt.) Ltd., Zimbabwe
09.50 - 09.55	Questions
09.55 - 10.10	**"Environment and Health Implications of Urbanization, with Special Reference to Johannesburg"** *Ms Angela Mathee,* Senior Specialist Scientist, Environmental Health, Medical Research Council of South Africa
10.10 - 10.15	Questions
10.15 - 10.45	Tea
10.45 - 12.30	Discussion on background paper: **"Health and Sustainable Development"**
12.30- 13.45	Lunch
13.45- 14.00	**"Strengthening the Role of Health in Sustainable Development: from Rio to Johannesburg"** *Dr Yasmin von Schirnding,* Focal Point: Agenda 21, World Health Organization, Geneva
14.00- 15.30	Discussion on paper outlining ideas for the Declaration
15.30 - 15.45	Way forward *Dr. Ayanda Ntsaluba,* Director-General, Ministry of Health, South Africa
15.45- 16.15	Tea

Sunday 20 January

19.30	Opening banquet *Dr K. Chetty,* Programme Director, Assistant Director-General, Ministry of Health, South Africa Welcome address *Hon. Dr Manto Tshabalala-Msimang,* Minister of Health, South Africa

Monday 21 January

08.00 - 09.00	Registration
09.00 - 10.30	Opening ceremony *Mr P. Sello Moloto,* Programme Director, Member of Executive Council, Northern Province, South Africa
09.05-09.15	Opening remarks *Dr Welile Shasha,* WHO Liaison Officer, South Africa
09.15 - 09.30	**"Reflections on Health and Sustainable Development"** *Dr Andrew Cassels,* Director, Health and Development, World Health Organization, Geneva
09.30 - 09.45	**"South Africa's Approach to the World Summit on Sustainable Development"** *Hon. Mr Ronnie Kasrils,* Minister of Water Affairs and Forestry, South Africa
09.45 - 10.00	Opening address *Hon. Ms Mathabiso Lepono,* Minister of Environment, Gender and Youth Affairs, Lesotho/Chairperson of SADC Environmental and Land Management Sector
10.00 - 10.25	Keynote address *Hon. Dr Manto Tshabalala-Msimang,* Minister of Health, South Africa
10.30 - 10.45	Photo session for Ministers
10.45 - 11.00	Tea
	Session 1 - Chairperson: *Hon. Dr Manto Tshabalala-Msimang,* Minister of Health, South Africa
11.00 - 11.10	Overview of the process of the meeting
11.10 - 11.25	**"Poverty, Disease Burden and Development"** *Professor Eric Buch*
11.25 - 12.00	Discussion
12.00 - 12.05	Summary by Chairperson
12.05 - 12.20	**"Globalization, Trade and Health"** *Hon. Dr D. Parirenyatwa on behalf of Mr. N. Masuku*

12.20 - 12.55	Discussion
12.55 - 13.00	Summary by Chairperson
13.00 - 14.30	Lunch
	Session 2 - Chairperson: *Hon. Dr P. Dlamini,* Minister of Health, Swaziland
14.30 - 14.45	**"Environment and Health Implications of Urbanization, with Special Reference to Johannesburg"** *Ms Angela Mathee*
14.45 - 15.20	Discussion
15.20- 15.30	Summary by Chairperson
15.30 - 16.00	Tea
	Session 3 - Chairperson: *Hon. Dr. F. Songane,* Minister of Health, Mozambique
16.00 - 17.30	Presentation and discussion of background paper **"Health and Sustainable Development"** *Dr. R.B. Pendame,* Permanent Secretary, Ministry of Health, Malawi

Tuesday 22 January

	Session 1 - Chairperson: *Hon. Dr Manto Tshabalala-Msimang,* Minister of Health, South Africa
08.30 - 10.00	Presentation and discussion of draft Declaration *Dr J. Kunene,* Director-General, Ministry of Health, Swaziland
10.00 - 10.30	Tea
	Session 2 - Chairperson: *Hon. Dr P. Dlamini,* Minister of Health, Swaziland
10.30 - 11.15	Presentation and adoption of revised background paper **"Health and Sustainable Development"** *Dr. R.B. Pendame,* Permanent Secretary, Ministry of Health, Malawi
11.15 - 12.15	Presentation and adoption of the **"Johannesburg Declaration on Health and Sustainable Development"** *Dr J. Kunene,* Director-General, Ministry of Health, Swaziland
12.15 - 12.30	Closing remarks *Hon. Dr Manto Tshabalala- Msimang,* Minister of Health, South Africa
12.30 - 14.00	Lunch
14.00 - 15.00	Press Conference

Annex 2 - List of participants*

Angola
Dr A. R. M. Neto
Permanent Secretary, Ministry of Health

Botswana
Mr I. Joseph
Director HIV/AIDS, Ministry of Health

China
Ms Z. Rong
Programme Officer, Department of International Cooperation, Ministry of Health
Dr C. Xianyi
Deputy Director General, Department of Diseases Control, Ministry of Health

India
Ms P. Sharma
Counsel General, High Commission of India, Johannesburg, South Africa
Mr R. K. Jha
Commercial Counsel and Head of Chancery, High Commission of India, Johannesburg, South Africa

Indonesia
Dr H. Darpito
Director of Department of Health, Embassy of the Republic of Indonesia, Pretoria, South Africa
Dr I. N. Kandun
Senior Staff of Minister of Health
Mr K.A.Z. Saputra
Chargé d'Affaires, Embassy of the Republic of Indonesia, Pretoria, South Africa
Mr R.T. Saragih
First Secretary, Embassy of the Republic of Indonesia, Pretoria, South Africa
Mr S. Sunggono
Minister Counsellor, Embassy of the Republic of Indonesia, Pretoria, South Africa

Lesotho
Hon. Ms M. Lepono
Minister of Environment, Gender and Youth Affairs and Chairperson of the SADC Environmental and Land Management Sector
Hon. Dr P. Sekatle
Minister of Health and Social Welfare
Ms N. Majara
Principal Land Use Planner, SADC Environmental and Land Management Sector
Dr M. Motheetee
Chief Executive, AIDS Programme Coordinating Authority (LAICA)
Dr P. Ntsekhe
Tuberculosis Programme Manager, Disease Control, Ministry of Health
Dr T. Ramatlapeng
Director General of Health Services, Ministry of Health
Ms J. M. Rasenthuntsa
Deputy Principal Secretary, Ministry of Health

Malawi
Hon. Mr Y. Mwawa
Minister of Health
Dr R. B. Pendame
Permanent Secretary, Ministry of Health

** Based on information provided by the Secretariat*

Mauritius
Hon. Mr A. Jagnauth
Minister of Health
Dr R. Sungkur
Adviser to the Minister of Health

Mozambique
Hon. Dr F. Songane
Minister of Health
Dr A. P. Cossa
Director of Planning and Cooperation, Ministry of Health

Norway
Mr T. Hetland
Senior Adviser, Royal Norwegian Ministry of Health and Social Affairs
Ms I.G. Naess
First Secretary, Embassy of Norway to South Africa

South Africa
Mrs D. Mafulbelu
Health Counsellor, Permanent Mission of the Republic of South Africa to the United Nations Office at Geneva and other International Organizations in Switzerland

Swaziland
Hon. Dr P. Dlamini
Minister of Health
Dr J. Kunene
Director General, Ministry of Health

Tanzania
Hon. Ms A. Abdallah
Minister of Health
Dr N. Eseko
Head of Epidemiology Unit, Ministry of Health
Mrs S. Nyanduga
Minister Counsellor, High Commission of Tanzania, Pretoria, South Africa

United States of America
Mr W. B. Christensen
Environment Science Technology Officer, Embassy of the United States of America to South Africa

Zambia
Hon. General B. Chituwo
Minister of Health
Dr S. K. Mitti
Acting Director General for Central Board of Health, Ministry of Health

Zimbabwe
Hon. Dr D. Parirenyatwa
Deputy Minister of Health
Dr E. Xaba
Permanent Secretary, Ministry of Health

Representatives of the Ministry of Health, South Africa

Hon. Dr M. Tshabalala-Msimang
Minister of Health
Dr A. Ntsaluba
Director General, Ministry of Health
Dr K. Chetty
Deputy Director General, Ministry of Health

Dr T. Balfour
Director, SADC Health Sector Coordinating Unit
Ms J. Collinge
Chief Director, Communication
Professor R.V. Gumbi
Chief Director , Human Resources Development
Professor S. Hendricks
Chief Director, Health and Welfare Sector, Bargaining Council
Ms C. Kotzenberg
Director, Chronic Disease and Disability
Advocate P. Lambert
Legal Adviser to the Minister of Health
Ms L. Lebese
Deputy Director, SADC Health Sector Coordinating Unit
Ms K. P. S. Makatesi
Coordinator, South Africa Tuberculosis Control Initiative (SATCI)
Ms M. P. Matsoso
Chief Director, Medicine Regulatory Affairs
Dr R. E. Mhlanga
Chief Director, Maternal and Child Health
Mr S. Mngadi
Liaison Officer, Communication (Spokesperson for the Minister of Health)
Ms Z. Mthembu
Director, Health Promotion
Mr T. Moshoesho
Communication Officer, SADC HSCU
Dr U. Nagpal
Director, Communicable Diseases
Dr L. Ndelu
Director, Medical Bureau Official Diseases
Ms Q. Ntsele
Deputy Director, Environmental Services
Dr G. Sekobe
Chief Director, Non-Personal Health Services
Dr N. Simelela
Chief Director, HIV/AIDS Unit
Dr F. J. Smit
Director, Oral Health
Dr M. van Heerden
Chief Director, Communicable Diseases
Mr Z. Zincume
Deputy Director, Environmental Health
Dr H. Zokufa
Chief Director, Pharmaceutical Services

Members of Executive Council for Health, South Africa

Free State Province
Mrs O. Tsopo

Gauteng Province
Dr G.W. Ramokgopa

Mpumalanga Province
Ms S. Manana

North West Province
Mr M. Mosenogi

Northern Province
Mr S. Moloto

Northern Cape Province
Ms D. Peters

Representatives of Provincial Departments of Health, South Africa

Eastern Cape Province
Dr Chabula
Acting Head of Department

Free State Province
Mrs L. Katzen
Senior Manager of Health Programmes
Dr R. D. Chapman
General Manager for Health Support
Mr W. H. de Villiers
Assistant Director, Environmental Health
Mr M.S. Shuping
General Manager, Clinical Health
Mrs L.A. Tlali
Assistant Director of Promotion, Department of Health

Gauteng Province
Dr A. Rahman
Deputy Director General
Dr L. Rispel
Head of Department

KwaZulu-Natal Province
Professor Green-Thompson
Head of Department
Mr J. Maniram
Provincial Food Coordinator and Port Health Manager

Mpumalanga Province
Mrs R. Charles
Head of Department, Deputy Director General

North West Province
Mr O. M. R. Mokate
Deputy Director, Environmental Development and Occupational Health
Mr N. R. Mphahlele
Chief, Environmental Health Programme
Mr J. M. van Niekerk
Head of Environmental Health

Northern Province
Dr H. N. Manzini
Senior General Manager and Acting Head of Department

Northern Cape Province
Mrs L. Nyati-Mokotso
Director of District Priority Programmes and Support Services

Western Cape Province
Professor K. C. Household
Acting Head of Department

Representatives of Ministries and Governmental Departments, South Africa

Ministry of Agriculture and Land Affairs

Hon. Ms A. T. Didiza
Minister of Agriculture and Land Affairs

Ministry of Water Affairs and Forestry

Hon. Mr R. Kasrils
Minister of Water Affairs and Forestry

Department of Environmental Affairs and Tourism

Ms H. Anderson
Consultant of the World Summit on Sustainable Development (WSSD)
Mr B. T. Dioka
Assistant Manager, National Office
Ms M. Pressend
Deputy Manager, National Office

Department of Foreign Affairs

Mr T. Kumalo
Assistant Manager, National Office
Mr L. Marais
Assistant Director, WSSD Policy Unit, National Office
Mr Z. Masiza
Consultant, Cluster Coordinator, National Office
Ms R. Nel
Deputy Director, Foreign Service Officer, Social Development

Department of Minerals and Energy

Dr E. M. Ohaju
Director, Directorate of Occupational Medicine

Representatives of Non-Governmental Organizations

ANC Women's League, South Africa

Ms N. M. Twala
National Executive Committee Member and Member of Parliament

Environmental Justice Forum (EJNF), South Africa

Mr T. Madihlaba
National Project Coordinator
Mr J. Sithole
Environmental Management Officer

Network for Equity and Health (EQUINET), South Africa

Ms T. Maistry
Coordinator

Group for Environmental Monitoring (GEM), South Africa

Mr M. Ibinibini
Project Officer

International Federation of Environmental Health (IFEH), South Africa

Mr J. Chaka
Representative

Stakeholder Forum for Our Common Future (Formerly UNED), United Kingdom

Mr R. Whitfield
Project Coordinator - Implementation Conference

TRANSMED, South Africa
Mr S. Mathivha
Pharmacist

WSSD, Civil Society Secretariat, South Africa
Ms J. Brown
Chief Executive Officer

Representatives of Academic and Research Institutions

Professor E. Buch
Professor of Health Policy and Management, School of Health Systems and Public Health, University of Pretoria
Dr N. Gqaleni
Senior Lecturer, University of Natal
Ms A. Mathee
Senior Specialist Scientist, Environmental Health, Medical Research Council of South Africa
Dr Mbewu
Executive Director for Research, Medical Research Council of South Africa
Professor D.D.N. Nghatsana
Vice-Principal, University of Venda
Dr O. Shishana
Executive Director of Social Aspects of HIV/AIDS, Human Sciences Research Council (HSRC)

Representatives of Programmes and Specialized Agencies of the United Nations System

United Nations Development Programme
Mr H. Bjorkman
Senior Adviser, Special Initiative on HIV/AIDS, Bureau for Development Policy, UNDP, New York

World Health Organization

Headquarters
Dr A. Cassels
Director, Department of Health and Development
Dr Y. von Schirnding
Focal Point: Agenda 21, Department of Health and Development
Mrs C. Mulholland
Temporary Adviser, Department of Health and Development

Regional Office for Africa, Brazzaville
Mr E. Kariisa
Technical Officer, Healthy Environments in Sustainable Development
Mr T. A. Pule
Environment Health Policy Officer

WHO Liaison Office, South Africa
Dr W. Shasha
WHO Liaison Officer
Mrs G. van Zyl
Health Information and Promotion Officer

Annex 3 - Background paper:

"Health and Sustainable Development"[2]

Introduction

1. This background introductory paper, adopted at the Ministerial meeting on Health and Sustainable Development, outlines how health is a product of sustainable development, and how improvements in health, and indeed health services, contribute to sustainable development. After outlining health trends, it explores the links between health and poverty, economic growth and equity (particularly with regard to the process of globalisation), natural resources and the environment, and health services. While the links with health are addressed separately for purposes of elucidation, it cannot be overemphasised that they do not happen independently of one another. Rather, they are all interconnected, with sustainable development in one area positively influencing the others, and vice versa, setting up a virtuous cycle.

Health and Sustainable Development

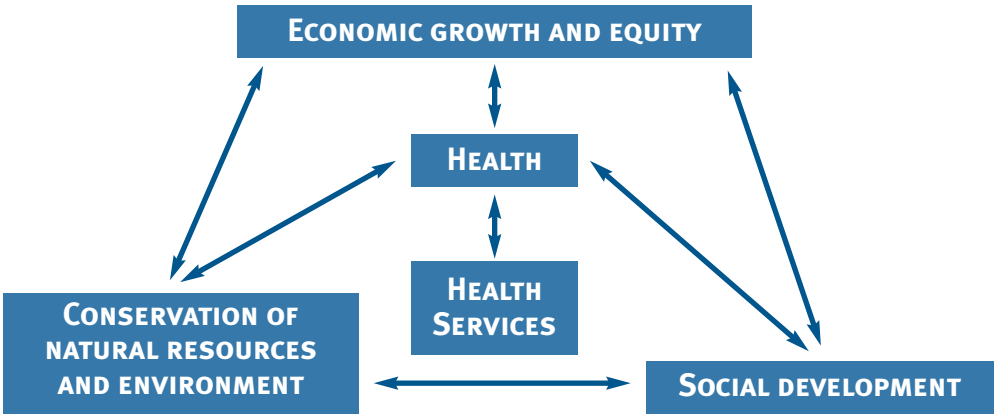
2. Sustainable development aims at improving the quality of life of all the world's people without increasing the use of our natural resources beyond the earth's carrying capacity. This requires integrated action towards economic growth and equity, conservation of natural resources and the environment, and social development. Each of these elements is mutually supportive of the others, creating an interconnected sustainable development triad.

3. Health is recognised as a key goal of sustainable development in the first principle of the Rio Declaration on Environment and Development, which states that: "Human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature". The extent to which sustainable development benefits a community is closely tied to its level of health, as health is a product of economic, social, political and environmental factors, as well as of health services. If our development path is not conducive to sustained improvements in health, then it is not sustainable development.

4. Health, in turn, contributes to economic, social and environmental development through multiple pathways. Improved health feeds sustainable development, and sustainable development feeds improved health in a virtuous cycle, supported by effective health services.

[2] For more detail see: *Health in the Context of Sustainable Development*: Background Document for the WHO Meeting "Making Health Central to Sustainable Development", Oslo, Norway, 29 November-1 December 2001. (WHO/HDE/HID/02.6)

The triad of Health and Sustainable Development



5. The opposite is experienced by many of the world's people: a vicious cycle of under-development and ill-health. The poor, marginalized, displaced and refugees carry the greatest burden of preventable and treatable disease and death. Inappropriate development and over-consumption also drive the disease burden.

6. Women, children, youth, the elderly, orphans and people with disabilities are amongst those vulnerable to disproportionate burdens of specific forms of ill-health. This holds true at all levels of development, but is most pronounced under circumstances of poverty.

7. Whole communities are often marginalized and excluded from the opportunities for sustainable development and health – be it in rural or urban areas, amongst minority groups, in the face of direct discrimination, or amongst refugees or those displaced by war or conflict. There are health consequences of social exclusion, poorer services and lack of opportunities for development and empowerment.

8. Peace, good governance, political stability and concern for its people are the foundation for the sustainable development of nations.

9. There are patterns of development that undermine health and sustainable improvements in health. These include factors related to lifestyles, consumption patterns and particular forms of economic development and inequity. Improved health is a pre-requisite for effective development. Poor health, amongst other things, undercuts improvement in gross domestic product.

10. Agenda 21, the global plan of action agreed to at the United Nations Conference on Environment and Development (UNCED) devotes an entire chapter to "Protecting and Promoting Human Health". Chapter 6 recognises the interconnection between health and environmental, social and economic development, supports an intersectoral approach and identifies five programme areas: meeting primary health care needs, particularly in rural areas; control of communicable diseases; protection of vulnerable groups; meeting the urban health challenge; and reducing health risks from environmental pollution and hazards.

Health Trends[3]

11. Over the past decade, there have been improvements in life expectancy and declines in infant and child mortality rates – all key indicators of health. However, these global trends, while highlighting what has been achieved, hide the fact that the gains of development are being reversed in a number of countries, particularly in sub-Saharan Africa. This is strongly associated with the impact of HIV/AIDS, but is also tied to underdevelopment, people becoming poorer, or being negatively affected by war and conflict.

12. In 1999, average life expectancy at birth was 49.2 years in the least developed countries, 61.4 for all developing countries and 75.2 for developed countries. These gaps highlight the increased disease burden in the absence of sustainable development. The differences in life expectancy are paralleled by similar differentials in the burden of morbidity and mortality related to pregnancy and childbirth: more than 90% of the over half a million annual maternal deaths occur in Africa and Asia. Chances of a woman dying in childbirth in sub-Saharan Africa range from 1 in 11 in Eastern Africa, to 1 in 65 in Southern Africa, compared to 1 in 1100 in Eastern Europe and 1 in 5000 in Southern Europe. The mortality rate for children in the least developed countries is 159 per 1000 births, compared to 6 per 1000 in developed countries.

13. In communicable diseases, notable successes have been achieved against polio, guinea worm (dracunculiasis) and river blindness (onchocerciasis). However conditions such as AIDS, tuberculosis and malaria (which result in approximately 2 million, 1.5 million and 1 million deaths respectively each year), as well as the major communicable diseases of childhood such as acute respiratory infections (predominantly pneumonia), diarrhoea and measles (which lead to approximately 4 million, 1.5 million and 800 000 deaths respectively each year). Together they are responsible for more than 90% of deaths from communicable disease. Malnutrition, including micronutrient deficiency, is associated with more than half of these deaths. The death burden is greatest in sub-Saharan Africa. Developing countries remain vulnerable to epidemics, such as cholera.

14. According to UNAIDS, about 40 million people are now living with HIV/AIDS; 95 per cent of them in developing countries. In 2001, 2.3 million people died of AIDS in sub-Saharan Africa, out of a total of 3 million worldwide. Life expectancy in the most severely affected countries in sub-Saharan Africa has been reduced by almost a third, from about 60 years to 43 years, reversing gains made over the past half century. Poverty, underdevelopment and illiteracy increase the vulnerability to HIV infection, and AIDS exacerbates poverty. Poverty leads to migration, influences sexual behaviour and limits care and education. In turn, AIDS threatens efforts to revitalize economies and has devastating social impacts, not least of which is children orphaned. But, as with many other communicable diseases, there is much that can be done.

[3] For more detail, see: WHO. *Health and Sustainable Development: Key Health Trends.* (WHO/HDE/HID 02.2)

15. Consequent on unsustainable development, non-communicable diseases (NCDs) are a significant and growing burden in developing countries. Most non-communicable disease deaths and high levels of morbidity occur in the developing world. 77% of deaths from NCDs worldwide occur in developing countries. These include diseases of lifestyle (for example due to unhealthy diets, physical inactivity, tobacco and alcohol use), injuries, violence, mental ill-health, disability and occupation. In developing countries each year, there are around 5.5 million deaths from heart attacks, 5.1 million from strokes and 2.9 million from tobacco-related disease.

16. Concern about the high disease burden is increasing. A number of programmes to address these have been put in place over the past decade, and have significant potential to impact on disease burden.[4]

17. A number of targets have also been set for reduction of the disease burden, notably the Millennium Development Targets, and targets set in global and regional fora (see Box 1). If current trends continue, it seems that, as was the case with many previous efforts, these targets will not be reached. A major scaling-up of effort, not only in regard to disease programmes, but also with respect to improving basic health services (and impacting the sustainable development triad), is required if these targets are not to be seen as empty words. Inequity in health status within and between countries strongly reflects inequalities in development, and also in health systems.

Box 1: The Millennium Development Targets and Other International Development Targets

1. Reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries, by 25% and by 25% globally by 2010[5]
2. By 2005, reduce the proportion of infants infected with HIV by 20%, and by 50% by 2010[6]
3. Reduce TB deaths and prevalence of the disease by 50% by 2010[7]
4. Reduce the burden of disease associated with malaria by 50% by 2010[8]
5. Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate[9]
6. Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio[10]

[4] These include various AIDS programmes, Roll Back Malaria, Stop TB, the Integrated Mother and Child Initiative and Safe Motherhood Initiative, the Framework Convention on Tobacco Control, Vision 2020 - The Right to Sight and the Global Campaign against Epilepsy.
[5] Declaration of Commitment on HIV/AIDS, "Global crisis – Global action" adopted at the Twenty-sixth Special Session of the General Assembly of the United Nations, 25-27 June 2001.
[6] Idem
[7] For more detail see: Final Communiqué of the G8 Kyushu Okinawa Summit, 21-23 July 2000.
[8] Idem
[9] For more detail see: "Millennium Development Goals", adopted at the United Nations Millennium Summit, 6-8 September 2000.
[10] Idem

Poor Health Undermines Development

18. Poverty leads to ill-health, but possibly ultimately more debilitating is the negative impact of poor health on development. Malaria alone is estimated to have slowed economic growth in Africa by up to 1.3% each year and HIV/AIDS by up to 2.6% in high prevalence countries. These percentages translate into billions of dollars lost. When the consequences of the high burden of other preventable diseases and lack of effective care are added, the result translates into hundreds of billions of dollars. Considering what an annual investment of hundreds of billions of dollars would have on life in poorer countries succinctly illustrates how investments in health and health care are productive, and not simply consumptive - as some are prone to think - with more than tangible returns.

19. Good health enhances development through multiple pathways. This includes survival of trained labour, higher productivity among healthier workers, higher rates of savings and investment, greater enterprise and agrarian productivity and increased direct foreign investment and tourism. Children's educational attainment is higher, which ultimately enhances productivity, lowers rates of fertility and changes the dependency ratio. In short, health is a positive economic asset for countries.

20. Ill-health exacerbates poverty at the family level. The most visible impact is a catastrophic illness or injury which, in the absence of an effective public health service or pre-payment system, can lead to a debt trap that impoverishes families for years, driving ill-health in the entire family through mechanisms such as malnutrition. This in turn undermines the potential of families for development.

Poverty Leads to Ill-Health

21. Poverty is the predominant underlying cause of the huge burden of disease in poorer countries, and the disproportionate burden amongst the poor elsewhere.

22. Examples of how poverty and the absence of sustainable systems in every sector of socio-economic life ultimately (in a complementary way) undermine health are illustrated in Table 1 below.

Table 1: Examples of how Poverty Undermines Health

1. Economic underdevelopment, including through reduced production and raw goods prices, and protective trade and market practices, damages health through a number of paths, including unemployment and low incomes. Countries cannot ensure basic services for their people and individuals are unable to purchase the necessities of health. Long work hours are among the many stresses that undermine the health of workers in poor countries.

2. Shortfalls in agricultural production and lack of land reform have a direct effect on food security, and hence on malnutrition. In spite of a world surplus of food, hundreds of millions of people go hungry each day. Malnutrition directly causes illness and vulnerability to infection.

3. Lack of education, and in particular women's education, limits the ability of the poor to identify and take appropriate action to improve their own health, and indeed to secure their basic needs.

4. The oppressed position of women in poverty leads to poorer health in many ways, including a weak position in ensuring safer sex practices.

5. People living in informal settlements with poor infrastructure are exposed to the health problems of social instability and communicable disease, including respiratory infections, and to environmental hazards such as air pollution and fire.

6. The more than one billion people who are without access to improved water supply, and the 2.4 billion without access to improved sanitation are exposed to water-related diseases.

7. Lack of general infrastructure, such as good roads and transport, not only impede access to health services, but add to fatalities and injuries from accidents.

8. The "digital divide" not only entrenches poverty by holding back development, but also impedes the chances of care in an emergency.

9. Governance and institutional weaknesses, although not uniform, influence health both indirectly and directly. Governments are faced with an array of pressures and health services are not necessarily afforded the priority required; nor is what is available necessarily equitably distributed or efficiently managed. The effectiveness of public and infrastructure services, the basis for development and for encouraging investment, may also be weak. This quality of governance impacts on economies and, through this, on health.

10. Besides directly causing death and political instability, war and conflict have had catastrophic effects on health, disease control and disability. Not only are health services prone to collapse, resources are diverted away from health-promoting actions and poverty becomes more pervasive as the health impact extends beyond the war zone. Displaced people become victims of the health impacts of even more acute poverty.

23. Poverty resulting in ill-health is multidimensional and requires broad intersectoral interventions. The importance of these intersectoral factors on health is being recognised ever more acutely in international fora and by international organisations, and are now an important feature in poverty reduction strategies.

Health and the Environment

24. Underdevelopment, unsustainable patterns of development, and production and consumption processes, at both global and local level, are using resources and degrading the environment in a manner that is seriously damaging to health now, and even more so in the future.

25. It has been estimated that poor environmental quality contributes to around 25% of all preventable ill-health in the world today, the majority of which is poverty related.

26. The future impact on life support systems and consequent health effects often take second place to short term gains, albeit that one-third of the world's stocks of natural ecological resources have been lost since 1970. In contrast, balanced and functional ecological systems contribute to health through a number of pathways.

27. Local environmental problems impacting on health are widespread and varied, but among the most harmful to health are inadequate water (quantity and quality) and sanitation (sewage and waste disposal), and fuel combustion. The extent of the harm is influenced by factors such as sanitation behaviour, poverty (for example the cost of purchasing water impacting on money for food and other essentials), and housing-through factors such as overcrowding and rudimentary shelter. More than one billion people are without access to improved water supply and 2.4 billion without access to improved sanitation. Over two million deaths annually are attributed to air pollution, mainly from use of traditional biomass fuels. Local environmental burdens and the ability to manage them are influenced by social, political and economic forces at country and international level and by the quality of governance.

28. Rapidly urbanising areas in middle and also lower-income countries face a number of environmentally-driven health problems related to industrialisation, poverty, social dislocation (for example trauma from violence) and lack of utilities. The problems of unplanned human settlements - overcrowded housing, pollution, noise and waste lead to widespread ill-health. In addition, social instability and undermining of moral values are contributing to increased violence, the abuse of women and children, drug and alcohol abuse and mental ill-health. The effects are generally worse in urban fringes and inner cities.

29. Although different hazards and health consequences are frequently associated with levels of poverty, affluence and types of settlement, the relationships vary widely. Also, the future health risks will have an impact beyond the source creating them.

30. Examples of how unsustainable patterns of development affect health through environmental degradation are shown in Table 2 below.

Table 2: Examples of how Environmental Degradation Affects Health

1. Excessive use of fossil fuels is leading to global climate change, increasing weather-related disasters and communicable diseases.
2. Emissions such as chlorofluorocarbons are depleting stratospheric ozone, leading to increases in skin cancer.
3. Impairment of food-producing ecosystems (including productive soils) and fish stocks threaten nutrition, particularly as downturns in yields are greater in food-insecure regions.
4. Biodiversity loss reduces the chances of finding new medicines derived from indigenous plants.
5. Depletion of freshwater supplies poses increased water stress, while declines in quality will increase water-related diseases.
6. Chemical hazards may have direct toxic effects, such as in the case of persistent organic pollutants, asbestos, lead, arsenic and many other substances. Many chemicals in commercial use have not been adequately tested for their toxicological properties.
7. Poor water, sanitation and hygiene are associated with diarrhoea (a big killer of children in the developing world) and other water-related diseases including skin and eye infections.
8. Household fuel combustion, particularly using firewood and crop residues indoors, contributes to acute and chronic respiratory infections, especially pneumonia (another big killer of children in the developing world).
9. Exposure of workers in poorly controlled industries leads to an array of occupational diseases and to pollution of air and water.
10. Poor housing incorporates a range of environmental hazards associated with communicable and non-communicable conditions, including social causes of ill-health.

Health and Globalisation

31. The complex relationship between globalisation and health occurs via effects of international governance and agreements, globalisation's impact on economic, social, political and environmental conditions, exposure to health-damaging and health-benefiting commodities and conditions, and access to health care.

32. One argument that has been used in support of globalisation and trade liberalisation, deregulation and privatisation is that it will reduce poverty and improve services, and thereby improve health. The evidence for this is weak. Indeed, there is greater inequality between and within countries now than there was twenty years ago. This has raised the question of whether patterns of globalisation have widened health differentials, and has resulted in calls for more pro-poor sustainable development processes, so that development has a positive impact where the health burden is greatest. Concern has also been expressed about the impact of globalisation on the cost of basic services, such as water, and the effects of this on health.

33. In the longer term, one needs to ensure that the current pattern of globalisation, that depletes natural resources and increases emissions of industrial toxic substances at an alarming rate, does not bequeath an unsustainable situation to future generations with massive and varied health consequences.

34. Although the direct impact is difficult to measure, and some positive effects have been identified, globalisation has had some harmful effects on health, as illustrated in Table 3 below.

Table 3: Examples of how Globalisation can Harm Health

1. Trade barriers have blocked growth of the economies of poor countries and helped to maintain them as commodity-led exporters, limiting manufacturing growth and domestic enterprise. This has left countries more vulnerable to the full range of diseases of poverty.
2. The implications of the use of international trade and intellectual property rights agreements which are blind to their consequences on the health of people in poor countries has been most explicitly illustrated in the case of drugs for treating HIV/AIDS, and other conditions prevalent in the developing world.
3. Trade liberalisation, including reduction of excise taxes, has led to increased use of tobacco in low-income countries, with all the concomitant health damage that will occur.
4. Erosion of public services has been linked to various consequences of globalisation in some countries. The extent to which this undermines education, supply of utilities and health services will impact negatively on health.
5. The "digital divide", besides its economic impact, blocks access to information beneficial to the health of individuals and communities.
6. The high cost of hazardous waste disposal in the developed world has opened the door to widespread unofficial movement of this waste into developing countries, which have poorer safety precautions.

Health and Health Services

35. Disease control programmes have the potential to impact massively on the disease burden. Influencing sexual behaviour to prevent HIV/AIDS, treatment compliance for tuberculosis, rapid treatment for malaria, reaching children to immunise them against measles, use of oral rehydration to prevent dehydration from diarrhoea and early identification and treatment of pneumonia are all within our grasp. Programmes and initiatives such as the International Partnership Against Aids in Africa, Stop TB, Roll Back Malaria, the Integrated Management of Childhood Illnesses, and Making Pregnancy Safer are all making a major contribution. However, overall success to date has been limited, because the overall effort has not been of sufficient scale to impact at the level desired. The concept of disease control is commonly erroneously applied only to communicable diseases. The potential for effective prevention and control programmes to impact on non-communicable diseases, such as chronic obstructive airways disease, diabetes, hypertension, myocardial infarction, epilepsy and blindness is similarly massive.

36. Success in reducing the disease burden requires more than disease control programmes. Besides sustainable economic, environmental and social development, countries also require a solid health care system, capacity for strategic support and effective mobilization of personal action and technological development to improve health.

37. Effective health services are the backbone of health interventions, and have the potential to impact dramatically on health. To be effective, services need to be accessible and offer good quality care. This requires appropriate focus, equitable distribution, good organisation and sufficient resources (human, physical and supplies). Yet many countries are unable to secure or sustain their health services at the level required to make the desired impact to effectively support disease reduction. Governance and management weaknesses do continue to compromise the system but, however judiciously available money is spent, current funding levels are inadequate to allow for viable health systems.

38. According to some estimates, total health spending in the least developed countries is around US$ 13 per capita per annum and US$ 21 in other developing countries. This is well below what is required, even to sustain basic health services. This compromises the ability of countries to afford generic drugs, to retain sufficient numbers of capable and committed health workers, and to ensure supply chains, particularly so in more remote and unstable areas. The continuing loss of health professionals from developing countries compromises services, and results in a waste of the investment made in their education.

39. Coverage of health services in sub-Saharan Africa and other countries with a GNP less than or equal to US$ 1200 is low: only 44% for Directly Observed Treatment (DOTS) for Tuberculosis, 2% for malaria prevention, 31% for malaria treatment, 59% for acute respiratory infections (ARIs), 68% for measles immunisation, 45% for skilled birth attendants, 20% for smoking control, and below 10% for most components of HIV

prevention within the health sector. In consequence, many conditions that are treated in the developed world are death sentences for the worlds' poor. The HIV/AIDS epidemic has made this contrast more striking than ever.

40. Some of the pathways through which insecure health services worsen health are illustrated in Box 2 below.

Box 2: Examples of how Insecure Health Services Worsen Health

Whether a person is suffering from a genital discharge that, untreated, increases manifold the risk of contracting HIV, a chronic cough which could indicate tuberculosis, a high fever that could signal (resistant) malaria, or shortness of breath that may be pneumonia, access to health care is imperative to reduce death, suffering and to avoid the spread of infection, directly or indirectly. The reality for many of the world's poor is that there is no accessible service and, even where there is access, the health worker may not be capable of accurately diagnosing or treating their condition. Essential drugs and supplies required for treatment and care are commonly not available. They may also be unable to effect referrals to hospital in emergencies, such as for women in obstructed labour. Adherence to therapy for chronic diseases, such as tuberculosis, is particularly difficult in a weak health system, rendering treatment ineffective and leading to drug resistance. It is in this context that the lack of consistent care for non-communicable diseases, such as diabetes and asthma, add to the death toll, while uncontrolled epilepsy and untreated mental health problems add to morbidity. The effect of the epidemiological transition, often driven by lifestyle changes imposed on the poor, albeit hidden beneath the burden of communicable disease, should not be underestimated. Disease prevention and health promotion measures, such as immunization and contraception are also impeded by ineffective health systems. In addition, people are not enabled to take action to protect and improve their health, nor to intervene early through simple measures, such as oral rehydration to prevent diarrhoea deaths, as the health service has not been able to achieve a sufficient level of health literacy in communities. Thus, although poverty is at the root of much ill-health, poor health services add dramatically to disease burden and death.

41. The lack of sufficient strategic support capacity for health system development is shown by the dearth and impoverishment of centres of excellence in the developing world. Health research capacity is also underdeveloped, and even accounting for contributions from developed countries, 90% of the world's research goes into less than 10% of its health problems.

42. The potential for technological development to advance disease control is not realised. A key reason for this is that the commercial opportunity is not good enough. So, although there are important new initiatives, there is slow progress for more effective drugs for the treatment of malaria, tuberculosis and sleeping sickness (trypanosomiasis) and for vaccines against the strains of pneumococci, rotavirus, shigella and meningococcus causing disease in the developing world.[11]

[11] The pneumococcus causes pneumonia, the rotavirus and shigella cause diarrhoea and the meningococcus causes meningitis.

43. There is much that individuals and families can do to improve their own health, as illustrated in Box 3 below. This potential for reducing disease is not realised, as not enough is done to empower individuals and communities to take action to improve their own health – nor is it done in a manner that enhances dignity and consciousness. Exploitative advertising is a counter-force, which not only needs to be controlled, but whose power to use the media needs to be emulated in pursuit of health.

Box 3: Examples of Actions that Families can Take to Improve their Health

A drop of chlorine in a litre of water and hand-washing with soap can prevent cholera and many cases of diarrhoea, while the early use of home-made oral rehydration solutions can prevent death from dehydration. Use of insecticide-impregnated materials helps prevent malaria and use of condoms, AIDS. Lifestyle changes, such as healthier eating patterns and not smoking, could impact on disease, while seeking health care early for children with fast breathing, a cough and a hot body would reduce deaths from pneumonia.

44. The inequity in burden of disease and of development opportunities is mirrored by health services often not being evenly spread between and within countries. As the poorest and most marginalized people and those displaced by war and other emergencies are especially vulnerable and bear a disproportionate burden of disease, if the aim is to massively reduce disease burden, then health care should be skewed towards them. Yet, the inverse is generally true.

Way Forward

45. To date, overall efforts to achieve sustainable development and improved health have not been successful enough. A major commitment will be required to allow history to judge this generation as the one that turned the corner on improving the quality of life and health of all the world's people without increasing the use of our natural resources beyond the earth's capacity.

46. Significant changes will be required if we are to reduce poverty, alter patterns of globalisation and environmental degradation, and achieve provision of effective health services so that the resultant improved health can enhance sustainable development, and sustainable development can improve health in a virtuous cycle. The negative macroeconomic impacts on sustainable development and on health will need to be addressed.

47. The measures required to achieve sustainable economic, social and environmental development are manifold and will require co-ordinated intersectoral action. Programmes for the reduction of disease burden and for improved health services will also require massive scaling-up if they are to play their part in enhancing well-being on our planet.

For further information contact:
Dr Yasmin von Schirnding
Focal Point: Agenda 21
World Health Organization
1211 Geneva 27, Switzerland
Telephone: +41 22 791 35 33
Fax: +41 22 791 41 53
e-mail: vonschirndingy@who.ch