Implementation Conference

Stakeholder Action For Our Common Future

Health

Issue Paper v4, May 2002

Preamble

Healthy individuals and communities are at the core of sustainable development. Without health, the innate potential of each person to contribute to their family's and community's well-being is lost, with grave consequences for our collective future. By "health" we do not simply mean the absence of disease or infirmity, or the alleviation of suffering. WHO's definition, "complete physical, mental and social well-being" is the goal that we believe every society should embrace.

Poverty, underdevelopment, illiteracy, lack of gender equity and other forms of exclusion contribute to the spread of disease (such as HIV/AIDS), which has reversed health and development gains of the past decade. Improvements to health should be regarded on the basis of their potential contribution to human capital, the building block of the future.

Health is a human right, as universally agreed in the UN Human Rights Declaration and Covenant on Economic Social and Cultural Development. Our ability to eliminate the economic, environmental, occupational and social barriers to good health will determine the quality of our future on Earth.

1. Framework for the Implementation Conference (IC) process

The IC process is designed to facilitate joint stakeholder action in order to contribute to the implementation of recent international agreements and convention outcomes, such as: the ILO Declaration on the Fundamental Principles and Rights of Work (1989); Agenda 21, Chapter 6 (Rio 1992); International Conference on Population and Development (Cairo, 1994) and its 5 year review (New York, 1999); Fourth World Conference on Women (Beijing 1995); Commission on the Status of Women 43rd Session (New York, 1999); Regional environmental meetings such as the Third European Ministerial Conference on Environment and Health (London, 1999); the United Nations General Assembly's 24th Special Session on Social Development (Geneva 2000), the Millennium Declaration, the Stockholm Convention on POPs and the 26th Special Session on HIV/AIDS (New York, 2001).

The principal goal of the IC is to deliver measurable joint collaborative action plans that contribute to poverty eradication; social inclusion and empowerment; good governance; gender equity and corporate and stakeholder citizenship. While this paper is entitled 'Health', linkages with the work undertaken by the Energy, Freshwater and Food Security groups will be established where relevant.

The IC process also aims to influence the intergovernmental process towards the Johannesburg Summit (WSSD). A two-pronged approach is proposed, aiming to impact the 'Type 1' (state ratified objectives) and 'Type 2' (stakeholder partnership objectives) summit outcome documents and enhance their inter-linkages. Hence, *the group may choose to develop joint statements and lobbying strategies as well as develop joint implementation action plans, but the opportunity to influence the formal text (Type 1) is likely to end in Bali*.

2. History of the IC process on Health so far

- Issue Coordinator appointed December 2001; Issue Paper v1 available Jan 2002.
- Workshop on Stakeholder Citizenship and the Health Sector, New York, 2-3 February 2002
- Issue Advisory Group ("IAG") selected, Issue Paper v2 distributed and initial one-to-one discussions held
- IAG dinner 3rd April 2002: outcome reported to group, Issue Paper v3 distributed for discussion; conference call 29th April.
- Issue Paper v4 available; meeting for those attending Bali PrepCom suggested.

3. Planned activities between now and the IC event

Develop action plans with working groups and identify advisers, contributors and participants.

Enlarge working groups to interested participants (and best practice programmes) as appropriate; IAG to offer advice and access to networks.

Finalise venue requirements and working group agendas to deliver action at IC.
Ensure finance available for implementation of action plans beyond IC.

Other possible activities: host relevant online debates (Open University have offered to host/promote). Select initial contributors.

4. Possible focus areas and possible joint stakeholder action

Possible focus areas from international agreements **Questions:** • Which of the following focus areas are priorities for effective joint stakeholder action? • Which are missing?	**Possible action towards governments and official WSSD process** (Type 1 outcomes) **Questions:** • Are there specific agreements / commitments / targets missing from the intergovernmental agreements at the WSSD? • Who should do what to achieve such inclusions? *NB Lobbying for Type 1 outcomes will need to be completed by Bali PrepCom (27 May)*	**Possible joint stakeholder action towards implementation** **Questions:** • Which of these ideas should be developed further into IC outcomes? • How can these actions focus on Africa? • Which existing programmes & experiences should be brought into the IC to broaden their scope and impact? • What is the appropriate workgroup size and composition for each idea? *NB Bold type below indicates action plan in draft on this subject*	**Possible participants (groups/organisations/ individuals)** **Questions:** • Who should be included to achieve widest possible impact?
Communicable Diseases			
HIV/AIDS: Numerous HIV/AIDS initiatives, but much remains to be done; esp. in Sub-Saharan Africa, E Europe, Asia and the Caribbean. Emphasise implementation of the UNGASS AIDS Conference commitments. Need for networking / communication tools for stakeholders to exchange best practice and experience; empower stakeholders to find their own solution and build responses and capacity organically. Need for reduced stigma and discrimination and targeted educa-	• Persuade governments to accept the moral responsibility to inform / demystify their populace re. the disease, transmission and protection and to implement proven effective means of tackling existing problems.	• **Educate re HIV/AIDS and provide support systems for sufferers (school, workplace, community), following ILO Code of Practice. Targeted, specific interventions for eg truckers and healthcare workers (others?)** • **Identify community-driven solutions (non-pharmaceutical) and promote exchange, through 'model community / programme' to disseminate best practice (rural, urban settings?). Replicate at national level through understanding and sharing successes of eg Uganda (others?)** • **Facilitate the creation of a networking tool to share knowledge and enhance communication between people working on HIV/AIDS.**	• WHO, UNAIDS, governments, oil companies (Africa); ILO, Trade Unions, • WHO, NEPAD, Gates Foundation, Community leaders, physicians, grassroots groups, business community, ILO, educators, micro credit institutions,

tional/ behavioural interventions, eg men, truckers, health workers.		**tion between people working on HIV/AIDS.** • Extend awareness/ cultural campaign under World AIDS Campaign banner (e.g. I care…do you?) using large group facilitation techniques to mobilise change – e.g. existing programmes in South Africa	credit institutions, NGOs
Malaria Initial multi-sector approach to tackling malaria: education (school/ workplace), housing (house by house monitoring, rapid response with nets, sprays and medicine), ecosystem (water, sanitation) management and farming, within health and environment ministry structures.		• **Replicate best practice examples, particularly regarding effective communication from local, regional or national programmes championing community involvement towards eradication of the disease and elimination of DDT.** • Add environmental awareness / management into sustainable education curricula at schools (tie into / extend WHO's School Health Programme), extend training network of IUHPE (Health Promotion and Education)	• Roll Back Malaria, GEF, PAHO, farmers, grassroots groups, rural unions, educators, DDT proponents, care providers, health and environment ministries)
Water borne diseases 1 billion without access to water; 2.4 billion without access to sanitation; 1.5 million children die each year from diarrhoea.		• Identify health/ water overlaps with Freshwater issue; **eg hygiene practice, oral rehydration campaign**, and opportunities to improve effective communication • Promote best practice, eg Bangladesh example, education of women with infants in areas of poor water quality	• Bangladesh Centre for Health and Population
Non-communicable diseases			
Smoking: Alarming growth rate of tobacco consumption; rising prevalence rates, especially among children, youth and women. Prevention of new smokers is the key.	• Lobby for commitment to Framework Convention on Tobacco Control ("FCTC")	• Support the Tobacco Free Initiative and maintain the momentum towards the FCTC, building on the WHO campaign network around FCTC • Support World Bank efforts in developing countries promoting 'polluter pays' principle by raising tobacco taxes	• IUHPE, Physicians for Smoke Free Canada, World Heart Federation, others…

		• Employ 'strategy of small wins' approach: target groups of women (successful WHO, NGO campaigns in Japan), children (smoking at home), employees (in workplace), journalists (to expose companies), other?	
Obesity The shift in many countries to a more 'Western' (meat-based) diet is inefficient and unhealthy. 1 billion globally are overweight. Obesity enhances chronic diseases, effectively 'handicapping' people and burdening health care systems. Global population with diabetes projected to double to 300 million by 2025, 75% of increase in poor countries (Source: Novo Nordisk)	• Promote awareness of diet and nutrition and the known scientific links between diet, obesity and ill health.	• **Work with FAO/ILO/WHO to develop long-term strategy for significant reduction of meat in human diet** • Promote physical activity, replicate "Move for the World" campaign, tie into Olympics, other? • Promote specific campaigns of youth and elderly • Develop/support campaign for diabetes sufferers. • Extend access to diabetes diagnosis, drugs and care in developing countries • Consider interventions: reduce subsidies to agriculture (esp meat), campaign for foods to be taxed based on their nutrient value per calorie	• FAO, ILO, WHO, nutritionists, farmers, private sector, World Heart Federation
Work related illnesses: Claim similar numbers to the 'big killers' each year		• TBD in discussion with ICFTU, ILO	• ILO, ICFTU
POPS/PICS and related diseases: POPs are harmful to humans and environment. Prior Informed Consent ("PIC") relates to the clear labelling and regulation of hazardous chemicals, to help curb illegal trade. Asbestos remains a major threat.	• Promote the rapid ratification and implementation of the Rotterdam Convention on PIC and the Stockholm Convention on POPs	• Work with International POPs Elimination Network (IPEN). Support WIT in helping with Stockholm ratification	• TBD
Indoor Domestic Air pollution: 3 billion people rely on biomass fuels and coal-burning for household energy needs. Indoor air pollu-		• **Share best practice in stove building techniques for cooking/ ventilation. Create models for effective replication and community level**	• WHO, Energy companies, educators, NGOs

tion is a major source of illness, particularly with young children. What of workplace pollution as a health hazard – how to address?		**exchange. Discuss with Energy coordinator** • Extend and promote existing networks • Toxicity measurement (indoor and out, by region) needed to understand health impact	
Lead: Improvements made in reducing lead in gasoline (85% of supply is currently lead-free) but significant pockets remain, esp. LDCs and China.	• Lobby for worldwide commitment to remove lead from fuel, with timetable	• **Facilitate the implementation of the recommendations of the Bangalore International Conference on Lead Poisoning, Prevention and Treatment** • Extend existing networks • Pressure oil companies to upgrade refineries (higher octane fuel needed in absence of lead additive) in all countries • Encourage tax incentives to altering demand, identifying benefits to governments. • Toxicity measurement (indoor and out) needed to understand environmental impact on health	• Oil companies, OCTEL (lead additive producer), governments (esp China, Africa), youth, medical profession,
Health care systems			
Medical staff employment ethics Healthcare professionals (doctors, nurses, midwives, medical educators, dentists) feel push and pull factors; poorer regions are suffering shortages of trained staff and loss of investment in training.		• **Promote multi stakeholder discussion to address the ethical and practical problems involved; recommend potential solution (transfer pricing, taxation, incentives, global clearing house?)** • Ensure appropriate medical education regarding environmental triggers to ill health	• WMA, WHO, ILO, IMO (migration), medics, health ministers, ILO, trade unions, educators
Abuse of Antibiotics: The abuse of antibiotics in both human disease treatment and livestock is threatening humanity`s ability to treat diseases in the future		• Multi-stakeholder campaign in support of the WHO Global Strategy for Containment of Antimicrobial Resistance to educate and influence the main groups involved: patients, pharmaceutical companies, doctors, food producers and	• Physicians, farmers, pharmaceutical companies

		farmers	
Access to health care, healthy environments and healthy living conditions			
Non-pharmaceutical Well-being requires satiation of basic needs. The primary causes of premature mortality and high morbidity can be managed by known and proven measures. The challenge is to make healthcare a national priority, and to involve existing stakeholders in new, more effective partnerships. Also important is equity of information transfer, social reform, infrastructure development and resource mobilisation.	• Promote relationship between health, poverty, prosperity and civility. • Analyse/ suggest improvements to draft WSSD chair's text • Consider lobbying for "Right to Health / Healthy Environment" to be given legal meaning in countries where the law may be upheld.	• Build local capacity, empower communities for effective exchange and promote best practice. Emphasise health of children. • Promote productive labour force through both "carrots" and "sticks". Extend health care benefits by employers; empower organized labour to secure healthcare through collective bargaining. • Establish linkages with Freshwater, Energy, and Food Security issue coordinators	• Educators, faith communities, private sector, NGOs, microcredit institutions, medical staff in the field.
Pharmaceutical 95% of the WHO's "Model List of Essential Drugs" are available off-patent; over one third of the world's population lacks access to essential (generic) drugs (Source: Novartis study). High drug prices reward innovation but restrict access. This is within the TRIPS mandate, but there is a need for specific action by relevant stakeholders. Some pharmaceutical companies seek guidance. Tiered pricing/ distribution has appeared exist for rich/poor countries and rich/poor people within developed countries; this has governance implications.	• Support recommendations on Macroeconomics and Health re government responsibilities for health care and the need for richer nations to support developing countries. • Call on governments to clarify stakeholders' responsibilities.	• **Support the establishment of a research institute as a partnership initiative, and extend the network of partners to benefit from work done to address developing world diseases. Promote effective replication through knowledge management.** • **Develop new business model where multi stakeholder groups develop Key Performance Indicators (KPIs) of business model for pharmaceutical companies operating in the developing world** • Analyse the governance implications of tiered pricing strategies being implemented by pharmaceuticals and initiate a global debate with governments, stakeholders and international agencies • Jointly develop a Code of Conduct re. Access to Drugs	• Trade organisations (WTO), Private sector (pharmaceutical), Business, Physicians, Academia, ILO, trade unions, NGO's active in this area.

Financing			
Global Fund against AIDS, Tuberculosis and Malaria: The procedure of the Global Fund requires countries to prioritise their health needs. There is a lack of clarity of Country Coordination Mechanism (CCM) re. project selection and fund allocation. Difficulties in allocating funds (eg South Africa) and difficulty in effectively getting funds to ground level.	• Promote commitment of richer nations to provide funding. • Clarify process: 12 countries (mostly donor nations) represented on board: clarify criteria for project selection.	• **Work directly with one recipient country to create a transparent multi-stakeholder process for project identification, selection and implementation. Include monitoring ad evaluation mechanism. Create 'best practice' example and/or establish a global network of stakeholders willing to clarify procedure, as a resource for applicants to the Fund / provider of consultancy services where needed.** • Encourage higher funding from rich nations, base on per capita income and work with stakeholders to overcome source of scepticism of donor countries.	• UNDP, Global Fund, Academia, NGOs eg www.aidspan.org, Drs Sachs, Ruxin (Comm on Macroeconomics and Health) ad Rivers
Health Impact Assessments ("HIAs"): Currently being used in multiple sectors as a tool for assessment of health implications of projects, behaviour etc.		• Encourage adoption of HIA approach to assess action plans (stakeholder, government). • Educate governments and businesses as to methods, benefits of using HIAs	• Impact assessors, educators, ministers, academics
The **Commission on Macroeconomics and Health** report (Dec 2001) highlighted the strong economic benefits of good health.	• Lobby for the endorsement of the Commission's report by the Johannesburg Summit	• Lobby individual governments to implement the recommendations of the report.	• TBD