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**JOHANNESBURG DECLARATION ON
HEALTH AND SUSTAINABLE DEVELOPMENT**

Meeting of Senior Officials and Ministers of Health

Johannesburg, South Africa
21 – 22 January 2002



Department of Health
Republic of South Africa

World Health Organization
Geneva

JOHANNESBURG DECLARATION ON HEALTH AND SUSTAINABLE DEVELOPMENT

1. We, the Health Ministers of the SADC region and representatives of four E9 countries¹ (China, India, Indonesia and South Africa) met in Johannesburg, South Africa, from 21-22 January 2002 in the context of the preparations for the World Summit on Sustainable Development (WSSD), to be held in Johannesburg, from 26 August to 4 September 2002. The meeting was held to consider key issues relevant to health and sustainable development on a global basis, drawing special attention to the problems of the SADC region.

2. We recognise that sustainable development aims at improving the quality of life of all the world's people, both today and for future generations, 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 pillars is mutually supportive of the others, creating an interconnected sustainable development triad, which underpins good health.

3. We recall the first principle of the Rio Declaration, which proclaimed 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." We also recall the values and goals of the United Nations Millennium Declaration.

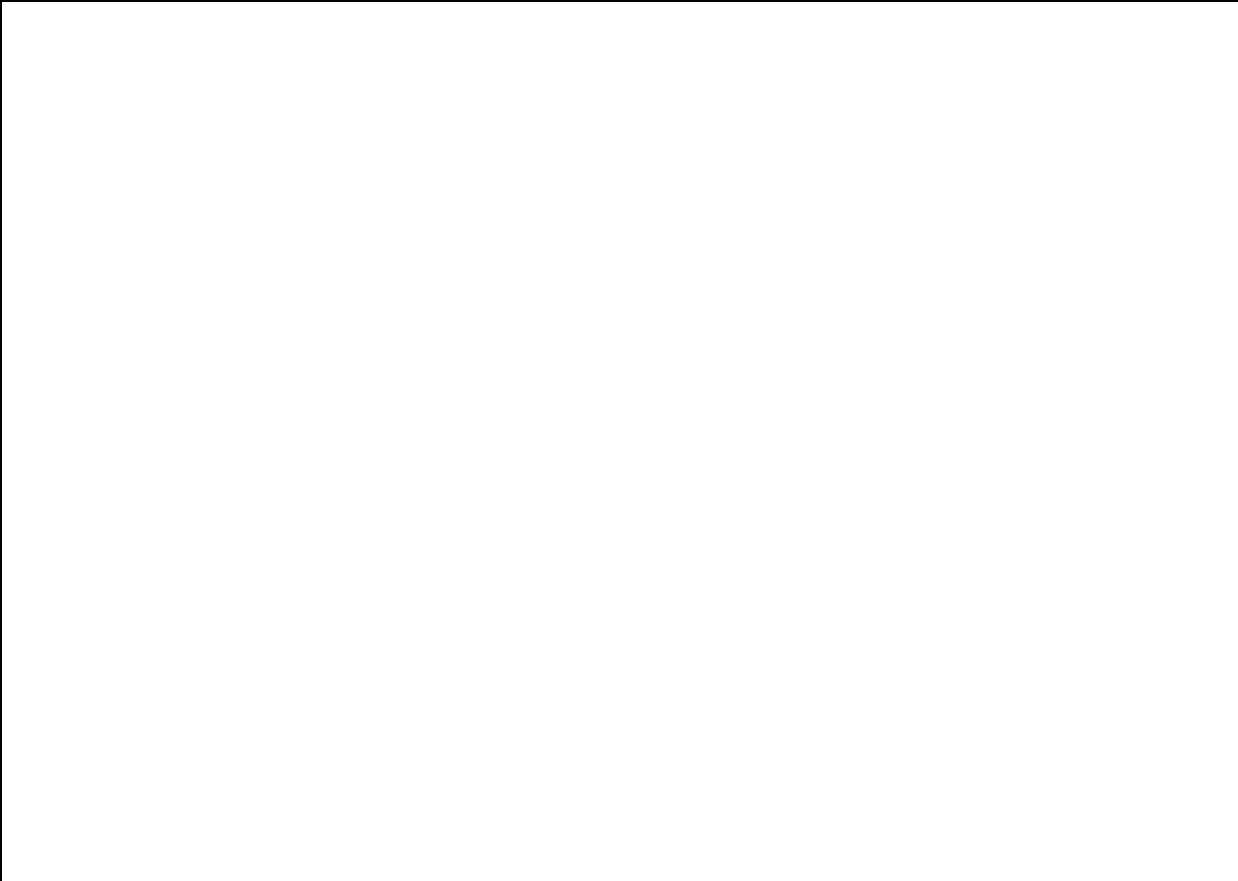
We note with concern the reality that, despite much progress, health today and into the future continues to be severely compromised by inadequacies in the implementation of required measures in all three of the pillars of sustainable development.

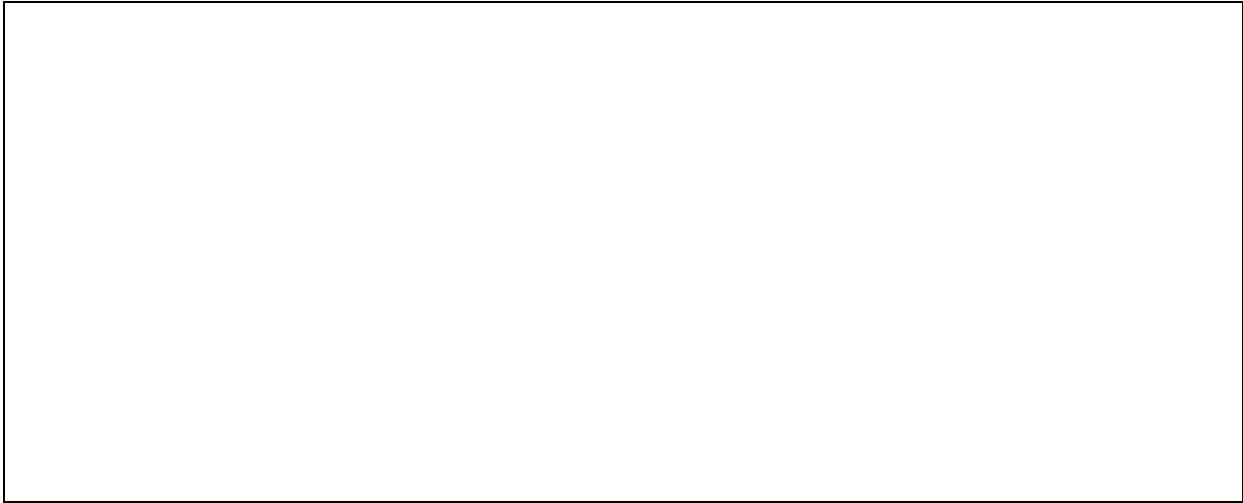
A "healthy life" remains a distant vision for many of the world's people, particularly the poor, the marginalized, the displaced and refugees, who face the greatest inequity, health burdens and lack of sustainable development.

¹ The United States of America, a designated E9 country also attended the meeting.

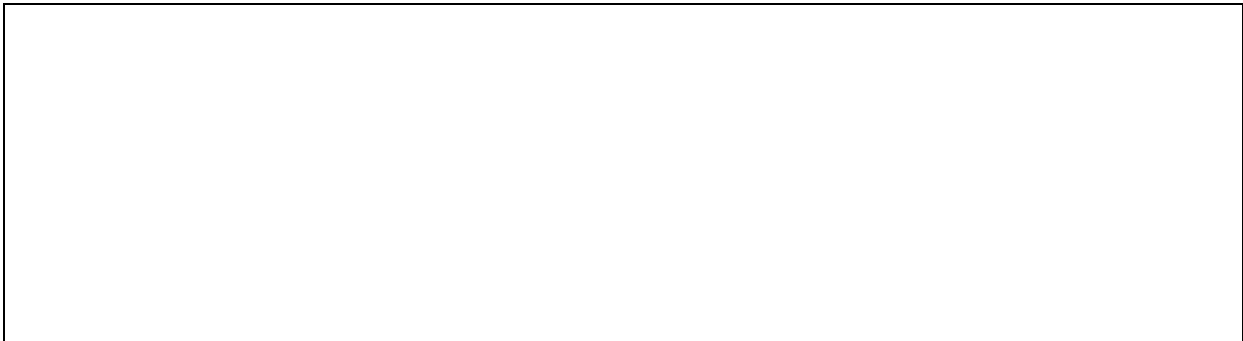
4. We further note that inequity is increasing between and within countries, widening the health gap. The following is illustrative: In 1999, average life expectancy at birth was 49.2 years in the least developed countries, and 75.2 for developed countries. More than 90% of over half a million maternal deaths occur in Africa and Asia. The mortality rate for children under five in the least developed countries is 159 per 1000 births, compared to 6 per 1000 in developed countries. In a number of developing countries, one in five children still fail to reach their fifth birthday, mostly as a result of easily preventable causes.

5. We draw special attention to the fact that sub-Saharan Africa carries the greatest burden of disease and underdevelopment. It should receive priority support. The broad based, intersectoral approach of the New Partnership for African Development (NEPAD), developed by Africans, with leadership from Heads of State themselves, offers a strategy for sustainable development. It is premised on African countries achieving peace and good governance and what they can achieve from their own abilities and resources, creating an environment for sustainability. Only then can we look with confidence to donor countries to partner Africa in its development.





6. We recall the number of laudable development targets for health that have been agreed to at the Millennium Summit, and in other United Nations conferences and international fora. These include, for example, reducing mortality rates for children under five by two-thirds, and the maternal mortality ratio by three-quarters by 2015; and, by 2010, reducing HIV prevalence in all young people (aged 15-24 years) by 25%, and the proportion of infants infected with HIV by 50%; as well as reducing TB deaths and prevalence, and the burden of disease associated with malaria by 50%, also by 2010. We note that, whilst there have been improvements in life expectancy and declines in infant and child mortality, the reality is that the world is not on track for achieving these targets. This is not because they are not achievable, but because the scale of the effort to achieve them falls far short of what is required. We emphasise that it is the joint responsibility of all nations to ensure that these targets are achieved, with a particular focus on, and support for, vulnerable developing countries.

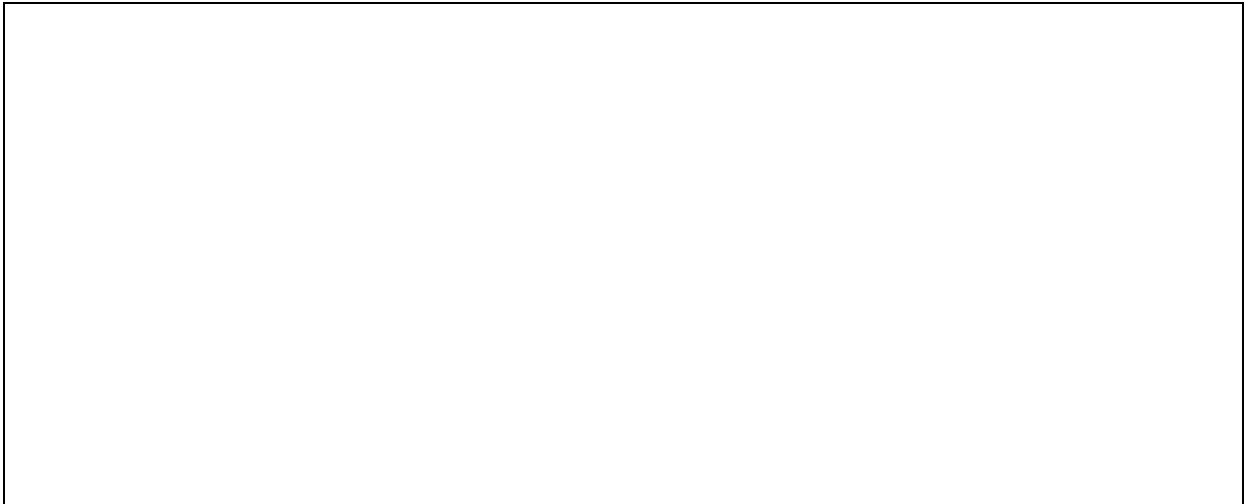


7. We recognise that notable successes have been achieved, such as against polio, guinea worm (dracunculiasis), and river blindness (onchocerciasis). But it is of great concern to us that disease burdens remain unacceptably high. Preventable and treatable communicable diseases cause many millions of deaths annually. These include 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). A majority of these deaths occur in sub-Saharan Africa. Furthermore, we note that many of these deaths are associated with poverty, underdevelopment, malnutrition and mismanagement of the environment.

8. We draw special attention to the health and development burden represented by the HIV/AIDS crisis. It is the fastest growing health threat to development today, and a potential risk to global security. According to UNAIDS, about 40 million people are now living with HIV/AIDS; 95% of them in developing countries. In sub-Saharan Africa, over 28 million people are infected with HIV. In 2001, 2.3 million died of AIDS in sub-Saharan Africa, out of a total of 3 million worldwide, and millions of children have been left orphaned. Life expectancy in the most severely affected countries in sub-Saharan Africa has been reduced by almost a third, from 60 years to 43 years, reversing gains made over the past half century.

9. We call attention to the fact that, in addition to communicable diseases, non-communicable diseases (NCDs) are a significant and growing burden in developing countries, resulting in a double burden of disease for the world's poor. 77% of NCD deaths worldwide and high levels of morbidity (including from mental ill-health and disability) occur in developing countries, which now account for 5.5 million annual deaths from heart attacks, 5.1 million from strokes and 2.9 million from tobacco-related disease. The roots of the NCD burden are multi-factorial, including lifestyles (factors such as unhealthy diets, physical inactivity, tobacco and alcohol use, injuries, violence, environment and poverty). Social instability and undermining of moral values are contributing to increased violence, the abuse of women and children, drug and alcohol abuse and depression.

10. We emphasise that effective control is possible. Indeed, this has led to an increasing number of programmes being put in place over the past decade, for example against HIV/AIDS, malaria, tuberculosis, communicable diseases of childhood, maternal death and tobacco-related disease. However, we note that the inadequate size of the programmes, gaps in implementation, and lack of integration of the programmes into broader development efforts continue to stifle their impact.



11. We emphasise that poverty is at the root of much of the untenable burden of disease worldwide. The poverty that increases vulnerability to ill-health is multidimensional - economic underdevelopment, unemployment and low incomes, environmental degradation, shortfalls in agricultural production, inequitable land reform, lack of education, poor infrastructure and the oppression of women are but some of the drivers of poverty - emphasising the need for broad intersectoral interventions. In spite of a world surplus of food, hundreds of millions of people go hungry each day.

12. Possibly ultimately more debilitating than the impact of poverty on health, 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 and untold suffering. 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.

Resolution 4

We recognise the contribution of sustainable poverty reduction to health, and of health to poverty reduction. In this regard, we call:

- On developing countries to prepare and implement sustainable poverty reduction strategies and to invest an increased percentage of GDP in health and health care.*
- On the international community to fulfil their commitment to allocating 0.7% of GDP to development aid, to focus this on the poor and on achieving equity, and for the 20:20 principle to be applied, whereby 20% of development aid and 20% of country's own budgets are allocated to social services.*
- For donor commitment to the US\$ 22 billion per annum by 2007 for health programmes called for by the Commission on Macroeconomics and Health. This should be recognised as a productive and not simply a consumptive expenditure.*
- For a requirement for the inclusion of strategies to address the unacceptable burden of communicable and non-communicable disease in all Poverty Reduction Strategies (PRS), and for donors to align their PRS funding to address the multidimensional basis of poverty related ill-health.*
- For a viable plan and commitments to match it, to achieve basic food security for all the world's people.*
- On the private sector, as a major employer and potential contributor to health and sustainable development, to make clear its commitment to poverty reduction and health, and for those who are not doing so, to make a meaningful contribution.*

13. We note that underdevelopment, unsustainable patterns of development, including unplanned urbanization and production and consumption processes at both global and local level, are using resources, causing pollution and environmental degradation and encouraging unhealthy lifestyles in a manner that is seriously damaging to health now, and even more so in the future. We note with particular concern the impacts on health arising from rapid urbanisation and unplanned human settlements, including physical, environmental and social impacts. Overcrowded housing, pollution, noise, waste and associated ill-health result from mismanaged urbanisation.

14. Poor environmental quality contributes to around 25% of all preventable ill-health in the world today, the majority of which is poverty related. The following are indicative of the links between the physical environment and human health: Respiratory illnesses, such as chronic respiratory infections and pneumonia resulting from air pollution from the excessive use of fossil fuels and from biomass burning indoors, resulting in around 2 million deaths annually. Diarrhoea and other waterborne diseases cause millions of deaths annually, predominantly amongst the more than one billion people who are without access to improved water supply and the 2.4 billion without access to improved sanitation.

Global climate change is affecting the distribution of vector-borne diseases such as malaria, and disturbed weather patterns are contributing to natural disasters. Stratospheric ozone depletion is associated with skin cancer, and impaired food producing ecosystems lead to malnutrition. Biodiversity loss is reducing the chances of discovery of new medicines. Chemical hazards, such as asbestos, lead (particularly in petroleum) and arsenic have direct and indirect toxic effects, while exposure of workers in poorly controlled industries leads to an array of occupational diseases, and to pollution of air and water.

Resolution 5

We recognise the contribution that sustainable global and local environments make to health. In this regard, we call for:

- *Specific commitments to national and international environmental upgrading (for example, water supply and pollution control) and to reduction of environmental degradation and resource depletion (for example, deforestation and biodiversity loss).*
- *Setting and implementation of national commitments and action plans for moving environmental consumption patterns at the individual, national and global levels towards options that are sustainable and health-promoting.*
- *Meaningful implementation and enforcement of the conventions, accords and declarations that support sustainability of the environment and human health. There should be effective participation of the health sector to ensure that health protocols are included in Multilateral Environmental Agreements (MEAs). The “polluter pays” principle should be applied when health and the environment are threatened and the precautionary principle adhered to.*
- *Re-engineering of economic development and urbanisation patterns towards a sustainable, health-promoting environment.*
- *An international agreement on measures to reduce death and suffering from indoor air pollution by 50% by 2015, through the use of cleaner and safer sources of energy, and a reduction of lead pollution, particularly through the use of lead-free petroleum.*
- *Strengthened action on commitments to reduce water-related diseases through improved sanitation, personal and environmental hygiene, and quality and quantity of water.*
- *Commitment to stronger national and international “policing” of the exposure of workers to environmental hazards, and of the transfer of hazardous technology and waste to developing countries.*

15. We note that certain patterns of globalisation have had a positive effect on health, while others have harmed health. We have concerns about trade barriers blocking economic growth and domestic enterprise, international trade practices and intellectual property agreements preventing access to necessary drugs and technologies, trade liberalisation increasing use of tobacco in low-income countries, and the potential for travel to add to the spread of infectious diseases. We note further that the erosion of public services has been a consequence of globalisation in some countries, not only impeding health services, but also other services fundamental to improved health, such as education and supply of public utilities. Although technology offers many benefits, its pervasiveness and inappropriate messages can lead to undermining of moral values and consequent ill-health. Addressing the harmful consequences of globalisation offers an opportunity to enhance health.

Resolution 6

In order to enable globalisation to contribute positively to health, we call for:

- *Expeditious cancellation of the debt burden of developing countries so that the funds thereby mobilised can be utilised for poverty alleviation and health improvement.*
- *Positive support to, and clear incentives for economic investment strategies that support sustainable development, and which reach out to those most in need, without creating undue risk, for example, through unsafe working conditions.*
- *An agreement on how to alter the patterns of globalisation, so as to overcome the depletion of natural resources, reduce emissions of industrial toxic substances and counteract the effects of moral degeneration, thereby reaping benefits for health.*
- *Developed countries to open their markets to trade from developing countries and to invest in their sustainable development; and for developing countries to preferentially invest in health-promoting development, and specifically activities that are pro-poor and whose benefits are equitably distributed.*
- *A review of current international trade agreements to give legal standing to the concept of global public goods and the removal of trade practices that are harmful to health, particularly those that prevent access to necessary pharmaceuticals and technologies. Future trade agreements should be subject to health impact assessments.*
- *Finalisation and committed national and international implementation of the Framework Convention on Tobacco Control.*

16. We affirm that effective health services make a unique contribution to reduction of disease, and through this to economic development. However, to be effective, services need to be accessible and offer good quality care. This requires appropriate focus, equitable distribution, good organisation and sufficient human and financial resources to sustain it over the long term. The reality in many poorer countries is that services fall far short of that required to enhance well-being.

Coverage of health services in sub-Saharan Africa and other countries with a GDP less than or equal to US\$ 1200 is low: only 44% for Directly Observed Treatment Short Course (DOTS) for tuberculosis, 2% for malaria prevention, 31% for malaria treatment, 59% for acute respiratory infections, 68% for measles immunisation, 45% for skilled birth attendants, 20% for smoking control, and below 10% for most components of HIV prevention and care within the health sector. Consequently, hundreds of millions of people do not have access to basic health services – including capable health workers, essential drugs and referral to hospital in emergencies - despite their right to relief of suffering and prevention of simply avoidable death from major communicable and non-communicable diseases. Enhancement of disease control and system performance is further inhibited by the lack of effective monitoring, surveillance and health information systems as well as required health systems research.

17. Although we recognise that there is room for improved health system performance, the reality is that, however judiciously available money is spent, current funding levels in many countries are inadequate to allow for viable health systems. Total health spending in least developed countries is around US\$ 13 per capita per annum and US\$ 21 in other developing countries. 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 Global Fund to Fight HIV/AIDS, TB and malaria is an explicit recognition that poor countries are not in a position to achieve sustainability without partners.

The potential for technological development to provide drugs and vaccines to prevent millions of deaths annually from common conditions affecting the poor is often not

realised because of market forces. Because the commercial opportunity is not good enough, we are not seeing rapid progress towards more effective drugs for the treatment of malaria, tuberculosis and sleeping sickness (trypanosomiasis), nor for vaccines against the strains causing disease in the developing world of pneumococcus, which causes pneumonia, the rotavirus and shigella, which cause diarrhoea, and the meningococcus causing meningitis.

Resolution 7

We recognise the unique contribution that viable health services can make to health and to sustainable development. In this regard, we call for:

- *A global commitment to strengthening and securing the world's health systems, including its peripheral services, to the point of being strong enough to enable significant reduction in the burden of disease.*
- *Increased commitment to health sector funding from countries' own resources, supplemented by grants from donor countries, with a target of US\$ 22 billion annually in 2007.*
- *Countries to establish financing mechanisms that prevent the costs of health care driving households into a "long-term poverty and worsened health" trap.*
- *An international agreement and code of conduct that regulates the recruitment of skilled personnel from developing countries.*
- *Dedicated funds for health system research and focussed research on, and guarantees for the use of new drugs and vaccines that are required for preventing and treating diseases of poverty.*
- *Secure, effective, integrated monitoring and surveillance systems, and improved health information systems.*

18. While not seeing this as a replacement for proper health services, or a second-class care option, or indeed a replacement for broader environment and development interventions, there is much that individuals and families can do to improve their own health. Hundreds of millions of people worldwide have not even been empowered to use a drop of chlorine in a litre of water to prevent cholera and many cases of diarrhoea, home-made oral rehydration solutions to prevent death from dehydration, insecticide-impregnated materials to prevent malaria, or condoms to prevent AIDS. Lifestyle changes, such as healthier eating patterns and not smoking, would obviate a range of chronic diseases (but efforts are often overridden by trade and marketing practices); while knowledge of the urgency of seeking health care for children with symptoms of pneumonia would prevent many deaths.

Resolution 8

We call for an internationally supported programme of action, based on a multi-sectoral effort, to empower people to protect and promote their health and well-being through improved health literacy on a global basis by 2010.

19. Finally, we emphasize that many of the key determinants of health and disease – as well as the solutions – lie outside the direct control of the health sector, in sectors concerned with environment, water and sanitation, agriculture, education, finance, employment, industry, mining, urban and rural livelihoods, trade, tourism, transport, energy and housing. We draw attention to the fact that health issues are frequently inadequately considered when development decisions are made.

We reaffirm that addressing the underlying determinants of health is key to ensuring ecologically sustainable development and sustained health improvements in the long term, whilst further recognising that much progress has been made in forging closer links between health and other sectors.

Resolution 9

In recognising the intersectoral nature of health problems and solutions, we call for:

- *All countries to adopt an intersectoral and integrated approach to local and national health and development plans, policies and interventions.*
- *Strengthened measures at national and international level to ensure and guide the use of health impact assessments in development policy-making and planning, and for governments to carefully assess the health impacts of their development decisions.*

20. Finally, we, Health Ministers of the SADC region and representatives of four E9 countries (China, India, Indonesia and South Africa) pledge to advance the resolutions of this declaration, and commit ourselves to ensuring that health issues receive central attention in the preparations for, during, and after the World Summit on Sustainable Development.

Adopted in Johannesburg, South Africa

22 January 2002