

World Health Organization contribution to the High Level Political Forum on Sustainable Development, 9 to 18 July 2018

Introduction

Since 2000 significant progress has been made in addressing health challenges. Life expectancy has increased globally, child mortality has declined rapidly and major communicable diseases contained and on path towards eradication. However laudable this progress there have been new threats to health and well-being of particularly the poor and vulnerable in society, with increases in non-communicable diseases and mental health disorders (higher life expectancy does not mean healthier life expectancy) , epidemics and pandemics related to natural or man-made emergencies (threats to health security and economic stability) , and the growing impacts of climate change and demographic changes – hundreds of millions migrating or displaced as a result of socio-economic, political or environmental influences.

In most countries gender based differences continue to hamper improvements in health outcomes, while in the developing world hundreds of millions continue to suffer financial hardship in accessing safe and quality health services. The situation is exacerbated by widespread poor health literacy levels, coupled with weak health promotion policies, which result in poor health choices. Resilient health systems require much improved capacity in public health, both in terms of institutional architecture and more and better trained health professionals. Transformation towards stronger and people centered systems will enable countries to weather crises and ensure that health is both an indicator and outcome of sustainable development.

In the context of the 2030 agenda for sustainable development WHO has developed a mission statement which focuses on the promotion of health, keeping the world safe and serving the vulnerable. WHO's work is thus structured around strategic priorities aimed to ensure healthy lives and well-being for all at all ages. Core priorities are the achievement of universal health coverage (with 1 billion more benefitting from coverage), addressing health emergencies (with 1 billion better protected from emergencies) and promoting healthier populations (with 1 billion enjoying better health and well-being).

Overall theme of the 2018 HLPF “Transformation towards sustainable and resilient societies”

The key determinants of health frequently are found outside the health sector, requiring countries to engage sectors beyond health and moving towards a “whole of government” or “whole of society” approach.

WHO serves all people everywhere, but with a specific focus on the most vulnerable and poorest. In conflict affected countries there is a disproportional impact on women and children, the elderly and disabled. Such countries are also those where the majority of epidemics are prevalent, and unable to make progress towards implementing the 2030 agenda. As such they present an overlap between emergencies and the need for investing in universal health coverage to ensure healthier populations.

Health emergencies weaken health systems, and conversely weak health systems amplify health emergencies. Strengthened health systems build resilience against vector borne, water borne, food borne and work related diseases. WHO aims to substantially increase health related climate finance over the next 5 years to ensure that particularly small island states are resilient to climate sensitive diseases by 2030. Aside from structural and governance investment a specific focus on building the capacity of a well-trained health work force is necessary. Investing in women and girls is crucial as the majority of health workers are women and they provide by far the most informal care.

Thematic review of SDGs 6, 7, 11, 12 and 15

Goal 6. Ensure availability and sustainable management of water and sanitation for all

A significant percentage of disease burdens could be prevented through access to safe water supply, adequate sanitation services and better hygiene (WASH) practices. Diarrheal disease alone amounts to an estimated 3.6 % of the total disability-adjusted life-years (DALY) global burden of disease and is responsible for the deaths of 1.5 million people every year (WHO 2012). It is estimated that 58% of that burden, or 842 000 deaths per year, is attributable to unsafe water supply, sanitation and hygiene and includes 361 000 deaths of children under age five, mostly in low-income countries (WHO 2014).

Each year hundreds of millions of cases of diarrhea are treated with antibiotics, yet universal access to WASH could reduce this by 60%. Given such links between WASH and Antimicrobial Resistance (AMR), improving infection prevention and control (IPC) and WASH is one of the five objectives in the WHO AMR Global Action Plan, and greater awareness is needed at global, national, and local levels to make progress on both fronts. WHO works on aspects of WASH where the health burden is high and where evidence-based interventions could make a major difference.¹

Health care associated infections affect hundreds of millions of patients every year, with 15% of patients estimated to develop one or more infections during a hospital stay. Among newborns, sepsis and other severe infections are major killers estimated to cause 430,000 deaths annually. The risks associated with sepsis are 34 times greater in low resource settings. Lack of access to water and sanitation in health care facilities may discourage women from giving birth in these facilities or cause delays in care-seeking. Conversely, improving WASH conditions can reduce hospital-acquired infections, help establish trust in health services and encourage mothers to seek prenatal care and deliver in facilities rather than at home - important elements of the strategy to reduce maternal mortality. Recognizing this, the UN Secretary General issued a global call to action on WASH in health care facilities in March 2018.

WASH strategic priorities are preventing environmental health related disease in health care and other settings; Ensuring safe drinking-water; Monitoring water and sanitation for evidence-based policy and intervention; and preventing sanitation-related disease.

A wealth of evidence demonstrates the health impacts of individual environmental exposures – for example, to specific chemical or biological contaminants in water. At the same time, however, there is also strong evidence for the cost-effectiveness of many interventions, from small-scale (for instance, point-of-use water treatment) to large-scale investments (for instance, in sanitation infrastructure).² The need to provide targeted support for the most vulnerable nations and populations remains.

At the global level, the WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene identify the 892 million people practicing open defecation as being “left behind”. Decline in rates of open defecation in rural areas would need double in order to eliminate this by 2030. Significant inequalities in basic water and sanitation services persist within individual countries, between urban and rural areas, and wealth quintiles. WHO and UNICEF data show that in 34 of 38 African countries, less than 50% use basic handwashing facilities.

WHO is contributing to monitor SDG target 6.1 (safely managed drinking-water), 6.2 (safely manage sanitation) and 6.3 (wastewater treatment and ambient water quality) and the means of implementation targets 6a and 6b. Progress towards these targets will require policy responses that embrace preventive risk

¹ http://www.who.int/water_sanitation_health/about/en/

² A71/10 WHA71 Report by DG on Health, environment, and climate change http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_10-en.pdf

management, align with WHO Guidelines on water and sanitation, and would yield significantly more health benefits than basic services alone. However, current WASH coverage and trends, suggest that in many countries, meeting even basic access will be deeply challenging and require profound change,

If the SDG agenda for water is going to be translated into meaningful progress, countries need to take action now to set their own ambitious but achievable targets, taking into account their particular circumstances. This includes undertaking a serious appraisal of the current services used by people in the country, as well as the capacity to extend and improve these services. This appraisal should inform a critical review and possible revision of existing targets and policies.

Goal 7. Ensure access to affordable, reliable, sustainable and modern energy for all

Air pollution is a global public health emergency, causing about 6.5 million deaths a year, or one in eight of all deaths. 92% of the world's population lives in places where air quality exceeds WHO limits. It is one of the largest causes of the four main non-communicable diseases (NCDs) – stroke, lung cancer, chronic respiratory disease and heart disease – accounting for between one-third and one-quarter of those deaths.

Ambient (outdoor) air pollution caused more than 3 million deaths (2012), mainly from transport, waste burning, agriculture, building energy use, industry, power production and forest fires. Household air pollution causes about 4 million deaths annually (2012), mainly due to smoke from inefficient cook stove technologies and fuels, e.g. biomass, coal, and kerosene.³

Global health and welfare losses from air pollution in 2013 are valued at US\$ 5110 billion, or almost 7% of GDP. More generally, it is estimated that placing a price on polluting fuels in line with their health impacts through air pollution would more than halve the number of premature deaths globally due to air pollution, result in a 20% reduction in greenhouse gas emissions and generate some US\$ 3000 billion in tax revenues every year – equivalent to more than 50% of global health spending by governments⁴.

In 2015, WHO Member States adopted a resolution recognizing air pollution as a global health risk and committing to action in four areas: building the knowledge base; monitoring and reporting; institutional capacity strengthening and global leadership and coordination. In line with the 2015 WHA resolution and a 2016 “Road Map” for enhanced action, WHO is providing global leadership and technical support to member states through⁵:

1. Global monitoring of SDG progress (WHO monitors three air pollution–related SDG indicators: 3.9.1 Air pollution-related mortality; 7.1.2 Access to clean energy in homes; and 11.6.2 Air quality in cities);
2. WHO Air Quality Guidelines, which are a basis for formulating national standards and policies;
3. Support to countries for evaluating new policies and interventions;
4. Leadership, such as with the Global Air Quality and Health Platform where WHO collaborates with WMO and the UN Environment Programme on assessing air pollution's health burden, and the BreatheLife Campaign which raises awareness about the health risks of air pollution and its contribution to climate change.

WHO is also working at country level to increase national and city government commitments to attain WHO Air Quality Guidelines; conduct rapid situational assessment for clean household energy; assist with assessment of national and sub-national disease burden from air pollution in 70 countries through online AirQ+ tool; and assess air and health quality impacts of transport, household energy and waste interventions.

³ WHO Air Quality and health Factsheet

⁴ WP/15/105; <https://www.imf.org/external/pubs/ft/wp/2015/wp15105.pdf>

⁵ WHO Air Quality and health Factsheet

Goal 11. Make cities and human settlements inclusive, safe, resilient and sustainable

The world's urban population will double by 2050 and will require housing solutions. 828 million people live in slums, where crowding and lack of safe, healthy and durable housing is most pronounced, and the number keeps rising.

Most of the top ten causes of death (2015) are directly or indirectly influenced by faulty urban design and planning policies: Heart attack (1); stroke (2); chronic respiratory disease (4); lung cancers (5) – more than a quarter to one-third of deaths are caused by air pollution – with urban traffic, waste, industry, cooking, heating and power production, as leading sources; Pneumonia (3) – air pollution causes more than one half of deaths; Diabetes (6) – linked to obesity and physical inactivity common in car-dependent cities lacking robust transit and walking/cycling networks, as well as urban fresh food markets; Diarrheal diseases (8) and Tuberculosis (9) are closely related to poor sanitation and waste management and unhealthy housing; and Traffic injuries (10) Pedestrians & cyclists, including children, older people and the poor are exposed to traffic injury due to lack of safe, rapid transit, walking and cycling. Poor urban waste management also perpetuates transmission of vector-borne and diseases, including dengue fever as well as Zika and Ebola which are two emergent health challenges. Urbanization also is linked to soaring rates of depression, anxiety and other mental disorders, exacerbated by noise, lack of green spaces, and crowding, as well as poverty, poor working conditions and other stressors.⁶

Health can act as a powerful accelerator and a measure of progress of urban development. There is extensive evidence that urban planning and decisions in city infrastructure and development will affect the health of generations to come, play a crucial role in ensuring the right to health, promoting wellbeing and quality of life for all citizens. This is to be achieved by mainstreaming equity through indivisible/inter-sectoral action in all goals that are all impacting urban health, so as to leave no one behind.

WHO is building health sector leadership in urban development by:

1. New housing and health guidelines to set health standards, and support to countries in implementation;
2. Monitoring urban air pollution levels as a key health indicator;
3. Improved Tools for local decision-makers such as *HEAT* (Health Economic Assessment of Transport for Walking & Cycling);
4. Guidance for a healthier urban environment, such as WHO's report on *Health as the Pulse of the New Urban Agenda*, WHO's work on *Transport in its Health in the Green Economy* series and *Urban Transport and Health – Handbook for Policymakers*;
5. WHO's Urban Health Initiative, which is working in low and middle income cities to build health sector leadership in the urban transformation;
6. Support to countries in policy/interventions evaluation for addressing slum upgrading, such as collaborating with partners like UN Habitat and UN Environment, as well as civil society;
7. Global leadership and advocacy, such as in advocating for prioritized action on the health impacts of housing policies with key other UN agencies, e.g. UN HABITAT, UNECE etc. Currently WHO is working to integrate health standards into the Urban and Territorial Guidelines of UN HABITAT, and is also on several areas that are contributing towards the achievement and implementation of the New Urban Agenda.

At country level, WHO assists with assessment of key housing risks for health; Supports Ministries of Health & Housing & Urban Planning as well as civil society to establish effective collaboration; Applies validated tools for assessing expected impacts of intervention options on health, poverty, environment and economic

⁶ WHO Sustainable Cities: Health at the Heart of Urban Development Factsheet

development; Supports capacity building on housing; and Communicates country success stories and advocate for housing and health in global fora.

Goal 12. Ensure sustainable consumption and production patterns

It is estimated that 1.3 million lives and 43 million DALYs were lost in 2012 due to exposures to selected chemicals (WHO 2016). However, data are only available for a small number of chemical exposures and people are exposed to many more chemicals every day. Unintentional poisonings were responsible for over 100,000 deaths in 2016 (WHO 2018). Although the number of deaths from unintentional poisonings has shown a steady decline over the last two decades, mortality rates continue to be relatively high in low-income countries, however only 47% of countries have a poisons center. Addressing lead exposure would prevent 12.4% of idiopathic developmental intellectual disability, 2.5% of ischemic heart disease and 2.4% of stroke in the population, yet many countries do not regulate lead paint (IHME 2017 - Institute for Health Metrics and Evaluation (IHME). GBD Compare. Seattle, WA: IHME, University of Washington; 2017 <https://vizhub.healthdata.org/gbd-compare/>).

Some recent examples of WHO work in this area include:

- In 2015 WHO produced a step by step guidance of key considerations to support the development of national strategies for phasing out mercury containing thermometers and sphygmomanometers.
- In May 2017, the 70th WHA approved the Road map to enhance health sector engagement in the Strategic Approach to International Chemicals Management (SAICM) towards the 2020 Goal and beyond. It has four action areas: 1) Risk Reduction, 2) Knowledge, 3) Institutional Capacity and 4) Leadership and Coordination.
- The WHO Chemical Risk Assessment Network, which is a voluntary collaborative initiative whose overall goal is to improve chemical risk assessment globally through facilitating sustainable interaction between institutions on chemical risk assessment issues and activities. It has been established to enhance global efforts to assess risks to human health from exposure to chemicals. The activities of the Network promote the objectives of the SAICM, and are aligned with and advance the policies of the WHO GPW.
- An example of WHO's work at the country level includes efforts to improve the availability of poisons center services in the Eastern Africa Subregion, where a study was conducted and toolkit for setting up a poisons information service was produced.

Contemporary environmental risks to health are interdependent, and range from the transfer of polluting industries' dangerous work processes and hazardous waste to poorer and less regulated countries, to transboundary air pollution and radiation risks and the burning of fossil fuels that drive global climate change. Health should therefore be central to discussions around drivers such as production methods that pollute deleterious consumption and distribution patterns and disruption of ecosystems.⁷

Goal 15. Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss

Human health depends on ecosystems for elements essential to health and well-being. Biodiversity underpins the ecological functions and processes that give rise to the benefits provided by ecosystems, including purification of water and air, pest and disease control, pollination, soil fertility, and resilience to climate change. Furthermore, various species and genotypes of organisms provide diverse foods, essential nutrients and medicines. At the same time, biodiversity can sometimes be a source of pathogens and, when unsustainably managed, can exacerbate negative health outcomes. Thus the interactions between people and biodiversity can strongly influence population health, livelihoods, and the sustainability of public health interventions.

⁷ A71/10 WHA71 Report by DG on Health, environment, and climate change http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_10-en.pdf

An increasing body of evidence indicates that exposure to biodiverse green spaces, particularly in urban settings, can provide many health benefits in patients with NCDs, including improved psychological, cognitive and physiological health. Conversely, recent research has demonstrated that biodiversity loss in the natural environment, and reduced human contact with the natural environment, may lead to reduced diversity in the human microbiota, leading to weakening of the human microbiome's immunoregulatory role and onset of NCDs. As well, use of antibiotics and antimicrobial agents can alter the composition and function of the human microbiome.

In line with the "Health in All Policies" approach (resolution WHA67.12 (2014)), public health policies should seek to ensure that the impacts of ecosystem alteration are assessed and reflected in strategies through the engagement of different sectors, disciplines and local populations, as an opportunity to maximize the shared health and environment benefits of addressing the upstream drivers of hazards to health.

Particularly since the establishment of the joint work programme on biodiversity and health in 2012, WHO has worked closely with the Secretariat of the Convention on Biological Diversity. Joint activities include: writing papers for publication in peer-reviewed journals, synthesizing scientific information, generating awareness-raising materials and communication tools, producing the state of knowledge review, developing capacity, holding combined events in relevant international forums, interagency collaboration and elaborating policy guidance. In 2015, a liaison group was established, co-chaired by WHO and the Secretariat, in order to provide a platform for requesting expert advice and assistance, exchanging information and coordinating activities relating to linkages between human health and biodiversity. To support countries in mainstreaming biodiversity and health in national strategies, programmes and plans, both Parties (including WHO regional offices) and other partners have co-convened a series of regional capacity-building workshops, bringing together representatives from over 80 countries' health ministries and those responsible for biodiversity.

WHO is supporting Member States to consider the following activities in line with national priorities and capacities:

- facilitating dialogue among agencies responsible for health, those responsible for biodiversity, and other relevant sectors;
- better integrating health, biodiversity and ecosystem management into holistic approaches;
- considering relevant health-biodiversity linkages when developing and updating relevant national policies and strategies, programmes, plans and accounts;
- considering health-biodiversity linkages in environmental impact assessments, risk assessments and health impact assessments; and acting to address, monitor and evaluate negative impacts;
- identifying opportunities to promote healthy lifestyles, sustainable production and consumption and associated behavioral change that would benefit both human health and biodiversity;
- supporting interdisciplinary education, training, capacity-building and research programmes on linkages;
- strengthening the capacity of health, environment and other relevant ministries, agencies and organizations to consider health-biodiversity linkages in approaches to prevent ill-health and promote sustainable development, and to promote the multiple dimensions of health and well-being, with particular attention to vulnerable populations; and
- strengthening national capacities for monitoring and data collection.

Looking ahead, systematic use of risk analyses, vulnerability assessments and integrated impact and strategic assessments relating to the links between human health and biodiversity could help to identify actions to proactively manage non-communicable and infectious disease risks associated with biodiversity change, wildlife trade and other drivers of disease emergence and ill health, including the socioeconomic and behavioral factors that contribute to these threats. The development of common metrics and the linkage of

indicators on biodiversity with those on health, coupled with economic valuation tools, would also contribute to the evaluation of measures and the monitoring of their impacts on both biodiversity and human health.

There is an urgent need for further scientific research on the links between biodiversity and health in order to fill scientific gaps, to generate more integrated data, monitoring and indicators, and for broader dissemination of these findings. Even though further research is important, sufficient knowledge exists to support many “no regrets” measures. Mainstreaming health and biodiversity linkages into national strategies and programmes provides novel opportunities for nature-based solutions for strengthening resilience and facing major societal challenges that affect human health, such as food and water insecurity, climate change, disaster risk, social and economic inequity.⁸

⁸ A71/11 WHA71 Report by DG on Health, environment, and climate change: Human health and biodiversity
http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_10-en.pdf