IFMSA
International Federation of
Medical Students' Associations

IFMSA Policy
Climate Change and Health

Proposed by Team of Officials
Presented to the IFMSA General Assembly August Meeting 2018 in Montreal, Canada

Policy Statement

Introduction

Accumulating evidence has shown that climate change puts the lives and wellbeing of billions of people at increased risk. Health impacts can be directly mediated, through weather events, or indirectly mediated, through the effects on economies, access to healthcare, social structure and ecosystems. However, climate change action also offers great opportunities for improving global public health through co-benefits. This can arise through several pathways, including reduced air pollution, as well as dietary change and increased physical activity, leading to a reduction in the burden of disease such as cardiovascular and respiratory diseases.

IFMSA position

The IFMSA, as future health professionals, believes that our duty of care not only includes the future of our individual patients, but also that of communities locally, nationally and globally. In light of this, the IFMSA acknowledges i) the direct attribute of human activity to climate change, and ii) the urgent threat climate change poses to global health. IFMSA therefore stresses on the importance of climate change action including the health co-benefits of health mitigation and adaptation strategies and the need for building climate resilient health systems that can protect the promotion and provision of quality healthcare for all. Health must be placed at the center of any negotiations on climate change.

Call to action

Therefore, the IFMSA calls on:

Governments, according to ability, to:

1. Meet an emissions trajectory consistent with the limiting of the global temperature rise to 1.5 degrees above pre-industrial levels;
2. Engage in a fair international negotiation process under the UNFCCC, in which elements crucial for equity are protected and the rights of every country and their citizens are respected and represented equally;
3. Adopt a comprehensive approach to integrate health and health systems into national plans and policies and national disaster risk reduction frameworks;
4. Create a society wide transition to a fossil free economy, through the divestment of fossil fuels and the immediate withdrawal of fossil subsidies;
5. Incentivize the reduction of vehicular transport, promote active transport, and build the appropriate infrastructures to facilitate this;
6. Provide a strong mechanism to address loss and damages supported by financial means that are not in competition with climate finance for mitigation and adaptation;
7. Allocate public funds to support the clean energy transition and climate solutions research and development;
8. Support and actively promote meaningful youth engagement at all levels;
9. Develop and implement education, training, public access to information, public awareness, public participation and international cooperation.

The World Health Organization to:

1. Develop a systematic global standard for measuring the greenhouse gas emissions of the healthcare sector, in conjunction with UNEP;
2. Increase eco-medical literacy within climate change stakeholders and policy makers and publish and disseminate scientifically global public health information on climate change and health that supports policy-makers, researchers and practitioners;

3. Further continue the initiative of the WHO Country profiles on climate and health in collaboration with the UNFCCC, governments and the WHO;
4. Undertake an analysis of national policies and adaptation strategies in order to assess health gains for countries and to monitor the contribution of countries' policies and actions to the Sustainable Development Goals on climate change and health.

The UNFCCC to:

1. Provide an institutionalized space within the UNFCCC framework for all health-related issues to be discussed.

All relevant stakeholders to:

1. Lead by example by establishing and following an organizational sustainability policy;
2. Divest finances (including bank accounts and investment funds) from institutions and organizations associated with the fossil fuel industry, invest in ethical funds that promote health, renewable energy and sustainable industries;
3. Increase transparency around the extent investments in fossil fuel companies.

The Health Sector, Universities and Medical Faculties to**:**

1. Integrate climate change, its threat to health, organizational sustainability, and the role of the healthcare sector in adapting and mitigating to climate change within the curricula for healthcare students worldwide and into capacity building programs targeting health and educational professionals from a multidisciplinary approach;
2. Divest from non-renewable energy industries by powering healthcare facilities and universities by renewable sources;
3. Design healthcare facilities and universities to facilitate a proactive participation in mitigating and adaptation strategies including the intensification of recycling and low non-recyclable material use, the use of eco-friendly construction materials, accessibility by public transport and provision of sustainable food;
4. To avail resources for research and activities, including student-led initiatives, to understand the trends, geographical distribution and evolution of new and emerging health issues in regard to climate change risk factors and their impacts on social and economic structures, and disseminating the outcomes among national and subnational governments and health practitioners;
5. Develop climate resilient health systems, infrastructure and technologies that can protect the promotion and provision of quality healthcare for all people following the WHO operational framework for building climate resilient health systems.

IFMSA National Member Organizations (NMOs) and medical students to:

1. Where possible, use the *IFMSA recommendations for sustainable and climate-friendly meetings* as a guidance to limit the environmental impact of IFMSA and NMO meetings;
2. Improve the sustainability of their own NMO and Local Committees;
3. Take the lead in creating public awareness on climate change and its impact on global health promote sustainable lifestyle habits;
4. Collaborate with universities and other educational bodies to improve the education on climate change and its impact on health in medical curricula;
5. Lead the change by advocating towards key stakeholders, including governments, to take action in climate change mitigation and adaptation;
6. Lead by example by increasing transparency on and divestment from investments in institutions and organizations associated with the fossil fuel industry.

Position Paper

Background

In 2009, the first Lancet Commission called climate change "*the biggest global health threat (of) the 21st century*", stating that "climate change effects on health will exacerbate inequities between rich and poor" [1]. Since then, a growing body of evidence is providing insight into the impact of climate change on health. The World Health Organization highlighted the direct and indirect connections between climate change and health in various publications. Direct health impacts occur due to changes in temperature and increased frequency of severe weather events, which can lead to physical injuries or heat-related deaths. Indirect impacts arise from changes in ecological systems and human systems induced by climate change such as: *i)* environmental degradation leading to more forced migration and civil conflict, *ii)* changes to water and food supply, increasing malnourishment and diarrheal disease, *iii)* increased allergens and air pollution, contributing to respiratory and cardiovascular diseases, *iv)* changes in disease ecology, resulting in outbreaks of infectious disease. Current estimates indicate that globally 23% of all deaths could be prevented through healthier environments, with ambient and indoor air pollution causing respectively 4.2 and 3.8 million deaths every year [2]. The impacts vary between geographical regions and among socioeconomic groups, with some areas being affected more negatively than others [3]. Climate change is disproportionately affecting vulnerable populations (elderly, children, and coastal populations) and low-income and middle-income countries (LMICs), placing the burden of disease on those least responsible [1].

The wide-ranging impacts of climate change on health highlight that climate change adaptation (any adjustment in response to the expected impact/risk of climate change) and mitigation (all human activities aimed to reduce impact) is essential for protecting health, as well as environmental and social justice, and should be a public and global health priority in both policy and practice [4]. Loss and damage is a relatively novel area of action in climate change which reflects the inevitable impacts of climate change that we are unable to mitigate or adapt to. It has been adopted in the Paris Agreement and now forms a key element of climate negotiations to address past, current and projected future emissions. It also recognizes how international cooperation is required in high impact events to support developing countries [5].

Discussion

Political Processes

In 2015, at the historic Paris Climate Conference, the Paris Agreement was signed, which committed nations to limit global rise in temperature to 1.5-2 degrees Celsius. The Agreement was signed by 196 countries. At its heart was the creation of the Nationally Determined Contributions, that show each country's efforts to mitigate and adapt to the effect of climate change [6].

With the ratification of the Paris Agreement, parties acknowledged that "*Parties should, when taking action to address climate change, respect, promote and consider their respective obligations on human rights,* ***the right to health,*** *[...] as well as gender equality, empowerment of women and intergenerational equity"* [6]. However, a study by the World Medical Association indicated that out of the 184 Intended Nationally Determined Contributions (INDCs) analyzed, only 121 (65.8%) include a mention of health - of which 90 (74.4%) include health in the context of adaptation and 28 (23.1%) include health in the context of mitigation.

This illustrates an inadequate integration of NDCs, NAPs, development plans, other sector plans and policies [7].

The WHO collaborates with several other United Nations agencies to prevent deaths from environmental risk factors caused by climate change. Moreover, The WHO and the United Nations Environment Programme recently signed a collaborative framework for both immediate and long term actions to reduce mortality attributable to the environment and climate change [8]. Additionally, one of the UN Development Programme's focus areas is Climate and Disaster Resilience, recognizing that resilience to climate disasters strengthens access to healthcare, as well as the interconnectedness of the environment, sustainable development and health [9].

The 71st World Health Assembly recently noted a report by the WHO Director-General calling for alignment of national environmental risk factor and disease monitoring with the WHO's 2019-2023 General Programme of Work, including monitoring and assessing funding and financing of health in relation to climate change [10].

The World Bank, a United Nations agency, is one of the largest lenders to governments, as well as development data collectors. In 2016 it adopted a new framework that ensures that its loans do not lead to actions that are deleterious to its people or the environment. The implementation of this Environmental and Social Framework (ESF) will begin in 2018 and contains 11 detailed operational policies. Furthermore, it prioritizes loans for renewable energy capacity expansion of countries [11].

It is recognized that there is an urgency to increase the efforts to adapt to the adverse impacts of climate change and make finance flows consistent with reducing greenhouse gas emissions and becoming more climate-resilient [12].

Health co-benefits

In the context of climate change mitigation and adaptation, the term 'health co-benefits' is used to refer to health advantages that occur indirectly as a result of reductions in greenhouse and climate-altering emissions [13]. For instance, a community transition to non-combustion energy sources (such as solar) will simultaneously reduce greenhouse emissions and reduce exposure to pollutants and respiratory irritants. Other examples include reduced dietary fat intake through decreased meat consumption (resulting in reduced emissions from livestock farming) and decreased sedentary behaviors through promotion of active transport (as well as decreased vehicular use and emissions) [14; 15].

Health co-benefits should be considered as a major advantage when developing climate change mitigation projects and policies. Firstly, local health action has the potential to generate global climate benefits. Thus, implementing effective policy in resource-depleted countries provides an opportunity to increase the local health profile while also meeting global climate targets on the international stage. Additionally, this double-edged approach allows policymakers to address multiple social issues at once, maximizing the cost-effectiveness of the project and appealing to economic rationale [16]. In this way, it is clear that immediate climate change action addresses an imminent health emergency while simultaneously investing in future wellbeing in an efficient and resource-effective manner.

Health adaptation measures

Next to mitigation measures, the implementation of adaptation mechanisms (e.g. building

resilience of existing health systems, increasing the access to health services, constructing resilient health institutions) is crucial as climate change is likely to result in further demands on the healthcare services [17].
According to the WHO Climate and Health Country Survey, 30 out of 40 countries (75%) reported having a national adaptation strategy for health, approved by their governments. Yet only 16 of 40 responding countries (40%) have implemented activities to increase the climate resilience of their health infrastructure. Despite interest from countries in undertaking adaptation actions addressing health, the availability of and access to funding for health and adaptation is limited. In terms of finances only 4·63% ($16·46 billion) of the world's total adaptation spending is on health and 3·13% ($29-47 billion) is on health-related adaptation. Between 2003 and 2017, less than 1.5% of total adaptation funding for development, flowing through global climate change financing mechanisms, was dedicated to health adaptation [18].

Role of (future) health professionals
Healthcare professionals are a potentially powerful sector of our global community, which can be a critical part of the solution to climate change. It is undoubtedly imperative for healthcare professionals to be the link between the scientific evidence of the health impacts of climate change and societal awareness. Hence, the role of healthcare professionals is three-pronged:

Firstly, on a patient-level, healthcare professionals can advocate for the implementation of climate change policies with health co-benefits among patient communities. This can be achieved by suggesting the use of low carbon transport such as walking, cycling or public transport. This would both increase physical activity and reduce the risk of cardiovascular diseases, obesity and diabetes, as well as reducing greenhouse gas emissions [19].
Livestock rearing for meat and milk is also an important source of greenhouse gas emissions. Therefore, healthcare advocates can urge patients to reduce animal product consumption which would decrease the carbon footprint of people while simultaneously reducing the levels of saturated fat and meat consumed, decreased the incidence of cardiovascular disease and bowel cancer [20].

Secondly, external (non-patient) advocacy targets the health and governmental sectors. Healthcare professionals should start by advocating for sustainable policies in their hospitals. Next, advocacy must reach society's policymakers. This should include a multidisciplinary approach that targets all levels of government, from local to national. Advocacy should inform city planning, waste management, pollution control, transportation strategies, food origin, energy sources, water sanitation and conservation of biodiversity and natural resources [21]. This would result in more efficient policies for the benefit of the people and the environment. Research shows that these kinds of policies are also associated with economic benefits [22].

Lastly, there's an urgent need for a climate change curriculum based on the emerging scientific evidence and reviews on the health impacts of climate change [23].
This significant association calls for medical education to prepare future healthcare professionals for health sector mitigation and adaptation to climate change. There is a need for medical students and doctors to be trained on health sector mitigation and adaptation to climate change [24]. The recent surge of increasingly destructive hurricanes proves how disaster preparedness must be given high priority and thus be a part of medical education [25]. Medical students should be equipped with the knowledge and skills to manage climate-

related illness, engage in eco-health promotion, and disease prevention. In addition, such curriculum would pave the way for a climate-resilient society and health sector [26].

Sustainable healthcare facilities

Health facilities are large contributors to the global carbon footprint. Estimates suggest that in 2013, the US healthcare sector alone was responsible for the emission of 655 megatons of carbon in a twelve month period. Hence, there is a significant opportunity for emission reduction and for global leadership by example. Moving forward, healthcare facilities must endeavor to increase sustainability through minimizing carbon footprint and developing climate-resilient services [19].

There are a variety of ways for healthcare facilities to incorporate a greater degree of sustainability. Waste volume and toxicity can be reduced at the source with environmentally-preferable purchasing, and the impact of necessary waste can be reduced through a comprehensive waste management system (incorporating separation of wastes and employee training). Water can be more effectively conserved through the elimination of bottled water in favor of potable water, efficient fixtures and organizational frameworks for net zero water usage. Energy requirements can be decreased and sourced from renewables, ideally through onsite and self-sustainable infrastructure. Additionally, the physical healthcare buildings themselves can be designed and constructed according to green building principles, including carbon-neutrality, protection of natural surrounds, easy access to public transportation, and the use of local materials and services [27]. Many of these goals provide additional economic benefit in maximizing cost-effectiveness of the health service delivery; for instance, replacing bottled water with potable water eliminates transport and manufacturing costs and ensures water is supplied on an ‘as needed’ basis.

Healthcare services have an inherent ethical duty to ensure that service delivery doesn’t contribute to poorer health outcomes through environmental footprint. Keeping these considerations in mind during the planning and delivery of healthcare ensures long-term investment in public health, as well as secondary financial savings.

In low-income countries, projects run by the UN Development Programme, World Health Organization and Global Environmental Facility seek to work with national governments to integrate health to NAPs. These projects also aim to increase the capacity of health professionals to manage climate change related illness and build resilience of healthcare facilities to climate change.

Fossil fuel divestment

According to the WHO, 7 million premature deaths per year are caused by indoor and outdoor pollution led by accelerating rates of burning fossil fuels, posing an alarming hazard to our health [28]. Current fossil fuel extraction in this era of climate crisis is fundamentally unethical and irresponsible. This spurred the beginning of the international fossil fuel divestment campaign in 2011, with organizations and individuals removing their money from a variety of institutions that fund, invest in, or otherwise contribute to the fossil fuel industry. It is currently estimated that the fossil fuel divestment movement is ‘worth’ more than $5.99 trillion, with more than 800 major organizations around the globe having already taken steps to divest [29]. Organizations committed to fossil fuel divestment include the world’s biggest sovereign wealth fund; and, in the medical realm, the World Medical Association, the British Medical Association in 2014, the Canadian Medical Association in 2015 and the Royal Australasian College of Physicians in 2015.

Health professionals have a long and proud history of advocating for divestment from industries that harm human health. Hence, the health sector must lead by example the divestment movement, ceasing their investments in institutions and organizations associated with the fossil fuel industry, putting the issue firmly on the political agenda, and strengthening public understanding of climate change health risks. Additionally, health professionals can address the governments to cut their fossil fuel subsidies and to instead use that money to invest in renewable energy sources and increased healthcare coverage [30]. This would simultaneously impact the environment and healthcare by transitioning to a sustainable society and, consequently, improving the health of the people and planet alike. Medical students can also press their universities and hospitals onto mitigating carbon emissions by divesting. This was demonstrated by the University of Massachusetts in May 2016, which became the first major public university system to divest its investments in fossil fuels [31].

Organizational sustainability within the IFMSA

As the health of the planet directly influences the health of its inhabitants, including humans, IFMSA, strongly committed to the improvement of Global Health worldwide, decided to lead by example by initiating the reform of her own organizational sustainability. In the past years, our General Assemblies, Regional Meetings, and other activities have significantly increased in size and quantity. With this increase, the impact of our activities on our environment has increased, too. to set the first steps to a green and sustainable IFMSA wrote the IFMSA Recommendations for Sustainable and Climate-friendly meetings, focused on the following areas: Accommodation and Venue, Transportation, Food and Beverage, Material use & Merchandise [32].

References

1. Costello, A., *et al.* (2009). Managing the health effects of climate change: lancet and University College London Institute for Global Health Commission. *The Lancet*, *373*(9676), 1693-1733.
2. World Health Organization. (2012). Atlas of health and climate.
3. Arnell, Nigel W., et al. "The impacts of climate change across the globe: a multi-sectoral assessment." *Climatic Change* 134.3 (2016): 457-474.
4. World Health Organization. (2009). Protecting health from climate change: Global research priorities
5. Julia KreienKamp and Lisa Vanhala (2017). Policy Brief Climate Change Loss and Damage. Global Governance Institute UCL.
6. United Nations (2015). Paris Agreement. *United Nations Treaty Collect*, 1-27.
7. Wiley, E., Tcholakov, Y., Pétrin-Desrosiers, C., & Al-Qodmani, L. DETERMINED CONTRIBUTIONS (INDCS). World Medical Association
8. UN Environment Press Release (2018). [Accessed June 2018] https://www.unenvironment.org/news-and-stories/press-release/un-environment-and-world-health-organization-agree-major
9. UN Development Programme [Accessed June 2018] http://www.undp.org/content/undp/en/home/climate-and-disaster-resilience.html
10. WHO (2018). SEVENTY-FIRST WORLD HEALTH ASSEMBLY: Health, Environment and Climate Change Report by the Director-General. Provisional Agenda
11. WorldBank [Accessed June 2018] http://www.worldbank.org/en/projects-operations/environmental-and-social-policies
12. UNFCCC [Accessed June 2018] https://unfccc.int/process-and-meetings/the-paris-agreement/nationally-determined-contributions-ndcs
13. Workman, Annabelle, et al. (2018). The Political Economy of Health Co-Benefits: Embedding Health in the Climate Change Agenda. *International journal of environmental research and public health* 15.4: 674
14. Smith, Kirk R., et al. (2014). Human health: impacts, adaptation, and co-benefits. *Climate Change 2014: Impacts, Adaptation, and Vulnerability. Part A: Global and Sectoral Aspects. Contribution of Working Group II to the Fifth Assessment Report of the Intergovernmental Panel on Climate Change*
15. World Health Organization, et al. Health Co-Benefits of Climate Change Mitigation: Transport Sector. World Health Organization, 2011.
16. Smith. K.R., Balakrishnan, K. (2009). Mitigating climate, meeting MDGs, and moderating chronic diseases: The health co-benefits landscape .
17. World Health Organization. (2014). WHO Guidance to protect health from climate change through health adaptation planning.
18. World Health Organization (2015) Climate and Health Country Profiles - 2015. A global Overview.
19. Watts, Nick, et al. (2017) The Lancet Countdown on health and climate change: from 25 years of inaction to a global transformation for public health. *The Lancet*.
20. McMichael, Anthony J., et al. (2007). "Food, livestock production, energy, climate change, and health." *The lancet* 370.9594: 1253-1263.
21. Watts, Nick, et al. "Health and climate change: policy responses to protect public health." *The Lancet* 386.10006 (2015): 1861-1914.
22. Landrigan, Philip J., et al.(2017) The Lancet Commission on pollution and health. *The Lancet*.

23. Maxwell, Janie, and Grant Blashki. (2016) Teaching about climate change in medical education: an opportunity. *Journal of public health research* 5.1
24. UNFCCC SBSTA (2017) Human health and adaptation: understanding climate impacts on health and opportunities for action.
25. Purcell, Rachael, and Joe McGirr. (2014) Preparing rural general practitioners and health services for climate change and extreme weather. *Australian journal of rural health* 22.1: 8-14.
26. Bell, E. J. (2010). Climate change: what competencies and which medical education and training approaches?. *BMC Medical Education*, *10*(1), 31.
27. Karliner, J., & Guenther, R. (2011). A comprehensive environmental health agenda for hospitals and health systems around the world. *California: Global Green and Healthy Hospitals*, 42.
28. WHO Press Release http://www.who.int/mediacentre/news/releases/2014/air-pollution/en/ [Accessed June 2018]
29. Fossil Free. [Accessed June 2018]. https://gofossilfree.org/divestment/commitments/
30. Cuevas, S. *et al. (2015)* Unhealthy Investments: fossil fuel investment and the UK health community
31. RObert P. Connolly (2016). UMass becomes the first Major Public University to Divest from Direct Fossil Fuel holdings. UMassAmherst
32. IFMSA (2018). IFMSA Recommendations for Sustainable and Climate-Friendly Meetings.

Draft Policy Proposals have to be sent to all National Member Organizations (nmos@ifmsa.org) by the proposer to request for feedback by June 10 2018 23.59 GMT. Policy Proposals to be discuss at 67th August Meeting General Assembly 2018 have to be sent to gs@ifmsa.org by July 1, 2018 @ 23.59 GMT (please put the code [POL PROP] in the beginning of the subject of your email).

Bylaws Paragraphs concerning Policy

15.2 Definitions
a. Policy Statement: Short and concise document highlighting the position of IFMSA for specific field(s). A policy statement does not include background information, discussion related to the policy, a bibliography and neither does it quote facts and figures developed by outside sources. The maximum length of a policy statement is 2 pages, including introduction, IFMSA position and call to action.
b. Position Paper: A detailed document supporting the related policy statement that contains background information and discussion in order to provide a more complete understanding of the issues involved and the rationale behind the position(s) set forth. A position paper must cite outside sources and include a bibliography.
c. Policy commission: A policy commission is composed of three people, with 2 representatives of the NMOs and one representative of the Team of Officials. The proposer of the draft is part of the policy commission and is responsible of appointing its members. The tasks of the policy commission are the following:
i. They are responsible of the quality of the policy document with the approval of the proposal.
ii. Ensuring the content is based on global evidence.
iii. Collecting and incorporating NMO feedback after the call for input.
iv. Coordinating the discussion during the General Assembly.

Adoption of policies
15.3. A draft policy statement, position paper and the composition of the policy commission must be sent to the NMO mailing list by the proposer and in accordance with paragraph 9.4. Input from NMOs is to be collected between submission of the draft and submission to the General Secretariat.
15.4. The final policy statement and position paper are to be sent in accordance with paragraph 9.4, using the template provided in the call for proposals. The proposal must be co-submitted by two NMOs from different regions or the Team of Officials.
15.5. Policy statements and position papers must be resented to NMOs during the first working day of the IFMSA General Assembly.
15.6. A motion to adopt the policy statements and position papers must be submitted the day before the relevant plenary and submitted by two NMOs from different regions. Adoption requires ⅔ majority.
15.7. Amendments may be sent to the proposer and in accordance with paragraph 9.4. Amendments made during a General Assemblies or after the deadline in accordance with paragraph 9.4, will be voted upon during the relevant plenary and require ⅔ majority.