

SUMMARY RECORDS

FIRST MEETING

Monday, 17 January 2005, at 09:35

Chairman: Mr D.Á. GUNNARSSON (Iceland)

- 1. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA:** Item 1 of the Provisional agenda (Documents EB115/1 and EB115/1 Add.1)

The CHAIRMAN declared open the 115th session of the Executive Board.

- 2. EXPRESSION OF SYMPATHY AND SOLIDARITY WITH PEOPLE AND COUNTRIES SUFFERING AS A RESULT OF THE EARTHQUAKE AND TSUNAMI IN SOUTH ASIA**

At the invitation of the CHAIRMAN, the Board observed a minute of silence in memory of all who had lost their lives in the tragic events in south Asia.

- 3. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA:** Item 1 of the Provisional agenda (resumed)

The CHAIRMAN proposed, following consultations among Board members from the African Region, that Dr Ndong (Gabon) be elected as Rapporteur for the current session, replacing Dr Nyikal (Kenya) who was unable to attend.

It was so agreed.

The CHAIRMAN, turning to the provisional agenda (document EB115/1), said that in view of the large number of items already on the agenda, some of the items proposed by Member States had had to be deferred to the Board's 116th session. Document EB115/1 Add.1 contained a proposal by the United States of America to include, under Rule 10 of the Rules of Procedure of the Executive Board, a supplementary agenda item of an urgent nature on influenza pandemic preparedness and response. If the Board so agreed, the item would be considered under agenda item 4, Technical and health matters.

Dr ANTEZANA ARANÍBAR (Bolivia) suggested, in the light of that proposal, that discussion of agenda item 5, Programme and budget matters, be brought forward so that the objectives and strategies decided on could be borne in mind when considering item 4.

Dr THAKSAPON THAMARANGSI (adviser to Dr Suwit Wibulpolprasert, Thailand) supported the proposal for the supplementary agenda item, in view of the increasing burden of new and emerging infectious diseases, including avian influenza and severe acute respiratory syndrome (SARS). Improvement of epidemiological surveillance systems was urgently needed to allow rapid

identification and prompt control of any outbreak, given the strong possibility of a genetic reassortment of avian and human influenza viruses during epidemics.

The CHAIRMAN said that, in the absence of any further comments, he took it that the inclusion of the supplementary agenda item was acceptable.

The agenda, as amended, was adopted.¹

4. ORGANIZATION OF WORK

In view of the interest expressed by Member States in assessing the effects of the recent tsunami in south Asia and WHO's response to it, the CHAIRMAN proposed that subitem 4.3, Responding to health aspects of crises, should be taken up as the first subitem under item 4, Technical and health matters. Further timetable adjustments might have to be made later on in line with the Board's deliberations and daily developments. Referring to the proposal by the member for Bolivia, he suggested that, since such a change would inconvenience several members of the Board whose experts on budget issues were not due to attend the session until later in the week, the Board might agree to holding a short discussion on the budget immediately after discussion of agenda item 3, Report of the Programme, Budget and Administration Committee.

He took it that the proposed changes were acceptable.

It was so agreed.

The CHAIRMAN pointed out that in compliance with Rule 7 of the Rules of Procedure of the Executive Board, subitems 7.1 and 7.2, concerning appointments of Regional Directors, would be considered in an open meeting. He proposed that, as in the Board's 113th session, the reports of the awards Selection Panels should be considered and recipients of the awards be determined in public session, under subitem 7.5, Reports of the foundation committees. The reports of the Selection Panels for the prizes to be awarded in 2005 would continue to be circulated as restricted documents to Board members. Should a member of the Board feel that the proposals in those reports should be considered in a forum other than a public meeting, a proposal to change the nature of the meeting could be made and considered by the Board at the opening of the item.

He took it that the Board agreed to those proposals.

It was so agreed.

(For continuation of the discussion, see the summary record of the second meeting, section 1.)

5. REPORT BY THE DIRECTOR-GENERAL: Item 2 of the Agenda (Document EB115/2)

The DIRECTOR-GENERAL said that the tsunami disaster had devastated countries bordering the Indian Ocean and had claimed the lives of more than 160 000 people. While the world's attention had been focused on the countries most badly hit, it should not be forgotten that communities much further away had also been affected.

¹ See page ix.

During his recent visit to Indonesia and Sri Lanka, he had been impressed by the work being done by the surviving local health workers in caring for the many thousands of injured people, and by survivors already rebuilding their homes and communities.

Much had been achieved through the massive international and national relief effort. An early warning and control system for epidemics had been set up, and no outbreaks had yet been reported. Assessments of health services, which would also help to determine reconstruction needs, were being carried out in the affected areas. Health system supply chains were being restored and public health services re-established. WHO was establishing ways of meeting the immediate and longer-term mental health needs of the survivors, their families and carers, and was also supporting national authorities in coordinating the work of those responding to the disaster, namely, local and national staff and health workers with intergovernmental and nongovernmental agencies.

He interrupted his speech for a video conference with Dr Rob Holden, Operations Manager for the South Asia Crisis Assessment Team; Dr Wayan Widaya, Communicable Disease Specialist, Centre of Diseases Control Research and Development, Indonesia; Rear-Admiral Crowder, Commander, Naval Forces of the Combined Support Forces; Dr Eigil Sorensen, Special WHO Representative for Disaster Relief and Coordination in Indonesia; and Dr Georg Petersen, WHO Representative, Indonesia, who described their work in supporting the health and rehabilitation needs of the victims of the disaster.

Resuming his address, he confirmed that the emergency phase was rapidly becoming one of rehabilitation and self-reliance. The long-term aim was to ensure that people were protected from health threats by an effective global system of alert and response. The transition from relief to reconstruction had to be given sustained support to ensure that communities did not languish for many years in a state of dependence, with high levels of disease and mortality, as rebuilding the physical infrastructure might take several years. It would also be essential to invest in people, as thousands of health workers and other public service employees had been killed.

The disaster had seriously set back the social, economic and health development gains of recent years within the region. It was imperative that both immediate and long-term needs were met and that international support was adequate, effective and sustained, but such support must be led and coordinated by the affected countries themselves.

Of the US\$ 67 million requested the previous week by WHO as part of the United Nations Flash Appeal, two thirds had already been pledged. The generous international response to the disaster and the resilience shown at local and national levels gave hope for rapid recovery and reconstruction. It was essential, however, that the resources pledged were used effectively, without reducing support for other areas of need in the world. The launch by the United Nations of "A practical plan to achieve the Millennium Development Goals", which showed the investment needed to reach those goals by 2015, would help to maintain the momentum of those global efforts. To mark the launch of that plan, an event focusing on its health components would be held at WHO headquarters the following day.

The world's response to the tsunami emergency had shown the willingness of governments and the public to support communities that were suddenly afflicted by disaster. The United Nations and its specialized agencies had been established as a result of a similarly clear view of global need and of the decision to meet it with an effective, long-term system of support and cooperation. The recently released report of the United Nations Secretary-General's High-Level Panel on Threats, Challenges and Change underlined WHO's indispensable role in ensuring international security. Its invitation to the Health Assembly to consider the recommendation that it increase resources for global monitoring and response to emerging infectious disease signalled the importance of ensuring that WHO had an adequate regular budget in future bienniums.

The demand for global public health activities, against both infectious and noncommunicable diseases, had grown rapidly in recent years. The danger of a pandemic, for example of SARS, avian influenza or influenza, required rapid response systems to be in place. The need to tackle the social determinants of health was also increasingly apparent. All of that was in addition to the need to be prepared for unforeseeable disasters, such as the tsunami in south Asia.

Those were just some of the concerns of Member States that were reflected in the Proposed programme budget for 2006-2007 which recommended an overall increase of 12.8%; the proposed increase in the regular budget component was 9%. The Proposed programme budget also included measures to reduce costs by increasing efficiency and accountability. The goodwill represented by voluntary funding, which had continued to be a major resource for WHO, was much appreciated but an increase in assessed contributions was nevertheless being proposed to enable the Organization to fulfil its triple obligation to act decisively, consistently and impartially.

World Health Day 2005 had as its theme "Make every mother and child count". Every year, more than 10 million children died, 40% of them in the first month of life, and half a million women died from pregnancy-related causes. Nearly all those deaths, which could be greatly reduced if the resources needed to attain the Millennium Development Goals were made available, occurred in developing countries. Tackling that problem would be a major focus of work in 2005.

The WHO Commission on Intellectual Property Rights, Innovation and Public Health would complete its work and submit its report during 2006, and the WHO Commission on Social Determinants of Health would be launched in Santiago in March 2005. Human resources for health development would be a major focus of work during 2005 and would constitute the theme of *The world health report 2006* and World Health Day 2006.

With unprecedented attention on health needs, WHO had not only to respond rapidly to emergencies, but also to maintain prevention and control work. To meet those obligations, it had to evolve to reflect the world's changing health situation.

The CHAIRMAN observed that WHO's rapid response to the tsunami disaster showed how important it was to have a strong Organization that could respond to such emergencies as quickly as possible.

It was so agreed.

6. TECHNICAL AND HEALTH MATTERS: Item 4 of the Agenda

Responding to health aspects of crises: Item 4.3 of the Agenda (Document EB115/6)

The CHAIRMAN invited the Regional Director for South-East Asia to take the floor before the Secretariat briefed the Board on the current situation with a view to discussion of WHO's work in general.

Dr SAMLEE PLIANBANGCHANG (Regional Director for South-East Asia) said that the events of 26 December 2004, the brunt of which had been borne by countries of his Region, would remain forever in the world's memory. The countries least affected had been Bangladesh and Myanmar, but India, Indonesia, Maldives, Sri Lanka and Thailand had been hard hit. To respond to the crisis, a tsunami task force and operations room had been established and were working around the clock. The task force was acting in close coordination with headquarters and the various countries affected in monitoring public health conditions, mobilizing resources and coordinating information. A Regional Office web site, established on the second day, provided situation reports and access to a range of key guidelines for emergency management. Coordination was enhanced by daily teleconferences between the affected countries, headquarters and the Regional Office. In addition, satellite communication had been established with Aceh, Indonesia, Maldives and Sri Lanka, and WHO operational units were being established in Indonesia and Sri Lanka.

In the early stages, priority had been given to the provision of technical advice. WHO emergency staff and field staff from other programmes had been deployed in the affected areas. Vital medical supplies had been provided. WHO had also responded speedily to a request for technical

advice and guidance to tackle the psychosocial consequences. The Regional Office's main task, however, had become coordination with other international agencies in assessing health infrastructure damage, restoring basic health services and advising on rehabilitation plans. A tsunami health bulletin would be issued regularly, and a strategy for health action during the first 100 days was in place, focused on five key areas: disease surveillance and response, including early warning systems; coordination of health activities in relief operations; access to essential health care; provision of technical guidance on critical public health issues and improved routine health services; and coordination of efforts to restore medical supply chains.

To respond to the affected countries' immediate needs, WHO had mobilized more than 60 professional staff to work in Indonesia, 20 in Maldives, 50 in Sri Lanka and 27 in Thailand. In addition, epidemiologists and other experts were on standby to be deployed as and when required. Additional supplies and equipment, such as a mobile laboratory, had also been made available, with the support of many countries.

Teams of senior staff would visit the affected countries in order to ensure efficiency of work, provide on-the-spot assessment and ensure coordination among WHO staff and those of other international agencies. The use of financial resources would also be closely monitored to ensure transparency and accountability. A rehabilitation strategy plan had also been developed and would be implemented, as the second phase was entered, in close consultation with the World Bank and other key partners.

Most of WHO's efforts, although impressive, were modest compared to the response from many countries. The scale of the catastrophe was beyond any single organization's capacity to cope with alone, and the contribution of all participants was greatly appreciated. Never before, however, had the United Nations system demonstrated the ability to react to a crisis with such unity, professionalism and speed. The response had been unprecedented. He thanked the Director-General and all Regional Directors for their sympathy, concern and solidarity in helping the South-East Asia Region through such a difficult time.

Every disaster presented an opportunity to enhance emergency preparedness capacity. WHO's efforts, therefore, should also be aimed at helping to rebuild and strengthen the health infrastructure that existed before the tsunami struck. The challenge was immense, but he was convinced that the efforts would succeed and thus promote long-lasting benefits.

The CHAIRMAN expressed the Board's appreciation of the regional efforts, and wondered whether there was any action that the Board itself could take to help.

Dr SAMLEE PLIANBANGCHANG (Regional Director for South-East Asia) said that further enhancing global solidarity could undoubtedly help. It was of the utmost importance to support all efforts in the field through the mobilization of human resources, supplies and equipment. The second phase would provide a good opportunity to enhance the capacities of individual countries, and to make them sustainable.

Dr NABARRO (Representative of the Director-General for Health Action in Crises), summarizing cooperation with other agencies and countries and WHO's ongoing response to humanitarian crises everywhere, said that WHO's involvement was essential in all crises because, whatever the causes, there were always substantial numbers of people whose health was threatened by resultant sickness as well as by the event itself. It provided guidance and expertise through staff on the spot, headquarters, regional offices and collaborating centres. Its advice was increasingly sought through the Internet as well as in global and local media.

The destruction in Aceh, Indonesia, and elsewhere in the region had been immense. More than 160 000 people had been killed and millions more had been affected; vital water, food, care and sanitation services had been disrupted; and many areas remained inaccessible even three weeks after the event. Health workers had been among the first to respond to the disaster, focusing on the most vulnerable groups and giving priority to protecting life and providing clean water and sanitation, while

devoting attention to hygiene and a healthy environment. Efforts had been made at all times to keep families together and to help communities. A wide range of countries had been affected, with loss of life and other grave consequences, and deaths among people from many other parts of the world present in the region at the time.

As the scale of the emergency became clear, WHO had begun to coordinate the relief offered by various groups: for example, within a few hours of the disaster its staff in Sri Lanka had been helping to provide life-saving care, move supplies from warehouses, assess needs, supply public-health expertise and coordinate assistance. Some 120 members of staff in the region had been deployed to support those who were having to cope with the crisis. Medical supplies for more than two million people had been delivered, together with one million cholera kits, and suboffices with functioning telecommunications had been established in the affected communities, despite sometimes dire weather conditions. Thanks to the generosity of Member States and the willingness of the Director-General to release funds from the reserves, money had reached countries within days. Progress was being assessed daily, communicable diseases early-warning surveillance systems were already some 75% operational, and 70% of public health strategies were in place. The greatest success, however, had been achieved in coordinating health actions. Staff had teamed up with national health ministries, the World Bank and the Asian Development Bank to ensure that health-sector issues were properly taken into account during repair and rehabilitation, above all in India, Indonesia, Maldives, Sri Lanka and Thailand.

Although the initial response had been rapid, it had sometimes been hampered by logistical complications. However, the Strategic Health Information Centre in Geneva and the operations room set up at the Regional Office for South-East Asia had permitted close cooperation between all concerned, and the recently established operational platforms were currently making it possible to work effectively in each country. All WHO regions had provided staff and expertise. All departments at headquarters and in the Regional Office for South-East Asia had offered administrative and technical support, and many members of staff had foregone annual leave in order to volunteer for the relief effort. The communicable diseases response groups, already tested by the SARS crisis, had played a key role, and the Global Outbreak Alert and Response Network, which drew on professionals in many Member States, had been activated, with good effect.

The pattern of WHO support differed from country to country. The Indian Government had responded rapidly to the dramatic impact of the tsunami on the southern and eastern coasts of the country and on the Nicobar and Andaman Islands, where injured survivors had required medical treatment. Priority had been given to safe drinking-water, sanitation, infrastructure and hygiene, and the existing disease surveillance network had been strengthened. The Government had provided substantial assistance to neighbouring countries, and had worked closely within the framework of existing partnerships with WHO and UNICEF to prioritize mental health, disease surveillance and measles immunization.

In Indonesia, the massive destruction of infrastructure meant that assessments were still being carried out, and pockets of people in need were still being found. Half the health staff were reportedly dead or missing. Tetanus cases had been reported, and there was a risk of malaria, diarrhoea and dengue fever. Cooperation between the civil and military authorities was exemplary and the quality of supply systems was being improved by tailoring responses to meet assessed needs. The systematic assessments being undertaken in conjunction with military personnel and with the USS *Abraham Lincoln* as a base, were yielding extremely useful reports, which were being posted immediately on web sites.

Malaysia and Myanmar had both suffered significant casualties and had been working with WHO to respond to the catastrophe.

Although the death toll in Maldives had been relatively low, the country's infrastructure had been severely damaged and, unless ports and piers were repaired quickly, the long-term impact on its economy, social services and government was likely to be substantial. Communicable disease threats were being investigated with care. There was a shortage of drinking-water, but disease surveillance had been established and health facility assessments were being conducted.

In Somalia, where 30 000 people had been affected, 4000 displaced and more than 150 people had died, WHO had worked jointly with the Ministry of Health to collect surveillance data, measure disease, assess needs, distribute emergency health kits, coordinate the health sector and send in emergency response teams.

In Sri Lanka, where a narrow coastal belt had been devastated, assistance to displaced persons had been prompt. A disease surveillance system had been launched. There had been no significant outbreak of diarrhoeal or other serious diseases. All the hospitals were currently functioning, and repair work was under way.

In the six disaster-stricken provinces on the west coast of Thailand, the first, most pressing need had been to ensure safe drinking-water, sanitation and hygiene facilities for displaced people and to identify the dead. The Thai Government had quickly ensured that disease surveillance was in place and there had in fact been no outbreaks of disease. A major programme of mental health and psychological support had been initiated, and rapid action taken to rehabilitate fishing and other communities in the affected region.

Discussions with communities on the ground had indicated that there would be need to look beyond emergency relief and to help rebuild lives, livelihoods, and governmental and social service infrastructures. For that reason, the relief endeavour must underpin recovery and the reconstruction of health systems, as well as economic repair. At the same time, it would be vital to strengthen local capacity for preparedness and response, so that no natural disaster could ever again wreak such havoc.

The Secretariat, a major contributor to the coordinated efforts of United Nations bodies, had sought at all times to liaise closely with Member States. It had relied heavily on close cooperation with both the civil and military authorities of the affected countries and those of Australia, France, Germany, Singapore and the United States of America. It was already involved in repair and reconstruction, and in the coming months would be turning its attention to the recovery of vital systems. The capacity to contain outbreaks already existed and a major epidemic was therefore unlikely.

The tsunami response would have implications for future efforts to improve performance in crisis situations, which were currently affecting some 40 Member States, chiefly as a result of long-term conflict. Even before the tsunami, the Secretariat had been busier than ever responding to the needs of communities suffering from conflict and natural disaster, and had introduced a strategy for scaling up action by raising fresh resources from Member States and engaging all parts of the Organization in a performance improvement programme.

In helping Member States prepare for, and respond to crises, WHO had four core functions: assessing health status, coordinating action, filling gaps and strengthening local systems and capacities. Thanks to the experience gained, in three years' time its response to crises should be more competent and sensitive, with better cooperation with other United Nations agencies and key partners, and upgraded and effective administrative procedures. In turn, enhanced effectiveness would make the Organization better equipped to meet the challenges of HIV/AIDS and to deal with issues of gender, women's health, mental health and health systems in communities at risk because of crises, to promote post-conflict recovery and to facilitate attainment of the Millennium Development Goals by countries with fragile economies and systems of governance.

Dr YOOSUF (Maldives) said that his country consisted of 1200 small islands, 200 of them inhabited, with a population of only 280 000 people. The tsunami had devastated the whole country. The country's poverty had made it more difficult to respond adequately to the crisis. There was very little safe drinking-water and most of the topsoil had been washed away, destroying the country's agriculture. Some 15 000 people had been made homeless. Fishing boats and harbour facilities had been destroyed, and in any case the fishermen were too busy rebuilding their homes to go fishing. The tourist industry had been badly affected: 25% of tourist resorts were still closed, and bookings were down because people did not wish to visit a disaster zone, or feared the possible health risks. The impact on the country's three main sources of income – tourism, fishing and agriculture – would affect the people's nutritional status for a long time to come. Many survivors, particularly children, needed

psychosocial support, which was being provided by nongovernmental organizations and intergovernmental agencies.

What lessons could be learnt from the disaster? The first was that WHO could not respond to such a situation alone: many other partners, national and international, civil and military, must be involved. Protocols and procedures must be established for the various partners to follow, so that the number of lives lost could be minimized and reconstruction more effectively organized.

There was currently no early-warning system for natural disasters in southern Asia. The tsunami had struck Sri Lanka a full hour before it reached Maldives, but it had not been possible to issue a warning. WHO's Strategic Health Information Centre, with its potential for round-the-clock surveillance at headquarters and constant contact with the regional offices, might usefully be adapted to take on that responsibility.

He thanked WHO, the International Federation of Red Cross and Red Crescent Societies and United Nations, intergovernmental and bilateral agencies for their goodwill and relief efforts, and hoped for their continued support. However, offers of personnel, equipment and medicines must be properly coordinated. With the assistance of the international community, his country hoped to regain as soon as possible the level of development it had enjoyed before the tsunami.

Dr AL-SAIF (alternate to Dr Al-Jarallah, Kuwait) agreed that a round-the-clock operations room was required to coordinate health needs, particularly in the case of natural disasters. Later that day, his Minister of Health would present a cheque for US\$ 500 000 to the Director-General as a contribution to the financing of the Strategic Health Information Centre.

Dr PHOOKO (Lesotho), speaking on behalf of the African group, also commended the response of WHO and other international organizations to the disaster. The most vulnerable groups, particularly women and children, had been the worst affected, and he emphasized the need to guard against exploitation and trafficking of members of such groups at times of crisis.

The African Region, with the largest number of least developed countries of all regions, suffered from constant crises, both natural and man-made. Famine in Eritrea and Ethiopia; armed conflict in Central African Republic, Democratic Republic of Congo, Liberia, and Sudan; outbreaks of disease and locust infestations were just a few examples. Thousands of lives were lost in Africa every day from those and other causes, including complications of pregnancy and childbirth, HIV/AIDS, malaria, tuberculosis and noncommunicable diseases, compounded by poverty and underdevelopment. He applauded the global commitment to and solidarity with the disaster in south Asia, but urged the international community not to forget Africa.

There was an urgent need for early-warning systems to counter the effects of natural disasters. The health sector must improve its global disease outbreak preparedness and response system. The current revision of the International Health Regulations was none too soon.

Dr HANSEN-KOENIG (Luxembourg), speaking on behalf of the Member States of the European Union and the candidate countries, Romania and Turkey, said that the health threats facing the thousands of people displaced and made homeless after the tsunami made the work of WHO highly topical. The Organization's effective and rapid response to the disaster, the availability of its staff and the relevance of the analyses undertaken were to be commended.

There had been an unprecedented show of solidarity by the European Union in the wake of the disaster: Member States had provided €1500 million of public aid, and civil society, too, had made an exceptional financial commitment. The European Union had involved WHO in its crisis planning, and appreciated the coordination that had resulted and the quality of WHO's cooperation, including its participation in the meeting of the Council of the European Union on the disaster (Brussels, 7 January 2005). It was more important than ever for WHO to have the institutional capacity to mobilize, centralize and act in such crisis situations. Despite the unprecedented humanitarian response, it should not be forgotten that long-term rehabilitation and reconstruction would be a major challenge for the international community, but that should not eclipse other humanitarian needs elsewhere in the world.

Although the first responsibility to the survivors was to provide assistance and to give hope, the international community still had an obligation to consider ways of preventing the consequences of natural disasters, including health-related consequences. At the imminent World Conference on Disaster Reduction (Kobe, Hyogo, Japan, 18-22 January 2005) the European Union would be supporting the strengthening of measures for prevention, early warning and disaster preparedness in coordination with the United Nations. It was also studying possibilities for the development of a rapid response capacity of its own, which would have both a medical and a social dimension.

Natural disasters were most devastating in poorer countries with lower levels of health, since HIV/AIDS, tuberculosis, malaria and other threats to health made populations more susceptible. Raising the health status of populations would thus not only achieve WHO's primary objective, but would constitute a significant step towards making nations and communities more able to resist the potential detrimental effects on health of crisis situations.

Professor CİNTEZA (Romania) said that his Government had provided about €400 000 worth of aid to different countries affected by the tsunami. A forthcoming challenge was to help those countries to plan for long-term reconstruction and to prepare for disasters, and Romania supported initiatives such as the World Conference on Disaster Reduction.

He welcomed the three-year programme aimed at enhancing WHO performance in crises, which was a global framework for action and a unified work plan, and emphasized the importance of the forum on health action in crises, which would provide Member States with information on progress and developments with respect to work in crisis and disaster situations. If WHO was to meet the health needs of all populations in disaster and crisis situations it should be given the basic tools to do so. It should not be forgotten that there were many other vulnerable people in crisis situations, including women and children, the elderly, and people suffering from acute trauma, chronic illnesses, mental health problems or disabilities.

He called on the Director-General to ensure the necessary technical support for the health elements of national disaster preparedness and response systems; mobilize adequate resources for the Emergency preparedness and response area of work; streamline the administrative, financing and personnel procedures; and mobilize additional resources to maintain WHO's improved performance.

Dr ACHARYA (Nepal) expressed his deepest sympathy to those affected by the tsunami, and commended WHO's work, particularly that carried out under the leadership of the Regional Director for South-East Asia. He hoped that immediate problems such as water and sanitation, control of epidemics, psychological after-effects and long-term rehabilitation would be dealt with successfully.

Dr YIN Li (China) said that WHO's extremely rapid response to the tsunami disaster proved that the Organization was indispensable, since its role in disease control and prevention in the disaster-stricken areas could not have been undertaken by any other international organization.

The Chinese Government had provided 500 million renminbi to disaster-stricken countries and 20 million for relief operations. It had also dispatched five health and DNA testing teams to Indonesia, Sri Lanka and Thailand. He himself had visited four of the countries affected by the tsunami, and believed that WHO should play a leadership and coordinating role in all disaster relief and disease prevention efforts. For the future, WHO's goal should be to strengthen emergency preparedness and response capacity, and create greater global awareness of the need for international cooperation in dealing with public health problems.

(For adoption of the resolution, see summary record of the twelfth meeting, section 1.)

The meeting rose at 12:30.