

SEVENTH MEETING

Monday, 27 May 2013, at 14:30

Chairman: Mrs K. TYSON (United Kingdom of Great Britain and Northern Ireland)

- 1. PROGRESS REPORTS:** Item 18 of the Agenda (Documents A66/27 and A66/27 Add.1)
(continued)

Preparedness, surveillance and response

- D. Strengthening national health emergency and disaster management capacities and the resilience of health systems (resolution WHA64.10)**

Mr DEMIRALP (Turkey) commended the work that had been carried out under the WHO Emergency Response Framework over the previous 12 months. Through its work as the lead agency of the Health Cluster of the Inter-Agency Standing Committee and, with the cooperation of Member States, WHO would be strengthening its capacity and building on its experience within the Framework. Turkey endorsed the Organization's non-political approach to humanitarian and health situations arising from large-scale human rights violations, and encouraged it to continue to limit its scope to ensuring the conditions for a healthy life.

The situation in the Syrian Arab Republic had been categorized by the United Nations as a Level 3 emergency and merited special attention. The WHO report on health conditions in the country (document A66/27 Add.1) was particularly important as it was the first presented to the Health Assembly since the start of the crisis. The Secretariat should prepare regular progress reports, in which the unique nature of the Syrian conflict should be acknowledged, in order to draw the international community's attention to the country's deteriorating humanitarian situation and to provide objective information, including WHO's response to the challenge of humanitarian access and its geographical coverage of the country; the specific needs of the country's populations; and WHO's relations with the Syrian opposition, in particular its cooperation with the Assistance Coordination Unit of the Syrian National Coalition for Syrian Revolutionary and Opposition Forces.

Mr BOUGACHA (Tunisia) commended the efforts made by WHO, its field structures and its partners, as well as by neighbouring countries and United Nations organizations, to deliver a wide range of health care services to Syrians, both inside and outside the Syrian Arab Republic, and to cope with the significant shortage of medical teams and supplies. WHO had played a pioneering role as the Health Cluster lead agency, and he urged it to intensify its efforts. He also requested Member States to refrain from politicizing WHO's involvement in the Syrian crisis to avoid hindering the delivery of assistance or endangering those working in the field.

The Organization's interventions in Mali were satisfactory and its support for the health sector, including the supply of medicines, should continue on the basis of needs estimates. As to the situation in the Central African Republic, WHO was playing a valuable role in coordinating collaboration with the Ministry of Health in order to restore the disease surveillance system, establish a rapid response mechanism and resume immunization services. Such health care efforts must be pursued.

Ms LANTERI (Monaco) thanked WHO and its staff for their work in what were sometimes extremely hazardous circumstances. It would be particularly appropriate, in the context of WHO reform and the implementation of the Emergency Response Framework, for the Secretariat to report to

the Executive Board and the Health Assembly on the humanitarian operations being conducted by WHO under its mandate as Health Cluster lead agency. In response to the conflict in Mali, her country was providing food aid to more than 1000 displaced families and carrying out various health projects, while remaining attuned to changes in the situation and in people's needs. With regard to the Syrian Arab Republic, Monaco was profoundly concerned about the deterioration in sanitary conditions and access to water. It vigorously condemned the deliberate and repeated attacks on medical personnel; medical and humanitarian personnel must have full, immediate and unrestricted access to people, in complete security and without any discrimination, in order to meet health needs. The efforts made by the authorities and populations of neighbouring countries to host refugees and meet their needs were commendable.

Dr AL-THANI (Qatar) commended WHO's multi-pronged approach to providing Syrian citizens greater access to health services and its efforts to develop an essential medicines list in order to alleviate the acute shortage of medicines and supplies in the interior of the country. The health infrastructure in the Syrian Arab Republic had collapsed, yet the Government continued to block access to various locations that were in need of medical assistance.

He condemned the embargo imposed on Qusair and the killings of civilians, including women and children, by the Government, which must be reminded of its obligations under international humanitarian law, and of the need to ensure that health workers had access to the injured. The health services provided by WHO and other humanitarian organizations were inadequate in the face of growing needs and the restrictions imposed on humanitarian workers generally. Cooperation with the Assistance Coordination Unit of the National Coalition for Syrian Revolutionary and Opposition Forces was thus essential to ensuring service delivery to the largest possible number.

The high numbers of Syrian refugees in neighbouring countries had led to the disintegration of health facilities. WHO and other humanitarian organizations were therefore urged to increase support to enable those countries to meet vital health needs. Qatar was fully committed to standing by the Syrian people, and had launched a fourth phase of humanitarian assistance; funding of US\$ 25 million would be provided for the inhabitants of Syrian refugee camps in Lebanon, where it had also established a public health centre for treating emergency patients.

Ms GOLBERG (Canada) said that the Emergency Response Framework, which had been applied to a large number of humanitarian crises over the previous 12 months, had proved to be an important means of identifying and prioritizing health interventions to save lives when emergencies arose, and she endorsed the Organization's plan to strengthen it further. By improving coordination, supporting enhanced United Nations leadership and strengthening accountability to those in need, WHO would ensure that its emergency interventions were more efficient and effective. With respect to the situation in the Syrian Arab Republic, she commended WHO's efforts to ensure access to medical services under difficult circumstances, and urged all parties to the conflict to respect international humanitarian law. She endorsed the Organization's call for all those concerned to protect the neutrality of health workers, facilities and services, and for health workers to deliver services in an impartial and ethical manner. A key opportunity for coordination and exchange of information between WHO and its partners was provided by the Health Care in Danger project, implemented by the International Committee of the Red Cross in order to determine where violations against health care workers and facilities were taking place.

Mr CORR (Ireland), speaking on behalf of the European Union and its Member States, pointed out that the situations in Mali, the Central African Republic and the Syrian Arab Republic were all complex but differed in nature and scale. The European Union was appalled by the dire humanitarian and health situation in the Syrian Arab Republic and by its impact on neighbouring countries, which had generously taken in so many refugees. In particular, it deemed unacceptable the fact that medical personnel, health facilities and vehicles were being deliberately targeted in acts that might amount to war crimes, the prime responsibility for which lay, as had been established by various United Nations

reports, with the Syrian authorities. He therefore called on all parties to the conflict to respect international humanitarian law, and stressed the urgent need for them, in particular the Government of the Syrian Arab Republic, to remove all obstacles to the delivery of humanitarian assistance. The European Union was committed to remaining a leading donor of such assistance. It fully supported WHO's role as Health Cluster lead agency and urged it to continue monitoring the situation in the Syrian Arab Republic and provide a comprehensive update on it and other such crises to the Sixty-seventh World Health Assembly through progress reports.

In response to the situation in Mali, the European Union called for basic services to be restored, for humanitarian organizations to have unimpeded access to the most vulnerable populations, and for international humanitarian law and human rights to be respected. It was nevertheless encouraged by the positive outcome of the recent high-level donor conference for development in Mali and would make every effort to support humanitarian relief and build resilience. It was equally concerned by the situation in the Central African Republic and called on the transitional authorities and all other parties to work together to restore public services and meet the basic needs of the population, and to respect international humanitarian law.

Professor HALTON (Australia) said that lack of protection for those providing and receiving health care in situations of armed conflict was a global problem. Her own country had therefore become a key partner in the Health Care in Danger project, which aimed to strengthen health care protection in armed conflicts. Australia, deeply concerned at the scale of the crisis in the Syrian Arab Republic, and its impact on health services, was working to ensure, as a priority, access to essential medicines, and full protection and access for medical workers, supplies and facilities. It had contributed nearly 80 million Australian dollars for humanitarian assistance both within and outside the country, nearly one third of which had been allocated to health care support. It had also endorsed the February 2013 Common Statement on Access to Medical Care in Syria, which called on all parties to the conflict to respect the rules of international humanitarian law. The serious and growing refugee crisis in neighbouring countries was putting a strain on their health systems and called for greater international assistance. However, United Nations appeals remained underfunded, and she therefore urged all partners to honour the pledges made at the International Humanitarian Pledging Conference for Syria held in Kuwait in January 2013.

Mr NIEMTCHINOW (France) said that the situations in Mali, the Central African Republic and the Syrian Arab Republic were extremely complex but in no way comparable. The humanitarian crisis in the Syrian Arab Republic was alarming in nature and scope, with the authorities in Damascus flouting the basic principles of international humanitarian law. Their deliberate targeting of physicians, hospitals and health centres constituted war crimes and had been denounced in several United Nations reports. The health system was on the verge of collapse, the epidemiological situation was deteriorating dangerously quickly and people were afraid to attend health facilities. He commended the Organization's efforts to provide health care to the Syrian people, and encouraged it to continue doing so. He also urged it to monitor the situation in the Syrian Arab Republic closely and report thereon to the Sixty-seventh World Health Assembly. The Health Assembly must call upon the Syrian authorities to respect and ensure the security of medical personnel and health care centres.

With regard to the situation in Mali, a recent donor conference for development had mobilized US\$ 3.2 million and pledges had been made to resume the country's development programmes, which should make it possible to restore health services in Mali to an adequate level. Those commitments had sent a message of hope to the entire population. France was particularly alarmed by the health care crisis in the Central African Republic, however, and called on the international community to come to its aid.

Dr TRAORE (Mali), speaking on behalf of the Member States of the African Region, said that, despite being frequently obliged to operate under difficult social and political circumstances, the Region's countries had made progress towards strengthening their capacity to manage health

emergencies and disasters. In 2012, the Regional Committee for Africa had adopted resolution AFR/RC62/6 on disaster risk management: a health sector strategy. Five regional economic communities in Africa had adopted risk prevention policies or strategies based on the priorities set out in the Hyogo Framework for Action 2005–2015. In addition, several countries had established epidemic or disaster funds and emergency health services. However, owing essentially to financial constraints, Africa had not yet fully attained its objectives in that regard.

The Member States of the African Region called on all stakeholders to step up their post-crisis reconstruction efforts in the Central African Republic and Mali and requested them to provide the technical, financial and material support needed to strengthen the resilience of the Region's health systems, a necessary step towards attainment of the Millennium Development Goals.

Ms STIRØ (Norway) commended WHO's response to the health care emergency in the Syrian Arab Republic and encouraged it to pursue its efforts to gain access to all parts of the country and to expand its cross-line operations. The Organization's success in forming partnerships with a network of local nongovernmental organizations at an early stage in the conflict had made it one of the most efficient United Nations organizations in terms of operational outreach, and less dependent on the Syrian Arab Red Crescent, whose capacity was stretched to the limit. That had also enabled it to act promptly in providing cross-line humanitarian assistance in areas that had previously been inaccessible to the United Nations, especially in the north of the country. Her country had been providing WHO with funding earmarked for health sector and sanitation operations in the Syrian Arab Republic, and had recently extended its funding agreement.

Mr MULREAN (United States of America) fully supported the work being done by WHO and other organizations to address health needs in Mali and the Central African Republic and the Syrian Arab Republic.

He expressed profound concern about the health crisis in the Syrian Arab Republic, which had been classified as a Level 3 emergency. Medical facilities and staff were being deliberately targeted, public health was at grave risk, and humanitarian organizations were facing dire conditions or being refused access. Neighbouring countries, which were providing the majority of health services to Syrian refugees, also faced difficult challenges. In the case of Jordan, the majority of Syrian refugees were not in camps and were therefore beyond the reach of the Office of the United Nations High Commissioner for Refugees, thus overburdening the country's health system.

The United States of America was providing humanitarian support both inside the Syrian Arab Republic and in neighbouring countries. With funding from his country, WHO was working to strengthen and expand the Syrian Arab Republic's early warning and response system for epidemic threats. The United States of America was also providing support to the Assistance Coordination Unit of the Syrian National Coalition for Syrian Revolutionary and Opposition Forces with early warning and disease surveillance activities.

In addition to its humanitarian efforts, WHO was actively supporting the United Nations Secretary-General's team investigating the possible use of chemical weapons in the Syrian Arab Republic. The international community had made it clear that all violations of international humanitarian law in the Syrian Arab Republic were unacceptable, and he called on all parties to protect medical personnel, facilities and transport systems, to ensure unimpeded and non-discriminatory access to those in need of assistance, and to respect their obligations to ensure humanitarian access and assistance in the Syrian Arab Republic. Those activities were urgently required and were independent of the political conflict.

Dr AMMAR (Lebanon) said that Lebanon had witnessed a massive influx of displaced persons since the beginning of the Syrian conflict. The first wave of arrivals had been rapidly integrated into Lebanese households, which had generously shared shelter and food, but host family capacity had been exceeded, and several camps had recently been set up, albeit with very poor sanitary and hygiene conditions. Primary health care services were being provided to displaced persons without any

discrimination, overstretching the Lebanese supply system and leading to periodic shortages of vaccines and medicines. The early warning system had been strengthened to deal with the threat of epidemics, and national immunization campaigns had been conducted throughout the country. However, communicable diseases were on the rise and there was an urgent need to improve water quality and sanitary conditions. Lebanon urged the Organization to play a more active role in fundraising and assistance on the ground. The WHO country office in Lebanon should be given the support it needed to lead the Lebanon Crisis Health Cluster in conjunction with the country's Ministry of Health.

Mr USTINOV (Russian Federation) said that the Secretariat's response to the grave situation in the Syrian Arab Republic was appropriate and timely; the use of a multi-pronged approach had enabled it to improve access to health services and essential medicines for the affected population. His country condemned any politicization of the debate on strengthening national health emergency and disaster management capacities, and refused to be drawn into the present political discussion, despite disagreeing with the viewpoints of several countries. Humanitarian assistance must be governed by the principles of neutrality, impartiality, humanity and independence, as well as respect for territorial integrity and sovereignty, as set out in the Charter of the United Nations and the relevant United Nations resolutions.

Dr AFZAL (Pakistan) said that her country's vulnerability to natural and man-made disasters had prompted it to draw up a national disaster risk management framework and a national disaster risk reduction policy. The national health emergency and response network was active in various fields including coordination and liaison, capacity-building, training, identifying gaps in the health system, ensuring that medicines and medical supplies were available, and developing national guidelines for disaster prevention and surveillance. Pakistan looked forward to additional cooperation with WHO and other international partners in seeking to manage and reduce disaster risk.

Ms PENEVEYRE (Switzerland) said that her country was concerned by the catastrophic impact of deteriorating health systems on people affected by emergency and disaster situations. It was also profoundly concerned about attacks targeting health personnel, facilities and services, and underscored the obligation of all parties to a conflict to comply with the rules of international humanitarian law. She commended WHO's efforts to provide support to the populations concerned, in very difficult circumstances, and deplored the difficulties it encountered in the discharge of its functions.

Dr NICKNAM (Islamic Republic of Iran) said that he was confident that the Health Assembly, in considering the matter of strengthening national health emergency and disaster management capacities, would respect the Organization's Constitution and long-standing practice, and would not allow its prevailing professionalism to be overshadowed by matters that might jeopardize its integrity and efficiency. The Secretariat's efforts to help people on the ground and to attain the principal emergency response goals required support. WHO needed an enabling environment to discharge its functions, and all constraints, including insufficient core financing and rapid response funds, should be eliminated without delay.

Disruption of the health systems in Mali, the Central African Republic and the Syrian Arab Republic was a matter of serious concern, the consequences of which could have long-term adverse effects on population health. There was no excuse for attacks on health workers, facilities and services; such attacks must be categorically condemned by the international community and stopped immediately. Health staff, facilities and equipment, and health care recipients should be protected at all times.

He endorsed WHO's decision to strengthen further, in collaboration with the national governments concerned, its capacity to furnish a rapid response to the needs of emergency-affected populations. Governments must avoid taking any action that violated the independence, sovereignty

and territorial integrity of the countries concerned. The international community should strive to create the conditions under which the populations in those countries could act on their own.

Dr SUKAYRI (Jordan) said that his country's health budget was under immense pressure owing to its efforts to fulfil its obligations to deliver health services to the many refugees from the neighbouring Syrian Arab Republic, in addition to its own citizens. While thanking WHO and other international humanitarian organizations providing health and other services to those refugees, he drew the attention of Member States and donors in particular to the fact that those services were virtually confined to refugees living in camps, who accounted for less than one third of Syrian refugees in Jordan. The Ministry of Health of Jordan was providing services, including the immunization of children under five years of age, to many more refugees outside the camps. Cases of infectious diseases long ago eradicated in Jordan had also emerged and the fear was that further diseases would appear during the summer owing to environmental degradation and water shortages. Citing the principle of burden-sharing, he appealed to donors to provide material and other support to enable the Jordanian Ministry of Health to continue its delivery of health services to Syrian refugees.

Dr WARIDA (Egypt) expressed deep concern over the catastrophic health situation resulting from the Syrian crisis, which had caused many thousands of deaths and injuries and disrupted the country's health system. Egypt was doing its best to provide integrated health services to the Syrian refugees it was hosting. It supported WHO's efforts to deliver health and medical services to the Syrian people, including the war-injured, mothers and children, and those with psychological problems. He called for an end to the attacks on health workers and facilities: their neutrality must be respected and health service delivery must be carried out in an unbiased and ethical manner, in accordance with international humanitarian law.

Ms ISSA (Syrian Arab Republic) said that the apparent attempts to politicize the Syrian situation and divert focus away from its humanitarian dimension were highly regrettable. Her delegation fully rejected the delegation of Turkey's call for WHO to work with a political entity such as the National Coalition's so-called Assistance Coordination Unit, as such action would constitute a violation of the guiding principles for the provision of humanitarian assistance, annexed to United Nations General Assembly resolution 46/182, pursuant to which the affected State had the primary role in overseeing humanitarian operations within its territory. Furthermore, a large quantity of medicines looted from Aleppo had been smuggled into Turkey in flagrant violation of international humanitarian law.

Her delegation likewise rejected all accusations contained in the statements made by the delegates of France, Qatar and the United States of America. Those Member States were directly involved in supporting, financing and training armed terrorist groups, which were thus encouraged to target Syrian hospitals, health centres and pharmaceutical facilities. Atrocious as that situation was, it did not prevent the Government of the Syrian Arab Republic from delivering full health care services, including medicines, to citizens in all regions, without discrimination and free of charge.

Living conditions for Syrian citizens had undeniably deteriorated as a result of the unilateral economic sanctions imposed primarily by the European Union, the United States of America, France, Qatar and Turkey while simultaneously claiming concern for those citizens and their essential needs and denying that they were the target. Those immoral sanctions had had an adverse impact on efforts to meet citizens' needs, in particular medical needs; moreover, relief operations had been so badly affected as to prompt the Government to authorize United Nations organizations to import the oil needed to carry them out.

Certain countries, and member states of the European Union in particular, should bear in mind that, pursuant to United Nations General Assembly resolution 46/182, in providing humanitarian assistance, the sovereignty, territorial integrity and national unity of States must be fully respected. The Government of the Syrian Arab Republic rejected the direct and indirect transfer of assistance across borders on humanitarian pretexts as a violation of that provision. It was cooperating fully with

the United Nations and its humanitarian agencies, offering every facility for the delivery of assistance to all areas, without discrimination, as evidenced by its committed actions on that score. At the same time, however, it refused to countenance any attempted violation of its sovereignty and borders on humanitarian pretexts; nor would it permit any exploitation of the humanitarian suffering of its people by countries seeking to further political agendas through interference in Syrian internal affairs.

The Government of the Syrian Arab Republic would continue to cooperate in providing assistance to its citizens, in compliance with the guiding principles annexed to United Nations General Assembly resolution 46/182.

Mr CARTER (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, commended the work of WHO and its partners in strengthening national health emergency and disaster management capacities. However, more efforts should be made to link nutrition interventions with health system strengthening. His organization was committed to strengthening community action and to pursuing its focus on local capacity for disaster preparedness and response; its huge network of volunteers across the globe reached many millions of people affected by disasters every year. Community-based action was vital to ensuring clinical coverage, disease prevention and sustainable behaviour change. Its effectiveness would be enhanced by action to ensure funding for local health systems, consisting of local health workers, strong coordination structures, comprehensive surveillance systems and reliable logistic supply chains. He encouraged Member States to use his organization's substantial community-based resources in tackling malnutrition crises.

Ms Chun-Ying HUANG (Chinese Taipei) said that Chinese Taipei had set up medical assistance teams on the first anniversary of the September 1999 earthquake in order to bolster front-line health care systems facing increased demands for emergency medical care in times of crisis. It had also established six regional emergency operation centres to coordinate emergency response measures; the centres were responsible for dealing with hazards, monitoring, and ensuring immediate access to information on regional catastrophes. Chinese Taipei was eager to share its experience with health authorities in other Member States.

Ms CHAPMAN NYAHO (World Vision International), speaking at the invitation of the CHAIRMAN, said that Member States should give priority to ensuring: that emergency management and disaster preparedness were included in health budgets; that disaster risk reduction was included in health policies and plans at all levels; and that specific health concerns were included in disaster management policies across sectors. In addition, Member States should comply with United Nations guidelines when planning and building health facilities and strengthen local emergency risk management through closer ties with relevant central authorities. Health staff, including community health workers, should be involved in contingency planning and simulation exercises for all hazards, and community participation in policy development and advocacy should be encouraged. Training in disaster management should be provided at all levels. Member States should also establish community safety nets, including insurance; strengthen early warning and information systems; and use environmental and disease surveillance data to prepare for and respond to disasters.

Dr AYLWARD (Assistant Director-General) said that much of the Organization's work in emergency response during the previous year had been based on the new Emergency Response Framework, which was fully aligned with the Inter-Agency Standing Committee agenda and the major thrust of which was to give WHO country offices the capacity to act as quickly as possible in emergency situations. The Framework would be the object of an inter-agency review at the end of its first 12 months of operation.

WHO had been scaling up its operations in Mali rapidly and, at the request of governments, had focused on coordination of the sector response, technical support in specific areas, and information management. However, it had been impeded in those efforts by a lack of funding. A recently

completed assessment on the impact of the crisis on Mali's health facilities was guiding the efforts of the Organization, the country's health ministry and other partners, and was determining the priorities for response and recovery activities.

WHO was focusing its activities in the Central African Republic on early warning systems and vaccination delivery, but again was faced with a shortage of resources. With regard to the 2013 health sector appeal for the Central African Republic, only 13% of the target had been reached to date. An additional constraint was the looting and destruction of the Organization's own facilities in the country.

With regard to the Syrian Arab Republic, the Organization was working both inside the country and in neighbouring countries to meet the needs of the Syrian people, as indicated in document A66/27 Add.1. The WHO country office had rapidly reoriented its focus, and staff with substantial expertise in dealing with emergencies had been brought in.

The Regional Director of the European Region and the Regional Director of the Eastern Mediterranean Region had together spearheaded the effort to establish a new standard framework for enhancing support to refugee populations and host communities in the five neighbouring countries most deeply affected by the crisis in the Syrian Arab Republic. WHO was working closely with UNHCR and health ministries in those five countries. It had also established an emergency support team in Amman and was setting up with UNHCR a regional coordinating committee for the health needs of Syrian refugees.

WHO would be transmitting information on the geographical scope of its operations and on health needs in each area where assistance was being provided through briefings in the Syrian Arab Republic, at the centre in Amman and at headquarters in Geneva. It would continue to press for additional mechanisms to reach all Syrians in need, and was committed to stepping up its support.

In the period 2013–2014 the Secretariat would be working with Member States to develop a disaster and emergency risk management framework that would build more systematically on the International Health Regulations (2005), and would expand capacity-building and preparedness efforts to include all hazards, in conjunction with national disaster management agencies.

WHO continued to urge all parties to protect and respect the neutrality of health workers and services and to encourage health workers to deliver services in an impartial and ethical manner in all crisis areas. He reiterated WHO's commitment to leading the Global Health Cluster, and said that he would endeavour to respond to Member States' call for more frequent reporting on WHO's emergency and disaster management capabilities.

E. Climate change and health (resolution EB124.R5)

Ms LANTERI (Monaco) commended WHO's efforts in the important area of climate change and health. Monaco had been cooperating for many years, through the Monaco Scientific Centre established in 2006, with WHO's Department of Public Health and Environment. The study of climate change and health was especially significant in the light of the new global action plan for the prevention and control of noncommunicable diseases and the proposed global mechanism to coordinate United Nations system activities in that field.

Ms WANGMO (Bhutan) said that climate change represented a significant and emerging threat to public health and affected the key social determinants of health – air, water, food and shelter. She noted WHO's efforts, in conjunction with other United Nations agencies and partners, to include a health perspective in the climate change framework, and to promote and support the production of scientific evidence. Bhutan was one of the seven countries participating in the global pilot project on health adaptation to climate change and considered the project to be highly relevant.

Mr DEANE (Barbados) said that Barbados was the only country in the Region of the Americas to participate in the global pilot project on health adaptation to climate change. The project would provide the vulnerable Caribbean region with an opportunity to study management and mitigation

strategies. It had drawn the attention of a wide range of stakeholders and had helped to raise the population's awareness of global climate change, primarily through the local press. Data gathered so far suggested that mitigation measures and more extensive monitoring were needed in certain areas. Global climate change would require longitudinal studies, and new questions arising in the course of data collection would also need to be investigated. To that end, he suggested that the Director-General should conduct an assessment of the project and extend its workplan beyond 2014.

Dr HAQUE (Bangladesh) said that Bangladesh was among the countries most affected by extreme weather events. According to the Intergovernmental Panel on Climate Change, the rise in sea levels due to global warming could flood large areas, leaving millions of Bangladeshis as refugees by 2050. Climate change would also exacerbate health inequalities between rich and poor people. Bangladesh had established an adaptation programme to cope with natural disasters and had conducted research aimed at understanding the relationship between diarrhoeal diseases and climate change. It had set up a special unit within the Ministry of Health to coordinate various programmes on risk reduction and increasing adaptive capacity to climate-sensitive diseases. Most countries in the South-East Asia Region, including his own, lacked the scientific expertise and financial resources needed for effective management of climate change programmes, and he urged industrialized nations, which contributed the most to greenhouse gas emissions, to provide greater technical and financial support to countries that experienced their consequences.

Ms PETRAVIČIŪTĖ (Lithuania) commended the Secretariat's work in the field of climate change and health, in collaboration with Member States and other partners. Further efforts were needed, for example, to study the impact of climate change on health and health systems, and the need to build national capacities to measure that impact. In addition, more health topics should be included on the international agenda, including that of the United Nations Framework Convention on Climate Change negotiations. Lithuania had adopted a climate change management strategy for 2013–2020 and an intersectoral action plan, but owing to its lack of capacity and expertise in the field, would need the Organization's support to implement its plans. In that connection, it endorsed the development of a WHO workplan on climate change and health for the period 2014–2019.

Mr TOMLINSON (United Kingdom of Great Britain and Northern Ireland) said that in April 2013 his country had contributed an additional £6.8 million to support WHO's valuable work on climate change and health, one highlight of which was the excellent Atlas of Health and Climate, produced in partnership with WMO. He welcomed WHO's contribution to developing the Global Framework for Climate Services, again in conjunction with WMO, and encouraged it to ensure that health remained on the Global Framework's agenda. He requested the Secretariat to revise the Organization's current workplan on climate change and health, in line with the Twelfth General Programme of Work and the Programme budget 2014–2015 adopted by the current Health Assembly.

Mr IZWARDI (Indonesia) said that his country was facing a rapid and acute impact of climate change on human health owing to its geography, and was making substantial efforts to deal with the situation. It had established a national climate change council and an intersectoral roadmap for climate change, and instituted measures including health vulnerability mapping, drawing up regulations and policy, and collecting evidence-based data. In 2012 the Ministry of Health had set up a team to coordinate intersectoral cooperation under the national strategy for climate change adaptation. Policy- and evidence-based interventions were being introduced in order to raise awareness within the health sector and in communities. Further activities included ensuring that health system capacity and institutional arrangements were adequate to deal with the anticipated disease burden resulting from climate change; expanding disease surveillance systems; and providing support for health research. Technical support from United Nations agencies and development partners as well as sharing of experiences would bolster his country's efforts to cope with climate change.

Mr LI Mingzhu (China), endorsing the development of a WHO workplan on climate change and health for 2014–2019, welcomed WHO's efforts to raise awareness of the impact of climate change on health since that would encourage the international community to pay greater attention to the issue, encourage countries to integrate the climate change and health dimension into their overall strategies for responding to climate change, and in turn strengthen the health sector's capacity to respond to it.

Climate change had increased the frequency of natural disasters worldwide, creating serious health threats and overburdening the delivery capacity of health systems. It was therefore important to strengthen health infrastructures to cope with emergencies more effectively. His Government had taken a multisectoral approach, and was participating in the global pilot project on health adaptation to climate change. Mitigation of climate change was a relatively long-term undertaking while adaptation was a more realistic and immediate approach, better suited to developing countries. WHO should embrace the principle of shared but differentiated responsibilities in its work with such countries.

Ms BURRIS (United States of America), endorsing WHO's workplan on climate change and health, said that it was important for the Secretariat to use the assessments carried out by the Intergovernmental Panel on Climate Change and the United Nations Framework Convention on Climate Change to guide its work in that area. She encouraged WHO to join the Climate and Clean Air Coalition to Reduce Short-lived Climate Pollutants; the Coalition had expressed an interest in working with WHO to help advance understanding of the human health implications of those pollutants. In drawing up its plans for developing the health aspects of national adaptation plans, the Organization should focus on the collection and dissemination of reliable data on which Member States could base their policy decisions, and the provision of technical support for their implementation.

Ms JAMEEL (Maldives) said that her country was actively engaged in climate change efforts. It had played an important role in the negotiations that had led to the United Nations Framework Convention on Climate Change and had been among the first to sign the Kyoto Protocol. Maldives was one of the countries most vulnerable to the predicted effects of climate change, including the risks from sea level rise, decreased food and water security, and increased prevalence of vector-borne diseases. Like other small island states, its country's inadequate sewage and waste management systems favoured the spread of diarrhoea and other water-borne diseases. Most critically, its health systems were funded by tourism, which depended on the environment as its main asset. If Maldives failed to pay adequate attention to the health impacts of climate change, its health and development achievements would be compromised. She urged WHO to step up its support to Member States in respect of both mitigation and adaptation measures, and to continue efforts to collect evidence on the health impacts of climate change.

Dr AFZAL (Pakistan) said that the effects of climate change on health were placing an extra burden on health care systems. Under its national climate change policy, Pakistan was instituting various measures, which included assessing health vulnerabilities, building community capacities, incorporating climate change issues into the national health plan, mobilizing resources, upgrading monitoring and forecasting systems, and conducting research. In drawing up the workplan on climate change and health for the period 2014–2019, the Secretariat should place greater emphasis on the specific topic of strengthening health systems to protect populations from the adverse impacts of climate change on health.

Dr HARTIGAN-GO (Philippines) said that his country's department of health was working with WHO to meet the challenge of climate change, guided in particular by the Regional Framework for Action to Protect Human Health from the Effects of Climate Change in the Asia-Pacific Region. His Government had taken a number of key policy initiatives including the drafting of legislation, development of a national framework, and establishment of a special division and a technical committee on climate change and health. From 2008 to 2012, the Philippines had implemented a

flagship programme on climate change strategies in cooperation with United Nations organizations and government partners.

Dr AL-TAAE (Iraq) said that environmental factors could have significant effects on the prevalence and epidemiology of communicable and noncommunicable diseases. Iraq had included strategies to combat the adverse effects of climate change in its public health and primary health care workplan, with emphasis on vulnerable population groups. It had also shared expertise with Afghanistan, the Islamic Republic of Iran and Pakistan, under the auspices of WHO. Joint activities had focused on climate-change preparedness and responding to the health challenge of mass gatherings. He urged WHO to foster capacity-building within and between regions and to encourage partnerships among stakeholders to deal with the health effects of climate change.

Mr CORRALES (Panama), commended WHO's efforts in the field of climate change and sustainable development. Countries like his own that were the most vulnerable and had the greatest exposure to violent weather events and disasters must use a multisectoral approach to cope with the effects of climate change on human health. Greater attention should be paid to strengthening the health component of adaptation plans. WHO had an important role to play in the negotiations under the United Nations Framework Convention on Climate Change, and he encouraged Member States to participate actively in those negotiations.

Ms MALONE (World Meteorological Organization) said that, as delegates had pointed out, weather, water and climate, especially extreme conditions, clearly affected health, the decisions WHO took in terms of investment in infrastructure and programmes, and programme outcomes. Effective planning for preventive action against climate-related health risks was dependent on a better understanding of the relationship between climate and health and broad cooperation between climate and health services at all levels across the world. Key tools in that regard were the Atlas of Health and Climate and the Global Framework for Climate Services. In 2012, WMO had adopted an implementation plan for the Global Framework for Climate Services, launched in 2009. WMO acknowledged with appreciation the active participation of the Director-General and her staff in that process. Following on from their effective collaboration on the Atlas of Health and Climate, WMO and WHO were establishing a joint change project office on climate and health, which was expected to commence operations later in 2013. In addition, WMO, WHO and the WFP, together with partners in Norway, were developing projects to demonstrate the application of climate services in support of health and nutrition in Africa. Such projects were financed through the Global Framework for Climate Services Trust Fund, thanks to the generosity of donors to the Fund.

Ms Yu-Hsuan LIN (Chinese Taipei) said that health care systems could play an important role in mitigating the effects of climate change. Chinese Taipei had been working with the WHO International Network of Health Promoting Hospitals and Health Services to promote activities consistent with WHO guidance on climate change. Hospitals, which had a high energy consumption, were being encouraged to reduce their carbon footprints and to work with the international coalition Health Care Without Harm in order to promote environmental sustainability in medical institutions; a manual had been produced to assist hospitals in assessing environmental compliance; and healthy lifestyles were being encouraged in order to reduce the use of medical resources. Chinese Taipei would continue to strengthen international cooperation in the field of climate change and health by freely sharing its monitoring tools and methods.

Ms MARIC (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, said that climate change, one of the most significant challenges to global public health, was best addressed through a rights-based approach that emphasized the need to protect the most vulnerable. In its efforts to draw attention to the health consequences of climate change, the Organization had made valuable contributions at the United Nations Conference on Sustainable

Development (Rio+20) and at the eighteenth session of the Conference of the Parties to the United Nations Framework Convention on Climate Change. However, it should show stronger leadership in promoting action that met the standards required by the best available science, in particular, by spearheading Member States' efforts to obtain adequate public funding for adaptation through the establishment of health-related funding windows in the Green Climate Fund; stepping up its efforts to measure the health-related consequences of climate change; and encouraging Member States to take the most appropriate action to deal with the adverse effects of climate change on health.

Dr FUKUDA (Assistant Director-General) said that climate variability affected all countries, although some, as the delegates of Bangladesh and Maldives had made clear, were particularly vulnerable to the short- and long-term effects of climate change. The delegate of Iraq had rightly pointed out that climate change had a very broad impact on health and affected both communicable and noncommunicable diseases in a variety of ways. He acknowledged with appreciation the financial contribution made by the United Kingdom of Great Britain and Northern Ireland. He thanked WMO for its collaboration, in particular in the development of the Atlas of Health and Climate, and assured the delegate of the United States of America that WHO collaboration with the Climate and Clean Air Coalition to reduce Short-lived Climate Pollutants was already under way. As suggested by the Executive Board, and supported during the current discussion, the current workplan on climate change and health would be extended, and contributions from Member States would be welcome in that regard. He noted that a large number of countries were developing national plans using intersectoral approaches to tackle the effects of climate change on health, which were crucial to work in that area.

Health systems (continued from the sixth meeting, section 3)

- H. Patient safety (resolution WHA55.18)** (continued)
- I. Drinking-water, sanitation and health (resolution WHA64.24)** (continued)
- J. Workers' health: global plan of action (resolution WHA60.26)** (continued)
- K. Strategy for integrating gender analysis and actions into the work of WHO (resolution WHA60.25)** (continued)
- L. Progress in the rational use of medicines (resolution WHA60.16)** (continued)
- M. Health policy and systems research strategy** (continued)

Mr FEDOTOV (International Labour Organization) said that ILO and WHO had cooperated for the previous five years on implementation of the global plan of action on workers' health, which had included the establishment of national programmes for the elimination of silica- and asbestos-related diseases, development of the ILO List of Occupational Diseases, integration of essential interventions for workers' health in primary health care, development of healthy workplace programmes, and formulation of national occupational safety and health policies, programmes and services. Although joint action at national level by ministries of health and labour had given rise to significant gains for workers' health, too many countries still lacked policy and services for protecting the health of their workers, and more than 2 million people died of occupational diseases every year. WHO's efforts to link occupational health services to universal health coverage and to integrate occupational health activities into global action on prevention of noncommunicable diseases were therefore welcome. ILO was strongly committed to continuing its fruitful collaboration with WHO on occupational health.

Mr CARTER (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that limited access to water and poor sanitation contributed to more than 3 million deaths each year and was one of the leading causes of child mortality. Water and sanitation were a basic human right that, when denied, brought shame and stigmatization. Progress in the two areas had not been equal, however, and current estimates suggested that the Millennium Development Goal targets for access to drinking-water would be achieved by 2015, while those for access to sanitation would not. Despite its critical importance, sanitation continued to receive less

funding and attention than water supply. Governments and donors should ensure that sanitation activities were at least as well funded as activities relating to water supply. A modern world needed sanitation, and sanitation required time, effort and resources.

Ms Chun-Ying HUANG (Chinese Taipei) said that in recent years, various interventions had been implemented under Chinese Taipei's patient safety campaign, launched in 2002. Those activities had included creating a patient safety committee, setting goals for quality of medical care and patient safety, devising a patient safety reporting system, celebrating an annual patient safety week, and providing training and education.

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, congratulated the Secretariat and Member States for their efforts to promote the rational use of medicines and integrate the issue into national policy. As a follow-up to the meeting of ministers of health held in October 2012 during the Federation's centennial congress, the Ministry of Health of Ireland would be hosting, with WHO support, a symposium on responsible use of medicines on 30 August 2013 in Dublin.

Dr KIENY (Assistant Director-General) said that WHO was preparing a global report on patient safety in the context of universal health coverage that would be published in late 2014. Concerning the request for technical support from the delegate of Maldives, the Secretariat would be consulting with the Regional Office for South-East Asia in that regard. In response to a question from the delegate of Mauritius, she said that the resources and tools developed by the African Partnerships for Patient Safety were available on the WHO web site. In the context of the Programme budget 2014–2015 and in view of the current emphasis on universal health coverage, the Secretariat was in the process of reviewing people-centred integrated service delivery from the perspective of service quality and patient safety.

In respect of progress in the rational use of medicines, the Secretariat would be working to respond to the request that had been made for a report on antimicrobial resistance and suggestions for how to deal with it, to be submitted to the Executive Board at its 134th session in January 2014. The Secretariat also planned to integrate a specific module on antimicrobial resistance surveillance into the new global research and development observatory, as suggested by the delegates of the United States of America and Colombia. She had also taken note of the request to scale up support to Member States on rational use of medicines, in particular, in the areas of health technology assessment, accreditation, and strengthening of national pharmacies.

She thanked the delegate of South Africa for his positive comments concerning the topic of health policy and systems research strategy.

Dr BUSTREO (Assistant Director-General) noted that Member States had welcomed the establishment of a Gender, Equity and Human Rights unit as part of the Organization's overall reform. Bringing gender into the mainstream of activities across the Organization was a key priority for the Director-General and 120 focal points were now in place. Based on the analysis and assessment made under the United Nations system-wide approach on gender equality and the empowerment of women, the Secretariat had drawn up an action plan that included accountability indicators and a greater level of detail than in previous plans, which would be implemented shortly. Many Member States had highlighted the importance of developing an integrated strategy on gender, equity and human rights since those three cross-cutting issues were not just complementary, but synergistic. Analysis of the gender dimension would anchor the framework in a proper context of multiple inequalities, while analysis of the human rights dimension would help to identify appropriate accountability mechanisms and tools for policy dialogue. She looked forward to working with Member States on the strategy, which would shortly be submitted for consideration to the governing bodies.

Dr FUKUDA (Assistant Director-General) said that with regard to the question of drinking-water, sanitation and health, he had taken note of the comments on indicators for the post-2015 agenda. Responding to the comments made by the delegate of Bangladesh, he said that the cholera vaccine could be regarded as a cholera prevention approach in addition to clean water and sanitation. WHO was working to establish a cholera vaccine stockpile and was pursuing its efforts to set up a task force. The representative of the International Federation of Red Cross and Red Crescent Societies had pointed out that although progress was being made on water goals, progress on sanitation was lagging. WHO was collaborating with various partners to solve that problem. The Deputy Secretary-General of the United Nations had specifically identified the area of water and sanitation as a target for revitalization and renewed efforts in light of the 1000 days before the end of the Millennium Development Goals, and WHO was cooperating on that initiative.

In respect of the progress report on workers' health: global plan of action, he wished to thank the delegates of Indonesia, Italy and Liberia for pointing out the importance of occupational health. WHO recognized that many work settings presented dangerous conditions for workers, and that there was a need for increased awareness and attention to safety in such settings. The Organization was using primary health care as a strategic element towards achieving that goal. There had been general agreement among Member States on the need to reduce and eliminate asbestos-related disease, and he thanked the delegate of the Russian Federation for offering to share its research findings in that regard. A risk analysis conducted by WHO in conjunction with IARC, and made available to countries in 2011, had concluded that all forms of asbestos were carcinogenic, that no safe threshold had been identified, and that it was extremely difficult to control exposure to asbestos in the workplace.

Dr TROEDSSON (Executive Director, Office of the Director-General) said that linking progress reports to the programme budget, as had been suggested by several Member States, could be done simply and efficiently by systematically comparing the actions taken by the Secretariat to the programme budget outputs, and by comparing the current status referred to in the progress reports to programme budget outcomes. Information on those comparisons would be included in the progress reports.

The Committee noted the progress reports.

3. FOURTH REPORT OF COMMITTEE B (Document A66/72)

Mr HAZIM (Morocco), Rapporteur, read out the draft fourth report of Committee B.

Miss PACHAREEWAN PHUNGIL (Thailand) proposed two minor editorial amendments.

The report, as amended, was adopted.¹

4. CLOSURE OF THE MEETING

After the customary exchange of courtesies, the CHAIRMAN declared the work of Committee B completed.

The meeting rose at 16:55.

¹ See page 312.