

# COP27 Health Community Recommendations

As of 16<sup>th</sup> October 2022, this document is supported by the following organisations (organisational websites are hyperlinked in the lists below). The list of signatories continues to be updated; the latest list will be refreshed regularly in the pdf accessible from [this page](#).

**International Organisations:** Global Climate and Health Alliance (GCHA), Health Care Without Harm, Clean Air Fund, Nurses Across the Borders, Health and Climate Network (HCN), University of the West Indies, YOUNGO Health Working Group, NCD Alliance, World Heart Federation, The George Institute for Global Health, Mentor Point Africa, International Pharmaceutical Students' Federation, EuroHealthNet, International Network on Children's Health, Environment & Safety (INCHES), Afrihealth Optonet Association, International Society for Environmental Epidemiology (ISEE), International Society of Doctors for the Environment (ISDE), Youth Centre for Global Health Research, Center for Global Health Security and Diplomacy.



**National Organisations:** Climate and Health Alliance (Australia), Canadian Association of Physicians for the Environment (CAPE), UK Health Alliance on Climate Change, Deutsche Allianz Klimawandel und Gesundheit (Germany), Armée de Jeunes Contre le Paludisme (Democratic Republic of the Congo), Physicians Association for Nutrition South Africa (PAN-SA), Green Health Wales, Faculty of Public Health (United Kingdom), Association for the Promotion of Youth Leadership, Advocacy and Volunteerism (APYLAV; Cameroon), Canadian Medical Association (CMA), Health and Global Policy Institute (Japan), Climate & Health Program, University of Colorado School of Medicine (United States), Ukana West 2 Community Based Health Initiative (CBHI; Nigeria), Public Health Foundation of India.



*This document contains an introduction, followed by specific recommendations pertaining to [loss and damage](#), [adaptation](#), [mitigation](#) and [finance](#).*

## Introduction

The Paris Agreement acknowledges the relevance of the right to health to climate action. To date, integration of health issues into policymaking and monitoring under the UNFCCC has been insufficient, despite IPCC warnings of human health impacts since 1990<sup>1</sup>. In its sixth assessment report published in 2022, the IPCC describes the scientific evidence confirming climate change to be a “threat to human well-being” as “unequivocal”<sup>2</sup>. Indeed, climate change is recognised by the World Health Organization (WHO) as the greatest threat to health of the 21st century<sup>3</sup>. Climate-sensitive health threats already cause millions of avoidable deaths annually<sup>4</sup>, undermining the right to health and a healthy environment, and driving severe productivity losses.

Failure to implement the Paris Agreement through action across all sectors will result in catastrophic **health impacts** in every region of the world<sup>5</sup>. As described by the IPCC, climate change has profound direct and indirect impacts on health and wellbeing, driving heatwaves and other extreme weather events, vector- and water-borne disease transmission, food and water insecurity, negative mental health impacts, and adverse outcomes from non-communicable diseases such as cardiovascular disease. Under a business-as-usual scenario, climate change will likely cause 83 million cumulative excess temperature-related deaths between 2020 and 2100<sup>6</sup>. Many more deaths will result from indirect impacts of temperature rise. Mitigation and adaptation efforts can reduce health impacts, but health-related loss and damage as a result of insufficient mitigation and adaptation are growing.

In order to address mounting threats to health, adaptation is required in both the **healthcare sector** and in other sectors. The healthcare sector (including but not limited to hospitals, clinics, community health centers, social care facilities, and ambulance transportation) is one of the three sectors most often prioritised for adaptation in Parties’ nationally determined contributions (NDCs)<sup>7</sup>. The healthcare sector is a significant sector in every country and can play a key role in delivering progress on mitigation (the healthcare sector contributes 4-5% of global emissions<sup>8,9</sup>) and adaptation. At COP26, and in the months since, 61 governments committed to climate-resilient health systems and 56 to sustainable, low-carbon health systems (of which 22 have committed to net zero health systems)<sup>10</sup>.

Climate action across sectors can yield **health co-benefits**: emissions reductions in the energy sector improve air quality; multimodal transport systems and green infrastructures improve air quality, support physical activity and can increase mobility equity and social cohesion and reduce the urban heat island effect; and sustainable food and agriculture systems protect and promote healthy nutrition<sup>11</sup>. Mitigation in the energy, food and agriculture, and transport sectors in line with the Paris Agreement could avoid 1.18 million, 5.86 million, and 1.15 million deaths respectively each year by 2040 across just nine countries<sup>12</sup>. This leads to reduced burden of respiratory and cardiovascular conditions, type 2 diabetes and some cancers. Nature-based solutions offer mental health benefits; adaptation measures in water and sanitation ensure safe drinking water and hygiene; and resilient buildings and cities protect the safety of those who live and work within them. **Overall, mitigation and adaptation action across sectors are key factors in shaping the overall health of populations.**

Healthy populations, which can be ensured by mitigation and adaptation efforts across sectors, are necessary for both economic productivity and overall climate resilience, being more likely to withstand and recover from climate shocks. This can be understood as **health resilience**.

**Health is therefore both a prerequisite for and a critical indicator of climate action.** Furthermore, **health is a powerful accelerator for climate action**: framing and monitoring climate action in health terms can build widespread support for ambitious action, and yield high economic returns on investment as discussed later in this document.

The health community (including but not limited to healthcare delivery staff from family doctors to tertiary specialists, administrators, public health and other health professionals, allied health workers, United Nations experts, academics, and staff of health professional associations and health NGOs) has expertise in integrating health into climate policymaking and implementation to maximise the gains described throughout this document, and stands ready to assist on these issues at national and international level. Finance for research to quantify the health impacts of climate and to generate new evidence on measures which offer the greatest protection to health (with associated increased returns on investment) is critical.

We further call for the inclusion of Indigenous peoples, women, children, and other often marginalised and climate vulnerable communities in climate decision-making at international, national and local levels.

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<sup>1</sup> IPCC, 1990. Working Group II First Assessment Report: Impacts Assessment of Climate Change ([link](#))

<sup>2</sup> IPCC, 2022. AR6 Working Group II Summary for Policy Makers ([link](#))

<sup>3</sup> World Health Organization, 2019. COP24 Special Report on Health and Climate Change ([link](#))

<sup>4</sup> IPCC, 2022. AR6 Working Group II Report ([link](#))

<sup>5</sup> IPCC, 2022. AR6 Working Group II Report ([link](#))

<sup>6</sup> Bressler, 2021. The mortality cost of carbon ([link](#))

<sup>7</sup> World Health Organization, 2021. 2021 WHO Health and Climate Change Survey Report ([link](#))

<sup>8</sup> Romanello et al, 2021. The 2021 report of the Lancet Countdown on health and climate change: code red for a healthy future ([link](#))

<sup>9</sup> Health Care Without Harm, 2019. Health Care's Climate Footprint ([link](#))

<sup>10</sup> World Health Organization, 2022. COP26 Health Commitments, accessed 11 October 2022 ([link](#))

<sup>11</sup> Negev et al, 2022. Barriers and Enablers for Integrating Public Health Cobenefits in Urban Climate Policy ([link](#))

<sup>12</sup> Hamilton et al, 2021. The public health implications of the Paris Agreement ([link](#))

## Loss and Damage

### *Loss and damage: recommendations relating to loss and damage finance*

#### **Ensure discussion of loss and damage finance as a dedicated agenda item at future COPs and Subsidiary Body meetings, and establish a loss and damage finance facility with new and additional finance**

- Health impacts of climate change include vector-borne and water-borne disease; mental health impacts; and injury, illness and mortality arising from wildfires, drought, extreme heat, food insecurity, floods, storms and other extreme weather events<sup>13</sup>. There are also many less visible health effects of climate change, not least forced migration and conflict. These impacts may in turn contribute to loss of livelihood and larger-scale reduced economic productivity. Reduced labour capacity due to increasing extreme heat exposure will increasingly reduce the income of the poor in particular<sup>14,15</sup>.
- Health impacts of climate change, while classified as non-economic losses, have far-reaching economic implications for households, health systems, and entire countries, providing clear additional rationale for the need to establish a loss and damage finance facility.
- A loss and damage finance facility can disburse funds to strengthen social protection for those experiencing non-economic losses including health impacts such as loss of life and disease. Social assistance programmes such as those that could be funded through a loss and damage finance facility have been linked to increased health services access by low-income and climate vulnerable populations<sup>16</sup>.

### *Loss and damage: recommendations relating to the Santiago Network*

#### **Operationalisation of the Santiago Network should include technical guidance on addressing health-related loss and damage**

- While the Santiago Network is not sufficient for addressing loss and damage, technical assistance for developing country Parties experiencing losses and damage is nonetheless necessary. This should include support to quantify the extent of health-related losses and damages, including the application of approaches to attribute health effects to climate change, and guidelines for emergency response. Coordination and collaboration among emergency response teams is important to protect health.
- Establishment of an advisory body for the Santiago Network on Loss and Damage which ensures representation and inclusivity, will facilitate strong decisions on the delivery of needs-based technical assistance.

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<sup>13</sup> IPCC, 2022. AR6 Working Group II Report ([link](#))

<sup>14</sup> Andrews et al, 2018. Implications for workability and survivability in populations exposed to extreme heat under climate change: a modelling study ([link](#))

<sup>15</sup> Romanello et al, 2021. The 2021 report of the Lancet Countdown on health and climate change: code red for a healthy future ([link](#))

<sup>16</sup> Aleksandrova & Costella, 2021. Reaching the poorest and most vulnerable: addressing loss and damage through social protection ([link](#))

## Adaptation

### *Adaptation: recommendations relating to the Global Goal on Adaptation*

#### **Develop health metrics to measure progress towards the Global Goal on Adaptation**

- The health and wellbeing of populations is an outcome of climate action across all sectors, and provides a vital indicator of progress. Meanwhile, healthy societies are a core pillar of climate resilience, being more able to withstand and recover from climate shocks and stressors.
- In developing these health metrics for measuring progress towards the Global Goal on Adaptation (GGA), it will be valuable to cooperate with relevant technical experts from the health sector, including WHO, other UN Agencies, and academic institutions.
- For more information on potential health metrics, see this [submission](#) by WHO and GCHA in collaboration with the Lancet Countdown. In addition to data on deaths, emergency admissions and hospitalisations, it may be relevant to consider primary care data and community impacts that do not necessarily require hospitalisation, such as those related to malnutrition.

### *Adaptation: recommendations relating to the COP27 Cover Decision and national action*

#### **Raise adaptation ambition across sectors and at national and global levels, with attention to health co-benefits**

- The GGA will be furthered by attention to locally-led adaptation, recognising that adaptation action planned, managed and assessed at the most local level possible is the basis for the most effective strengthening of resilience, enhancing adaptive capacity, and reducing vulnerability. The unique and necessary contribution of local and Indigenous people to leadership at all stages of the adaptation cycle must be recognised and acted upon.
- In addition to adaptation in the health sector to respond to health impacts, adaptation in other sectors, including agriculture, sanitation, energy, and urban planning is necessary for nutrition, hygiene, cooking and heating, and safe living environments, while nature-based solutions offer mental health co-benefits. Implementing measures which offer health co-benefits can increase returns on investment.
- International finance is required to support adaptation in developing countries.

#### **Include health in national adaptation plans and develop a dedicated Health National Adaptation Plan**

- The healthcare sector is one of the three sectors most often prioritised for adaptation in Parties' NDCs<sup>17</sup>, together with water and agriculture.
- At national level, many Parties are taking steps to improve healthcare sector resilience. Health National Adaptation Plans (HNAPs), for which guidance has been published by WHO<sup>18</sup>, may also be developed under the national ministry of health to provide additional detail.
- Given the vulnerability of the health sector in many countries, it may be relevant to recognise and promote HNAPs as a component of party-driven work which incorporate adaptation under the UNFCCC, alongside NDCs, NAPs, adaptation communications (ADCOMs) and sectoral adaptation plans for other sectors.
- Where possible, adaptation in the health sector, as for other sectors, should be integrated with mitigation to minimise trade-offs and unintended adverse consequences.

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<sup>17</sup> World Health Organization, 2021. 2021 WHO Health and Climate Change Survey Report ([link](#))

<sup>18</sup> World Health Organization, 2021. Quality Criteria for Health National Adaptation Plans ([link](#))

## Mitigation

### *Mitigation: recommendations relating to the Mitigation Work Programme*

#### **The MWP should include a sectoral approach to monitoring progress, and sharing good practice**

- In addition to its role in adaptation, the healthcare sector (including but not limited to hospitals, clinics, community health centers, social care facilities, and ambulance transportation) produces 4-5% of global emissions<sup>19,20</sup> and can contribute to mitigation. At COP26, and in the months since, 56 governments have committed to sustainable, low-carbon health systems (of which 22 have committed to net zero health systems)<sup>21</sup>. Delivery of these commitments will be accelerated through the sharing of good practices between Parties and regions.

#### **The MWP should advance implementation of the Glasgow Pact by developing a timeline for the phase-out of all fossil fuels (and not only unabated coal), as a public health imperative, as well as phase-out of fossil fuel subsidies.**

- Burning fossil fuels is a leading driver of air pollution; extraction and processing also threaten health<sup>22</sup>. This includes coal, but also oil and gas. As for coal and oil, gas extraction and combustion also carry health impacts<sup>23</sup>: gas must not be considered as a bridging fuel.
- Short-lived climate pollutants (SLCPs<sup>24</sup>) released during fossil fuel extraction, transport, and combustion present particular risks for public health and the climate. Black carbon and tropospheric ozone are health-damaging air pollutants, while methane is both a precursor of the latter and a powerful greenhouse gas, with a 20-year global warming potential 84-86 times more potent than CO<sub>2</sub> and a 100-year global warming potential 28-34 times that of CO<sub>2</sub><sup>25,26,27</sup>.
- Improvements in air quality alone yielded by fossil fuel phase-out would save 3.6 million lives annually<sup>28</sup>. Air quality improvements will reduce air pollution associated with illnesses such as respiratory conditions, cardiovascular disease, and some cancers, which can in turn reduce health system costs and increase economic productivity.
- Funds from fossil fuel subsidies should be rechanneled to renewable energy, energy efficiency strategies, and protections for communities who are especially at risk of climate impacts.
- A just transition is required to protect both health and equity<sup>29</sup>. Access to reliable and affordable energy, and to income, must be maintained for all populations.
- Developed country Parties should take the lead in phasing out all fossil fuels, according to the principle of common but differentiated responsibilities and respective capabilities, and should also provide adequate support to developing country Parties to facilitate this transition.
- A definition should be clarified for “inefficient” fossil fuel subsidies.
- In a review of 84 countries, 65 provided a net subsidy to fossil fuels in 2018. In many cases, subsidies were equivalent to substantial proportions of the national health budget<sup>30</sup>. Meanwhile, in 2014, G20 governments paid out 444 billion USD in subsidies to fossil fuel companies but the use of fossil fuels resulted in estimated health costs of at least six times this amount: 2.76 trillion USD<sup>31</sup>.

### *Mitigation: recommendations relating to the COP27 Cover Decision and national action*

#### **Submit NDCs in line with the Paris Agreement by the end of 2022, as per paragraph 29 of 1.CMA/3, and follow up with rapid implementation. Raising mitigation ambition and closing the emissions gap prevents health impacts, and real emissions reductions also offer health co-benefits.**

- The IPCC 6th Assessment Reports have shown that the window of opportunity to stay within the temperature target of 1.5°C is rapidly closing. Failure to mitigate climate change increases the risk of catastrophic health impacts in every region of the world. As described by the IPCC, climate change has profound direct and indirect

impacts on health and wellbeing, driving heatwaves and other extreme weather events, vector- and water-borne disease transmission, food and water insecurity, and negative mental health impacts<sup>32</sup>.

- In addition, climate action can yield health co-benefits: emissions reductions in the energy sector improve air quality; multimodal transport systems improve air quality, support physical activity and can increase transportation equity; and sustainable food and agriculture systems protect and promote nutrition<sup>33,34</sup>. These improvements lead to reduced burden of respiratory and cardiovascular conditions, type 2 diabetes and some cancers. Meanwhile nature-based solutions offer mental health benefits; and resilient water and sanitation systems ensure safe drinking water and hygiene, preventing transmission of water-borne diseases such as typhoid and cholera.
- Health co-benefits can offer high economic returns - in China and India, costs of reducing greenhouse gas emissions could be compensated with the health co-benefits alone, with a similar, health related partial offset of costs in the United States and Western Europe<sup>35</sup>. Overall, compared to continuing with a fossil fuel-based system, a rapid green energy transition is likely to result in trillions of dollars of net savings<sup>36</sup>.
- Net zero emissions reliant on bioenergy use with carbon capture and storage (BECCS) - if achieved - would not yield the same health co-benefits associated with real emissions reductions described here, nor the associated returns on investment.
- The CaRBonH<sup>37</sup> and HEAT<sup>38</sup> tools by the WHO, Low Emissions Analysis Platform (LEAP)<sup>39</sup> by the Stockholm Environment Institute and the GAINS<sup>40</sup> model by the International Institute for Applied Systems Analysis (IIASA) enable the quantification of public health and economic co-benefits from mitigation actions and provide invaluable data for both national and international public health and climate monitoring efforts. Several Parties are currently undertaking health co-benefit assessments for their NDCs and/or sectoral mitigation targets.

#### **Integrate health considerations into future party-driven work relating to mitigation, including NDCs, long-term strategies, national mitigation plans, and sectoral action plans.**

- Most of the recently submitted NDCs reflect health and climate linkages to some extent - 90% of the 94 updated or enhanced NDCs prior to COP26 included health<sup>41</sup>. Health was predominantly included in relation to adaptation and health impacts, followed by health co-benefits of mitigation. Few NDCs included financial provisions or economic assessments relating to health considerations, and mentions of health and climate links are rarely accompanied by targets for commensurate reductions in greenhouse gas emissions.
- In addition to ambitious NDCs that keep to the 1.5°C target, all Parties must develop long-term strategies. As of September 26, 2022, 53 countries have submitted their long-term strategies<sup>42</sup>. Of the long-term strategies analysed prior to COP26, 94% include health considerations respectively<sup>43</sup>, but work to deliver the targets outlined in long-term strategies is in the earliest stages.
- All Parties should develop clear and transparent monitoring and learning systems to monitor the implementation of the NDCs and long-term strategies.

Reflecting the interlinkages between mitigation and health, we suggest the following language for inclusion in the COP27 cover decision and/or texts on the Mitigation Work Programme:

***"Recognise that reduction of greenhouse gas emissions consistent with the Paris Agreement temperature goal will both reduce health impacts of climate change and also yield additional health co-benefits including clean air, healthy sustainable diets, and increased physical activity".<sup>44,45</sup>***

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<sup>19</sup> Romanello et al, 2021. The 2021 report of the Lancet Countdown on health and climate change: code red for a healthy future ([link](#))

<sup>20</sup> Health Care Without Harm, 2019. Health Care's Climate Footprint ([link](#))

<sup>21</sup> World Health Organization, 2022. COP26 Health Commitments, accessed 11 October 2022 ([link](#))

<sup>22</sup> Global Climate and Health Alliance, 2022. Cradle to grave: The health harms of fossil fuel dependence and the case for a just phase-out ([link](#))

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- <sup>23</sup> Global Climate and Health Alliance, 2022. Cradle to grave: The health harms of fossil fuel dependence and the case for a just phase-out ([link](#))
- <sup>24</sup> *Short-lived climate pollutants including black carbon, methane, tropospheric ozone, and hydrofluorocarbons are the most important contributors to the man-made global greenhouse effect after carbon dioxide, responsible for up to 45% of current global warming* ([more information](#))
- <sup>25</sup> Global Climate and Health Alliance, 2022. Cradle to grave: The health harms of fossil fuel dependence and the case for a just phase-out ([link](#))
- <sup>26</sup> Climate and Clean Air Coalition, n.d. Short-Lived Climate Pollutants (SLCPs) ([link](#))
- <sup>27</sup> UNECE, n.d. The Challenge ([link](#))
- <sup>28</sup> Lelieveld et al, 2019. Effects of fossil fuel and total anthropogenic emission removal on public health and climate ([link](#))
- <sup>29</sup> Health and Climate Network, 2022. A Just Energy Transition for a healthy fossil fuel free world ([link](#))
- <sup>30</sup> Romanello et al, 2021. The 2021 report of the Lancet Countdown on health and climate change: code red for a healthy future ([link](#))
- <sup>31</sup> Gordeljevic & Jensen, 2017. Hidden Price Tags: how ending fossil fuel subsidies would benefit our health ([link](#))
- <sup>32</sup> IPCC, 2022. AR6 Working Group II Report, Chapter 7 ([link](#))
- <sup>33</sup> *The IPCC Working Group III Report chapter on agriculture addresses sustainable healthy diets in section 7.4.5.1. It notes that the term ‘Sustainable healthy diets’ refers to dietary patterns that ‘promote all dimensions of individuals’ health and wellbeing; have low environmental pressure and impact; are accessible, affordable, safe and equitable; and are culturally acceptable’. In addition to climate mitigation gains, a transition towards more plant-based consumption and reduced consumption of animal-based foods, particularly from ruminant animals, could reduce pressure on forests and land used for feed, support the preservation of biodiversity and planetary health* ([more information](#))
- <sup>34</sup> Hamilton et al, 2021. The public health implications of the Paris Agreement ([link](#))
- <sup>35</sup> Markandya et al, 2018. Health co-benefits from air pollution and mitigation costs of the Paris Agreement: a modelling study ([link](#))
- <sup>36</sup> Way, 2022. Empirically grounded technology forecasts and the energy transition ([link](#))
- <sup>37</sup> World Health Organization Regional Office for Europe, 2018. Carbon Reduction Benefits on Health ([link](#))
- <sup>38</sup> World Health Organization Regional Office for Europe, 2017. Health economic assessment tool (HEAT) for walking and for cycling ([link](#))
- <sup>39</sup> Stockholm Environment Institute, 2018. Low Emissions Analysis Platform ([link](#))
- <sup>40</sup> International Institute for Applied Systems Analysis, 2021. The GAINS Model ([link](#))
- <sup>41</sup> Global Climate and Health Alliance, 2021. Healthy NDC Scorecard ([link](#))
- <sup>42</sup> UNFCCC. Long-term strategies portal ([link](#))
- <sup>43</sup> Wynn & Beagley, 2021. COP26 and beyond: long-term climate strategies are key to safeguard health and equity ([link](#))
- <sup>44</sup> IPCC, 2022. AR6 Working Group II Report, Chapter 7 ([link](#))
- <sup>45</sup> Hamilton et al, 2021. The public health implications of the Paris Agreement ([link](#))

## Finance

### *Finance: recommendations relating to negotiations on Finance at COP27*

#### **Deliver the USD 100 billion goal and ensure high ambition for the New Collective Quantified Goal (NCQG)**

- As addressed in the recommendations for mitigation and adaptation, both climate mitigation and adaptation are essential for healthy populations.
- At COP26, 39 governments and public finance institutions committed to end international fossil fuel finance by the end of 2022 and shift that finance into renewable energy. If fully implemented, this could shift USD 28 billion in international public finance for fossil fuels toward a clean and just energy transition each year<sup>46</sup>. Advancement of this agenda at COP27, both in terms of new signatories to the Glasgow Statement and progressive ambition and implementation, will offer benefits for both climate and health.
- Revenues from carbon taxation (set at a level to account for true costs including health impacts<sup>47</sup>) as well as levies on fossil fuel companies’ profits, levies on shipping and aviation, and levies from market-based mechanisms — should be repurposed to ensure adequate international climate finance.
- At COP26, and in the months since, 61 governments committed to climate-resilient, and 56 governments to sustainable low-carbon health systems<sup>48</sup>, but finance is urgently needed to ensure that these commitments can be delivered, particularly in developing countries. While the majority of countries surveyed by WHO have developed health adaptation policies and plans, 70% of these reported that financing was a major barrier to their implementation<sup>49</sup>.

#### **Close the financing gap for health adaptation and include a subtarget for health adaptation finance**

- At COP26, Parties agreed on the need to double the amount of climate finance going to adaptation in 2019 by

2025. At COP27, Parties must develop a clear plan to achieve that target. This should include sectoral adaptation finance targets for vulnerable and underfunded sectors such as health, food and agriculture, and water and sanitation. This should be accompanied by a transparent implementation plan showing progress towards the 2025 doubling target.

- Health is one of the three sectors most often prioritised for adaptation in Parties' NDCs<sup>50</sup> but has not received the attention or funding it requires. Between 2018 and 2020, a mere 0.3% (\$14.0 million) of multilateral climate change adaptation funding was directed specifically at the healthcare sector.
- Accreditation of WHO to the Green Climate Fund will enable mainstreaming and targeting of funding needed to enhance health sector resilience, and minimise risks to vulnerable communities.

### **Prioritise interventions with health (co)benefits**

- In addition to financing health-sector specific projects, allocation of climate finance to mitigation and adaptation measures in other sectors that offer health co-benefits can yield high economic returns. In China and India, costs of reducing greenhouse gas emissions could be compensated with the health co-benefits alone, with partial offsetting in the United States and Western Europe<sup>51</sup>.
- It is essential to evaluate the effectiveness of climate action for public health. Funding should include resources for evaluation of project impacts and context-appropriate scale-up of good practice. A compendium of successful interventions should be compiled, with implementation guided by locally led planning to ensure benefit to local communities.

### **Strengthen reporting and monitoring to ensure impactful allocation of climate finance**

- Improved reporting and monitoring, including standardised reporting of the effects on population health and wellbeing from climate finance responses are required. It is furthermore necessary to ensure transparency accountability in the disbursement of funds.

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<sup>46</sup> IISD, 2022. Report: Countries could shift almost USD 28 billion/year from fossil fuels to jump-start the energy transition—if they follow through on their pledges ([link](#))

<sup>47</sup> According to [Bressler, 2021](#), one excess death globally is estimated to occur between 2020-2100 for every 4,434 metric tons of carbon dioxide emitted in 2020 (equivalent to the lifetime emissions of 3.5 average Americans) Many more deaths will result from indirect impacts of temperature rise. Taking this directly temperature-driven mortality into account, the social cost of carbon stands at \$258 per metric ton of 2020 emissions.

<sup>48</sup> World Health Organization, 2022. COP26 Health Commitments. Accessed 11 October 2022 ([link](#))

<sup>49</sup> World Health Organization, 2021. 2021 WHO Health and Climate Change Survey Report ([link](#))

<sup>50</sup> World Health Organization, 2021. 2021 WHO Health and Climate Change Survey Report ([link](#))

<sup>51</sup> Markandya et al, 2018. Health co-benefits from air pollution and mitigation costs of the Paris Agreement: a modelling study ([link](#))