EB156/2025/REC/2

World Health Organization

Executive Board

156th session

Geneva, 3–11 February 2025

Summary records

Geneva
2025

Abbreviations

Abbreviations used in WHO documentation include the following:

ASEAN	–	Association of Southeast Asian Nations
FAO	–	Food and Agriculture Organization of the United Nations
IAEA	–	International Atomic Energy Agency
IARC	–	International Agency for Research on Cancer
ICAO	–	International Civil Aviation Organization
IFAD	–	International Fund for Agricultural Development
ILO	–	International Labour Organization (Office)
IMF	–	International Monetary Fund
IMO	–	International Maritime Organization
INCB	–	International Narcotics Control Board
IOM	–	International Organization for Migration
ITU	–	International Telecommunication Union
OECD	–	Organisation for Economic Co-operation and Development
PAHO	–	Pan American Health Organization
UNAIDS	–	Joint United Nations Programme on HIV/AIDS
UNCTAD	–	United Nations Conference on Trade and Development
UNDP	–	United Nations Development Programme
UNEP	–	United Nations Environment Programme
UNESCO	–	United Nations Educational, Scientific and Cultural Organization
UNFPA	–	United Nations Population Fund
UNHCR	–	Office of the United Nations High Commissioner for Refugees
UNICEF	–	United Nations Children's Fund
UNIDO	–	United Nations Industrial Development Organization
UNODC	–	United Nations Office on Drugs and Crime
UNRWA	–	United Nations Relief and Works Agency for Palestine Refugees in the Near East
WFP	–	World Food Programme
WIPO	–	World Intellectual Property Organization
WMO	–	World Meteorological Organization
WOAH	–	World Organisation for Animal Health
WTO	–	World Trade Organization

The designations employed and the presentation of the material in this volume do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Where the designation "country or area" appears in the headings of tables, it covers countries, territories, cities or areas.

Preface

The 156th session of the Executive Board was held at WHO headquarters, Geneva, from 3 to 11 February 2025. The proceedings are issued in two volumes. The present volume contains the summary records of the Board's discussions and details regarding membership of committees. The resolutions and decisions, and relevant annexes, are issued in document EB156/2025/REC/1. The list of participants and officers is contained in document EB156/DIV./1 Rev.1.

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[1] As adopted by the Board at its first meeting (3 February 2025).

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[1] See page xi.

[2] See document EB156/2025/REC/1, Annex 6.

[3] See document EB156/2025/REC/1, Annex 8.

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[4] See document EB156/2025/REC/1, Annex 8.

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[6] See document EB156/2025/REC/1, Annex 8.

[7] See document EB156/2025/REC/1, Annex 4.

[8] See document EB156/2025/REC/1, Annex 5.

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[9] See document EB156/2025/REC/1, Annex 8.

[10] See document EB156/2025/REC/1, Annex 7.

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EB156/INF./2	International Health Regulations (2005) Proposed procedure for the correction of errors in the text of the instrument
EB156/INF./3	Statement by the representative of the WHO staff associations
EB156/INF./4	Report of the Ombudsperson

[11] See document EB156/2025/REC/1, Annex 8.

[12] See document EB156/2025/REC/1, Annex 6.

[13] See document EB156/2025/REC/1, Annex 2.

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Committees and selection panels[1]

1. Programme, Budget and Administration Committee[2]

Mr José Acacio (Australia), Mr Wayne Marshall (Barbados), Dr Jerome X. Walcott (Barbados, member ex officio), Mr Tovar da Silva Nunes (Brazil), Dr Said Anli Aboubacar (Comoros), Dr Pak Jong Min (Democratic People's Republic of Korea), Ms Cathrine Marie Lofthus (Norway), Dr Salih Ali Al-Marri (Qatar), Mr Andrei Cazacu (Republic of Moldova), Mr Minsoo Park (Republic of Korea), Dr Ibrahima Sy (Senegal), Dr Ali Haji Adam Abubakar (Somalia), Ms Rhena Forrer (Switzerland, member ex officio), Dr Viroj Tangcharoensathien (Thailand).

Forty-first meeting, 29–31 January 2025: Ms Cathrine Marie Lofthus (Norway, Chair), Mr José Acacio (Australia), Mr Wayne Marshall (Barbados), Dr Jerome X. Walcott (Barbados, member ex officio), Mr Tovar da Silva Nunes (Brazil), Dr Issa Ben Imani (Comoros, alternate to Dr Said Anli Aboubacar), Dr Pak Jong Min (Democratic People's Republic of Korea), Dr Salih Ali Al-Marri (Qatar), Mr Andrei Cazacu (Republic of Moldova), Mrs Hyejin Kim (Republic of Korea, alternate to Mr Minsoo Park), Dr Babacar Guèye (Senegal, alternate to Dr Ibrahima Sy), Dr Ali Haji Adam Abubakar (Somalia), Ms Barbara Schedler Fischer (Switzerland, alternate to Ms Rhena Forrer, member ex officio), Dr Viroj Tangcharoensathien (Thailand).

2. Sasakawa Health Prize Selection Panel

The Chair of the Executive Board (member ex officio), a member of the Executive Board and a representative of the founder.

Meeting of 4 February 2025: Dr Jerome X. Walcott (Barbados, Chair), Mr Marcus M. Samo (Federated States of Micronesia), Professor Etsuko Kita (representative of the founder).

3. United Arab Emirates Health Foundation Prize Selection Panel

The Chair of the Executive Board (member ex officio), a member of the Executive Board from a Member State of the WHO Eastern Mediterranean Region and a representative of the founder.

Meeting of 3 February 2025: Dr Jerome X. Walcott (Barbados, Chair), Dr Abdelkrim Meziane Bellefquih (Morocco), Dr Mohammad Salim Alolama (representative of the founder).

[1] Showing current membership and the names of those who attended the meetings to which reference is made.

[2] Showing the membership as determined by the Executive Board in decision EB155(2) (2024), with a change of representative for Comoros, the Republic of Korea, Senegal and Switzerland.

4. The State of Kuwait Health Promotion Foundation Selection Panel

The Chair of the Executive Board (member ex officio), a member of the Executive Board from a Member State of the WHO Eastern Mediterranean Region and a representative of the founder.

Meeting of 4 February 2025: Dr Jerome X. Walcott (Barbados, Chair), Ms Hilda Harb (Lebanon), Dr Hisham Kelendar (representative of the founder).

5. Dr LEE Jong-wook Memorial Prize Selection Panel

The Chair of the Executive Board (member ex officio), a member of the Executive Board and a representative of the founder.

Meeting of 3 February 2025: Dr Jerome X. Walcott (Barbados, Chair), Mr Li Mingzhu (China), Mr Kwan Baek Baek (representative of the founder).

6. Nelson Mandela Award Selection Panel

The Chair and first Vice-Chair of the Executive Board (members ex officio) and a member of the Executive Board from a Member State of the WHO African Region. A representative of the Nelson Mandela Foundation invited as an observer.

Meeting of 5 February 2025: Dr Jerome X. Walcott (Barbados, Chair), Dr Abdulla Khaleel (Maldives, first Vice-Chair), Dr Aspect J.C. Maunganidze (Zimbabwe), Ms Lebogang Lebese (representative of the Nelson Mandela Foundation as observer).

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Summary records[1]

[1] These summary records attempt to capture the essence of interventions made during the meetings recorded. The necessary summarization, involving omission of specific words spoken, is merely clerical and should not be taken to reflect any position on the part of WHO. Likewise, except where members of the Secretariat are speaking, the views expressed in statements recorded in these summary records are those of the speakers alone and do not necessarily reflect the position of WHO; and the recording of terminology or characterization of events used by speakers does not imply any endorsement or approval on the part of WHO.

First meeting

Monday, 3 February 2025, at 09:40

Chair: Dr J.X. Walcott (Barbados)

1. Opening of the session and adoption of the agenda: Item 1 of the provisional agenda (documents EB156/1 and EB156/1 (annotated))

Opening of the session

The CHAIR declared open the 156th session of the Executive Board.

Adoption of the agenda

The CHAIR said that the Executive Board was meeting at a time when global health governance was under scrutiny, multilateralism under threat and the climate crisis unrelenting, all of which heightened geopolitical tensions and conflict, posing risks to global health. Misinformation and disinformation on public health challenges affected the credibility of WHO and its ability to build consensus on and implement global health policy. The funding of WHO's global agenda demanded the Organization's full attention and required creativity to develop innovative means of financing. Since decisions made at the current session of the Executive Board would have an impact on the future of WHO as an institution, on global health governance and on the health of billions across the world, it was important to focus on concrete deliverables ensuring that the Organization was fit for purpose, sustainably financed and agile enough to address its programme of work and any health emergencies.

Presenting a summary of the previous day's informal meeting, he said that the participants had discussed critical issues; the notification by the United States of America of its intention to withdraw from the Organization, governance reform, and agenda and resolution management, particularly the financial implications of draft resolutions. They had also discussed strategic matters, such as the development of the Proposed programme budget 2026–2027 and the increase in assessed contributions, which had been supported by the Programme, Budget and Administration Committee of the Executive Board. There was a common understanding of the current difficult financial situation, in response to which WHO would pursue the twin goals of resource mobilization and efficiency gains. The need for WHO to improve communication activities had also been also highlighted.

He drew attention to the Secretariat's proposal to delete items 23.3 (Scale of assessments 2026–2027 [if any]), 23.4 (Amendments to the Financial Regulations and Financial Rules [if any]) and 26.2 (Independent Expert Oversight Advisory Committee: membership renewal [if any]), as there were no matters to discuss under those items. He took it that the Board agreed to that proposal.

It was so agreed.

The agenda, as amended, was adopted.[2]

The representative of POLAND, speaking on behalf of the European Union and its Member States, recalled that, as agreed in an exchange of letters in 2000 between WHO and the European Commission on the consolidation and intensification of cooperation, and without prejudice to any future general agreement between WHO and the European Union, the European Union attended sessions of the Board as an observer. He requested that, as at previous sessions, representatives of the European Union should be invited to participate, without vote, in the meetings of the 156th session of the Board and its committees, subcommittees, drafting groups or other subdivisions that addressed matters falling within the competence of the European Union.

The CHAIR took it that the Board wished to accede to the request.

It was so agreed.

The UNITED NATIONS DEPUTY DIRECTOR-GENERAL said that, at a time when the world was facing global threats, geopolitical tensions, deepening inequalities, climate shocks and the erosion of multilateralism, the United Nations system stood in support of WHO and its mandate. Global health needs were expanding while already diminished resources were being stretched. Against that backdrop, WHO, as the guardian of global health, was working constantly, responding to disease outbreaks, mobilizing resources for conflict-related activities, deploying life-saving resources and providing unparalleled technical expertise where it was needed most. There was much more to do, however, and the outcomes of certain 2023 high-level meetings of the General Assembly had strengthened collective resolve, resulting in, inter alia, the Pact for the Future. The United Nations development system would play a critical role in implementation of global commitments in order to see action on the ground. With the 2030 deadline for the Sustainable Development Goals fast approaching, action must be taken to build strong health systems, thereby investing in a healthy and safe world for generations to come.

2. **Report by the Director-General:** Item 2 of the agenda (document EB156/2)

The DIRECTOR-GENERAL outlined the Organization's achievements on multiple fronts in 2024: delivering an impact at the country level; supporting countries in developing systems to protect their populations from climate risks and introducing universal health coverage; expanding health services during humanitarian crises; improving access to medicines; and strengthening regulatory authorities around the world. Other achievements related to initiatives to reduce smoking and tobacco use, improve diets, prevent obesity, counter antimicrobial resistance, eliminate diseases, promote mental health among young people and maintain the momentum to address maternal and child mortality.

WHO had also responded to various health emergencies around the world, including by delivering millions of dollars' worth of supplies, and to insecurity in areas of conflict, for example by meeting acute health needs and supporting the operation of hospitals in the Gaza Strip. Attacks on healthcare were becoming the "new normal" in conflicts, and he urged Member States to implement the recommendations published by WHO for bringing to account those responsible for attacks on healthcare. Drawing on the lessons learned during the coronavirus disease (COVID-19) pandemic, WHO had strengthened its work in every dimension of emergency prevention, preparedness and response, monitoring developments of outbreaks, and scanning the world for

[2] Document EB156/1 Rev.1.

public health threats. Further to a 2024 review, the Organization's transformation process had been reprioritized and realigned with the priorities of the Fourteenth General Programme of Work, 2025–2028.

He regretted the announcement by the United States of America that it intended to withdraw from WHO and hoped that the decision would be reconsidered. In response to the main reasons cited for the withdrawal, he observed that the Organization had implemented the deepest and most wide-ranging reforms in its history, including the recommendations of the Action for Results Group to strengthen WHO country offices. It had addressed the imbalance between assessed and voluntary contributions, and its overreliance on a handful of traditional donors. It had activated its emergency incident management system even before the first COVID-19 death had been reported in China, and, in response to the multiple independent reviews of the global response to the pandemic, had taken steps, together with Member States, to strengthen global health security. As a United Nations agency, WHO was impartial and existed to serve all countries and all people. Even before the announcement by the United States of America, the Organization had been contending with a financing shortfall due to the economic difficulties faced by many countries and had been working to simultaneously mobilize new resources and reduce expenditure. In the face of the current more acute situation, it had introduced a set of measures to protect its workforce and enable it to continue carrying out its duties.

The representative of BRAZIL reaffirmed his country's support for multilateralism and emphasized the need for sustainable and predictable funding for WHO. It was essential to prioritize equitable, integrated and high-quality health services based on digital technology and a highly trained workforce, and to encourage social participation, as the entities concerned understood the plight of the most vulnerable. Efforts must be made to work together on all areas to be addressed at the current Board session. His country was committed to the climate and health agenda, which it would focus on at the thirtieth session of the Conference of the Parties to the United Nations Climate Change Conference.

The representative of CANADA welcomed the Secretariat's work to strengthen organizational integrity, transparency and accountability, which it should pursue. It was essential to continue the reform process, as the success of the Organization's work was predicated on the well-being of its workforce. Member States should return to first principles and guide the Organization, through action and intervention, as it implemented their priorities. It was imperative to provide the Secretariat with a single set of clear instructions since splitting focus across multiple resolutions led to a piecemeal approach, further straining resources and undermining the drive for efficiency gains. All resolutions were premised on the same fundamental approach and Member States should therefore provide guidance and signal priorities in a consolidated way through the core governance documents of the Fourteenth General Programme of Work, 2025–2028, and the Programme budget 2024–2025.

The representative of CHINA, noting the significant gap between developed and developing countries in accessing equitable and affordable health services, expressed firm support for multilateralism and WHO's central leading role in advancing health equity. WHO should focus on its core responsibilities, continuously improve transparency and accountability, increase representation of developing countries and involve experts from those countries in its work. It should define performance indicators to assess the effectiveness of Member States' contributions, and promote Member State-led decision-making to improve the health sector in developing countries and ensure achievement of the relevant Sustainable Development Goals. He stood ready to strengthen communication and cooperation with all parties, improve WHO governance and reform and advance the principles of inclusiveness and equity in global health.

The representative of CHILE said that her Government, which was committed to leaving no one behind, stood ready to participate in efforts to address communicable and noncommunicable diseases, broaden universal health coverage and respond to public health needs, thereby contributing to multilateral discussions on emerging challenges and health emergencies. It was clear that WHO governance needed to adapt to current challenges; transparent discussion on the necessary reforms was appreciated.

The representative of UKRAINE expressed deep concern over the potential impact of any changes to WHO's membership and funding for global health initiatives. In the current war in her country, WHO played a crucial role in emergency response and humanitarian aid, thereby helping to ensure the resilience of Ukraine's healthcare system. WHO's support was essential to ensure stability in the region and global health security. In Ukraine, where medical infrastructure and the healthcare sector were being rebuilt, collaboration must be sustained after the war to ensure long-term recovery.

The representative of MALDIVES, observing that WHO had effectively implemented much-needed reforms despite the challenging times, said that it was encouraging that work in critical areas such as climate change and health had been prioritized under the Fourteenth General Programme of Work, 2025–2028. Emerging public health threats continued to strain the fragile health system in his country, and he therefore urged WHO and its Member States to support the efforts of climate-vulnerable countries to mitigate the impact of climate-related hazards. WHO's strong focus on global health security was welcome. In the ongoing discussions on the new pandemic agreement, it was essential to ensure inclusivity and prioritize vulnerable populations. As WHO faced new geopolitical realities, the health and well-being of communities worldwide must be safeguarded.

The representative of CAMEROON, speaking on behalf of the Member States of the African Region, said that, in the aftermath of the COVID-19 pandemic, demand for health services continued to grow. The steady increase in domestic debt burdens, particularly in countries in sub-Saharan Africa, compromised the ability to invest more in health systems and hampered achievement of the Sustainable Development Goals. Although advancements in technology and artificial intelligence offered the possibility of driving progress in health-related areas, the differences in digital and health infrastructure between countries meant that such advancements could even deepen inequalities. Strengthening primary healthcare to achieve universal health coverage was important in the African Region. His group supported the finalization of the discussions on the pandemic agreement, which must be equitable with regard to technology, human resources and funding. It was concerned by the reduction in the base segment of the draft Proposed programme budget 2026–2027, supported the 20% increase in assessed contributions and recommended that budget allocations should be aligned with the results of the prioritization process. It commended the success of the first investment round and trusted that the process would continue to attract new and traditional donors, as WHO must be financed in a predictable, flexible and sustainable manner.

The representative of the FEDERATED STATES OF MICRONESIA said that WHO's activity at the country level, which clearly made a difference, including in reducing mortality and controlling disease outbreaks, required financial and human resources and global cooperation. WHO responded to the needs of the most vulnerable in countries with limited capacity but more needed to be done. In the challenging decisions ahead, it was to be hoped that the Organization would not lose sight of the fact that it was the voice of the most vulnerable. He supported the proposed 20% increase in assessed contributions.

The representative of BARBADOS said that the report of the Director-General illustrated the Organization's continued relevance in a changing world and new geopolitical climate. A fundamental review was needed of assessed and voluntary contributions, in particular the reliance on voluntary contributions, and of prioritization of programmatic areas, particularly for the Region of the Americas. WHO's investment round was more critical than ever, as were efforts to improve the governance and technical capabilities of country offices under WHO/PAHO. Programme budgets must be more responsive to individual Member States; to that end, his Government was willing to participate in discussions on the increase in assessed contributions. Prioritization of needs with regard to small island developing States must cover a broad range of issues, including climate change and the digitization of healthcare.

The representative of the DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA welcomed the Organization's successful responses to emerging health challenges and the outcome of the investment round for sustainable financing for the Fourteenth General Programme of Work, 2025–2028. While the forthcoming biennium would be particularly challenging given the financial and economic conditions, the Member State commitment to increase assessed contributions and the introduction of mechanisms to secure and mobilize resources pointed to the way forward. The Secretariat should address financial constraints more actively and transparently, with the engagement of various donors and stakeholders. He called on Member States to stand by WHO.

The representative of SENEGAL said that WHO's current resource mobilization difficulties had been further complicated by the intention of the United States of America to withdraw from the Organization. In that regard, he proposed that global health diplomacy be strengthened to urge the United States of America to revisit its decision, particularly given the reform efforts already undertaken by WHO. Equity in healthcare depended not only on money but also on global health security. The United States of America could not remain outside discussions of global health security and strategy, which must be led by WHO. He therefore called on the Organization to engage in genuine consultative dialogue with the Government of the United States of America, which would be stronger within than outside WHO. The situation also presented an opportunity for all countries to reflect on the legacy that they would leave for future generations.

The representative of POLAND, speaking on behalf of the European Union and its Member States, said that the candidate countries North Macedonia, Montenegro, the Republic of Moldova and Georgia aligned themselves with her statement. She acknowledged the potential impact on the Organization's financing of the announced withdrawal of its largest donor and urged all stakeholders to focus on WHO's financial flexibility and predictability while prioritizing core functions and strategic objectives. The cost implications of new activities must be assessed to ensure continuity of essential programmes. Urgent attention must be paid to the issues of mental health – especially among young people and those affected by conflicts – and of antimicrobial resistance and climate hazards. Her region was committed to a successful conclusion of the work of the Intergovernmental Negotiating Body to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response. The rising number of health emergencies caused by armed conflicts across the world was deplorable and she called on all parties to uphold international humanitarian law. Robust health systems were needed to achieve Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and the European Union remained committed to the promotion, protection and fulfilment of human rights, including sexual and reproductive health and rights. A skilled and motivated health workforce was critical for quality healthcare and resilient health systems, and her Region therefore supported WHO's efforts to improve workforce planning and training, and working conditions. Referring to WHO's leadership in developing evidence-based standards and guidelines,

she said that the recent politicization of discussions was concerning and urged all Member States to prioritize public health.

The representative of NORWAY said that it was important to preserve WHO's unique functions. She urged the Board to submit a realistic programme budget for 2026–2027, including the scheduled 20% increase in assessed contributions. Transparency, accountability and efficiency should be further enhanced in order to build trust; the adoption by the Seventy-eighth World Health Assembly of the process for handling and investigating potential allegations against WHO Directors-General would be an important step in that direction. Member States had to take responsibility for improving the efficiency of the governing bodies. Ensuring access to preventative and integrated services was essential. The growing number of attacks on health facilities in areas of conflict was extremely concerning since such places must remain safe havens for patients and health workers.

The representative of ISRAEL, addressing the announced withdrawal of the United States of America, said that the main problem was a potential domino effect whereby other States lost interest in the Organization and in various other international bodies. It was essential to find a way to engage in a productive discussion with the United States of America on the possibility of it reversing its decision and on the next steps. That discussion should focus on accountability, budgetary reform, structural reform – especially the Organization's focus on its core functions – depoliticization, and countering misinformation/disinformation.

The representative of ETHIOPIA said that multifaceted challenges associated with the increasing triple burden of disease, compounded by disinformation, had hampered efforts to strengthen health systems. Enhanced collaboration was crucial, including to strengthen health workforces, healthcare financing and country capacities. The Organization and its Member States were at a critical juncture for global health and had to emphasize the need for significant investment, with a view to achieving economic growth and the Sustainable Development Goals. WHO's role as a scientific and evidence-based organization that set global standards and supported their implementation, was more important than ever. She expressed support for the sustainable, predictable and flexible financing of WHO and called on Member States to honour the commitment to increase assessed contributions. She also urged Member States to accelerate the process of amending and implementing the International Health Regulations (2005) and to finalize the pandemic agreement.

The representative of BULGARIA expressed concern at the rising number of health emergencies. With health security a major priority, it was to be hoped that consensus would be achieved on certain provisions of the pandemic agreement, but it was also important to avoid duplication of initiatives when addressing global health threats, especially in a time of limited resources. Sustainable funding must be secured for WHO global health functions. Performance indicators for programme budgets should allow for objective assessments. Given the withdrawal of a major contributor, strict financial discipline was required, together with stronger monitoring and accountability. He welcomed WHO's governance reform and closer coordination with governments to better address country needs. Against a backdrop of ageing workforces and the migration of health workers, among other factors, he supported WHO's targeted action to ensure an effective and protected professional healthcare workforce. Critical issues such as antimicrobial resistance, mental health and climate change needed an urgent international response to prevent further devastating impacts.

The representative of BRUNEI DARUSSALAM said that the Seventy-seventh World Health Assembly had highlighted critical priorities, many of which remained central to the current agenda. He supported efforts to address the health impacts of climate change, such as accelerated disease burdens, and urged Member States to integrate health considerations into climate mitigation strategies with strong technical and financial support from WHO. The alarming burden of noncommunicable diseases and mental health challenges also required urgent attention. WHO's leadership in advancing various noncommunicable disease initiatives was commendable and such programmes must remain at the forefront of global health priorities, supported by sustained funding and innovative partnerships. Equally commendable was WHO's work in health emergencies. There was an urgent need to address the humanitarian crisis in the Gaza Strip and other areas of conflict. He urged all countries to uphold the principles of humanity and solidarity, strive for lasting peace, and reaffirm the commitment to multilateralism. WHO remained the cornerstone of global health governance and its strength lay in collective contributions.

The representative of the REPUBLIC OF KOREA said that the Fourteenth General Programme of Work, 2025–2028 marked a turning point for advancing the Sustainable Development Goals. Active cooperation among Member States was required to tackle emerging health threats. His Government would be actively involved in the efforts to finalize a workable pandemic agreement, and looked forward to discussing WHO's core functions and ways to prioritize WHO's work, in order to turn the current crisis into an opportunity.

The representative of AUSTRALIA, addressing the issue of health security, said that current disease outbreaks served as reminders of the need to draw on lessons learned and achieve better outcomes when responding to future emergencies. He encouraged all Member States to maintain the momentum with regard to the pandemic agreement. Board members could leverage that momentum by guiding regional counterparts. With regard to health policy priorities, WHO's work to help Member States to reorient their health systems towards primary healthcare was welcome, as that was the most efficient way to achieve universal healthcare under Sustainable Development Goal 3. His Government was a long-standing supporter of sexual and reproductive rights for everyone, everywhere.

Discussions on governance and sustainable financing of WHO had focused on resource mobilization, enhancing efficiency and prioritization. In respect of prioritization, the Secretariat should provide the Seventy-eighth World Health Assembly with clear guidance on decision-making rights, bearing in mind that WHO was Member State-driven; transparent proposals, costings and indications of funding gaps and alignment with the Fourteenth General Programme of Work, 2025–2028; and the process and timing needed to ensure a Member State-driven process. The increase in assessed contributions was critical for ensuring that WHO could play its unique role.

The representative of LEBANON expressed support for the scheduled increase in assessed contributions, given the need for further resources to deal with global challenges. The anticipated financing gap should be used as an opportunity to innovate while sustaining the improvements made over time. Advances in medical technologies required a dynamic approach to, for example, human resources, data innovation and financing, while the growing number of physical and mental health threats required emergency prevention and preparedness. She expressed support for the Secretariat's restructuring efforts but urged that WHO's role and mandate in the global health system be safeguarded. In view of the increased need for and scarcity of resources worldwide, it would be advisable to pool global funding.

The representative of THAILAND said that WHO should walk more of its talk. The Organization stated that there was no safe limit to alcohol consumption and yet wine had been served at the previous evening's reception. Four regional offices had taken the lead on the issue and had stopped serving alcohol; he invited headquarters to follow suit. The practice should become the norm at all the Organization's offices.

The representative of LESOTHO expressed support for the ongoing negotiations on the pandemic agreement and the amendments to the International Health Regulations (2005), to ensure an equitable and coordinated response to future healthcare crises. She urged WHO and development partners to provide support for low- and middle-income countries, with a view to strengthening their public health emergency preparedness and capacities. Noncommunicable and communicable diseases remained a significant burden for her country and region, and WHO's continued support in addressing such challenges was appreciated. Sustainable financing mechanisms were needed to speed up diagnosis and treatment efforts.

The representative of SOMALIA thanked the Organization for its guidance in areas such as health system strengthening and emergency preparedness, and commended the support provided to countries addressing complex health challenges. It was essential to prioritize universal health coverage to guarantee health for all.

The representative of SPAIN,[3] noting that the world faced multiple challenges requiring a coordinated response, said that the One Health and Health in All Policies approaches were crucial. In the interest of equity, it was essential to strengthen primary healthcare and to set out policies that took account of the social determinants of health. All health policies must incorporate a gender perspective, including sexual and reproductive health rights. Member States should not forget the consequences of a lack of international coordination in health emergency response and should therefore push for the successful finalization of the pandemic agreement.

Global health must not be compromised by other interests and must be a priority on all agendas. He therefore urged all Members States to reaffirm their commitment to WHO and to multilateralism.

The representative of FRANCE[3] called on all Member States to spare no efforts to ensure that the Seventy-eighth World Health Assembly adopted the pandemic agreement. As health emergencies were not limited to pandemics, it was important to augment the resilience of health systems. To that end, WHO required predictable and sustainable funding, and he therefore supported the ambitious effort to reform the Organization's funding. Investment in human resources and training in health were also crucial; he therefore welcomed the establishment of the WHO Academy in Lyon and urged all Member States to make use of it. His Government continued to defend the Organization, as the standard-setting body for public health, and multilateralism, as the means of ensuring an equitable international system that left no one behind.

The representative of DENMARK[3] said that WHO's difficult financial situation would require tough strategic choices. The growing number of human-made emergencies and their impact on human health, such as in Ukraine and the Gaza Strip, were deeply deplorable. Conflict resulted not only in victims but also in the destruction of health infrastructure. Multilateral cooperation and innovation were important to secure the sustainability of health systems.

[3] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND[4] said that his Government had pledged millions of pounds in fully flexible funding in the 2024 investment round to support the delivery of WHO's transformation efforts. Commending WHO's interventions in conflicts and crises, he said that 2025 would be a critical year for protecting global health. His Government remained committed to, inter alia, improving global health outcomes, protecting global health security, including through a new pandemic agreement, and tackling the health impacts of conflicts and noncommunicable diseases. International collaboration was crucial to achieving the collective goal of health for all, and his Government was keen to pursue its collaboration with WHO and Member States, including on prioritization efforts in the light of WHO budget pressures.

The representative of MOZAMBIQUE,[4] expressing deep thanks for WHO's support in the face of disease outbreaks and climate disasters, observed that the Organization provided aid where others could not, its employees often working at great risk to their own safety and security. All Member States should make efforts to improve their contributions and mobilize more partners, to allow WHO to accomplish its purpose to promote health and prevent disease, particularly given the current financial crisis. Her Government was endeavouring to increase its assessed contribution and would try to contribute to the investment round. It was committed to working with other Member States to conclude the pandemic agreement in May 2025.

The representative of ESWATINI[4] reaffirmed his Government's dedication to strengthening primary healthcare as the foundation for resilient health systems, ensuring services reached the most vulnerable; enhancing pandemic preparedness and response through regional collaboration and investment in health security; and addressing the double burden of disease. Decisions resulting from the discussions in the current Board session must translate into tangible improvements for all people, with global health equity at the centre of collective efforts.

The representative of FINLAND[4] said that, as things currently stood, the potential to reach the health-related Sustainable Development Goals by 2030 seemed to be slipping away. The Secretariat must guide Member States, provide accurate and up-to-date information and support responses to health threats. WHO and multilateral cooperation were key to ensuring sustainable and timely access to innovation and new technologies to address health challenges. Many Member States were limited in their ability to increase their assessed contributions and the withdrawal of WHO's biggest financial contributor left a gaping hole in finances. WHO was also losing many of its critical experts, and its cost structure and activities must be adjusted. Solidarity and a pragmatic approach to prioritization were essential to ensuring that WHO's crucial work continued.

The representative of URUGUAY,[4] describing measures taken in his country to address, inter alia, the impact of climate change on health and regulation of traditional healthcare, expressed gratitude to the Organization for tackling priority issues that affected global health and reaffirmed his commitment to the principles of the Organization.

The representative of JAPAN[4] said that WHO must fully leverage its expertise and take the lead, based on scientific evidence, to address global health challenges. It should prioritize infectious disease crisis management, as recent outbreaks had underscored the critical importance of disease prevention, preparedness and response. It should also prioritize its unique normative role, particularly in relation to the International Health Regulations (2005).

[4] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of BANGLADESH[5] said that international organizations were created precisely to provide international support when there were resource constraints at the national level. In view of the lessons learned from the COVID-19 pandemic, his Government strongly advocated diversification of production facilities across continents to make treatment available to all people. He expressed deep concern at the attacks on health services in conflict-stricken areas and urged that enhanced support be provided to the people of the Gaza Strip and Palestine. Despite the current financial constraints, interruptions to the WHO programme in vulnerable societies would be unfortunate and it fell to the Organization as a whole to sustain its activities. Caution should be exercised when addressing WHO expenditure on staff, taking into account that future recruits might be discouraged by career uncertainty.

The representative of EL SALVADOR[5] welcomed the report of the Director-General and outlined the progress made in his country with regard to measures to address the impact of climate change on health, among others. He supported efforts on digital training and artificial intelligence to optimize health services. Noting the budget challenges facing WHO, he trusted that the Organization would draw on its expertise to deliver results in an equitable and efficient manner.

The representative of BOTSWANA[5] said that, like many low- and middle-income countries, his country faced a disproportionately high burden of noncommunicable diseases. She therefore called on WHO to prioritize support for Member States to meet their noncommunicable disease targets ahead of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases in 2025. She remained optimistic that the Intergovernmental Negotiating Body would complete its work on the pandemic agreement in time for it to be considered at the Seventy-eighth World Health Assembly.

The representative of GERMANY[5] called on all Member States to provide robust and sustainable financial support so that WHO could fulfil its mandate while maintaining its independence and responding to health emergencies. Financing WHO was a shared responsibility and an investment in both global health and national health systems. The current financial outlook, coupled with increasing demands from Member States, was concerning. Continuity of WHO's essential programmes must be prioritized and the cost implications of new actions, including resolutions, must be assessed. She suggested that there be fewer resolutions and clear costing estimates from the outset.

The representative of IRELAND,[5] noting the intended withdrawal of the United States of America from WHO, expressed firm support for the Organization. In the face of global health challenges whose impact was felt collectively, beyond national borders, the international community had to work together. WHO's growing responsibilities made financial sustainability and predictability crucial, and the cost implications of any new activities should therefore be assessed to ensure the continuity of existing essential programmes.

The representative of CHAD[5] welcomed the activities of the Organization, including the establishment of the WHO Academy, which would help to strengthen the capacities of workers on the ground. Outlining the situation in his country, particularly migratory flows of refugees and displaced persons, he called on international partners to support efforts to address the related challenges. Interruptions to the financing of the Organization would have a significant impact on people's health in the African Region.

[5] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of the RUSSIAN FEDERATION[6] said that the international community supported WHO in maintaining its leading role in global health and an effective selection process for the Organization's priorities was therefore important. His Government was willing to continue to provide expertise and support to the Organization, particularly in fighting communicable and noncommunicable diseases. The inclusion on the agenda of irrelevant or politicized items had led to more important issues being ignored. Climate change issues were addressed under several agenda items, while other topics were addressed together, which made discussion more difficult. Restrictive measures taken by individual countries affected not only WHO but also ordinary people and prevented the sustainable financing of the Organization, thereby undermining its ability to respond to health emergencies. Decisions on, for example, the adoption of the pandemic agreement should be taken by consensus.

The representative of NAMIBIA[6] said that the theme of the 2025 World Health Day (Healthy beginnings, hopeful futures) was timely considering the approaching deadline for meeting the Sustainable Development Goals. The draft Proposed programme budget 2026–2027 and efforts to ensure transparency, efficiency and accountability in its formulation were welcome. He supported the 20% increase in assessed contributions and called for budget considerations that addressed country-specific priorities. Predictable, flexible and sustainable financing for WHO was essential, and the Organization's resource mobilization efforts were therefore welcome. Investment in workforce training was crucial for strong and resilient health systems.

The representative of BELGIUM[6] condemned all attacks on healthcare professionals and infrastructure. The humanitarian situation in eastern Democratic Republic of the Congo was alarming, and he called for respect for international humanitarian law and human rights. The intention of the United States of America to withdraw from the Organization was deeply regrettable, as it weakened multilateralism and global health. It was important to focus on the Organization's core mission and to collectively foster meaningful multilateralism that delivered concrete results on the ground. WHO's efforts to combat misinformation were also critical. He expressed concern about the inclusion on the Board's agenda of numerous items that would entail sensitive and lengthy discussions, and would welcome a more streamlined decision-making process, with fewer resolutions, to obtain a realistic set of priorities.

The meeting rose at 12:30.

[6] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Second meeting

Monday, 3 February 2025, at 14:35

Chair: Dr J.X. Walcott (Barbados)

1. Report by the Director-General: Item 2 of the agenda (document EB156/2) (continued)

The representative of SLOVAKIA said that the challenges ahead required decisive action, strategic prioritization and sustainable commitment from all Member States. To address challenges and sustain critical programmes, there was a need for innovative approaches, close collaboration with Member States through transparent priority reassessment; enhanced financial sustainability through flexible and innovative funding; and a more robust governance framework based on a science-led analysis of gaps and risks to ensure that new commitments aligned with available resources. Efforts to strengthen regulatory oversight should be accelerated to ensure equitable access to medicine and health technologies, particularly for vulnerable populations and those in humanitarian need. Sustainable financing models were needed to prevent catastrophic out-of-pocket spending. To tackle noncommunicable diseases, there should be greater technical and financial investment in WHO's leadership role in the development of behavioural and social science to continue shaping effective public health innovations. The Organization's financial realities must be addressed with reforms, efficiency and stronger global cooperation. He called on Member States to support WHO's financial sustainability measures, including the proposed 20% increase in assessed contributions; to engage constructively in governance reform, ensuring that WHO could remain focused on its most important and pressing priorities and normative role; and to strengthen global solidarity and multilateralism, recognizing that a well-funded and effective WHO was in the collective interest of all nations.

The representative of TOGO expressed appreciation for the Secretariat's continued support for Member States in combating communicable and noncommunicable diseases and in responding to health emergencies. She encouraged the broadening of the donor base and the optimal use of mobilized resources while prioritizing country needs. The Secretariat should also ensure flexibility, transparency and predictability in financing and in strengthening solidarity.

The representative of GUINEA-BISSAU,[1] commending the Organization for its stewardship and its contribution in the response to global health challenges, said that continued investment in public health was essential to prevent future crises and save lives.

The representative of the PHILIPPINES[1] said that WHO's resilience would enable it to face sustainable financing challenges. By working closely with Member States and in line with the Fourteenth General Programme of Work, 2025–2028, WHO could fulfil its obligations in terms of global health governance. Carrying out the Organization's mandate required consistent and

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

sustainable financing. Member States must take bold and decisive action to ensure greater investment in health through increased assessed and voluntary contributions, in order to achieve the outputs and priorities set forth in the Fourteenth General Programme of Work, 2025–2028. His Government's participation in the investment round had demonstrated that every economy could contribute substantially to sustaining regional and global efforts. He highlighted the importance of addressing shared health challenges through multilateralism and collective action. The priority should be to sustain, manage and adequately resource WHO, with a strong focus on results, value for money and equity.

The representative of PORTUGAL[2] said that urgent action was needed to integrate health into climate policies, ensuring mitigation and adaptation efforts to protect vulnerable populations. The fourth high-level meeting of the General Assembly on the prevention and control of non-communicable diseases would provide a critical opportunity for strong commitments on prevention, early detection and equitable care to tackle the growing burden of noncommunicable diseases, including mental health.

In view of the devastating effects of active conflicts on health systems and lives worldwide, he called for an end to hostilities and the protection of healthcare under international law. Global health challenges demanded solidarity, and the Organization's role in uniting nations was indispensable. Member States must rally behind WHO to strengthen its mandate and safeguard global health.

The representative of SINGAPORE[2] said that, given budgetary concerns, there was greater impetus to advance the transformation agenda to make the Organization leaner and more effective. Member States should help WHO to prioritize its work to focus on the most impactful initiatives, informed by country and regional contexts. WHO must be adequately resourced to do its work; she therefore expressed support for the proposed 20% increase in assessed contributions.

The Observer of PALESTINE said that while the occupied Palestinian territory, including east Jerusalem, had long been overrun by multiple emergencies, the year 2024 had been the worst yet, as Israeli attacks on healthcare facilities and workers had led to poliovirus outbreaks and the collapse of the public health system. Strong commitment was required from the international community to rebuild the Palestinian public health sector and support mental health programmes to address the trauma faced by Palestinians. WHO programmes must be sustainably funded.

The representative of the PLURINATIONAL STATE OF BOLIVIA[2] said that, amid global crises and actions that were challenging international law and undermining multilateralism, it was essential to promote dialogue and close cooperation with a view to strengthening WHO's work, ensuring its effective functioning and overcoming contemporary challenges. The right to health must be defended through joint efforts, including on health systems strengthening and health emergency prevention, preparedness and response. An ambitious pandemic agreement was needed that centred on equity and solidarity, to enable a more effective pandemic response. She stressed the importance of avoiding politicization and double standards in WHO programmes and plans, which should adopt a gender-sensitive approach and include Indigenous Peoples and people in vulnerable situations; in particular, the draft global traditional medicine strategy: 2025–2034 should ensure respect for and the preservation of Indigenous knowledge.

[2] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of SOUTH AFRICA[3] expressed support for the continued predictable funding of WHO. Noting that the programme budgets for the implementation of the Fourteenth General Programme of Work, 2025–2028 were being drawn up during a time of financial and political difficulties, she called on the global community to remain resolute and foster innovation in responding to those challenges. Her Government continued to support the increase in assessed contributions, which should be coupled with robust resource mobilization efforts in the context of the investment round. Solidarity and commitment were needed from all actors if the world was to get back on track towards the achievement of the Sustainable Development Goals. In particular, a commitment to building resilient health systems by strengthening primary healthcare and ensuring universal health coverage would remain fundamental to the achievement of health equity. Addressing universal health coverage would be key to ensuring the availability of adequate human resources and implementing the Fourteenth General Programme of Work, 2025–2028. To support Member States in building relevant capacities, there was an urgent need to finalize the work of the Intergovernmental Negotiating Body to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response.

The representative of the ISLAMIC REPUBLIC OF IRAN[3] said that, at a time when multilateralism was under severe pressure, Member States needed to strengthen international solidarity and promote equity at the global level. Working together to bridge the gap between developing and developed countries would help to achieve the highest attainable standard of health for all. In the light of recent budgetary concerns, a realistic and comprehensive approach to adjusting or resetting the Organization's priorities would support efforts to achieve its goals. The consultation process should remain inclusive and involve all Member States, including those in the Eastern Mediterranean Region, which were the most affected by debilitating challenges.

The representative of the UNITED REPUBLIC OF TANZANIA[3] urged Member States to finalize negotiations on a pandemic agreement through the Intergovernmental Negotiating Body. Collective efforts among Member States and partners were needed to address persistent challenges such as limited access to healthcare, inadequate health infrastructure and the need for robust health data systems.

The representative of MALAYSIA[3] expressed support for the Fourteenth General Programme of Work, 2025–2028. The base segment of the programme budget should respond to the unique needs of Member States and seek to strengthen country capacities and enhance WHO's accountability. Her Government remained committed to the proposed 20% increase in assessed contributions, which should be accompanied by appropriate governance reforms and improvements in transparency, efficiency, accountability and compliance. Member States should support the investment round to increase voluntary contributions.

There was an urgent need to address health challenges such as the increasing burden of noncommunicable diseases, communicable diseases and climate change. Hospitals and health facilities must remain safe havens for patients and health workers. Her Government continued to advocate for the rights of the Palestinian people and would play a role in rebuilding the Gaza Strip. She invited countries to mobilize efforts to rebuild the Gaza Strip and the occupied Palestinian territory and to alleviate the suffering of the Palestinian population.

The representative of ZAMBIA[3] underscored the importance of realistic and pragmatic budgeting, and priority-setting criteria in budget allocation that focused on WHO's core functions

[3] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

and country-level interventions. The Secretariat should prepare a comprehensive analysis regarding priority-setting and the impact of additional activities on the programme budget. In the light of the significant budgetary implications of recent resolutions on the draft Proposed programme budget 2026–2027, she expressed support for a further review and streamlining of resolutions and decisions. It was necessary to find innovative ways to broaden the donor base to reduce dependency on earmarked funds.

The DIRECTOR-GENERAL thanked Member States for expressing their confidence in the multilateral system and highlighting the central role played by WHO in global health. The Secretariat would work hard to ensure that the Organization continued to adapt to changing situations. Member States' support for sustainable financing was deeply appreciated since volatility and a lack of flexibility in funding made it difficult to plan and provide tailored support to countries, thus hindering the achievement of the Sustainable Development Goals. Sustainable financing would also help the Secretariat to support staff employed on temporary rolling contracts. He encouraged Member States to support the second phase of the proposed increase in assessed contributions, which would be especially important in view of the current situation. The Secretariat would welcome further guidance from Member States with regard to new financing mechanisms.

The Board noted the report.

2. Report of the regional committees to the Executive Board: Item 3 of the agenda (document EB156/3)

The representative of QATAR, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that discussions at the 71st session of the WHO Regional Committee for the Eastern Mediterranean had underscored a shared commitment to strengthening health systems, improving access to essential health services and addressing pressing health challenges that had a disproportionate impact on the Region. Member States had recognized that achieving universal health coverage and sustainable development required collective action, political will and strategic investment in public health. The endorsement of the Strategic Operational Plan for the Eastern Mediterranean Region, 2025–2028, had demonstrated the Region's ambition to build more resilient, responsive and equitable health systems. That vision would be translated into action aimed at tackling public health challenges such as improving trauma care in humanitarian settings, combating antimicrobial resistance and promoting mental health support in emergencies. Strengthening local vaccine production capacities, laboratory services and the digital transformation of the health system would be crucial to the provision of timely and quality healthcare services. Member States in the Region remained committed to accelerating progress on the Immunization Agenda 2030.

Effective governance and sustainable financing were essential to translating strategies into actions. Discussions on WHO's investment case, the programme budget and ongoing global health negotiations had reinforced the importance of securing predictable resources and ensuring that WHO remained fit for purpose in responding to global and regional health challenges. Member States had reaffirmed their commitment to addressing noncommunicable diseases, including by extending the mandate of the High-level Ministerial Group on the Control of Tobacco and Emerging Tobacco and Nicotine Products in the Eastern Mediterranean Region and calling for stronger regional and global collaboration to tackle other public health threats.

The representative of ZIMBABWE, speaking on behalf of the Member States of the African Region, offered condolences for the passing of the Regional Director-elect, Dr Faustine Ndugulile. Issues of particular importance for his Region included the rising burden of noncommunicable diseases, owing to ageing populations, urbanization, globalization and trade and limited healthcare infrastructure; the slow progress of negotiations on the pandemic agreement, especially considering recent infectious disease outbreaks in the Region; and the need to build sustainable health systems. Climate-resilient programmes must be scaled up in the Region, given the need to protect livelihoods, enhance food security, support human health, reduce poverty and inequality and promote sustainable development.

The Member States of the Region had been fully involved in the Organization's initial investment round, which would create an Organization capable of taking the lead on pressing global health threats and initiatives. Establishing a fund similar to the South-East Asia Regional Health Emergency Fund could help countries in the African Region to mount a swift response to natural disasters, epidemics and other crises, improve coordination and collaboration, enhance preparedness and resilience and increase accountability and transparency. Increasing multilateral collaboration to support local manufacture of medicines, vaccines and other technologies would improve access to vaccines, create jobs, boost health security and reduce dependence on external aid.

The representative of the REPUBLIC OF MOLDOVA commended the efforts made by the Secretariat and the regional committees in fostering alignment between regional and global health priorities and welcomed decisions adopted by the WHO Regional Committee for Europe on preparedness, response and resilience; resilient and sustainable health systems; and emergency medical teams. Equitable access to medical products, local vaccine production and health workforce resilience were essential to achieving universal health coverage and sustainable healthcare financing.

The representative of TOGO commended the WHO Regional Office for Africa on the implementation of the transformation agenda and flagship health emergency prevention, preparedness and response initiatives. She called on the Secretariat to support the realization of an expedited process for the nomination of a new Regional Director for Africa; ensure equitable resource allocation, taking into account regional priorities; expedite negotiations on a pandemic agreement; and strengthen multisectoral collaboration.

The representative of INDONESIA[4] noted with appreciation the discussions on the reassignment of her country from the South-East Asia Region to the Western Pacific Region, which had taken place at recent meetings of the regional committees. Most countries sharing land or maritime borders with, and maintaining direct flight routes to, Indonesia were situated in the Western Pacific Region, which generated a heightened epidemiological risk at points of entry and underscored the importance of a robust cross-border surveillance and response. Shifting demographics, the growing noncommunicable disease burden and the intensification of climate change-related health risks demanded the development of comprehensive strategies in coordination with countries with similar epidemiological profiles. Reassignment to the Western Pacific Region would allow her country to contribute more effectively to WHO and the regional health agenda and to align its health priorities with those of its neighbours and ASEAN Member States, while also providing opportunities for mutual learning and regional collaboration. Her Government would continue to engage with Member States of the South-East Asia Region in bilateral and multilateral forums to advance health priorities.

[4] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The REGIONAL DIRECTOR FOR AFRICA expressed condolences on the passing of the Regional Director-elect for Africa. The recent review by the WHO Regional Committee for Africa of the impact of the transformation agenda in the Region had enhanced resource allocation to country offices and had permitted faster outbreak detection and response. Lessons learned from the COVID-19 pandemic and climate change emergencies were being transformed into strategies to strengthen national health systems, and almost 90% of countries in the Region now had national health system strategies based around primary healthcare. The Regional Committee had discussed the close connection between epidemic preparedness and response and health systems strengthening. It had drawn on the experience of small island developing States that had established a pooled procurement mechanism to reduce the cost of essential medicines by over 40% in some cases. The Regional Office was sharing those experiences with the African Union to support its efforts to address the high cost of medicine procurement in the Region. There had been agreement on the need to build on the progress made in increasing the percentage of women employed at the Regional Office in Professional and higher categories. Key frameworks had been adopted on climate-resilient health systems, local production of medicines and vaccines, diabetes prevention and control, data integration and digitalization and strengthening the health systems preparedness and response architecture. The need for predictable and flexible funding had been emphasized, and Member States had responded by reaffirming national health financing commitments and supporting an increase in assessed contributions, pledging over US$ 45 million to the investment round.

The REGIONAL DIRECTOR FOR THE AMERICAS said that, at its 76th session, the WHO Regional Committee for the Americas had discussed the draft Proposed programme budget 2026–2027, emphasizing the importance of transparency, efficiency and measurable impact in that regard. Member States had noted the proposed 20% increase in assessed contributions and had requested the Secretariat to outline various funding scenarios. Member States had stressed the importance of regional participation in the work of the Intergovernmental Negotiating Body to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response. In addition, they had expressed confidence in the existing Regional Director election procedure while expressing their openness to potential improvements and underscoring the need to preserve regional autonomy, given that the Regional Office also functioned as an independent organization in the inter-American system. The Regional Committee had endorsed the Roadmap for Developing the Strategic Plan of the Pan American Health Organization 2026–2031, which addressed regional and global priorities, and had adopted 14 resolutions on a range of health topics. Member States had received briefings on issues relevant to the Region, and an event relating to the investment round had been held, with representatives of Member States, non-State actors, donors and stakeholders.

The REGIONAL DIRECTOR FOR THE EASTERN MEDITERRANEAN said that the recently adopted Strategic Operational Plan for the Eastern Mediterranean Region, 2025–2028, would guide implementation of the Fourteenth General Programme of Work, 2025–2028, in the Region and included flagship initiatives to strengthen the health workforce, tackle substance use and promote equitable access to medical products. The plan contained interventions aimed at supporting WHO transformation by streamlining processes, improving the support provided to countries and leveraging partnerships through the Regional Health Alliance. The WHO Regional Committee for the Eastern Mediterranean had also adopted a regional operational framework for trauma care in humanitarian settings, a regional action plan for mental health and psychosocial support in emergencies, and regional instruments on several key issues.

The REGIONAL DIRECTOR FOR EUROPE said that, following five years of unprecedented turbulence, it was clear that there was no national security without health security. The WHO Regional Committee for Europe had therefore adopted the Strategy and action plan on health emergency preparedness, response and resilience in the WHO European Region (Preparedness 2.0), its first regional action plan on emergency medical teams and a regional framework for resilient and sustainable health systems. Transparency, accountability and efficiency were key to maintaining the trust of Member States at a time of fiscal constraints; the continued groundbreaking work on participatory governance by countries in the Region was therefore appreciated.

A European programme of work for the period 2026–2030 was being developed through an innovative process and would be grounded in technical excellence and financial sustainability. Consultations would be convened to discuss the main trends shaping health in the Region. The programme of work would be aligned with the Fourteenth General Programme of Work, 2025–2028 and the Sustainable Development Goals, and foresight exercises were being conducted using artificial intelligence while respecting privacy.

The REGIONAL DIRECTOR FOR SOUTH-EAST ASIA said that, at its 77th session, the WHO Regional Committee for South-East Asia had emphasized the need for collaboration, innovation and solidarity to transform the Region's health landscape. Cooperation among countries and WHO regional offices was instrumental in improving health for all. The Regional Committee had adopted two decisions and four resolutions, including a resolution endorsing a ministerial declaration on adolescent-responsive health systems. Over US$ 345 million had been pledged by Member States and partners during the investment round. The Regional Committee had agreed to increase the corpus of the South-East Asia Regional Health Emergency Fund to US$ 3 million and had endorsed the Strategic Plan for measles and rubella elimination and sustenance in the WHO South-East Asia Region: 2024–2028. While the Regional Committee had urged the Government of Indonesia to reconsider its request to be reassigned from the South-East Asia Region to the Western Pacific Region, that decision had been respected. Member States had commended initiatives to strengthen transparency and accountability regarding leadership positions in WHO. The Regional Committee had expressed support for the proposed measures for nominating and appointing Regional Directors and had agreed to establish an evaluation group to assess candidates' suitability and qualifications.

The REGIONAL DIRECTOR FOR THE WESTERN PACIFIC highlighted the recent endorsement of the new vision for the Region, entitled Weaving health for families, communities and societies in the Western Pacific Region (2025–2029), which stressed the importance of working collectively to achieve the highest possible level of health and was aligned with the Fourteenth General Programme of Work, 2025–2028. The Regional Committee had also addressed other key topics at its 75th session, including health financing, digital health, climate resilience, primary healthcare and oral health. An exhibition called "Weaving health for all" had highlighted innovative approaches to delivering health services, even in challenging situations, and a side event to the investment round had showcased the Region's solidarity and commitment, with non-traditional donors and small Pacific island States pledging their support.

The Board noted the report.

3. Report of the Programme, Budget and Administration Committee of the Executive Board: Item 4 of the agenda (document EB156/4)

The CHAIR reminded the Board that the Programme, Budget and Administration Committee of the Executive Board had considered items on the agenda for the current session of the Board. The Board would be invited to consider the Committee's recommendations on each relevant agenda item as it came under discussion by the Board.

The representative of NORWAY, speaking in her capacity as Chair of the Programme, Budget and Administration Committee of the Executive Board, said that the Committee's forty-first meeting had taken place against the backdrop of a precarious financing situation, given the recent announcement by the United States of America of its intention to withdraw from the Organization. The Committee had agreed on recommendations regarding a reduced draft Proposed programme budget 2026–2027, a way forward for implementing further budget revisions and a 20% increase in assessed contributions. The Committee had made a number of other recommendations to the Board, including on governance reform; engagement with non-State actors in official relations with WHO; and amendments to the Staff Regulations and Staff Rules.

The Committee had welcomed the observations and recommendations of the Independent Expert Oversight Advisory Committee. The Committee had called on the Secretariat to continue providing adequate funding for internal audits and investigations, and implementing the risk management framework and the recommendations of the Advisory Committee. In response, the Secretariat had confirmed that the capacity of the Office of Internal Oversight Services had been substantially expanded and a process to update the accountability framework had begun. The Secretariat had also stated that greater attention was being paid to the evaluation function and its recommendations for regular monitoring of all accountability functions. The Committee had proposed that the recommendations contained in the report of the Advisory Committee should guide the Secretariat's implementation of existing mandates.

The representative of SENEGAL, speaking on behalf of the Member States of the African Region, said that his Region would feel the greatest impact of the withdrawal from WHO by the United States of America and called on Member States to show solidarity and bridge the gap until a sustainable structural solution could be found. He urged Member States to respect their commitment to a 20% increase in assessed contributions and welcomed the consensus reached on the options presented for the implementation of the draft Proposed programme budget 2026–2027. Core functions should be strengthened at the country level, taking into account data, innovation and research, while maintaining transparency and accountability. The Secretariat should promptly report on the results of resource mobilization mechanisms and their anticipated use over the forthcoming biennium. The Organization's limited resources should be mobilized to respond to priorities identified by Member States.

He encouraged the Secretariat to promote a multisectoral approach to the prevention of sexual exploitation, abuse and harassment. The Secretariat should continue holding discussions with Member States to identify further areas for WHO reform, taking into account the need to strengthen country-level impact, and should report on the progress and impact of the implementation of reforms.

The representative of BRAZIL said that WHO's dedicated staff deserved the highest respect. Governance reform and sustainable financing went hand in hand, and Member States and the Secretariat had the responsibility to steer the Organization with efficiency, transparency and accountability. Member States must support WHO in their shared pursuit of health equity.

The representative of CHINA said that several countries had raised concerns about budget-related issues at the most recent meeting of the Programme, Budget and Administration Committee that required further in-depth discussion.

The Board noted the report.

Pillar 4: More effective and efficient WHO providing better support to countries

4. Management and governance matters: Item 24 of the agenda

Governance reform: Item 24.2 of the agenda

- **Member State-led governance reform** (documents EB156/29 and EB156/29 Add.1)
- **Process for handling and investigating potential allegations against WHO Directors-General** (documents EB156/30 and EB156/30 Add.1)
- **Secretariat implementation plan on reform** (document EB156/32)

The CHAIR invited the Board to consider the reports contained in documents EB156/29, EB156/30 and EB156/32. The Board was also invited to consider the draft decision contained in document EB156/29 and the draft decision contained in paragraph 29 of document EB156/4, the financial and administrative implications of which were contained in documents EB156/29 Add.1 and EB156/30 Add.1, respectively.

The representative of NORWAY, speaking in her capacity as Chair of the Programme, Budget and Administration Committee of the Executive Board, drew attention to the recommendations and guidance proposed by the Committee, set out in paragraphs 24–33 of document EB156/4.

The representative of SENEGAL, speaking on behalf of the Member States of the African Region, said that, while the progress made on the Secretariat implementation plan on reform was commendable, the report had mainly focused on WHO headquarters and had not highlighted the significant achievements attributable to the African Region. The Secretariat should increase regional and country interventions to strengthen country-level impact and include the results of the introduction of new reforms and implementation of existing reforms in subsequent reports.

In the light of the current financial context, he invited the Secretariat to submit an updated overview of the financial implications of resolutions and engage in a people-centred priority-setting exercise, taking into account resolutions already in force and their connection to existing programmes, with a particular focus on those concerning digitalization.

The governing bodies must be involved as decision-makers at key stages in the process for handling and investigating potential allegations against WHO Directors-General; the Member States of the Region would therefore not support the attribution of decision-making powers to an external investigative entity. The decision to open a full investigation following an allegation should be taken by the Board with the full participation of Member States. He welcomed the draft decision contained in document EB156/30 and encouraged the Chair of the Programme, Budget and Administration Committee to organize a full, inclusive and transparent consultation with Member States to reach consensus on the outstanding issues.

The representative of CANADA said that approaching agenda items in a comprehensive and integrated manner and clarifying their correlation to core governing bodies documents would

enable Member States to continue working towards a system focused on the governing bodies' core purpose of providing the Organization with appropriate guidance and oversight.

Regarding the process for handling and investigating potential allegations against WHO Directors-General, she expressed support for the proposal for the Chairs of the Board and the Programme, Budget and Administration Committee to resolve remaining areas of divergence through inclusive, transparent and participative engagement with Member States. She expressed confidence that Member States would soon reach agreement on a clear and thorough process to handle such allegations. That would ensure that future potential allegations were handled quickly and fairly; protecting the WHO's integrity and reputation, and demonstrating that Member States were strengthening organizational governance and transparency, with the support of the Secretariat. The agenda item should not be closed until consensus was reached.

The representative of SOMALIA, speaking on behalf of the Member States of the Eastern Mediterranean Region, highlighted the importance of establishing a robust and transparent framework for handling and investigating potential allegations against WHO Directors-General; ensuring that such procedures adhered strictly to the Organization's legal and procedural frameworks; and preserving the independence of the investigation process while upholding the authority of WHO's governing bodies in overseeing such matters. The investigation process must be free from external interference and politicization, and the Organization's integrity must be preserved by ensuring that investigations were conducted by an independent entity in a manner that maintained confidentiality, protected all parties concerned and maintained Member States' trust in WHO's governance. The finalized procedures must balance transparency with the protection of due process, ensuring that investigations were fair and conducted in line with internationally recognized standards. He encouraged Member States to hold further deliberations to resolve outstanding areas of divergence, maintaining a strong commitment to accountability and good governance. WHO's institutional framework was fully equipped to manage such processes internally.

The representative of POLAND, speaking on behalf of the European Union and its Member States, said that the candidate countries of Türkiye, North Macedonia, Montenegro, Albania, Ukraine, the Republic of Moldova, Bosnia and Herzegovina and Georgia aligned themselves with her statement. To ensure that the Board was equipped to perform its functions, in particular to prioritize and allocate resources effectively, it would require a greater understanding of the connections between proposed resolutions and the Organization's general programmes of work, and their impact on programme budgets. She therefore called for enhanced efforts to explain how resolutions were aligned with general programmes of work and their core priorities and how they would contribute to achieving WHO's objectives. Evidence of the impact of resolutions and consideration of equity in health outcomes could also help the Board in prioritizing interventions. Enhanced financial transparency and a comprehensive understanding of the costs and impact of draft resolutions – such as detailed estimates of implementation costs, human resource requirements and long-term financial sustainability – would help the Board in identifying which elements were meaningful, impactful and feasible.

The number of resolutions proposed should be prioritized in accordance with available funding and resources and good agenda management practices; while the responsibility for that process rested with Member States, the Secretariat's support was also needed. Given the Organization's budgetary constraints, the European Union would temporarily refrain from sponsoring resolutions, pending the presentation of the revised and reprioritized draft Proposed programme budget 2026–2027. The Secretariat was requested to share an updated overview of the expected costs of all resolutions, taking into account the expected availability of financing in 2025 and the revised draft Proposed programme budget 2026–2027.

An independent entity, selected and appointed by the Board, should be made responsible for investigating allegations against Directors-General, rather than the Board itself.

The representative of BULGARIA said that governance reform should be carried out in an integrated and systematic manner and aligned at all three levels of the Organization. It was important to remember that changing one component would have ripple effects throughout the system. In view of the need for stricter financial management, the Board should discuss whether to require Member States to express their intent to submit a draft resolution, in order to avoid the proposal of similar resolutions. The Board could consider providing preliminary support to Member States that had provided financial implications with their proposals and had amassed the support of at least 30 other countries. She highlighted the need for closer alignment between proposed resolutions and general programmes of work and consideration of their effect on the programme budget.

An independent entity selected and appointed by the Board – if not the Executive Board itself – should be in charge of the process for handling and investigating potential allegations against WHO Directors-General and should determine whether to close a case or proceed to a full investigation. In the case of the latter, the Board should be involved in the process in an inclusive manner to ensure an unbiased and transparent procedure and minimize the possibility of political pressure.

The risks associated with limited human resources could be mitigated by establishing an improved selection process and ensuring the optimal use of human resource capacities on the basis of staff members' strengths. In the light of recent financial developments, the Organization needed a realistic budget that balanced ambition and capacity with due prioritization and closer coordination with governments on domestic health challenges. That would better address country needs, enhance country impact and support the implementation of the Fourteenth General Programme of Work, 2025–2028.

The representative of THAILAND said that Member States' right to propose agenda items and draft resolutions should be protected. Resolutions would be easier to manage if Member States focused only on operative paragraphs, which should be kept to a minimum to avoid lengthy resolutions. Prioritization of budget allocations should be the responsibility of the Director-General. Noting that some technical departments had convinced Member States to propose certain agenda items or draft resolutions to secure a budget for the department's work, she called on the Secretariat to implement a system to manage such action. WHO might not need a certain amount of funding to implement each resolution; its international standing could be sufficient to achieve its targets, particularly as the Director-General's endorsement of an initiative could lead to change.

The representative of AUSTRALIA said that implementing governance reforms must be a priority for Member States. The structure of the governing bodies should be reoriented to make the Board more strategic and the Health Assembly more action-oriented, thus reducing duplication and enabling Member States to engage meaningfully on the right issues at the right time. Systemic controls should be established to moderate the number of resolutions and ensure their timely alignment with the general programme of work. The Secretariat could present a white paper to the Health Assembly outlining issues concerning Member State control and decision rights, transparency and relevant processes. He expressed support for the draft decision on Member State-led governance reform.

The finalized procedure for handling and investigating potential allegations against WHO Directors-General must ensure that independent investigations would be conducted in a manner that upheld full due process and protected all parties without the hinderance of politicization,

interference or conflicts of interest. Since it appeared that there was an opportunity to finalize the procedure at the current session of the Board, he suggested that the relevant draft decision could be amended accordingly, while making it clear that the matter must be resolved no later than the Seventy-eighth World Health Assembly.

The representative of SWITZERLAND said that, in the light of the Organization's financial situation, Member States must focus on the proper functioning of the governing bodies, so that WHO could provide its added value where it was most needed. It would be crucial to set strict priorities and avoid burdening the Organization with new tasks. She echoed the request for the Secretariat to provide an overview of all new proposals and their financial implications and called for a more efficient process for managing resolutions by introducing mechanisms for their prior consideration. Encouraging Member States to discuss their intentions regarding resolutions after each Health Assembly could improve planning. She expressed support for the proposals of the Programme, Budget and Administration Committee and for the continuation of Member State-led governance reform.

The representative of NORWAY said that transparency and accountability created trust, an important premise for flexible and predictable financing; she therefore expressed support for the continuation of the Secretariat implementation plan on reform and Member State-led reform.

Accountable, independent, confidential and trustworthy procedures were needed to protect the confidentiality of all people involved in processes for handling and investigating potential allegations against WHO Directors-General. She expressed support for the draft decision on the process for handling and investigating potential allegations against WHO Directors-General, encouraging all Member States to engage actively in finalizing the procedure by the Seventy-eighth World Health Assembly. Member States should hold honest discussions on how best to address the proliferation of resolutions at a time when prioritization was key.

The representative of CHINA said that, given the current financial constraints, reform initiatives should be prioritized, with those promoting cost-cutting and efficiency gains addressed first. When proposing new reforms, Member States should fully consider their necessity and financial implications. To minimize the decision-making burden, no additional tiers should be added to the structure of the governing bodies. All reforms must be aligned with the WHO Constitution. The financial implications for existing resolutions should be recalculated in the light of the current funding situation and spending should be further reduced; the Secretariat was requested to provide further information in that regard. To aid Member States in decision-making, the Secretariat should regularly review and publish details of draft resolutions in consideration of the key areas of work in the Fourteenth General Programme of Work, 2025–2028 and provide information on further steps required.

The process for handling and investigating potential allegations against Directors-General must ensure fairness and transparency while allowing meaningful participation by the governing bodies and Member States. The draft procedure should ensure the independence of investigations while also strengthening the Board's role. His Government did not oppose the proposal to submit a draft document to the Seventy-eighth World Health Assembly and would actively participate in that work. However, since divergences remained on key issues and extensive negotiations on a pandemic agreement would be held ahead of the Seventy-eighth World Health Assembly, he called for a degree of flexibility in the timings of that process.

The representative of LEBANON said that investigations into allegations against WHO Directors-General should be conducted by an independent entity composed of Member States, with a view to upholding confidentiality, fairness and internationally recognized standards.

Member States should continue discussing outstanding concerns while reinforcing WHO's institutional capacity to manage investigative processes effectively, safeguarding trust, accountability and good governance. If no agreement could be reached at the forty-second meeting of the Programme, Budget and Administration Committee, she suggested postponing the discussion to the 157th session of the Board.

The representative of SLOVAKIA requested the Chair to allocate time during the current session of the Board for discussions on the process for handling and investigating potential allegations against WHO Directors-General, with a view to resolving the matter. The technological tools introduced during the session were appreciated; further innovations, such as electronic voting, would be welcome in future governing bodies meetings. WHO's increasing financial and geographical challenges required a strategic data- and evidence-driven approach to adopting resolutions. He suggested establishing, in advance of the May governing bodies meetings, a structural gap and risk analysis framework and a resolution management mechanism. A gap- and risk-based approach should also guide the short-term evaluation of all programmes implemented at WHO headquarters and in the regions, assessing their scientific justification, financial feasibility and health equity impact, and the risk of inaction.

A framework should be established to evaluate the preparation and implementation of resolutions and divide them into at least two categories: urgent strategies addressing health emergencies through accelerated mechanisms, and mid- and long-term strategies with multiyear financial sustainability. A technical advisory group on resolution prioritization should work with the Science Division to evaluate resolutions on the basis of scientific rigour, strategic alignment and cost effectiveness. Governance reforms should formalize submission criteria, establish an urgency threshold and enhance Member States' engagement. The Secretariat should require financial plans and road maps for the implementation of resolutions, limit the number of new resolutions adopted each year and expand flexible multi-donor funding under a new regulatory framework.

The representative of BRUNEI DARUSSALAM said that it was often difficult for small developing countries with small delegations to keep up with the increasing number of resolutions, decisions and agenda items. He therefore expressed support for discussions on innovative evidence-based approaches to prioritization and stressed the importance of ensuring a fair, inclusive and efficient decision-making process aligned with WHO's mandate and the Fourteenth General Programme of Work, 2025–2028.

To safeguard the Organization's credibility, investigations into allegations against WHO Directors-General must remain independent and free from conflicts of interest or politicization. Any investigative framework must ensure a balanced and impartial approach, possibly by drawing on best practices from other United Nations organizations. He called for inclusive consultations to finalize the process, with all Member States adequately represented.

Turning to the Secretariat implementation plan on reform, he called for clear prioritization strategies to optimize the use of financial and human resources. Regular evaluations could be conducted to assess the impact of reforms and identify areas for further strengthening.

The representative of ETHIOPIA said that, regarding the Secretariat implementation plan on reform, more emphasis should be placed on strengthening country-level impact and assessing the outcomes of reforms. At its next session, the Board should take stock of reforms implemented thus far and discuss next steps. Given that significant time and resources had been expended recently on negotiations, further work was needed to address the drivers for proposing resolutions, and further discussions should be held to determine ways to promote advocacy, resource mobilization and country support. In the process for handling and investigating potential

allegations against WHO Directors-General, it would be important to strike a balance between the independence of the investigation process, the availability of timely information and the decision-making role of the governing bodies.

The representative of MALDIVES said that finding a balance between governance reforms and sustainable financing reforms was especially crucial for smaller States; a realistic budget would be a fundamental starting point. For nations with limited resources, it was important to explore avenues for increasing assessed contributions to ensure the Organization's long-term financial health. However, financial sustainability alone did not guarantee effectiveness. Equity in decision-making must be at the heart of governance reforms, and the issue of participation must be central to discussions. It would be important to consider how to ensure broad and meaningful engagement, especially from small delegations with resource and capacity constraints. Governance structures must foster inclusivity, ensuring that all voices carried weight in shaping global health priorities. Agile prioritization was needed, and WHO should consider current outcomes to inform decision-making.

In improving resolution management, it would be important to address the challenges of Member State participation, the ineffective costing of resolutions and the identification of resolutions not mandating concrete work. He called for greater coordination and transparency in resolutions and their alignment with the Fourteenth General Programme of Work, 2025–2028. It was vital to identify the underlying reasons for proposing resolutions and to establish an accountable mechanism for their implementation. The discussion should be linked to ongoing budget discussions to ensure a coherent and sustainable approach.

The representative of BARBADOS said that the draft decision on Member State-led governance reform outlined a clear and structured pathway to advancing such reforms. Focusing on a sustainable governance model would ensure that reforms would be maintained over time, promoting stability and continuity. Regular progress reporting would foster transparency and accountability and facilitate any necessary adjustments.

Balancing transparency with confidentiality would be essential to maintaining the integrity of the process for handling and investigating potential allegations against WHO Directors-General. He urged Member States to adopt a balanced and solution-focused approach in finalizing the outstanding issues. Pragmatism and consideration of all Member States' views would result in an independent process and a balanced determination of the Board's role. Adopting the draft decisions would ensure effective, sustainable improvements aligned with Member States' needs and expectations.

The representative of BANGLADESH[5] called for continued Member State-led discussions to ensure that the reform process would be responsive to contemporary requirements. While the number of resolutions had proliferated beyond the capacity of small delegations to address them, he did not support placing a limit on resolutions in connection with the Fourteenth General Programme of Work, 2025–2028 as it could leave new pressing initiatives unaddressed. He echoed the call to preserve the right of Member States to propose resolutions. The Secretariat should hold consultations with Member States to finalize resolutions to avoid the proposal of unnecessary resolutions.

In handling and investigating potential allegations against WHO Directors-General, Member States' participation in decision-making would help to avoid politicization. Further discussions would contribute towards consensus on the remaining areas of divergence.

[5] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of the PHILIPPINES[6] expressed support for the introduction of systemic controls on draft resolutions and decisions, such as clear submission timelines and prioritization criteria. She called for greater clarity on the financial implications of draft resolutions to prevent implementation gaps. While recognizing the need to manage the volume of draft resolutions, she cautioned against measures that might inadvertently limit the participation of Member States, particularly low- and middle-income countries, in shaping WHO's agenda, highlighting the need for equitable opportunities to contribute to WHO policy direction. She called for a balanced approach in refining the model for Member State-led governance reform.

The representative of MONACO,[6] expressing concern regarding the announcement of the intended withdrawal by the United States of America and its impact on the Organization's budget and activities, encouraged the Secretariat to step up efforts to mobilize resources and diversify its donor base to ensure predictable and sustainable financing of its programmes, especially those addressing health emergencies. Every effort should be made to optimize budgetary and governance mechanisms, which would require greater transparency. The number of resolutions should be limited and clear criteria established for prioritizing draft resolutions and decisions to ensure efficient resource allocation in alignment with general programmes of work. To preserve the Organization's integrity, the process for handling and investigating potential allegations against WHO Directors-General must be grounded in the principles of impartiality and independence.

The representative of the RUSSIAN FEDERATION[6] said that any initiatives to improve the functioning of the governing bodies should not worsen the quality of discussions. Imposing additional restrictions on Member States, especially in the work of the Programme, Budget and Administration Committee, hindered in-depth discussion on highly specialized topics. The Committee's session should therefore be extended in years when the programme budget, general programme of work or other important issues were under consideration. Work on the process for handling and investigating potential allegations against WHO Directors-General must be concluded as quickly as possible, with the participation of all interested Member States, to avoid leaving the Organization at risk in terms of monitoring and accountability. He highlighted the importance of having an online tool to track progress on the Secretariat implementation plan on reform. In time, the Secretariat's reform initiatives should be evaluated with the participation of Member States to inform conclusions on their added value.

The representative of GERMANY[6] said that sustained commitment to reforms was essential to ensure long-term impact, particularly in the light of current financial constraints. Regarding Member State-led governance reform, he expressed support for measures that would enhance strategic decision-making, including refining the process for draft resolutions, while keeping cost in mind. Better integration of resolutions into WHO's strategic priorities would improve resource allocation and decision-making efficiency.

He stressed the importance of a transparent and independent process for handling and investigating potential allegations against Directors-General, with investigations conducted by an external independent entity to maintain credibility and fairness. It was crucial to avoid politicization while maintaining strong accountability mechanisms.

Given the current financial constraints, prioritization and efficiency remained critical to the Secretariat implementation plan on reform. Continued efforts were needed to enhance transparency, particularly regarding the financial implications of governance decisions.

[6] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of JAPAN[7] said that continued implementation of all reforms was vital for securing future increases in assessed contributions; progress in that regard would be closely monitored. To sustain WHO reform, sufficient human and financial resources must be secured on the basis of prioritized discussions with Member States. Approving the process for handling and investigating potential allegations against WHO Directors-General was essential to strengthening the Organization's governance; he therefore expressed the hope that consensus could be reached on the remaining issues of divergence by the Seventy-eighth World Health Assembly.

The representative of FRANCE[7] said that the current circumstances required strengthened reform efforts. The discussions on the process for handling and investigating potential allegations against WHO Directors-General should result in robust procedures that ensured independence, prevented interference and politicization and fulfilled WHO's commitments. She encouraged the Board to take the opportunity to conclude that work at its current session, if possible, but certainly before the closure of the Seventy-eighth World Health Assembly.

The Organization's exceptional financial situation necessitated substantial budgetary adjustments and provided an incentive for an in-depth review of its governance mechanisms. It would be crucial to ensure genuine alignment between the Fourteenth General Programme of Work, 2025–2028, the Programme budget 2024–2025 and technical programmes, and a link between the strategic directions and priorities of the Fourteenth General Programme of Work, 2025–2028 and the resolutions adopted each year. She expressed support for all suggestions made by Member State representatives for streamlining that process.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND[7] welcomed the progress made with regard to the Secretariat implementation plan on reform. Reaching agreement on the process for handling and investigating potential allegations against WHO Directors-General was a key element of the transformation agenda. She highlighted the importance of transparency and due process in that regard and expressed support for the suggestion that inclusive discussions should be held on the outstanding issues with a view to finalizing the process at the current session of the Board. Having a clear process for resolving allegations quickly and fairly would help to protect WHO's reputation and demonstrate its commitment to effective governance.

The DIRECTOR (Governing Bodies), referring to Member States' requests for additional documentation, said that a document containing an overview of the financial implications of all resolutions could be prepared for the following day. The Secretariat would work closely with the leads for Member State-led governance reform and consult with Member States on the possibility of producing a report on governance reform that focused on managing agendas, resolutions and costing. If the Board decided to proceed in that regard, an item on governance reform would need to be added to the agenda of the 157th session of the Board.

The ASSISTANT DIRECTOR-GENERAL (Business Operations), expressing appreciation for Member States' support for the Secretariat implementation plan on reform, recalled that the plan was dynamic and the Secretariat had reacted to Member States' requests for additions. The Secretariat had recently provided training on the dashboard for tracking the Secretariat implementation plan on reform to demonstrate how Member States could examine the Organization's operations in depth and provide feedback, which was necessary for continued improvement. The Secretariat needed to establish a process to include Member States in prioritizing reform initiatives, focusing on those that would increase efficiencies.

[7] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Responding to a concern raised regarding information on regional- and country-level reform efforts, he said that the dashboard provided aggregated data from action taken at all three levels of the Organization. He recognized, however, that contributions made at the regional and country levels could be better articulated.

Regarding strengthening country-level impact, the Secretariat implementation plan on reform provided for delegation of authority, empowering WHO Representatives, and for a core predictable country presence through the assignment of human resources to Member States, enabling the Secretariat to better respond to country needs.

The CHAIR took it that the Board wished to note the reports contained in documents EB156/29, EB156/30 and EB156/32 and concur with the proposed guidance of the Programme, Budget and Administration Committee set out in paragraphs 24–33 of document EB156/4.

The Board noted the reports.

The CHAIR took it that the Board wished to adopt the draft decision contained in document EB156/29.

The decision was adopted.[8]

The CHAIR took it that the Board wished to adopt the draft decision contained in paragraph 29 of document EB156/4, on the understanding that the Board would continue working to reach consensus at its present session on the remaining areas of divergence on the process for handling and investigating potential allegations against WHO Directors-General.

The decision was adopted.[9]

(For the adoption of a revised decision, see the summary record of the nineteenth meeting, section 4.)

- **Draft terms of reference to strengthen the effectiveness of the functioning of the Officers of the Executive Board** (documents EB156/31 and EB156/31 Add.1)

- **Involvement of non-State actors in WHO's governing bodies** (document EB156/33)

The CHAIR invited the Board to consider the report contained in document EB156/31 and the draft decision contained therein, the financial and administrative implications of which were contained in document EB156/31 Add.1. The Board was also invited to consider the report contained in document EB156/33, in particular the guiding questions set out in paragraph 21.

The representative of CANADA said that new Officers of the Board must have clear guidance on the time and engagement required to successfully carry out their roles. Member States should work together to promptly update the criteria to be applied by the Officers when considering proposed agenda items. That would ensure that they were better equipped and actively supported to adopt more strategic decisions, in particular by considering the proposed role for the Board concerning newly proposed agenda items.

[8] Decision EB156(1).

[9] Decision EB156(2).

The representative of SWITZERLAND underscored the importance of strengthening the terms of reference for Officers of the Board to ensure targeted preparation for meetings. The increasing length of agendas for governing bodies' sessions was concerning. Strict adherence to meeting agendas would allow Member States to address key issues with the attention and diligence required. Incorporating a troika model would ensure continuity and facilitate long-term planning. A clear timetable for the submission of agenda items and proposed resolutions should be established to give Officers an overview of the situation prior to meetings; both of those elements should be incorporated into the draft terms of reference to strengthen the effectiveness of the functioning of the Officers of the Executive Board. She called for enhanced initial training for Officers in close cooperation with the Secretariat. The role requirements of members and Officers of the Board must be clear to all.

The representative of SENEGAL, speaking on behalf of the Member States of the African Region, said that the effectiveness of the governing bodies depended on the leadership of the Officers of the Board, with the full support of Member States. The Secretariat should facilitate the implementation of the draft terms of reference and ensure intersessional communication between the Officers and members of the Board.

While noting the valuable contribution of non-State actors at meetings of the WHO Regional Committee for Africa, he stressed that their participation in the Organization's governance processes should be strengthened only through a series of measures in the context of the overall strengthening of WHO's cooperation with non-State actors. The Secretariat should ensure respect for the Framework of Engagement with Non-State Actors and the preservation of the Organization's interests and credibility.

The representative of YEMEN, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that constructive and strategic engagement with non-State actors was critical to advancing public health outcomes and enhancing Member States' collective capacity to address health emergencies, achieve universal health coverage and tackle the social determinants of health. Such partnerships should fully respect the sovereignty of Member States, be aligned with national health policies and prioritize strengthening national health systems, guided by the principles of transparency, accountability and alignment with public health objectives.

The representative of THAILAND expressed support for the draft decision contained in document EB156/31. While the meaningful participation of non-State actors in WHO's governance processes was essential, they must adhere to the Framework of Engagement with Non-State Actors. Clear rules on their involvement would help to strengthen engagement.

The representative of NORWAY, expressing support for the draft terms of reference, welcomed the proposal for the Officers of the Board to hold strategic discussions when deciding on additional agenda items and suggested that Member States might wish to explore additional criteria for agenda management.

The representative of BULGARIA suggested that, to improve agenda management and avoid duplication, topics could be categorized according to whether they would be discussed by both the Board and the Health Assembly, or by the Health Assembly alone. The Board, aided by the Secretariat, might wish to consider which agenda items could be discussed on a biennial or cyclical basis or delayed to a future session of the Board to fairly distribute work across sessions. Engaging the Officers of the Board in monitoring the meeting document dissemination process could help to prevent the late submission of documents. Strict management of speaking time in plenary meetings, including by imposing disciplinary measures on speakers failing to adhere to allotted time limits, would prevent prolonged meetings, reduce the number of evening meetings and

promote a healthier working style. Prioritizing expertise and technical discussions at the Board would add value to its meetings, make it fit for purpose and differentiate it from the Health Assembly.

The representative of LEBANON, speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the draft terms of reference. Maintaining the independence of the Officers of the Board while fostering open and transparent engagement with all Member States was key to reinforcing trust and collaboration. Strengthening agenda management and procedural oversight would boost the Board's effectiveness and ensure that governance processes would remain adaptable to evolving needs. She called for continued dialogue to ensure alignment of the draft terms of reference with the principles of good governance, accountability and inclusivity. Reviewing them periodically would allow for necessary adjustments and ensure their continued relevance to the Organization's objectives.

The representative of AUSTRALIA welcomed the draft terms of reference and the formalization of the roles and expectations of Officers of the Board, who should be empowered to determine the Board's agenda from a strategic lens. Noting the need for efficiency, he welcomed efforts to enable more non-State actors to join constituency statements.

The representative of SLOVAKIA expressed appreciation for the draft terms of reference and called for a one-year pilot of their implementation, following which the Secretariat and Officers of the Board could provide feedback and propose improvements. To decrease repetition and facilitate fruitful discussions, a new practice could be introduced whereby Member States and non-State actors could submit their written statements online in advance of meetings, which could then be summarized by the Officers at the beginning of the discussion of each agenda item.

The representative of POLAND echoed the statements made by the representatives of Bulgaria and Lebanon.

The representative of JAPAN[10] said that he understood that the role of the regional coordinators had not been officially defined. While his Government did not oppose their attendance at meetings of the Officers of the Board, it was concerning that the current wording of the draft terms of reference allowed representatives without formally defined roles to be invited to observe such meetings. He requested the Secretariat to justify that wording and suggested amending the relevant paragraph.

The representative of the NCD ALLIANCE, speaking at the invitation of the CHAIR, said that she was speaking also on behalf of World Cancer Research Fund International, the Union for International Cancer Control, FDI World Dental Federation, the World Heart Federation, the International Federation of Medical Students' Associations, HelpAge International, the International Association for Dental Research and The Save the Children Fund.

While WHO's efforts to enhance the meaningful participation of non-State actors in governing bodies' meetings were welcome, more could be done to address ongoing challenges. The oversubscription of certain agenda items diluted the messages of different parties, owing to the limited number of constituency statements allowed. Greater flexibility was required, such as the ability to submit additional constituency statements when items were oversubscribed. To improve the process for presenting constituency statements, she called for relevant information to be shared at least two months prior to governing bodies' meetings and for the option of individual

[10] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

statements to be maintained to allow for a more nuanced and representative expression of diverse views. She recommended improving interactions with non-State actors throughout the year, including by creating a mechanism to enable Member States to consult non-State actors when preparing resolutions; organizing pre-meetings for non-State actors ahead of sessions of the Board and the Health Assembly; and inviting non-State actors to information-only sessions organized for Member States. Information-sharing and logistical arrangements for the participation of non-State actors in governing bodies' meetings should also be improved, including by providing comprehensive pre-meeting materials, ensuring space for non-State actors in main meeting rooms and allowing the use of video statements.

The representative of BANGLADESH[11] requested the Secretariat to clarify how many Member States had responded to the consultation referred to in document EB156/33. The assertion in paragraph 15 of the document – namely, that the experience of constituency statements had been positive among both Member States and non-State actors – did not appear to be justified by the figures presented. While constituency statements were useful, Member States might benefit from hearing specific statements by individual civil society organizations.

The representative of the GLOBAL HEALTH COUNCIL, speaking at the invitation of the CHAIR, said that she was speaking also on behalf of the Anesvad Foundation, Association Africaine des Centrales d'Achats de Médicaments Essentiels, HelpAge International, Humatem, the International Agency for the Prevention of Blindness, the International Alliance of Patients' Organizations, the International College of Surgeons, the International Federation of Gynecology and Obstetrics, the International Federation on Ageing, the International Planned Parenthood Federation, the International Society of Physical and Rehabilitation Medicine, the International Union for Health Promotion and Education, Lifting The Burden, The Save the Children Fund, The Royal Commonwealth Society for the Blind – Sightsavers, the International Lactation Consultant Association, The Task Force for Global Health, Inc., Women Deliver, Inc., Women in Global Health, Inc., the World Federation for Mental Health, the World Federation of Hemophilia, the World Hepatitis Alliance and the Worldwide Hospice Palliative Care Alliance.

She welcomed WHO's efforts to ensure that the Framework of Engagement with Non-State Actors was fully implemented at all levels of the Organization. Constituency statements should remain integrated into the proceedings of meetings in between Member State statements to ensure that the views of non-State actors were considered throughout discussions. While the opportunity to continue presenting joint statements was welcome, it was difficult to provide in-depth information and actionable recommendations from experts on specific agenda topics in such statements. Member States should therefore ensure that the ability of non-State actors to present individual statements would not be diminished. WHO could not fulfil its mandate without the meaningful participation of non-State actors, which served on the front line of public health and therefore understood public health challenges and the needs of poor and at-risk populations.

The events at the 154th session of the Board regarding the admission of certain civil society organizations into official relations with WHO had been gravely concerning. While the outcome of discussions at the 155th session of the Board had been satisfactory, Member States should in future adhere to the objective criteria used to evaluate applications and uphold the recommendations and independent role of the Secretariat.

The representative of PANAMA[11] said that ensuring the availability of meeting documents within the required time frame would facilitate the Board's work and make it more effective. The

[11] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

participation of non-State actors contributed to the Board's transparency. It would be important to include regional coordinators with clearly defined roles and functions in the Board's work.

The representative of MALAYSIA[12] said that the selection of agenda items for constituency statements might hinder meaningful engagement by non-State actors. Efforts to improve time management and efficiency should not come at the expense of the opportunity to hear perspectives from non-State actors and should be examined with a view to ensuring inclusiveness and diversity of views. Non-State actors should be allowed to make individual statements. She called on the Secretariat to take note of the points raised and allow flexibility with regard to current practice.

The representative of the INTERNATIONAL PHARMACEUTICAL STUDENTS' FEDERATION, speaking at the invitation of the CHAIR, called for clearer guidelines for non-State actors and early access to agenda items; a wider range of agenda items to be considered for constituency statements; and meaningful youth engagement, with global platforms for discussion and the formation of youth councils in all WHO regions. The Secretariat should strengthen the participation of non-State actors in accordance with the Framework of Engagement with Non-State Actors and the Fourteenth General Programme of Work, 2025–2028; ensure that policies reflected community needs; and uphold transparency in decision-making.

The representative of INTERNATIONAL BABY FOOD ACTION NETWORK, speaking at the invitation of the CHAIR, said that the independence, integrity and trustworthiness of institutions such as WHO must be protected to empower all governments to protect health in all forums, including trade. She urged the Organization to screen offers of collaboration and funding from non-State actors for conflicts of interest.

The representative of KUWAIT,[12] speaking on a point of order, expressed reservations regarding the manner in which the statement made by the representative of Yemen had been interrupted, especially as other speakers had made similar points and the topics of involvement of non-State actors in WHO's governing bodies and Member States' engagement with non-State actors were interrelated. Member States had the right to express their views within the allocated time without interruption.

The LEGAL COUNSEL, responding to a question raised by the representative of Japan, said that the draft terms of reference reflected the current practice of inviting regional coordinators to meetings of the Director-General and the Officers of the Board at which proposed additional agenda items were discussed. The term "representatives of coordinating mechanisms for WHO" had been used in the light of the informal nature of the regional coordinator role. While Member States were free to amend the draft terms of reference to remove that point, doing so could give rise to questions as to whether regional coordinators or other regional representatives could continue to attend such meetings.

While the suggestions made by Member States had been noted, he clarified that the draft terms of reference had been developed with the intention of reflecting the current practices, mandates and roles of the Officers, along with a few enhancements that did not require amendments to the Rules of Procedure of the Executive Board and did not prejudge the outcome of wider ongoing discussions on reform.

A review of the implementation of the draft terms of reference after two years had been proposed to allow time for the Board to determine whether it wished to make any changes.

[12] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

However, a review could be conducted after one year if the Board so wished. Adopting the draft terms of reference in their current wording did not preclude their amendment before the end of that two-year period.

The CHAIR took it that the Board wished to note the reports contained in documents EB156/31 and EB156/33.

The Board noted the reports.

The representative of SWITZERLAND advised caution in adopting the draft decision while questions remained unanswered, particularly as the Board was set to discuss matters relating to resolutions and agenda management during the current session.

The CHAIR took it that the Board wished to adopt the draft decision contained in document EB156/31.

The decision was adopted.[13]

The meeting rose at 17:50.

[13] Decision EB156(3).

Third meeting

Tuesday, 4 February 2025, at 10:05

Chair: Dr J.X. Walcott (Barbados)

Pillar 4: More effective and efficient WHO providing better support to countries (continued)

Budget and finance matters: Item 23 of the agenda

Financing and implementation of the Programme budget 2024–2025: Item 23.1 of the agenda (documents EB156/26 Rev.1, EB156/INF./1 and EB156/INF./5)

The CHAIR drew attention to the reports contained in documents EB156/26 Rev.1 and EB156/INF./1. He also drew attention to the report contained in document EB156/INF./5, containing an overview of draft resolutions and decisions and their costings, which had been produced overnight in response to the previous day's discussions.

The representative of NORWAY, speaking in her capacity as Chair of the Programme, Budget and Administration Committee of the Executive Board, drew attention to the guidance and recommendations proposed by the Committee on financing and implementation of the Programme budget 2024–2025, set out in paragraph 14 of document EB156/4.

The representative of the REPUBLIC OF KOREA welcomed the improvement in financing levels thanks to the greater availability of flexible funding, and expressed support for the work being done by the Resource Allocation Committee to bridge gaps in financing across regional outcomes. Monitoring of key performance indicators would help to enhance understanding of the level of flexibility and predictability of WHO's financing, promote sustainable financing and provide guidance for improvements. The heatmap should also be monitored to ensure that adequate attention was paid to areas with insufficient financing. Turning to reporting on WHO country presence, he welcomed the Secretariat's plan to shift to a web-based reporting platform, which would ensure greater transparency and accessibility of country office information. Given the current financial constraints facing the Organization, it was critical to reset programme priorities, and while it was to be hoped that the situation would improve, a contingency plan was also needed. Budget implementation should focus on sustainable sources of financing, fair and reasonable allocation of resources, and efficiency.

The representative of BRAZIL welcomed the improvement in the financing of the base segment and the increase in financing for country offices, which would ensure more targeted, responsive and impactful support. The ongoing high reliance on earmarked voluntary contributions limited flexibility in the allocation of resources to priority and underfunded areas and potentially hindered effective budget implementation; the Region of the Americas, for example, was chronically underfunded. Addressing financing challenges would therefore require a more balanced approach involving a reduced reliance on earmarked contributions and enhanced

capacity for strategic resource allocation. Such an approach would enable WHO to respond more effectively to emerging health challenges and ensure that all priority areas received adequate support.

The representative of THAILAND endorsed the proposed key performance indicators for sustainable financing but said that they could be improved by refining the benchmarks for indicators, for example those relating to pockets of poverty, donor diversification, short-term contracts and small grants. She strongly supported the shift in the allocation of flexible funds from headquarters to country offices, noting that the capacity of country offices should be further strengthened by making full use of WHO's social capital. She also expressed strong support for further consultations with Member States to ensure that funding was directed towards high-impact programmes that reflected country-specific priorities. Further measures should be taken to strengthen resource efficiency at all three levels of the Organization.

The representative of BARBADOS said that the recommendations of the Programme, Budget and Administration Committee reflected a pragmatic and balanced approach to addressing the current financial situation faced by the Organization. Continuous monitoring of the financing status of the Programme budget 2024–2025 and the submission of an updated report thereon to the Seventy-eighth World Health Assembly would help to ensure transparency and inform decision-making. Improved resource allocation among major offices was crucial for optimizing the use of available resources and ensuring that all offices received adequate support. The commitment to fund high-priority outputs to 80% of their budget was a commendable goal, and safeguarding the Organization's critical functions would ensure that WHO continued to fulfil its essential mandate. Reporting on cost reductions and efficiency gains would provide valuable insights into the effectiveness of such initiatives. By prioritizing transparency, resource optimization and efficiency, WHO would enhance its organizational effectiveness and continue to deliver on its critical global health mission.

The representative of SOMALIA, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the current financing status of the base segment showed that the initial 20% increase in assessed contributions was already helping to enhance WHO's financial sustainability. The negative impact, however, of the withdrawal of the United States of America on secured financing and projected programme budget implementation was a deeply concerning development that directly threatened WHO's life-saving interventions, particularly in his Region, which faced complex and protracted emergencies.

Disparities in base segment funding across major WHO offices was another significant concern. While headquarters was 125% funded, five regions were only 65% funded on average, which raised the critical question of alignment with WHO's strategic focus on strengthening country capacity and impact, and risked further slowing progress towards the achievement of the health-related Sustainable Development Goals. A clear explanation of those disparities and the development of a corrective road map was therefore required, and a report thereon should be submitted to the forthcoming Health Assembly. Furthermore, to enhance transparency and accountability and to ensure more equitable, needs-based resource allocation across the Organization, key performance indicators were needed to monitor and report on funding distribution across all three levels of the Organization.

The representative of CHILE expressed satisfaction at the progress made towards implementation of the Fourteenth General Programme of Work, 2025–2028, in particular in terms of optimizing resource allocation, developing gender parity processes within the Organization, strengthening country presence and improving operational efficiency. She welcomed the emphasis

on technical cooperation, the field in which WHO provided added value. Preliminary results on WHO country presence demonstrated the relevance of the strategy for the next biennium.

While all countries currently faced considerable economic difficulties, the period following the coronavirus disease (COVID-19) pandemic had been particularly challenging for the Region of the Americas, which had always had to optimize limited resources. In such a complex context, the focus should be on national needs, stronger technical cooperation, sustained emergency response capacity and strategies to maximize the impact of available resources. Operational sustainability was fundamental for ensuring that WHO was independent and responsive at times of constant epidemiological change. Initiatives to diversify funding sources and increase efficiencies in resource allocation, with a focus on measurable and concrete results, were therefore to be applauded. She commended efforts to tackle disinformation, noting the importance of ensuring WHO's impartiality in that regard, and highlighted the need for a robust multilateral response to global health challenges.

The representative of NORWAY said that continuous monitoring of the financing status of the Programme budget 2024–2025 was crucial given the current financial situation. While protecting WHO's unique normative role and impact at the country level, the Secretariat should strengthen measures to reduce costs and increase efficiency in the short and medium term, including in relation to management salaries, and report on the results to the Seventy-eighth World Health Assembly under the report on efficiencies. Certain programmes might be at immediate operational risk, particularly those related to health emergencies, and the Secretariat should therefore explain how it planned to safeguard critical work in those and other core areas. It should also inform Member States of the additional support they could provide beyond the scope of resource mobilization.

The representative of SENEGAL, speaking on behalf of the Member States of the African Region, welcomed regular reporting on implementation of the Programme budget 2024–2025 and commended the Organization's strong support for event-driven operations, including polio eradication and emergency operations. Expressing concern at the disparities in resource allocation between major offices, he called on the Secretariat to introduce a key performance indicator to measure progress towards the equitable distribution of resources.

He welcomed the Secretariat's strong commitment to optimizing predictable funding, but stressed the need for continued efforts to obtain sustainable and more flexible financing that would allow the Organization to allocate 80% of resources to high-priority outcomes, in line with the needs identified during the programme budget preparation process. To that end, the Member States of his Region remained committed to contributing to the WHO investment round. He called for stronger mechanisms aimed at ensuring the equitable allocation of resources and closer alignment between levels of financing and the priorities identified by Member States, with a focus on accountability. The needs of the various regions and levels of WHO should be taken into account, with a particular focus on country offices. Additional resource mobilization was needed for health promotion and preventive measures, in particular to control the spread of noncommunicable diseases. The Secretariat should measure the impact of WHO's activities by monitoring key performance indicators at all three levels of the Organization.

The representative of POLAND, speaking on behalf of the European Union and its Member States, said that the candidate countries Türkiye, North Macedonia, Montenegro, Albania, Ukraine, the Republic of Moldova, Bosnia and Herzegovina and Georgia, as well as Armenia, aligned themselves with her statement. She commended the progress made in funding the base budget compared with previous bienniums, but expressed deep concern about the reliance on highly earmarked contributions, which constrained WHO's ability to address certain areas

strategically, hindered the timely allocation of resources and had probably already led to serious delays or halts in the implementation of large parts of the base programme. Moreover, the announced withdrawal of the Organization's single largest donor country might also affect the implementation of critical programmes and WHO's ability to respond effectively to overlapping global health challenges. Member States and partners should address that situation collectively by reiterating the importance of providing flexible, predictable and sustainable funding, selecting and prioritizing the essential components of the base programme, and intensifying resource mobilization efforts.

The investment round had been an important step towards increasing the flexibility, predictability and sustainability of WHO's funding and broadening the funding base, and must be pursued to avoid reliance on a small number of donors. Global solidarity, shared responsibility and efficiency gains were paramount to safeguard the health and well-being of all. The Secretariat should be transparent about potential shortfalls and consult openly with Member States on the best way forward. Referring to the report contained in document EB156/INF./5, she said that Member States would appreciate more time to analyse it.

The representative of BULGARIA said that the programme budget should reflect the link between global health priorities and expected outcomes in terms of achieving better health and well-being for all, and performance indicators should provide an objective assessment in that context. While the Organization required flexible funding to ensure the predictability and effectiveness of its work, spending should be justified on the basis of real needs and a gap analysis of financial resources per budget item, involve timely consultation with Member States, and be carried out with full transparency and accountability. Although the improvement in the funding of the base budget was welcome, resource allocation mechanisms should be enhanced to optimize the relationship between funding levels and country office prioritization, taking into account national contexts and needs. Doing so would have a positive impact on high-priority outcomes that had lower funding levels.

She called for a consistent and transparent approach to the implementation of new initiatives and programmes and their rational costing; an improved decision-making process; assessment of the financial burden when planning to ensure prioritized and fair results-oriented budgeting, with appropriate monitoring of financial management; a stronger role for the Executive Board; and improved functioning of the governing bodies. Commendable steps had been taken to strengthen relations with independent donors, broaden the donor base and build longer-term, consolidated and results-based cooperation for which existing WHO functions and resources should be used.

She echoed the request for more time to examine the report contained in document EB156/INF./5 and expressed support for a common approach to handling resolutions.

The representative of BRUNEI DARUSSALAM said that it was important to set priorities to ensure that WHO's critical functions were safeguarded and that funding was directed to high-impact areas. Given that over 80% of funding came from voluntary, often earmarked, contributions, it could be difficult to strike a balance across major offices and programme outcomes. The Secretariat should therefore explore long-term sustainability approaches, including a systematic approach to priority-setting to ensure flexible funding and strategic resource allocation to high-impact areas, especially those at risk of underfunding; sustain efforts to diversify the donor base; and explore innovative budget management strategies to enhance sustainability and efficiency, including by optimizing resource allocation within established limits and adopting phased or staggered budgeting approaches. Key performance indicators should be continuously refined to track not only funding sustainability but also equity and effectiveness across all levels of the Organization.

The representative of SWITZERLAND expressed concern that certain programmes were directly affected by the current situation and faced an immediate operational risk. She asked whether sufficient funds were available to enable WHO to meet its obligations towards partners and staff, and for how long, and what measures had been taken or were planned following the announcement of the withdrawal by the United States of America. Noting the importance of transparent and clear communication to enable Member States to provide the best possible support, she called on the Secretariat to inform Member States about budget priorities in terms of programmes, regions and countries. The calculations currently being prepared should include the costs not only of the draft resolutions before the Board but also those of the Intergovernmental Negotiating Body to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response. Referring to the report contained in document EB156/INF./5, she concurred with previous speakers that more time was needed to examine the costing implications of draft resolutions and decisions.

The representative of TOGO commended the progress made towards strengthening country offices, underscoring the crucial link between a robust country presence and WHO's efforts to improve its response to Member States' health priorities and needs. The Secretariat should adopt a balanced approach, allocating resources equitably and transparently in a manner that took account of country and regional needs. It should also strengthen resource mobilization by diversifying its funding sources and integrating programmes to ensure optimal use of mobilized funds.

The representative of MALDIVES said that the proposed key performance indicators provided a valuable framework for tracking progress and financial accountability. Small island developing States such as his faced unique vulnerabilities and resourcing constraints, and therefore relied on WHO's technical support to meet their national and global health goals. The Secretariat's commitment to increasing the allocation of flexible funding to strengthen country delivery would enhance the Organization's capacity to meet the diverse needs of its Member States, in particular those with limited capacity. Equally commendable were the Secretariat's efforts to improve resource allocation and management across all three levels of the Organization, and the progress made to address pockets of poverty and ensure that critical public health areas were adequately funded. To further enhance transparency and accountability, the Secretariat should provide more detailed information on the impact of WHO's technical cooperation on health outcomes at the country level; the progress made towards implementing the recommendations of the Working Group on Sustainable Financing; and the challenges encountered in mobilizing resources for underfunded areas.

The representative of CHINA said that, in view of the current financial difficulties faced by the Organization, the Secretariat should reduce costs, improve efficiency and adapt its activities accordingly. The utilization rate for the base segment overall was 36% but varied sharply across the triple billion targets; the Secretariat should accelerate its efforts accordingly. It should also allocate more funds to the country and regional levels and, in conjunction with the investment round, make every effort to support underfunded areas. In view of the current financial context, the Secretariat should provide information on any further workplans and evaluate the current investment round in line with the evaluation plan and indicators previously presented, including a comparison of baseline levels, expected outcomes and actual results. It should also quantify the extent to which different programme areas relied on earmarked voluntary contributions and demonstrate any progress made in that regard following the investment round.

The representative of ETHIOPIA said that equity indicators were needed to measure progress in the allocation of the budget and resources. While the Regional Office for Africa had improved its capacity to maximize available resources effectively, urgent action and a strategic solution were needed to increase overall financing for the Region, which remained below the global average. Suggested improvements included equitable resource allocation for chronically underfunded areas and priority outcomes; intensifying resource mobilization; exploring innovative sources of flexible funding; effectively responding to emergencies and emerging priorities; enabling strategic investments in underfunded outcomes; maximizing the impact of the investment round on implementation of the Fourteenth General Programme of Work, 2025–2028; frontloading to address current gaps; and prioritizing country support, mainly with regard to data, innovation and WHO's core functions.

The representative of QATAR expressed support for the priorities outlined in the Programme budget 2024–2025, particularly in the areas of emergency preparedness and response. The challenges posed by the withdrawal of key financial contributions highlighted the need for strengthened and sustainable funding mechanisms to ensure the continuity of life-saving interventions in the Eastern Mediterranean Region. In view of the current multiple protracted crises and emergencies, it was vital that WHO's emergency response capabilities remained robust and adequately resourced. Disparities in base segment funding were another cause of concern and required the establishment of a transparent and needs-based resource allocation framework. Efforts to enhance financial equity across the three levels of WHO were welcome.

The representative of AUSTRALIA, agreeing with previous speakers that further time was needed to examine the report contained in document EB156/INF./5, requested confirmation that any proposals to suspend discussion of the agenda item would relate only to consideration of that document.

The representative of CAMEROON said that the current difficulties faced by the Organization called for specific measures and readjustments to ensure the sustainable financing of WHO's activities, and expressed support for the establishment of a transparent resource allocation framework.

The representative of SLOVAKIA said that Member States should continue to engage in dialogue on the issue of ensuring sustainable and balanced funding streams, explore alternative financing mechanisms and strengthen multisectoral partnerships so that resources were allocated strategically and with a view to achieving the highest impact and enhanced equity in global health outcomes. Disparities in country office staffing, financial resources and governance structures hindered effective programme implementation. More decentralized and responsive governance was therefore needed, providing country offices, in cooperation with national stakeholders, with greater decision-making authority and improved accountability and transparency. In addition, harmonized accountability frameworks should be established at the regional level to analyse potential risks, gaps, policies and implementation deficiencies, thereby enabling headquarters to refine its global guidance and set clearer annual priorities. He expressed support for the proposed key performance indicators and agreed that the extent to which different programme areas relied on earmarked voluntary contributions should be quantified. The Secretariat should continue to explore new funding sources in cooperation with Member States and the Working Group on Sustainable Financing.

He agreed with previous speakers that more time was needed to examine the report contained in document EB156/INF./5, but expressed support for the option to approve all draft resolutions and decisions concerned as proposed.

The representative of the FEDERATED STATES OF MICRONESIA said that the proposed key performance indicators would be useful for tracking WHO's performance in delivering expected results. In the next such report, information should be provided on the total budget repurposed, restructured and reallocated to the regional and country offices, given the expected reductions in the funding available for the Organization's core mandate.

The representative of ARGENTINA[1] said that, given the current situation affecting the Organization and the need for sustainability and efficiency, the responsible management of resources must be ensured by optimizing investments, prioritizing critical activities and strengthening budget transparency. WHO had to demonstrate that it could adapt to the new realities of budgetary constraints by acting with greater austerity. He expressed concern at the Secretariat's proposal to implement the 20% increase in assessed contributions, which his country was not in a position to pay in its current financial situation. It should not be forgotten that the countries of the Region of the Americas contributed to both WHO and PAHO and yet, paradoxically, benefited less than all other regions from WHO funding.

The representative of BANGLADESH[1] said that, at the current critical juncture, flexible donor funding was vital for addressing the financing gap in the base budget, which could be managed by setting aside a small portion of earmarked voluntary contributions as flexible funding. It would be unfortunate if WHO's health emergency programmes and critical functions related to poliomyelitis, tuberculosis and HIV/AIDS suffered a setback owing to a shortage of funding for the base budget. In his view, WHO's critical support for technology transfer was not adequately reflected in the outputs. He urged Member States to create enablers for WHO to promote technology transfer as a means of diversifying the manufacture of health products in all regions and ensuring equitable access to such products.

The representative of the PHILIPPINES[1] observed that, while the funding status of the Programme budget 2024–2025 appeared to be relatively strong, the continued heavy reliance on earmarked voluntary contributions remained a cause of concern. The reported funding gap highlighted both a potential challenge for fully implementing the Programme budget without cutting back on certain critical areas, and the importance of continued resource mobilization and a broader funding base. She welcomed the proposed key performance indicators, which should be supplemented with others on risk management, financial resilience, and equitable funding and allocation to bolster financial stability. Doing so would help to ensure that funding was equitably allocated across all regions based not just on donor preference but also on responsiveness to regional health needs and priorities.

The representative of ARMENIA[1] suggested that the Secretariat should consider launching an online real-time portal allowing Member States, donors and other stakeholders to track funding levels and flows across programmes. Such a platform would provide a transparent overview of which programmes were underfunded, overfunded or funded by earmarked contributions, facilitating better-informed decision-making and ensuring a balanced allocation of resources. It would also allow for more strategic and needs-based funding allocations, help to prevent resource imbalances and ensure that critical health priorities received adequate support. By heightening transparency and improving financial oversight, it would strengthen Member State and donor confidence in resource mobilization and promote contributions to a more sustainable and flexible funding model, thus ultimately reinforcing the Organization's ability to best fulfil its mandate.

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of NAMIBIA,[2] noting that the financing gap resulting from the withdrawal of the United States of America would have a significant impact on essential WHO technical programmes, stressed the importance of prioritizing the Organization's critical functions while seeking sustainable funding solutions. A major cause of concern was the uneven distribution of funding between headquarters and the regional offices, especially the WHO Regional Office for Africa, caused by earmarked voluntary contributions. Funds should be equitably reallocated to better support regional and country offices, while flexibility was needed to ensure that 80% of resources were directed towards high-priority outputs. Mechanisms for equitable resource allocation should be strengthened in alignment with Member States' priorities. He called for enhanced resource mobilization for disease prevention, particularly noncommunicable diseases, and health promotion. The proposed key performance indicators should be refined to include equity indicators. He commended the investment round for boosting financing flexibility and diversifying the donor base, and encouraged further exploration of innovative financing mechanisms.

The representative of SPAIN[2] said that, in the light of the present situation, it was essential to strike a balance between ambition and budgetary realism. Major public health challenges would continue to exist despite the expected reduction in funding, and must be addressed through an equity-centred, multilateral approach. As the only organization able to address those challenges, WHO had to show courage in adapting to the new situation, by acting intelligently and spearheading new approaches to health protection – inaction could be more costly.

He agreed with previous speakers that more time was needed to consider the report contained in document EB156/INF./5 but added that, in the present exceptional circumstances, approving the draft resolutions currently before the Executive Board as proposed would make it clear that WHO intended to pursue its activities; moreover, it was for the Health Assembly to make the final decision on each draft resolution, and it would therefore do no harm for the Executive Board to approve them.

The representative of JAPAN[2] said that the review of the Programme budget 2024–2025 should involve cost reductions, efficiency measures and other adjustments based on realistic estimates that reflected the current situation. He echoed previous speakers in requesting that the review of priorities and budget allocations should be conducted transparently.

The representative of FRANCE[2] said that the current situation, while unprecedented for WHO, had been experienced by other organizations and she was confident that WHO would be able to overcome it. She thanked the Secretariat for its transparency and encouraged it to continue regularly sharing detailed information and figures with Member States.

Strategic prioritization was now required, while preserving the Organization's essential tasks, notably its normative function, which was critical in guiding WHO's technical support at the country level and guaranteeing the quality of its work everywhere. Preserving the health and well-being of staff was also paramount. Future budget cuts should be made taking into account existing financing disparities between programmes in order to maintain the Organization's capacity to act and avoid paralysis. If Member States conferred new tasks on the Secretariat, they should ensure that the means were available to carry them out. In that regard, additional in-depth discussions would be needed to take a collective decision on the relevance of the draft resolutions before the Executive Board in the current context.

[2] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of INDONESIA[3] said that the Organization's heavy reliance on highly earmarked voluntary contributions limited its ability to respond to emerging health priorities, a challenge that would be exacerbated by the withdrawal of the United States of America. Efficiency had to be improved at all three levels of the Organization, including by reassessing non-essential programmes. Funds should be strategically reallocated to prioritize high-impact programmes aimed at meeting the triple billion targets, and Member States must be involved in the discussions on which activities to prioritize. The Organization's critical functions must be preserved, taking into account the diverse needs and priorities of Member States. Long-term, more sustainable and flexible financing was needed to ensure that WHO could continue to support Member States; the investment round was a step in the right direction in that regard. The Secretariat should also continue to explore new financing opportunities, including by making specific outreach efforts for the most affected programmes. She welcomed the proposed key performance indicators and agreed that they should be further refined to track equity and effectiveness.

The representative of GERMANY[3] acknowledged the improvements in resource mobilization but remained strongly concerned about structural funding challenges, in particular the unhealthy dependence on a very small number of donors. The announced withdrawal of the United States of America raised serious financial concerns and would affect core and emergency response funding. Indeed, some core functions could easily collapse unless short-term solutions were found. All Member States should step up their financial commitments to prevent wide-ranging disruptions to the Organization's ability to fulfil its mandate. The investment round had successfully expanded the donor base, which was an important step towards sustainable financing. He noted that one region had not contributed financially and asked why; it was concerning that 90% of the funding raised came from the European Region. Given the financial challenges ahead, he echoed the requests of previous speakers for more detailed information on programmes and risks, cash flows and the costing of resolutions. It might be helpful to organize an informal briefing on the subject, for example on the report contained in document EB156/INF./5, in the coming days.

The representative of GHANA[3] observed that tuberculosis, malaria, HIV/AIDS and other diseases would become more prevalent without adequate funding. He called for integrated and innovative resource mobilization for the Fourteenth General Programme of Work, 2025–2028, and for increased funding for underfunded regions, repeating earlier concerns about earmarked funding and its impact on the African Region. Equitable resource allocation, accountability, transparency and effective governance were all connected to the Organization's core mandate of health for all. He urged all Member States to support the investment round and widen the donor base. The outlook for the coming years, while daunting, could be improved through collective resolve.

The representative of MALAYSIA[3] applauded the progress made in terms of financing the Programme budget 2024–2025 but expressed concern at the continued reliance on highly earmarked voluntary contributions for the base budget. The Organization needed predictable and sustainable financing to respond to global health challenges. In the current financial situation, the Secretariat should pursue resource mobilization efforts such as the investment round, which had attracted new donors, while improving efficiency at all three levels. More detailed information should be made available on the outcomes of the investment round, funding levels, programmes targeted by earmarked funding and options for reallocating funds to high-priority underfunded programmes. It was crucial to ensure funding transparency across programmes before setting priorities. The funding gap could be bridged if earmarked funds were made flexible. On the costing

[3] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

of resolutions and decisions, she agreed that more time was needed to reflect on the options set out in the report contained in document EB156/INF./5 and to consider other options, if necessary.

The representative of INDIA[4] welcomed the Secretariat's initiative to transition to web-based reporting on country offices, which would enhance the transparency and accessibility of crucial information while also streamlining data management. The proposed key performance indicators were a positive step; specific overlaps should nevertheless be examined in order to enhance clarity, efficiency and accountability. A multipronged approach would be needed to address the challenges in achieving some of the indicators, including encouraging Member States to pay their assessed contributions for the current biennium in accordance with the agreed scale of assessments. Furthermore, aligning health priorities with realistic and sustainable financing options, in particular for high-priority outputs, required collaborative action, innovative financing mechanisms and the strategic allocation of available resources. Given that certain donor contributions were not likely to materialize in 2025, efficiency would have to be reimagined in such a way as to enable WHO to focus on its core competencies while providing the training and capacity-building that countries needed to run their programmes.

The South-East Asia Region should expedite fund utilization in accordance with the approved Programme budget 2024–2025 to facilitate timely implementation of the planned activities and maximize the impact of achieving the Region's health priorities and the broader objectives of the Programme budget. He encouraged the Secretariat to continue expanding the donor base and exploring options for resource mobilization.

The ASSISTANT DIRECTOR-GENERAL (Business Operations), responding to Member States' comments, said that the Secretariat had adopted a two-pronged approach to managing the current situation. In terms of strategic prioritization, that had meant aligning the work planned under the Programme budget 2024–2025 with anticipated funding levels. Rather than simply cutting activities based on the lack of funding, the Secretariat planned to conduct a strategic review before deciding on the best way forward. It had explained to Member States what was being done in terms of cost efficiencies and reductions, and was committed to consulting further and seeking their guidance on other avenues for action.

With regard to resource allocation and highly earmarked voluntary contributions, the Resource Allocation Committee had allocated 80% of the flexible funding received to regions and countries. The Secretariat made sure that funding was equitably allocated across the Organization when it had the authority to do so. Highly earmarked contributions could not be handled in the same way, however, although the Secretariat did negotiate with donors and partners for the reallocation of some of that funding to other priority areas that were underfunded or were being defunded as a result of the current circumstances. Member States' support was needed in that regard.

In terms of preserving WHO's normative function while strengthening country offices, the Secretariat considered that the Organization needed both a strong normative function and strong country and regional offices. In that respect, the alignment of funding remained a problem, the only solution to which was sustainable financing, for example in the form of the investment round and the increase in assessed contributions.

The key performance indicators constituted a starting point, and the Secretariat would welcome Member States' suggestions for updating them and developing other indicators. He agreed on the need for consultation and transparency, adding that financial, budgetary and human resource information was available on the WHO Programme budget web portal.

[4] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The Organization's cash flow was currently sufficient to meet commitments until the first quarter of 2026. The situation was expected to change, however: investment round income would be coming in and pledges continued to be confirmed. At the same time, the Secretariat was aware of the constrained financial environment and was doing everything possible to curtail expenses. In terms of Member State support beyond resource mobilization, he suggested that Member States might consider seconding human resources or implementing other initiatives to help to fill some of the present normative and technical gaps. He agreed that the Organization had to demonstrate courage and emphasize the many ways in which it provided added value.

The ASSISTANT DIRECTOR-GENERAL (External Relations and Governance) said that the Secretariat's progress towards improved resource mobilization and sustainable financing had been made possible by the help of Member States. Thanks to that support, as well as the increase in assessed contributions and the investment round, the budget indicators had improved significantly. The journey was far from finished, however, and Member States needed to continue to stand together with the Secretariat.

In line with decision EB154(1) (2024), the Secretariat would report on the investment round to the Seventy-eighth World Health Assembly through the Programme, Budget and Administration Committee. The report would cover all jointly agreed indicators and would reflect any further pledges received. The Secretariat was fully committed to transparency and would hold regular briefings on resource mobilization and efficiencies, involving Member States to the greatest extent possible. In terms of Member State support beyond resource mobilization, she pointed out that all pledges had to be rapidly converted into agreements, and those agreements into actual funding.

The Secretariat stood ready to brief Member States on the report contained in document EB156/INF./5, which had been prepared at very short notice at the request of the Board, with a view to helping them to work on a common approach for handling all proposed draft resolutions and decisions with costing implications comprehensively, given the current financing constraints.

The DIRECTOR-GENERAL confirmed that the Secretariat was committed to changing resource allocation as part of its reform process. Indeed, the sustainable financing initiative had been launched in order to obtain flexible funding, which empowered the Secretariat to better allocate resources. In addition, the Action for Results Group had been established to empower country offices, among other things, to allocate resources based on national priorities. The Secretariat was promoting a bottom-up approach to planning for the coming years, which would require flexible funding. Some immediate wins might be required as well, for example the renegotiation of earmarked contributions to improve flexibility. Flexible funding would also reduce the administrative burden, as the Secretariat was currently managing an estimated 2500 to 3000 grants, some of which were small grants of US$ 100 000.

Sustainable financing was the root cause of many of the problems facing WHO. Thanks to Member States' support, a long-term solution was at hand and country-level capacity, in particular, would be strengthened as a result. Moreover, the heatmap, which currently showed more allocations to headquarters than to the regional and country levels, would have improved by May 2025 because at that point it would incorporate contributions received at the end of the year and show more resources being allocated to the regions. It would not improve significantly, however, unless sustainable financing efforts were successful.

The CHAIR took it that the Board wished to note the report contained in document EB156/26 Rev. 1, and concur with the proposed guidance of the Programme, Budget and Administration Committee of the Executive Board, contained in paragraph 14 of document EB156/4.

The Board noted the report.

The CHAIR took it that the Board wished to suspend consideration of the item to allow delegations additional time to consider the report contained in document EB156/INF./5 on the costing implications of the draft resolutions and decisions recommended by the 156th session of the Executive Board for adoption by the Seventy-eighth World Health Assembly.

It was so agreed.

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

Proposed programme budget 2026–2027: Item 23.2 of the agenda (documents EB156/27 and EB156/INF./6)

The CHAIR invited the Board to consider the report contained in document EB156/27.

The representative of NORWAY, speaking in her capacity as Chair of the Programme, Budget and Administration Committee of the Executive Board, drew attention to the guidance and recommendations proposed by the Committee on the draft Proposed programme budget 2026–2027 set out in paragraph 23 of document EB156/4.

The representative of BRAZIL welcomed the draft Proposed programme budget but expressed concern at the proportion of the programme budget that continued to be funded by earmarked voluntary contributions. Given the recent increase in assessed contributions and aspirational commitments for further increases, as recommended by the Working Group on Sustainable Financing, Member States had an obligation to continue aiming for better accountability and other improvements, and to ensure comprehensive follow-up on the adoption and implementation of any guidelines deemed necessary by the Working Group, the Agile Member States Task Group on Strengthening WHO's Budgetary, Programmatic and Financing Governance, and other processes. The Secretariat was to be commended for adapting its means and platforms, and for reporting not only successes but also issues, given the current circumstances. In that respect, it should disclose all information on WHO expenditures and on which projects and initiatives would be privileged, in order to ensure total transparency.

The representative of SENEGAL, speaking on behalf of the Member States of the African Region, noted the 7% increase in the allocation of resources to the Region compared with the previous biennium, which showed that WHO recognized the health challenges it faced. Clearly, however, the African Region would be affected more than any other region by the current crisis and he therefore called for active solidarity to help it to bridge the gap until such time as a lasting structural solution had been found to prevent similar situations in the future. At the same time, the African Region would continue its efforts to diversify financing mechanisms, in particular through foundations.

He recommended that the Secretariat should maintain the budgetary allocations for country strengthening, data and innovation at their current levels; ensure that resources were allocated in line with Member States' priorities; take concrete action to improve equity in resource allocation and address heatmap disparities using an indicator such as the difference between maximum and minimum funding levels across the six regions and headquarters, which should exceed 10%; advocate for compliance with the commitment to increase assessed contributions by 20%; ensure equitable staff development; promote and sustain health system resilience to the impacts of climate change; fill data gaps; facilitate organizational learning; and promote innovation, research and technology transfer. He looked forward to receiving the finalized list of outcome and output indicators, including baselines and targets, in advance of the forthcoming Health Assembly.

The representative of CANADA, expressing support for the recommendations of the Programme, Budget and Administration Committee, highlighted the need for prioritization, which was a joint responsibility of the Secretariat and Member States. Timely payment of assessed contributions was crucial to support planning, operations and sustainable financing. She welcomed the orientation of the draft Proposed programme budget and its intersectoral approach to health promotion and to addressing the root causes of ill health and health inequities. She also welcomed the ongoing shift in budget allocations to country offices, which, alongside improved results-based management and results reporting, would have a significant impact in terms of country-level impact, and would position WHO to better contribute to fulfilling the conclusions of the Lusaka Agenda. The planned scope of work to address health and climate change was key; in that respect, the Secretariat's commitment to integrating climate change initiatives with efforts to help Member States to achieve universal health coverage, scale up primary healthcare and strengthen the health workforce was commendable.

She welcomed the commitment under the Fourteenth General Programme of Work, 2025–2028, to health equity, gender equality and rights, and the twin-track approach to incorporating targeted and integrated interventions. To that end, clear outcome indicators were needed to measure impact, including progress in closing gender gaps in health outcomes and access to health services.

The representative of QATAR, speaking on behalf of the Member States of the Eastern Mediterranean Region,commended the Secretariat's transparent and consultative approach to the development of the draft Proposed programme budget. She expressed support for a revised base budget of US$ 4.9 billion, as recommended by the Programme, Budget and Administration Committee, which struck a balance between financial realism and the ambition to meet Member States' health needs, but stressed the importance of prioritizing emergency response and polio eradication. The focus should be on making sure that WHO could deliver, which would require strategic partnerships, coordinated resource mobilization and operational efficiencies.

Now that the largest financial contributor to WHO was withdrawing, the planned gradual increases in assessed contributions approved by the Health Assembly in 2022 and the reprioritization of budget allocations were essential to safeguard critical life-saving interventions. The current situation required a shift from overreliance on a few major contributors to a more resilient and collective investment in global health. While she welcomed the simplified joint reporting approach focused on measurable results, the proposed outcome and output indicators needed to be refined to align with agreed criteria and meet Member States' key needs without imposing an excessive reporting burden. Details of the indicator baselines and targets to be shared at the Seventy-eighth World Health Assembly should be made available by country. Leveraging digital technologies was essential to improve data collection and monitoring, and health service delivery. She expressed strong support for independent evaluations of WHO's relevance and effectiveness, with a view to further strengthening accountability, transparency and organizational learning.

The representative of TOGO commended the fact that the draft Proposed programme budget took account of global health issues, notably chronic infectious diseases, new threats in the form of pandemics and the growing burden of noncommunicable diseases. She also welcomed its alignment with the pillars of the Fourteenth General Programme of Work, 2025–2028, through its proposals for a robust, adaptable and reactive health infrastructure, rapid and equitable access to health services, and coordinated global action. The Secretariat should ensure that budget increases for country office strengthening and data and innovation were shielded, that resource allocations were aligned with Member States' priorities, and that concrete action was taken to enhance equity and rectify disparities in resource allocation.

The representative of the REPUBLIC OF KOREA, noting that increased efforts would be required in the light of the present financial situation, welcomed the broadened funding base as a result of the investment round. He expressed support for the bottom-up approach, which highlighted country-level capacities and accommodated each Member State's circumstances and priorities, and for the output indicator approach, which was aimed at improving monitoring procedures. Effective measures were needed to ensure timely data collection for output indicators, especially in countries with limited data infrastructure. The Secretariat should formulate the best possible solution, bearing in mind both the possibility that the current situation would improve thanks to ongoing fundraising efforts and the need to adjust the distribution of funding among programmes within the proposed ceiling, taking into account WHO's core functions and top priorities.

The representative of POLAND, speaking on behalf of the European Union and its Member States, said that the candidate countries North Macedonia, Montenegro, Albania, Ukraine, the Republic of Moldova, Bosnia and Herzegovina and Georgia, as well as Armenia, aligned themselves with her statement. She agreed that, in the current circumstances, a balance had to be struck between realism and ambition. The process of reflecting on how to protect and sustain WHO's core functions in line with the Fourteenth General Programme of Work, 2025–2028 had to be transparent and engage all Member States. The aim was to improve the quality of support by increasing the flexibility and predictability of funding, to prioritize core functions and to enhance efficiency while maintaining WHO's essential role in global health. Additionally, efforts to improve and enhance governance reform must be pursued.

She expressed renewed support for funding reforms such as the investment round and the increase in assessed contributions, aimed at ensuring sustainable financing and making WHO less dependent on earmarked contributions. Further increases in assessed contributions would be subject to considerations outlined by the Working Group on Sustainable Financing; the Secretariat should engage transparently with Member States on the implications and next steps in that regard.

She welcomed the dedicated budget line for the global technical centres, which played a pivotal role in the work of WHO. The European Union had paused its co-sponsorship of draft resolutions pending the preparation of the revised draft Proposed programme budget and requested an updated cost overview of all resolutions to guide its future sponsorship decisions.

The representative of CHINA, noting that his Government had always paid its assessed contributions on time and in full, and that it had pledged a substantial amount during the investment round, pointed out that decision WHA75(8) on sustainable financing committed Member States to a 20% increase in assessed contributions in the 2024–2025 biennium. There had been no consensus on increases beyond that point and there was currently no clear information available on how assessed contributions would be calculated in the coming year; it would be difficult for any country to agree to such an opaque plan. The Secretariat should immediately launch a study of the feasibility of the 20% increase and avoid rushing into a decision. It should present multiple scenarios with varying levels of increase for Member States to discuss, in line with similar proposals made at regional meetings.

The representative of BULGARIA welcomed the alignment of the draft Proposed programme budget with the priorities set out in the Fourteenth General Programme of Work, 2025–2028 and highlighted the importance of better prioritization and strengthened accountability and monitoring. In order to secure WHO's financial sustainability, all further actions should be grounded in cost-benefit, cost-effectiveness and cost-prioritization analyses, and efforts made to stay within the available financial envelope. To achieve greater transparency and inclusivity in that

process, a financial task force could be formed, which would work in English and meet virtually to avoid additional costs.

Consideration should also be given to possible amendments to the Rules of Procedure of the Executive Board and the Rules of Procedure of the World Health Assembly, making it mandatory for draft resolutions and decisions to be accompanied by a draft financial framework indicating the funds available for implementation. Such amendments would improve the management of the WHO agenda, make it easier to predict the financial resources required, and avoid the practice of Member States tabling similar draft resolutions and decisions. The Board should ensure that draft resolutions and decisions had been the subject of prior consultation and coordination, had garnered support and were financially secured and well-aligned with the general programme of work before they were submitted for consideration.

The representative of AUSTRALIA said that the focus should be on developing an effective programme budget aligned with diverse, flexible and predictable financing and implemented with strong budget discipline, to ensure that WHO could still deliver on its ambitious Fourteenth General Programme of Work, 2025–2028. His Government remained committed to the consensus reached among Member States in 2022 to increase assessed contributions, as a means of addressing WHO's disproportionate reliance on earmarked voluntary contributions. He had noted the Secretariat's ability to direct funding to the country and regional levels when flexible funding was received, in contrast to earmarked voluntary contributions. The current risks were perhaps more critical than when the consensus agreement had been reached in 2022.

The recommendation of the Programme, Budget and Administration Committee to decrease the base segment of the draft Proposed programme budget to US$ 4.9 billion was in line with the principles established by the Committee for revising the programme budget, which included planning based on realistic financing and alignment with prioritized outcomes and outputs. It constituted a sensible and pragmatic approach to the budgeting process, despite a relatively ambitious view of resource mobilization, and would ensure that expectations were aligned with a revised budget.

The representative of ISRAEL welcomed the recommendations of the Programme, Budget and Administration Committee. While other organizations may have faced similar situations in the past, WHO was unique, and Member States must ensure that it was capable of performing its core functions, especially in health emergencies and on important health issues. It was not possible to continue adopting more resolutions without securing more financing. Indicators should be effective and relevant, and in line with the methodology discussed by the Executive Board. In terms of resource mobilization, the investment round was an important tool and merited further discussion by the Board to ensure its efficiency. Accountability was also important, not just on the part of the Secretariat but also of Member States, who had to stand by their commitments.

The representative of ETHIOPIA said that further development of the draft Proposed programme budget should ensure adequate funding for WHO's core mandate, including its unique role in setting norms and standards and supporting their adoption in countries. Priority should also be given to country office strengthening, and due emphasis should be placed on data and innovation, especially in the African Region, which continued to be underfunded in that regard. Bold action would be needed to address resource constraints in line with the country prioritization exercise, as well as to direct financing to chronically underfunded areas and rectify the disparities in the heatmap. An integrated approach should be implemented both within and with countries to enhance efficiency and effectiveness on the ground. Member States should maintain momentum on sustainable financing by honouring the commitment to increase assessed contributions and

contributing to the investment round. The Secretariat should accelerate efforts to materialize the pledges made and explore other sources of flexible financing.

The representative of LEBANON commended the Secretariat's transparent approach to the development of the draft Proposed programme budget based on jointly defined priorities. She highlighted the need for strengthened financial sustainability and the importance of the increase in assessed contributions in that regard. The decrease in the budget resulting from the announcement of the departure of the Organization's biggest financial contributor would negatively affect countries suffering from emergencies, where WHO's core function of protecting and providing for the most vulnerable was most needed. The recommendation to decrease the base segment of the draft Proposed programme budget to US$ 4.9 billion was the most realistic but should not come at the expense of safeguarding WHO's core functions, including in the areas of data and innovation, accountability and strengthening country capacities. Further consultations should be organized to discuss the proposed options, such as proportional deductions and reprioritization across the Organization. The flexibility of earmarked funding should continue to be improved, and consultations should be held during the run-up to the forthcoming Health Assembly on the revision of decisions and resolutions to reflect budget cuts. Consideration should also be given to the financing of major offices and to the number of outcome indicators, which should be reduced to capture the most impactful and most needed at the country level.

The representative of BARBADOS said that a decrease in the base segment of the draft Proposed programme budget to US$ 4.9 billion, while safeguarding core functions, accountability and country capacities, constituted a balanced approach that acknowledged current financial constraints while ensuring that essential operations were maintained. Building the draft Proposed programme budget on jointly defined country priorities under the Fourteenth General Programme of Work, 2025–2028 ensured that it was aligned with the specific needs and goals of Member States and promoted targeted and effective use of resources. Revisiting the costing of priorities at the three levels of the Organization and focusing on measurable impact reflected a commitment to practicality and accountability, while basing the budget on the agreed 20% increase in assessed contributions demonstrated a forward-thinking approach to sustainable financing. The Secretariat should present a detailed update on projected financing, including potential funding gaps, in May 2025, and continuously update the WHO Programme budget web portal to keep Member States informed and engaged. It should also continue to organize informal consultations with Member States and foster a collaborative and inclusive budget development process. Draft resolutions and decisions should be carefully costed in the light of the draft Proposed programme budget and potential financing constraints to ensure that financial realities were taken into account.

The representative of MALDIVES said that initiating the prioritization process at the country level would ensure maximum alignment with country contexts and priorities. The draft Proposed programme budget constituted a crucial step towards achieving the goals of the Fourteenth General Programme of Work, 2025–2028 and reflected a shared commitment to strengthening health systems, advancing health equity and addressing the escalating threat of climate change. The emphasis on country-level technical capacity-building, enhanced accountability and global technical centres was commendable, as were the Secretariat's efforts to refine the results framework and define baselines and targets for output and outcome indicators. It was important to make WHO's financing more sustainable; to that end, Member States should support the proposed increase in assessed contributions.

The representative of the DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA expressed support for WHO's commitment to strengthening country focus. In the light of the Organization's current

financial constraints, the Secretariat should strengthen the transparent, Member State-driven prioritization process, in line with the strategic objectives of the Fourteenth General Programme of Work, 2025–2028. While it was commendable that the draft Proposed programme budget was in line with commitments to improve transparency and accountability, as per the Secretariat implementation plan on reform, alignment between priorities and the budget needed to be improved. To that end, the Secretariat should distribute adequate flexible resources to countries and high-priority technical areas, and monitor their disbursement in a transparent manner. It should also further strengthen coordination and engagement with an increased number of international partners and stakeholders to secure sustainable and predictable financing. In that respect, her Government remained committed to the increase in assessed contributions.

The representative of THAILAND said that minimizing reliance on traditional donors was a step towards greater financial sustainability, and encouraged the Secretariat to explore innovative funding mechanisms, such as individual donor schemes. The WHO brand was well recognized; the Organization should leverage its strong reputation strategically to enhance programme implementation and impact.

She endorsed the Director-General's informal proposal to establish an endowment fund of US$ 50 billion based on voluntary unearmarked contributions, which would ensure the Organization's long-term independence and financial sustainability, and suggested that the fund should be referenced in the recommendations of the Programme, Budget and Administration Committee.

The representative of SWITZERLAND highlighted the importance of the commitment to increase assessed contributions by 20% as an essential means of ensuring more sustainable, flexible and predictable financing for the Organization. In view of the decision to be taken at the Seventy-eighth World Health Assembly, the Secretariat must be able at that time to show the initial results of cost-cutting and prioritization measures in terms of staff and activities. It was important to budget realistically, and Member States therefore had to limit the number of new requests made of the Organization through new resolutions. Every new request must be taken into account in the prioritization exercise; the overview made available by the Secretariat was very useful in that regard. The process leading up to the forthcoming Health Assembly must be inclusive and involve Member States, which needed more time to take well-founded decisions.

The representative of NORWAY said that the inclusive development process for the draft Proposed programme budget should be maintained in the months to come to ensure continued openness and transparency. The draft Proposed programme budget was results-based and aspirational in nature, but that did not eliminate the need for realistic budgeting; she expressed strong support for the recommendation to base the draft Proposed programme budget on a 20% increase in assessed contributions, which would ensure more sustainable, flexible and predictable financing of WHO. She welcomed the Secretariat's suggestion to draw on the current prioritization method for the revision of the draft Proposed programme budget but also noted the importance of safeguarding the Organization's core functions and normative mandate, as well as its work at the county level and activities to promote the achievement of the Sustainable Development Goals, including gender equality and sexual and reproductive health.

She welcomed the report contained in document EB156/INF./5 on the costings of draft resolutions and decisions. Although prioritization was always difficult, Member States should do what they could to alleviate the burden on the Organization, given the current circumstances. She was therefore in favour of the recommended decrease in the base segment of the draft Proposed programme budget, and stood ready to put on hold her Government's plan to propose a draft decision on resolutions and priorities.

The representative of CHILE commended the significant progress made in several key areas, in particular with regard to oversight mechanisms, transparency and country capacity-building. She expressed support for sustainable financing, given the financial challenges confronting the Organization, including, in principle, the increase in assessed contributions. However, given the current global economic context, in which countries were experiencing significant budget pressures, high inflation and challenges to their domestic health systems, careful consideration had to be given to the pace and extent of those increases. An examination of more gradual increases, conducted together with Member States and regional offices, should be accompanied by increased efforts towards operational efficiencies, greater diversification of sources of financing, strengthening of strategic partnerships with nongovernmental partners, and clear identification of critical programmes in order to maximize the impact of the resources available.

The representative of SOMALIA expressed full support for the recommendation of the Programme, Budget and Administration Committee to decrease the base segment of the draft Proposed programme budget to US$ 4.9 billion, which should ensure that resources were directed to places where they were most needed and would have the greatest impact. It was important to prioritize key areas, such as polio eradication, emergency preparedness and response, primary healthcare strengthening, the health workforce and addressing the impacts of climate change. Priority should also be given to supporting Member States in implementing their national health strategies. Ultimately, health outcomes were realized at the country level, and it was to that level that WHO had to direct its efforts to support capacity-building, policy development and implementation of evidence-based interventions.

The representative of FRANCE[5] said that the draft Proposed programme budget should be developed through a process that was as inclusive and transparent as possible, and should be revised downward to take account of the drop in resources following the withdrawal of the United States of America. The Organization's credibility was at stake, at a time when traditional government donors were experiencing severe budgetary constraints and new donors had yet to come forward. If efforts to mobilize additional resources, which must be continued, proved successful, the budget could be readjusted later. For the time being, there was no choice but to increase assessed contributions. Member States had to honour their commitments and confirm the 20% increase in assessed contributions. The current crisis should be seen as an opportunity to give fresh impetus to the ongoing governance reform process, including by developing an honest and realistic programme budget that more faithfully reflected anticipated revenues, and by ensuring coherence between the general programme of work, the programme budget and resolutions, all of which were currently prepared in silos.

The representative of PERU,[5] speaking also on behalf of Brazil, Colombia, Chile, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua and Uruguay, said that, in line with decision WHA75(8) (2022) on sustainable financing, those Member States continued to aspire to ultimately reach a level of 50% of base budget funding through assessed contributions, in order to increase financial sustainability and predictability. The decision to increase assessed contributions in the coming bienniums nevertheless required an objective review of financial and budgetary policies, taking into account the economic situation of Member States. The Member States he spoke for were confident that they could contribute significantly and creatively to the search for practical, sustainable and realistic solutions to the current financial

[5] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

crisis. Greater predictability of WHO's financing must be ensured, based on the principles of transparency, accountability, solidarity and equity.

The representative of LUXEMBOURG[6] said that, in the light of the unstable situation created by the withdrawal of WHO's largest contributor, the draft Proposed programme budget would have to be adapted following an in-depth analysis conducted primarily by the Secretariat. It would be essential for Member States to support the percentage proposed for the gradual increase in assessed contributions in order to reinforce budgetary sustainability and predictability. The Secretariat should not use those contributions simply to fill the financial gaps resulting from the current situation. The prioritization exercise should be rigorously conducted and aligned with available financial resources by adopting a public health risk management approach. To improve the chances of success, urgent consideration should be given to further expansion of the donor base and to the possibility of making voluntary contributions more flexible.

The representative of EL SALVADOR[6] said that comprehensive consultations should be conducted with Member States and at the regional level to ensure a more equitable and efficient distribution of resources and to obtain a detailed breakdown of outputs, outcomes and gaps to justify the increase in assessed contributions approved by the Executive Board.

The representative of the RUSSIAN FEDERATION[6] noted that realistic budgeting was essential for proper resource planning and accountability. Given the need to reprioritize the draft Proposed programme budget, he called on the Secretariat to provide specific proposals that fell within the Organization's mandate. He noted the Secretariat's intention to present indicative expenditure by key object of expenditure and requested the inclusion of a table on staffing in the next version of the draft Proposed programme budget. Although the allocation of resources might change, the presentation of those elements at the stage of approval of the programme budget would ensure accountability and would follow the practice at other organizations of the United Nations system.

The representative of MOZAMBIQUE[6] expressed appreciation for the active participation of Member States in the preparation process for the draft Proposed programme budget, which reflected their priorities and WHO's commitment to ensure a realistic budget despite the financial crisis facing the Organization, with clear results aligned with the Fourteenth General Programme of Work, 2025–2028, the Sustainable Development Goals and the challenges posed by recurrent emergencies arising from climate change and conflicts. Many countries in the African Region were dealing with multiple crises, limiting their ability to meet people's health needs. She therefore advocated for greater financial support from WHO in key areas, as well as support in relation to countries' resource mobilization capabilities, the increase in assessed contributions, the investment round, sustainable health financing, integrated planning and a holistic health approach. Verticalization had to be reduced and pragmatic resource allocation and efficiency improved to ensure better health outcomes.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND[6] encouraged all Member States to provide flexible funding to enable WHO to act with agility. The Secretariat should plan realistically, based on the most likely level of contributions, and set out the risks and mitigating measures if new funding was insufficient to fill the shortfall. It was more critical than ever to prioritize the activities set out in the Fourteenth General Programme of Work, 2025–2028, a responsibility shared by Member States and WHO leadership. She sought further

[6] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

clarity on that process, which should also recognize the very real financial constraints faced by the Organization and focus on WHO's core functions. Once clarity had been obtained on realistic resource mobilization and prioritization, Member States could review the level of cuts required before the forthcoming Health Assembly but needed to be informed quickly about the consultation plan in the critical months before May 2025.

The representative of PANAMA[7] expressed support for the recommendations of the Programme, Budget and Administration Committee. The decision whereby 50% of the base budget would eventually be funded by assessed contributions and 50% by voluntary contributions had been driven by the principles of solidarity, equity and international cooperation, and was intended to improve the Organization's financial sustainability. The new financial reality required a balance between assessed and voluntary contributions to enable WHO to discharge its mandate and implement the Fourteenth General Programme of Work, 2025–2028. The option to decrease the base segment of the draft Proposed programme budget to US$ 4.9 billion was an intermediate financing mechanism that included a 20% increase in assessed contributions, as provided for in decision WHA75(8) (2022). The programme budget must be implemented equitably, efficiently, transparently and with accountability, in continuous consultation with Member States, prioritizing mandates, distributing resources equitably, and not forgetting the relative impact on the Region of the Americas of the inequality in the distribution of financial resources.

The representative of SWEDEN[7] underscored the need for full transparency regarding the financial situation and during the preparation of the draft Proposed programme budget in the coming months. A realistic budget was essential given the recent changes in the donor landscape. The draft Proposed programme budget would have to be downsized and reprioritized, while safeguarding the Organization's core functions and containing costs. Scenario-planning based on an assessment of the consequences of the withdrawal of WHO's biggest donor needed to take into account the costs related to staff lay-offs. Sustainable financing of WHO through a higher share of assessed contributions coupled with a lower share of earmarked and unpredictable funding needed to go hand in hand with a broader donor base; the fact that over 30 of the pledges made during the investment round were from first-time donors was therefore a welcome development.

The representative of NAMIBIA,[7] noted that the recommendation to decrease the base segment of the draft Proposed programme budget came at a time when public health challenges were actually increasing. Strengthening country capacities and promoting data and innovation were key to implementation of the Fourteenth General Programme of Work, 2025–2028, and budget allocations in those areas should therefore be preserved, based on the principle of placing countries first. Developing a resilient health workforce meant prioritizing training and capacity-building, particularly in underserved regions. It was also crucial to fortify health systems against the impact of climate change and ensure equitable resource allocation to mitigate the disparities indicated in the heatmap. He endorsed the proposed 20% increase in assessed contributions, which constituted an essential element of sustainable health financing and would enhance implementation of the Fourteenth General Programme of Work, 2025–2028. He requested that a clear framework of indicators to measure progress and uphold governance and accountability standards be prepared in the run-up to the Seventy-eighth World Health Assembly.

The representative of the PHILIPPINES[7] expressed strong support for the Organization's sustainable financing goals and called for solidarity in approving gradual increases in assessed contributions. She expressed appreciation for the 7% increase in the budget for the Western

[7] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Pacific Region but noted the need to recalibrate costs and ensure that WHO had the resources it needed to deliver on its mandate. It was important to identify financing strategies to fully finance the Fourteenth General Programme of Work, 2025–2028, mitigate risks and retain the Organization's most precious resource – its staff.

Inclusive consultations should be held before the Seventy-eighth World Health Assembly to discuss funding gaps and prioritization and thus inform adjustments in resource allocations. It was also important to present an accurate picture in terms of the resolutions and decisions with budgetary implications for the 2026–2027 biennium; in that respect, she recommended presenting information on costings in a manner that showed the links between the actual costing implications of goals and the related outputs and outcomes. Budget cuts had to reflect evident disconnects between the mandates established in the resolutions and the financing received for their implementation. Consideration might also be given to shortening the five-year reporting period on operational efficiencies. Her Government would uphold the pledges it had made during the investment round in order to help to direct resources where they were most needed, especially in lower- and middle-income countries.

The representative of GERMANY[8] said that the announced withdrawal of the United States of America from WHO served as a wake-up call to reinforce the Organization's core functions, financial stability and governance structures. He expressed support for the increase in assessed contributions and emphasized the need to prioritize essential functions and ensure a more predictable, flexible and diversified funding model. Informal consultations with Member States on budget proposals should be continued ahead of the Seventy-eighth World Health Assembly. He supported WHO's work on governance reform – which should include efforts to boost accountability – and stressed the need for transparency concerning the budgetary impact of new resolutions.

The representative of INDONESIA[8] expressed appreciation for the draft Proposed programme budget and efforts to enhance transparency and involve Member States in its development. A balance was needed between ambition and pragmatism; the discussion must move beyond cost-cutting measures. Critical functions should not be sacrificed and the impact of financial decisions at the country level should be minimized. She called for inclusive consultations with Member States to finalize the draft Proposed programme budget and for clear, transparent information about which programmes would be affected under each budget scenario, the implications for the Organization's ability to meet its targets and details of mitigation measures and the allocation of flexible funds and voluntary contributions. Predictable and sustainable financing was needed more urgently than ever, and she urged the Secretariat to broaden revenue streams, continue the investment round initiative and explore innovative financing models.

The representative of SPAIN[8] said that courage was needed to avoid eroding the reputation of the Organization and support for multilateralism. The investment round had been an important step in financing reform. Member States and the Secretariat should step up efforts to effectively communicate the role of WHO in order to counter disinformation.

The withdrawal of the United States of America affected the entire global health architecture; analysis was needed to determine which priority areas should remain under WHO's leadership, in particular where it had a comparative advantage, and which areas should be the responsibility of other stakeholders, in order to avoid the duplication of efforts and resources.

[8] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of BANGLADESH[9] welcomed the draft Proposed programme budget, including the bottom-up approach to the base budget and the proposals concerning accountability and transparency. Member State solidarity and action were needed to meet budgetary aspirations and safeguard WHO's functions. The Secretariat should seek flexible donor funding to fill the financing gap in the base budget. The Organization's crucial functions, particularly at the country level, should not be compromised by a lowering of ambition.

The representative of MEXICO[9] welcomed the Secretariat's action to address the complex financial challenges resulting from the current situation, and called for a realistic programme budget with achievable fundraising targets. The current financial situation presented an opportunity to increase the number and diversity of donors and the amount of flexible funding to ensure the alignment of resources with priorities. Efforts in relation to transparency and accountability should be continued. He called on the Secretariat to provide updates on savings achieved through the implementation of efficiency measures and would have liked that request to be reflected in paragraph 23(f) of the report of the Programme, Budget and Administration Committee.

The representative of JAPAN[9] recognized that the target of US$ 4.9 billion for the base segment of the draft Proposed programme budget presented a challenge. Available funding should be closely monitored prior to the Seventy-eighth World Health Assembly and timely updates provided to Member States to allow for further dialogue, if needed, including on the reconsideration of the base budget. He emphasized the need for efficiency, transparency and accountability and for information-sharing concerning the increase in assessed contributions.

The representative of MALAYSIA[9] recalled that, since the increase in assessed contributions had been intended to strengthen country capacities and support governance reform, those elements of the programme budget should be preserved. A more realistic budget was needed that could counter the effects of inflation. It would be useful if information could be made available before the next meeting of the Programme, Budget and Administration Committee on how the voluntary contributions from the investment round could fund the base budget. Her Government remained committed to the proposed 20% increase in assessed contributions, accompanied by appropriate governance reform and enhanced transparency, efficiency and accountability.

She supported the call for the presentation of financial scenarios prior to the Seventy-eighth World Health Assembly and urged the Secretariat to pursue efforts to raise resources. Noting the misalignment of funding and priorities, she requested the Secretariat to map earmarked voluntary funds against country priorities in order to gain a clearer understanding of the constraints faced. A priority-setting exercise in the intersessional period would help Member States to reach an informed decision on the size of the budget. WHO should focus on core public health functions such as primary healthcare services and universal health coverage and minimize activity in areas primarily covered by other international organizations, with emphasis placed on human health and a human-centred approach.

The representative of INDIA[9] welcomed the emphasis in the draft Proposed programme budget on evidence-based prioritization, and noted the introduction of a new programme management system and the extension of the digital platform for the programme budget. The successful completion of the WHO investment round was also welcome.

When Member States had agreed to increases in assessed contributions, those increases had not been intended to make up for the withdrawal from the Organization of its largest donor.

[9] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Further work was needed to streamline and reimagine the draft Proposed programme budget, based on a realistic approach to restructuring programmes and reducing running costs. Technology could help to achieve greater efficiency and accountability. WHO's core functions must be preserved and strengthened, and he supported the call for the presentation of financial scenarios for Member States' consideration. The focus should be on the provision of capacity-building and technical advice that enabled countries to run programmes themselves in line with their priorities; global technical centres needed consistent support to that end.

The representative of ZAMBIA[10] welcomed the inclusive and transparent process for the development of the draft Proposed programme budget, and highlighted that the aims that had guided that process – promoting, providing and protecting health, directing resources to where they were most needed and the principle of equity – remained relevant and should form the basis of the prioritization process. Continued efforts should be made to strengthen the sustainable financing of the Organization to ensure impact where it was most needed.

The representative of SLOVENIA[10] noted that the prioritization process for the draft Proposed programme budget should be transparent and inclusive at all levels and based on an assessment of long- and short-term needs at the global, regional and country levels, while taking a balanced and equitable approach and considering the impact of activities. That process would require the cooperation of Member States. For lasting impact, a focus on investment in capacity-building and work at the country level would ensure implementation of agreed priorities. Forms of support beyond finance could include the exchange of good practices to capitalize on past investment in innovative solutions at the country level, while WHO collaborating centres could serve as knowledge hubs.

The representative of GHANA[10] expressed support for the draft Proposed programme budget and the call for flexible funding; however, a reduction in the budget for strengthening countries' capacities for data and innovation did not augur well for implementation of the Fourteenth General Programme of Work, 2025–2028. He encouraged the Secretariat to work with Member States to ensure effective implementation of the draft Proposed programme budget and echoed the call for a clear definition of the indicators to track results and measure progress in efforts to strengthen governance.

The ASSISTANT DIRECTOR-GENERAL (Business Operations) welcomed the recognition of a US$ 4.9 billion base budget as realistic yet ambitious. Based on that figure, the Secretariat could work on the prioritization process, which would be made inclusive through interaction with Member States at all levels of the Organization. That would ensure that the revised draft Proposed programme budget 2026–2027 reflected Member States' priorities and decisions. A plan for interaction with Member States would be made available by the end of the Board's current session.

The revised calculations for the scale of assessments, based on a base budget of US$ 4.9 billion and the increase in assessed contributions, would be made available before the end of the week and the Secretariat would update Member States on efficiency measures and seek their advice. He agreed that WHO collaborating centres and global technical centres could offer a means of providing support aside from the provision of financial resources.

The DIRECTOR-GENERAL recalled that Member States had agreed to increase assessed contributions to fund 50% of the base budget, based on the 2022–2023 base budget, by the

[10] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

biennium 2028–2029 or, failing that, by the biennium 2030–2031. That timeline required the first increase in assessed contributions for the biennium 2024–2025; if that first increase of 20% in assessed contributions was implemented for the biennium 2026–2027, the achievement of the targeted assessed contribution increase of 50% of the base budget would be achieved by the biennium 2032–2033. Should that increase not be approved for the biennium 2026–2027, it would push the timeline back further. Given the declining financial contributions from some donors due to economic upheaval and the withdrawal of membership by the United States of America, he urged Member States to approve the 20% increase for the biennium 2026–2027, with a view to achieving the targeted assessed contribution increase of 50% of the base budget by the biennium 2032–2033, and to empowering the Organization to allocate resources effectively and address the root causes of the problems it faced.

The CHAIR took it that the Board wished to note the report contained in document EB156/27, and concur with the proposed guidance of the Programme, Budget and Administration Committee of the Executive Board, contained in paragraph 23 of document EB156/4.

The Board noted the report.

The representative of CHINA said that he supported the majority of the suggestions made regarding the draft Proposed programme budget 2026–2027. In paragraph 23(d) of the report of the Programme, Budget and Administration Committee, however, he would have preferred to have four options for the increase in assessed contributions – ranging between 5% and 20% – with scenarios provided for each option to help Member States to decide which one would be best. He called for more time to allow for discussions among Member States on the increase in assessed contributions.

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

The meeting rose at 13:30.

Fourth meeting

Tuesday, 4 February 2025, at 15:15

Chair: Dr J.X. Walcott (Barbados)
later: Mr A.N. Ibrahim (Maldives)

Pillar 4: More effective and efficient WHO providing better support to countries (continued)

1. Staffing matters: Item 27 of the agenda

The meeting was held in private session from 14:30 to 15:05, when it resumed in public session.

Appointment of the Regional Director for Africa: Item 27.1 of the agenda (document EB156/46)

The CHAIR expressed his sincere condolences and those of the Board at the recent and untimely death of Dr Faustine Ndugulile, whom the WHO Regional Committee for Africa had nominated for the position of Regional Director for Africa and who had been due to be appointed to the role at the current session of the Board.

The Board stood in silence for one minute in tribute to the memory of Dr Ndugulile.

The LEGAL COUNSEL explained that, at its first special session on 14 January 2025, the Regional Committee for Africa had decided on an accelerated procedure for nominating a new candidate for the position of Regional Director for Africa following the death of Dr Ndugulile, as set out in document AFR/RCSS1/Decision 2. In line with that decision, on 20 January 2025 the Director-General had invited the Member States of the Region to submit proposals for the position of Regional Director, with a deadline of 28 February. A virtual candidates' forum was scheduled to be held on 2 April, followed by a second special session of the Regional Committee to be held in Geneva on 18 May, prior to the Seventy-eighth World Health Assembly, with a view to nominating the next Regional Director. In recognition of the invitation from the Regional Committee to the Executive Board to appoint the next Regional Director for Africa at its 157th session in May 2025, the Board had decided to include an item on the appointment on the provisional agenda of its 157th session.

At the request of the CHAIR, the SECRETARY read out the decision on the inclusion of an item on the appointment of the Regional Director for Africa on the provisional agenda of the 157th session of the Board, adopted by the Board in private session:[1]

> The Executive Board, expressing its condolences following the untimely death of Dr Faustine Ndugulile, whom the Regional Committee for Africa at its seventy-fourth session in August 2024 had nominated for the position of Regional Director for Africa; noting that at its first special session, on 14 January 2025, the Regional Committee for Africa adopted decision AFR/RCSS1/Decision 2, in which it made provision for the further selection of a candidate for the position of Regional Director for Africa through an accelerated process; and having considered document EB156/46,
>
> Decided, in recognition of the invitation from the Regional Committee for Africa to the Executive Board to appoint the next Regional Director for Africa at the Board's 157th session, to include an item on the appointment on the provisional agenda of its 157th session.

At the invitation of the CHAIR, the SECRETARY read out a resolution of appreciation adopted by the Board in private session:[2]

> The Executive Board,
>
> Desiring to express its appreciation to Dr Matshidiso Moeti for her services as Regional Director for Africa;
>
> Mindful of Dr Moeti's lifelong, professional devotion to the cause of global health, and recalling especially her 10 years of service as Regional Director for Africa;
>
> Recalling resolution AFR/RC74/R2 (2024), adopted by the Regional Committee for Africa at its seventy-fourth session, which designates Dr Matshidiso Moeti as Regional Director Emeritus,
>
> 1. EXPRESSES its profound gratitude and appreciation to Dr Matshidiso Moeti for her invaluable contribution to the work of the World Health Organization in the African Region;
>
> 2. ADDRESSES to her on this occasion its sincere good wishes for many further years of service to the global health community.

The DIRECTOR-GENERAL thanked the outgoing Regional Director for Africa for her outstanding leadership and achievements over the previous 10 years. Her work in transforming the Regional Office for Africa had been a strong source of inspiration for the WHO transformation agenda. He commended her steadfast dedication to building the health of the people of the Region and looked forward to continuing to collaborate with her in the future.

He expressed his deepest condolences to the family and friends of Dr Faustine Ndugulile and to the Government of the United Republic of Tanzania following his recent death. He had been impressed and encouraged by Dr Ndugulile's level of understanding and commitment to serving the people of Africa during his orientation visit to WHO headquarters in October 2024. The

[1] Decision EB156(4).

[2] Resolution EB156.R1.

decision of the Regional Committee for Africa to nominate a new Regional Director as soon as possible was welcome.

He confirmed the appointment of Dr Chikwe Ihekweazu, Assistant Director-General, WHO Health Emergencies Programme, as Acting Regional Director for Africa until the appointment of the new Regional Director at the 157th session of the Board. He was confident in the ability of Dr Ihekweazu to lead the Region over the next four months.

The OUTGOING REGIONAL DIRECTOR FOR AFRICA said that it had been an immense privilege to lead a Region of such potential, resilience and determination. She expressed her profound appreciation to the Executive Board for its support, which had been a cornerstone of the Region's progress over the past decade and key to the transformation agenda, resulting both in stronger, more agile country offices and strengthened leadership at all levels, and in an Organization that was better equipped to meet the complex and evolving health needs of the Region.

She expressed her heartfelt thanks to the Member States of the Region, whose courage, resilience and determination had been inspirational. Through joint efforts, groundbreaking milestones had been achieved, including the interruption of wild poliovirus transmission. Public health emergency preparedness and response capacity had also been significantly bolstered. To address inequities in access to key medicines and tools, efforts to build capacity for local manufacturing had been prioritized. Progress had also been made towards the elimination of diseases, notably neglected tropical diseases, while the Region's support for local innovation had provided a platform for young experts, scientists and public health workers to showcase their work at the global level.

She thanked partners for their technical and financial support, which had been instrumental in driving innovation and impact, and urged them to continue providing such support at the country, regional and global levels to improve health for all. She expressed her deep gratitude to the Director-General and WHO staff across the Region for their diverse and valuable contributions. She extended a warm welcome to the Acting Regional Director, who could count on the Region's support. On behalf of her entire team, she conveyed her condolences to the family of Dr Ndugulile, whose energy would inspire future work in the Region.

The representative of the COMOROS, speaking on behalf of the Member States of the African Region, conveyed his sincere condolences regarding the death of Dr Ndugulile and expressed his gratitude to the outgoing Regional Director, noting that her position as the first female Regional Director for Africa had strengthened gender equality in the Region. He expressed the hope that the next Regional Director would build on the achievements of the outgoing Regional Director's transformation programme and the vision of Dr Ndugulile. The Member States of the Region looked forward to working closely with the next Regional Director.

The representatives of MOROCCO, speaking on behalf of the Member States of the Eastern Mediterranean Region, POLAND, speaking on behalf of the European Union and its Member States and the candidate countries North Macedonia, Montenegro, Albania, Ukraine, the Republic of Moldova, Bosnia and Herzegovina and Georgia, and the European Free Trade Association country Norway, member of the European Economic Area, as well as Armenia, MALDIVES, speaking on behalf of the Member States of the South-East Asia Region, the FEDERATED STATES OF MICRONESIA, speaking on behalf of the Member States of the Western Pacific Region, CANADA, speaking on behalf of the Member States of the Region of the Americas, and TÜRKIYE[3] joined in

[3] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

conveying their condolences regarding the death of Dr Ndugulile and expressed their gratitude to the Outgoing Regional Director.

Appointment of the Regional Director for Europe: Item 27.2 of the agenda (document EB156/47)

At the invitation of the CHAIR, the SECRETARY read out the resolution on the appointment of the Regional Director for Europe adopted by the Board in private session:[4]

The Executive Board,

Considering the provisions of Article 52 of the Constitution of the World Health Organization;

Considering the nomination made by the Regional Committee for Europe at its seventy fourth session,[5]

1. REAPPOINTS Dr Hans Henri P. Kluge as Regional Director for Europe as from 4 February 2025;

2. AUTHORIZES the Director-General to issue a contract to Dr Hans Henri P. Kluge for a period of five years as from 4 February 2025, subject to the provisions of the Staff Regulations and Staff Rules.

The CHAIR congratulated Dr Kluge on his reappointment and conveyed the Board's best wishes for success in his post.

At the invitation of the CHAIR, Dr Kluge took the oath of office contained in Staff Regulation 1.10 and signed his contract.

The REGIONAL DIRECTOR FOR EUROPE thanked the Board for confirming the nomination of the WHO Regional Committee for Europe to reappoint him as Regional Director. He expressed his deepest condolences at the death of Dr Ndugulile.

To address the current crisis affecting WHO, 10 European donor Member States and representatives of the European Commission had held a strategy meeting the previous week and had reaffirmed their support for WHO. Efforts would be made to ensure that the Regional Office for Europe would remain able to deliver the new European Programme of Work, 2026–2030, establishing clear priorities in the financially constrained environment and ensuring relevance for all Member States of the Region. An emphasis would also be placed on going back to basics, including by ensuring technical excellence. Digital and artificial intelligence tools would be implemented to a greater extent to enhance effectiveness and agility. Ensuring political neutrality would enable WHO to fully play its normative role, providing country-level support and humanitarian aid everywhere, for everyone. The views of Member States would be listened to, with robust follow-up mechanisms.

He stood ready to take on the work expected of him, supported by an excellent team and taking on board the lessons learned from his first term of office. Noting that WHO's greatest asset was its staff, he was eager to further enhance cooperation with the WHO Staff Association. He

[4] Resolution EB156.R2.

[5] See resolution EUR/RC74/R1 (2024).

looked forward to the continued support of the Director-General and Member States in fulfilling his commitments and expressed appreciation for the support of his family.

The DIRECTOR-GENERAL congratulated the Regional Director for Europe on his reappointment. Over the past five years, the Regional Director had devoted himself to serving the people of the European Region. With commitment, vision and determination, the Regional Director had led the Region through health emergencies, including the coronavirus disease (COVID-19) pandemic, and other challenges such as the ongoing conflict in Ukraine.

The Regional Director had earned Member States' confidence and trust, notably through his initiatives on participatory governance, Member State engagement, mental health, immunization, digital health, and behavioural and cultural insights. He looked forward to the outcomes of the Regional Director's upcoming agenda, and to continuing to collaborate closely with the Regional Director going forward.

The representative of POLAND, speaking also on behalf of Albania, Armenia, Austria, Belgium, Bulgaria, Bosnia and Herzegovina, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, the Kingdom of the Netherlands, North Macedonia, Norway, Poland, Portugal, the Republic of Moldova, Romania, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Ukraine and the United Kingdom of Great Britain and Northern Ireland, congratulated the Regional Director for Europe on his reappointment, which was a testament to his outstanding leadership and unwavering commitment to public health and the well-being of all in the Region. During his first term of office, he had guided the Region through unprecedented challenges, where the vital relevance of his role had been clearly demonstrated.

She commended his exceptional diplomatic skills, commitment to efficiency, cost containment and improved governance, and for tailoring regional actions to the priorities of Member States. She was confident that, under his continued leadership, the complex challenges facing the Region would be effectively addressed in a challenging resource context. She looked forward to working closely with the Regional Director on the implementation of the second European Programme of Work, 2026–2030, which was aligned with the Fourteenth General Programme of Work, 2025–2028, with bold action at the country level.

The representatives of the COMOROS, speaking on behalf of the Member States of the African Region, MALDIVES, speaking on behalf of the Member States of the South-East Asia Region, the REPUBLIC OF KOREA, speaking on behalf of the Member States of the Western Pacific Region, BARBADOS, speaking also on behalf of Antigua and Barbuda, Argentina, Bahamas, Belize, the Plurinational State of Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay and the Bolivarian Republic of Venezuela, UKRAINE, ISRAEL, the REPUBLIC OF MOLDOVA, MOROCCO, QATAR, the RUSSIAN FEDERATION,[6] TÜRKIYE[6] and BELARUS[6] congratulated the Regional Director on his reappointment.

[6] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Pillar 1: One billion more people benefiting from universal health coverage

2. Universal health coverage: Item 6 of the agenda

- **Primary healthcare** (document EB156/6)

The CHAIR invited the Board to consider the report contained in document EB156/6 and to discuss the guiding questions set out in paragraph 22 of the document. The Board was also invited to consider four draft decisions under the item. The first draft decision, which contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly, on strengthening national capacities in evidence-based decision-making for the uptake and impact of norms and standards, proposed by Ecuador, Egypt, Georgia, Norway, the Member States of the African Region and the Member States of the European Union read as follows:

> The Executive Board, having considered the report by the Director General,[7]
>
> Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following resolution:
>
> > The Seventy-eighth World Health Assembly,
> > (PP1) Having considered the report by the Director-General;
> > (PP2) Recalling the collective commitment to achieve universal health coverage and the role of evidence, knowledge and innovation in promoting quality of care, improving financial protection and driving positive outcomes;
> > (PP3) Recognizing WHO's unique status as a science- and evidence-based organization and its normative leadership, as outlined in its Constitution and in the Fourteenth General Programme of Work, 2025–2028,[8] with its renewed focus on country-level impact including through timely delivery, expanded access to and uptake of WHO's normative, technical and data products;
> > (PP4) Recalling the experiences encountered during the pandemic of coronavirus disease (COVID-19) and the need for robust and timely clinical and public health guidance that is relevant to context and responsive to local needs and equity considerations;
> > (PP5) Recognizing scientific evidence as an important basis for the development of clinical and public health guidance; and recognizing the value of science and high-quality evidence in ensuring that complex information is synthesized and available in accessible formats for end-users to guide practice and improve health outcomes;
> > (PP6) Concerned that there are significant gaps, including inadequate resources, in the capacity of countries to produce and use relevant local and global evidence in developing new clinical and public health guidelines or in adapting existing guidelines with proper feedback systems to measure the cost-effectiveness and quality of clinical care, public health guidance and policy, and their impact on population health and well-being;
> > (PP7) Recalling the Constitution of the World Health Organization,[9] resolution WHA75.8 (2022)[10] on strengthening clinical trials to provide high-quality evidence on

[7] Document EB156/6.

[8] WHO Fourteenth General Programme of Work, 2025–2028 (document A77/16).

[9] Basic documents: forty-ninth edition. Geneva: World Health Organization; 2020.

[10] Document WHA75/2022/REC/1, resolution WHA75.8.

health interventions and to improve research quality and coordination, and resolution WHA63.21 (2010)[11] on WHO's role and responsibilities in health research;

(PP8) Acknowledging the recommendations from the external evaluation on WHO's normative function at the country level that addresses the impact and effectiveness of WHO's normative products within individual country context;[12]

(PP9) Emphasizing the critical role of evidence-based WHO norms and standards in health decision-making and the need to maintain trust in the health system and in the global health processes for establishing norms and standards, especially in the light of misinformation and disinformation;

(PP10) Underlying the need to foster strong local and regional clinical and public health leadership and innovation that are human-centred and based on science and evidence, which is key to creating a conducive environment for local investment in research, public health infrastructure and other supportive systems at local and regional levels;

(PP11) Acknowledging the importance of supporting local priorities and informing context-specific research, including through implementation research, local innovation and product development in priority diseases that include ongoing efforts, such as those on proven approaches focusing on quality vaccines, diagnostics, therapeutics, medical supplies and including non-pharmacological, digital, public health and prevention interventions,

(OP)1. URGES Member States,[13] in accordance with national contexts:

(1) to institutionalize, as appropriate, structures, systems and processes for the development and adaptation of clinical and public health guidance;

(2) to strengthen national quality control, as well as regulatory frameworks and authorities, to facilitate appropriate uptake of global clinical and public health recommendations;

(3) to enhance and sustain investment to strengthen national capability for guideline adaptation and timely uptake of normative products, including fit-for-purpose digital technologies that are tailored to public health needs and their respective health system maturity levels;

(4) to strengthen legal and policy frameworks and domestic support to enable high-quality research and development that provide contextual data to facilitate the adoption, adaptation or de novo development of clinical and public health guidelines, as needed; and to support monitoring and evaluation of the use and impact of these guidelines for improved and more equitable health outcomes;

(5) to coordinate efforts to strengthen the generation, synthesis and use of evidence for decision-making, with effective dissemination, use and local impact of clinical and public health recommendations;

(6) to facilitate collaborative and multicountry research on health decision-making frameworks focused on clinical and public health recommendations, taking into account national and regional contexts and regulatory practices;

(7) to create or support an enabling environment, including technical and regulatory frameworks for implementing clinical and public health guidelines,

[11] Document WHA63/2010/REC/1, resolution WHA63.21.

[12] WHO normative function at country level: evaluation report. Geneva: World Health Organization; 2024.

[13] And, where applicable, regional economic integration organizations.

with feedback on impact to enable evidence-based decisions and prioritization in health;

(8) to consider the use of economic evaluation and priority setting in national guideline development and the financial impact of dissemination and implementation;

(OP)2. REQUESTS the Director-General:

(1) to enable that WHO's normative products: remain of consistently high standard and are adapted to local context, with particular attention to developing countries including small island States; are driven by Member States' needs; and are designed and delivered in a timely manner to achieve impact;

(2) to use WHO's convening power to provide and support platforms for relevant stakeholders in a systematic and integrated manner across the evidence-to-policy and implementation spectrums, using digital systems and a living approach[14] to WHO's normative products for country implementation and impact;

(3) to identify the obstacles for Member States to uptake and implement WHO's normative products, and to support Member States upon request in priority-setting and the establishment of national capacity and mechanisms, as appropriate, to generate and use contextual evidence to support systematic adaptation and uptake of WHO's norms and standards;

(4) to support multilingualism and ensure that WHO's normative products are published in all six official languages of the United Nations, and to make efforts to extend possible support to Member States for publishing normative products in the local language;

(5) to support and facilitate, within and between countries and across regions, collaborations for strengthening national and regional science capacities;

(6) to identify opportunities for and consider, where appropriate, the establishment of regional collaborating mechanisms, such as centres of excellence, in order to facilitate access by Member States and other relevant stakeholders to the necessary expertise corresponding to need;

(7) to develop, within existing resources, in close consultation with Member States and with inputs from relevant stakeholders, in line with the Framework of Engagement with Non-State Actors, as applicable, a global framework on uptake and impact of norms and standards and a global plan of action for the implementation of the framework in 2027;

(8) to strengthen WHO's capacity for providing technical support to Member States, within existing resources, including through the WHO Academy and other WHO technical training platforms, for scaling up adaptation and implementation of WHO's normative products in line with the Fourteenth General Programme of Work, 2025–2028, with the appropriate structure, resources, assets and capabilities;

(9) to report on progress made in the implementation of this resolution to the Health Assembly in 2027, 2029 and 2031.

[14] Quality Assurance, Norms and Standards. Geneva: World Health Organization; 2025.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[15]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:

1.3.2. Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems

1.3.4. Research and development agenda defined and research coordinated in line with public health priorities

4.1.3. Strengthened evidence base, prioritization and uptake of WHO generated norms and standards and improved research capacity and the ability to effectively and sustainably scale up innovations, including digital technology, in countries

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:

Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:

Not applicable.

4. Estimated time frame (in years or months) to implement the decision:

Six years.

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:

US$ 56.82 million.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:

US$ 2.12 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:

Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:

US$ 21.37 million.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:

US$ 33.33 million.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions

- **Financial resources available to fund the decision in the current biennium:**
  US$ 1.50 million.
- **Remaining financing gap in the current biennium:**
  US$ 0.62 million.
- **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
  The required amount is not yet available. However, resource mobilization efforts are under way.

[15] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic “bridge” between results structures can be provided as needed.

Table. Breakdown of estimated resource requirements (in US$ millions)[a]

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.68	0.68
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	1.44	1.44
	Total	0.00	0.00	0.00	0.00	0.00	0.00	2.12	2.12
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	1.33	1.13	0.94	1.21	1.00	1.03	1.42	8.06
	Activities	1.72	1.72	1.72	1.72	1.72	1.72	2.99	13.31
	Total	3.05	2.85	2.66	2.93	2.71	2.75	4.41	21.37
B.4. Future bienniums cost of resources to be planned	Staff	2.08	1.77	1.46	1.89	1.55	1.61	2.21	12.57
	Activities	2.68	2.68	2.68	2.68	2.68	2.68	4.67	20.76
	Total	4.76	4.45	4.15	4.57	4.23	4.29	6.88	33.33
B.1. Total planned costs required to implement the decision									56.82

[a] The row and column totals may not always add up, owing to rounding.

The second draft decision which contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly, was on rare diseases: a global health priority for equity and inclusion. It was proposed by Brazil, Chile, China, Ecuador, Egypt, France, India, Iraq, Jordan, Kuwait, Luxembourg, Malaysia, Pakistan, Palestine, Panama, the Philippines, Qatar, Romania, Somalia, Spain and Vanuatu, and read:

> The Executive Board, having considered the report of the Director-General,[16]
>
> Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following resolution:
>
> > The Seventy-eighth World Health Assembly,
> > (PP1) Having considered the report by the Director-General;
> > (PP2) Recognizing that a rare disease is often described as a specific health condition affecting 1 in 2000 individuals or fewer in general population, and that there are currently over 7000 known rare diseases impacting more than 300 million people globally, with 70% of these conditions starting in childhood;[17] and that, while the frequency of most rare diseases can be described by prevalence, some rare diseases can be more precisely described by incidence;[18]

[16] Document EB156/6.

[17] The Lancet Global Health. The landscape for rare diseases in 2024. Editorial. 10.1016/S2214-109X(24)00056-1.

[18] Wang et al. Orphanet Journal of Rare Diseases. Operational description of rare diseases (2024), pp. 19–334.

(PP3) Noting that rare diseases are often complex and multisystemic, affecting multiple organs and leading to comorbidities, and that many of these conditions are chronic, progressive, and can consequently result in serious disabilities and premature death;

(PP4) Recognizing that some persons living with a rare disease have disabilities, which may have a greater impact on their health, and that they may also face various barriers, which may hinder their full and effective participation in society on an equal basis with others;[19]

(PP5) Recognizing also that, in addition to the physical impact, some persons living with a rare disease, their families and caregivers may experience discrimination and psychosocial consequences such as isolation, stigmatization, and limited opportunities for social inclusion, which are often intensified by a lack of public awareness and knowledge, and the absence, limited scope or poor implementation of policies and social support;

(PP6) Further recognizing that persons living with a rare disease (including those whose disease is undiagnosed), their families and caregivers may be psychologically, socially and economically vulnerable throughout their life course, facing specific challenges in several areas, including but not limited to physical and mental health, education, employment, financial well-being and leisure;

(PP7) Emphasizing the importance of adopting a holistic patient-centred approach to address the needs of persons living with a rare disease, focusing on enhancing their functioning and working with society to remove, to the extent possible, the barriers they face in accessing health, education, employment and other domains of life;

(PP8) Noting that the high prices of many health products for rare diseases, and inequitable access to such products within and among countries, as well as the financial hardships associated with their high costs, pose significant challenges for some persons living with a rare disease;

(PP9) Recognizing from an equity perspective, that women and children living with a rare disease encounter greater challenges in accessing care, including the late diagnosis, biases in symptom assessment, and reduced access to timely and appropriate treatment, which significantly impact their quality of life and overall health outcomes;

(PP10) Recognizing also the importance of achieving universal health coverage, including for persons living with a rare disease, their families, and caregivers, and that universal health coverage implies that all people have access, without discrimination, to nationally determined sets of essential quality health services, from health promotion to, prevention, treatment, rehabilitation, and palliative care, as well as essential, safe, affordable, effective, and quality medicines, vaccines, diagnostics, health technologies, including assistive technologies, ensuring that the cost of using these services does not lead to financial hardship;

(PP11) Further recognizing the importance of implementing integrated care, considering the health system along with social and community services, for enabling persons living with a rare disease to achieve optimal health and well-being;

(PP12) Acknowledging that to enhance physical and mental health, well-being, and life expectancy for everyone, it is essential to achieve universal health coverage, including persons living with a rare disease;

[19] Resolution WHA74.8 (2021).

(PP13) Recalling in particular the United Nations Sustainable Development Goal target 3.8 (Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all), the United Nations political declaration of the high level meeting on universal health coverage (2019),20 which includes rare diseases, and the political declaration of the high-level meeting on universal health coverage (2023),[21] reaffirming the commitment to ensure that no one is left behind, and other universally agreed resolutions and declarations;

(PP14) Recalling also resolution 76/132 (2021)[22] on addressing the challenges of persons living with a rare disease and their families, adopted in December 2021 by the United Nations General Assembly, which paved the way for greater integration of rare diseases into the agenda and priorities of the United Nations system;

(PP15) Noting that reaching the correct diagnosis can take over five years, that many persons living with a rare disease never receive a timely or adequate diagnosis, although nearly half of genetic diseases start in childhood, and that insufficient screening programmes, including newborn screening, and unequal access to diagnostic services, infrastructure and expertise contribute to delayed diagnosis and management;

(PP16) Noting also that for undiagnosed persons with a suspected rare disease, entering a coordinated diagnostic and research pipeline offers a unique hope to speed up diagnosis, as recognized by the International Rare Disease Research Consortium;

(PP17) Recalling resolution WHA76.5 (2023) on strengthening diagnostics capacity, which recognizes that diagnostic services are vital for the prevention, diagnosis, case management, monitoring and treatment of communicable, noncommunicable, neglected tropical and rare diseases, and which emphasizes equitable access to diagnostics for all, and highlights the importance of diagnostics for healthcare service delivery, ranging from prevention to treatment, as well as access to research projects on diagnostics;

(PP18) Recalling also resolution WHA75.8 (2022) on strengthening clinical trials to provide high-quality evidence on health interventions and to improve research quality and coordination, in which the Health Assembly called on Member States, inter alia, “to encourage the targeting of clinical trials towards the development of health interventions that address public health priorities and concerns of global, regional and national importance, including communicable and noncommunicable diseases, with a focus on the health needs of developing countries, and that evaluate the safety and efficacy of health interventions, including having special regard to common diseases in low- and middle-income countries, unmet medical needs, rare diseases and neglected tropical diseases”;

(PP19) Recalling further resolution WHA77.2 (2024) on social participation for universal health coverage, health and well-being, in which the Health Assembly urged Member States, inter alia, to strive “to ensure that social participation influences transparent decision-making for health across the policy cycle, at all levels of the system”;

(PP20) Further recalling resolution WHA77.5 (2024), in which the Health Assembly invited Member States, inter alia, to consider implementing a universal

[20] United Nations General Assembly resolution 74/2 (2019).

[21] United Nations General Assembly resolution 78/4 (2023).

[22] United Nations General Assembly resolution 76/132 (2021).

newborn screening programme, including comprehensive screening for congenital disorders; and, recognizing the importance of early detection programmes, including those for prevention and mitigation of health conditions that may result in disabilities, while also addressing the specific needs and considerations for diagnosis, management, and long-term care that meets the needs of affected children;

(PP21) Recognizing that early identification can prevent the onset of disease symptoms or delay the progression of both common and rare diseases, thereby reducing child mortality and morbidity, improving the quality of life of persons living with a rare disease and conferring significant benefits on them, their families, their caregivers and society as a whole;

(PP22) Acknowledging the disparity of resources between rural and urban areas within and among countries, the limited availability and geographical dispersion of rare disease specialists and centres of expertise, along with the lack of patient pathways, referral systems and effective knowledge-sharing platforms, which hinders necessary consultations with specialists on diagnosis and optimal patient care, thereby resulting in suboptimal clinical management for persons living with a rare disease;

(PP23) Noting that due, in part, to limited resources for research, diagnosis, and treatment along with the insufficient equitable investment and financial incentives for drug development in rare diseases, more than 95% of rare diseases still lack an effective treatment;

(PP24) Acknowledging that even when treatments and care are available, high costs may often lead to delayed, inconsistent, and inequitable access;

(PP25) Acknowledging also that rare diseases fall within the scope of the WHO's Fourteenth General Programme of Work, 2025–2028, as well as the WHO's efforts to achieve the goals outlined in its first strategic priority of extending universal health coverage to one billion more people as stated in the WHO's Thirteenth General Programme of Work, 2019–2025, and in alignment with countries' national context and priorities;

(PP26) Further acknowledging that although each country, in line with its national context and priorities, faces unique challenges in meeting the needs of persons living with a rare disease, there are common issues, such as constrained health budgets and a shortage of specialized services, resources and expertise leading to health inequities within and among Member States, which collectively result in persons living with a rare disease worldwide often struggling to access the care and support they need;

(PP27) Highlighting the WHO's commitment to promote health equity and support Member States in ensuring that all persons living with a rare disease, regardless of their condition, receive timely and appropriate healthcare services;

(PP28) Emphasizing the critical need for global collaboration to tackle the unique challenges faced by persons living with a rare disease, and by their families and caregivers, especially mothers – including: the implementation of policies and programmes that prevent and combat stigma and social exclusion; accurate data collection; and increased awareness – in line with countries' national context and priorities;

(PP29) Recognizing the need: to foster innovation that promotes social cohesion, reduces inequalities and discrimination; and to enhance research efforts and develop innovative therapies for rare diseases;

(PP30) Underscoring the need to address the root causes of inequality and discrimination faced by persons living with a rare disease, their families, and caregivers, and in this regard recognizing that there is a need for health policies and

programmes to foster inclusion and create an environment conducive to respect for their rights and dignity;

(PP31) Noting that rare diseases may lead to disabilities, and in this regard recalling the principles embodied in the Constitution of the World Health Organization and the Convention on the Rights of Persons with Disabilities, and stressing the importance of their implementation, including inter alia through relevant policies, programmes and strategies at national and international levels to promote inclusion and rights of persons with such disabilities;

(PP32) Recalling the United Nations General Assembly resolution 78/12 (2023) entitled "World Duchenne Awareness Day", [23] in which the General Assembly decided to designate 7 September, the current World Duchenne Awareness Day, as a United Nations Day, recognizing that Duchenne muscular dystrophy is one of the most common paediatric genetic rare diseases, and encouraging Member States to raise awareness on the specific challenges and needs faced by persons living with a rare disease, their families and caregivers, through national campaigns, educational programmes and information dissemination, with the goal of fostering greater understanding and empathy towards those affected by rare diseases and promoting global solidarity,

(OP)1. URGES Member States,[24] taking into account national context and priorities:

(1) to commit:

(a) to providing appropriate support to WHO in developing a comprehensive global action plan on rare diseases;

(b) to integrating rare diseases into national health planning by developing and implementing national policies, effective programmes and actions, including developing primary and secondary evidence-based preventive actions, and strategies aimed at preventing and improving healthcare services for persons living with a rare disease through an integrated approach, ensuring equitable access to timely, cost-effective and affordable, available, accurate diagnosis, particularly for newborns through universal screening programmes, and the necessary cost-effective treatment, social and healthcare services;

(c) to implementing effective programmes that promote mental health and psychosocial support for persons living with a rare disease, as well as policies and initiatives that enhance the well-being of their families and caregivers;

(d) to accelerating efforts toward achieving and extending universal health coverage by 2030, ensuring healthy lives and well-being for all individuals, including persons living with a rare disease, throughout their life course, in order to stop the rise, and reverse the trend, of catastrophic out-of-pocket health expenditure as appropriate, by re-emphasizing the commitment to progressively provide persons living with a rare disease with quality essential health products, healthcare services, and affordable medicines, diagnostics, and health technologies by 2030;

(e) to strengthening health systems, particularly in primary healthcare, to ensure universal access to a wide range of affordable and high-quality

[23] United Nations General Assembly resolution 78/12 (2023).

[24] And, where applicable, regional economic integration organizations.

healthcare services for persons living with a rare disease especially children;

(f) to fostering the inclusion of relevant competencies in the pre-service education of students and lifelong learning of health workers in preventing, diagnosing, treating and managing rare diseases;

(g) to further increasing awareness and education initiatives about rare diseases among healthcare providers, policy-makers and the public in order to promote understanding of and support for affected individuals;

(h) to removing barriers that persons living with a rare disease, their families and caregivers face in accessing safe water, sanitation, and hygiene, including addressing physical, institutional, social, and attitudinal obstacles, promoting appropriate measures to ensure equitable access for these individuals, their families, and caregivers in both rural and urban areas;

(i) to considering, as appropriate, the development and utilization of digital technologies,[25] including telemedicine and data-sharing platforms in order to improve access to specialists and treatments, especially in remote areas or those with limited medical resources, ensuring that technologies are accessible;

(j) to promoting the involvement of patient organizations, peer support groups, organizations of persons with disabilities, including groups led by persons living with a rare disease, in policy development to ensure that the voices of those affected by rare diseases are heard and incorporated into decision-making processes;

(k) to facilitating the establishment, as appropriate, of dedicated national task forces or coordination bodies to oversee the implementation of policies related to rare diseases, enhancing accountability and effective management;

(l) to encouraging the establishment of national, regional and international centres of excellence as specialized hubs for care, research and training for rare diseases;

(m) to encouraging the establishment of a national registry for rare diseases, or collaborating with existing international registries for rare diseases, as appropriate, to strengthen their capacity on data collection, analysis, and disseminating disaggregated data on persons living with a rare disease, while respecting data protection and privacy, to achieve evidence-based decisions at all levels; and

(n) to considering implementation of the eleventh revision of the International Classification of Diseases (ICD-11), and where appropriate, interoperable codification systems for rare diseases such as the Orphanet nomenclature of rare diseases (ORPHAcodes), at their earliest possibility, and in accordance with their available resources, in order to enable the recording, reporting and monitoring of rare diseases at national and international levels;

(2) to encourage collaboration between policy-makers, governmental health and research authorities, academic institutions, clinicians, patient organizations,

[25] Guided by, inter alia, WHO's global strategy on digital health 2020–2025.

the private sector, and civil society in order to foster innovation in research and innovative diagnosis and treatment that proactively address rare diseases;

(3) to support efforts to adopt innovative ways of funding, mobilize resources from all sources (for example, public and private funders) for integrated action on rare diseases, including research and innovation, and to consider expanding opportunities, with a focus on developing countries;

(4) to strengthen cooperation at the national, regional, and international levels to promote equitable and timely access to affordable, safe, effective, and quality medicines for all persons living with a rare disease across the world, leaving no one behind;

(5) to mobilize high-level attention to rare diseases and related aspects within multilateral forums, as appropriate, to help to ensure sustained and concrete political visibility and momentum, and explore ways in which to integrate rare diseases into health policy and programmes reflecting the national strategies and priorities;

(6) to regularly assess, where applicable, the implementation of their national action plans for rare diseases and, to the extent possible, evaluate their contribution to the implementation of regional action plans related to rare diseases;

(OP)2. REQUESTS the Director-General:

(1) to develop – in consultation with Member States, and in collaboration with nongovernmental organizations including patients' organizations, academic institutions, in line with the Framework of Engagement with Non-State Actors, as applicable, and experts in rare diseases – a comprehensive 10-year draft global action plan for rare diseases, in alignment with the agreed strategic priorities of WHO and its Fourteenth General Programme of Work, 2025–2028, including all necessary preparatory work, and budgetary aspects, to be submitted for consideration by the Eighty-first World Health Assembly in 2028;

(2) to conduct preparatory work, including: mapping existing WHO standards, guidelines and protocols relating to rare diseases; providing an initial technical report on rare diseases; identifying technological innovation opportunities (including e-health, m-health, digital and artificial intelligence solutions) to centralize clinical health information for diagnostics and treatment;

(3) to establish a workstream promoting universal health coverage for persons living with a rare disease;

(4) to identify centres of excellence around the world that are able to cluster clinical work in certain rare disease groups, and that can act as hubs to exchange experience and clinical knowledge and provide peer-to-peer medical reviews and advice, including across borders;

(5) to ensure that the global action plan for rare diseases encompasses, but is not limited to, the following key components:

- a comprehensive framework to foster equitable access to timely, cost-effective, affordable, available, accurate diagnosis and evidence-based treatments, and an adequate management of rare diseases, aligned with the principles of universal health coverage as outlined in the United Nations political declarations of the high-level meetings on universal health coverage of 2019 and 2023, and taking into account the social determinants of health;

- strategies for improving data collection, research and surveillance on rare diseases to enhance understanding, timely and confirmed early identification, including screening, diagnosis and treatment options in collaboration with Member States' national authorities, with the ultimate goal of sharing knowledge and data in the field and fostering investment in research;
- guidelines for the establishment of national and regional registries to facilitate the screening, monitoring, and management of rare diseases;
- global targets and strategic objectives, along with clear guidelines to improve access to affordable and equitable healthcare services for persons living with a rare disease, the essential health products needed for accurate diagnosis and effective treatment for persons living with a rare disease, as well as an accompanying process for accountability and monitoring to track implementation progress, including at the national level;

(6) to support Member States, upon request, in the development of national policy and strategies to enhance the health of persons living with a rare disease, including addressing the social and financial implications of supporting persons living with a rare disease in a sustainable and inclusive way;

(7) to submit a draft global action plan on rare diseases for consideration by the Executive Board at its 162nd session, with the intention of submitting this draft Global Action Plan to the Eighty-first World Health Assembly for adoption;

(8) to report on the implementation of this resolution to the Seventy-ninth World Health Assembly in 2026, through the Executive Board at its 158th session, and to submit progress reports to the Health Assembly in 2028, and 2030.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[26]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:

1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary healthcare strategies and comprehensive essential service packages

1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results

3.2.2. Countries enabled to reinforce partnerships across sectors, as well as governance mechanisms, laws and fiscal measures

4.1.3. Strengthened evidence base, prioritization and uptake of WHO generated norms and standards and improved research capacity and the ability to effectively and sustainably scale up innovations, including digital technology, in countries

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:

Not applicable.

[26] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic "bridge" between results structures can be provided as needed.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:
Not applicable.

4. Estimated time frame (in years or months) to implement the decision:
Six years (2025–2030).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:
US$ 9.06 million.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:
US$ 0.62 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:
Zero.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:
US$ 6.52 million.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:

US$ 1.92 million.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions

- **Financial resources available to fund the decision in the current biennium:**
  Zero.
- **Remaining financing gap in the current biennium:**
  US$ 0.62 million.
- **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
  Fundraising has commenced and opportunities for funding are being explored.

Table. Breakdown of estimated resource requirements (in US$ millions)[a]

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.41	0.41
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.22	0.22
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.62	0.62
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	0.16	0.13	0.11	0.14	0.11	0.12	1.40	2.18
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	4.34	4.34
	Total	0.16	0.13	0.11	0.14	0.11	0.12	5.74	6.52
B.4. Future bienniums cost of resources to be planned	Staff	0.08	0.07	0.06	0.07	0.06	0.06	1.32	1.72
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.20	0.20
	Total	0.08	0.07	0.06	0.07	0.06	0.06	1.52	1.92
B.1. Total planned costs required to implement the decision									9.06

[a] The row and column totals may not always add up, owing to rounding.

The third draft decision under consideration, which contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly, was on strengthening health financing globally, proposed by Bangladesh, Botswana, Cameroon, Canada, Chile, Ecuador, Ghana, Japan, Lesotho, Luxembourg, Morocco, Mozambique, Nigeria, Norway, Senegal, South Africa, Ukraine, the United Kingdom of Great Britain and Northern Ireland, the United Republic of Tanzania, Zambia and Zimbabwe. The draft decision read as follows:

> The Executive Board, having considered the report of the Director-General,[27]
>
> Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following resolution:
>
> > The Seventy-eighth World Health Assembly,
> >
> > (PP1) Having considered the report by the Director-General,
> >
> > (PP2) Having considered the UHC Global Monitoring Report 2023 which shows that the world is off track in making meaningful progress towards universal health coverage (UHC) and aligned with the Sustainable Development Goals by 2030, with no, or little, improvement in related indicators (3.8.1 or 3.8.2) since 2015. Recognizing that growth has had uneven benefits with almost 2 billion people facing any form of financial hardship due to out-of-pocket expenditure; 1 billion people globally spending more than 10% of their household budgets on healthcare; and over 340 million people being pushed or further pushed into extreme poverty by out-of-pocket expenditure;

[27] Document EB156/6.

(PP3) Recalling resolution WHA77.17 (2024) on Strengthening preparedness for and response to public health emergencies through targeted amendments to the International Health Regulations (2005) including collaboration to address the needs of developing countries to develop, strengthen and maintain IHR core capacities in accordance with IHR Article 44;

(PP4) Recalling also resolution WHA58.33 (2005) and resolution WHA64.9 (2011) on sustainable health financing and universal coverage; and the effect of health systems in delivering comprehensive healthcare services, with a focus on primary healthcare, including preventive services;

(PP5) Recalling the Political Declaration of the 2023 High-level Meeting of the United Nations General Assembly on Universal Health Coverage (A/RES/78/4), which identified gaps, including in the financing of health systems across the world, and solutions, such as close collaboration between finance and health authorities and capacity-building among decision-makers and practitioners in strengthening health financing through various initiatives, to accelerate progress towards the achievement of UHC by 2030, including recognizing domestic public resources as a major source of financing and that health financing requires global solidarity and collective effort to support efforts to build and strengthen capacity in developing countries;

(PP6) Recalling also resolution WHA77.13 (2024) on the interconnectedness of health and the economy and an economy of well-being perspective underlining the mutually reinforcing nature of health, well-being and the economy;

(PP7) Recalling also resolutions United Nations General Assembly 74/2 (2019) to strengthen efforts to address non-communicable diseases as part of progress towards UHC, and the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases, as contained in United Nations General Assembly resolution 73/2 (2018). Both resolutions recognize the primary role and responsibility of Governments to respond to the challenge of noncommunicable diseases by developing adequate, national, multisectoral responses for their prevention and control while also acknowledging the critical relevance of UHC for addressing infectious diseases;

(PP8) Recalling also resolution WHA67.23 (2014) on health intervention and technology assessment in support of UHC, recognizing the significant share of pharmaceutical expenditure, diagnostics, and human resources in healthcare financing within countries, health technology assessment (HTA) can support resource allocation decisions in all resource settings;

(PP9) Acknowledging increasing demands and priorities besides health, including from debt servicing, in national budgets of developing countries, while recognizing there is a gap in national health strategies including the 15% government budget allocation goal to health of the Abuja Declaration of 2001, stressing the importance of placing health as a priority on the government's agenda and that investing in health is an investment in the country's economic growth that may lead to macroeconomic stability;[28]

(PP10) Recognizing the importance of political leadership and commitment beyond the health sector in order to pursue whole-of-government, whole-of-society and economy of well-being approaches, to improve financing for health;

(PP11) Recalling WHO's Fourteenth General Programme of Work (GPW 14) underscores the central role of sustainable health financing to make progress towards

[28] See resolution WHA77.13.

achieving all of the health outcomes including UHC, with its specific inclusion in both outcomes 3 and 4 around both the need for sustainable health financing policies and systems and the importance of financial protection;

(PP12) Acknowledging that public financing mechanisms should provide the core of primary healthcare funding to ensure that everybody, including the poorest, receives the healthcare services they need without financial hardship;

(PP13) Recalling the resolution WHA77.2 on Social Participation for UHC, health and well-being, noting the important role that social participation can have in fostering mutual respect and trust, while making health systems, including health financing systems, more responsive, equitable and resilient;

(PP14) Recognizing technical guidance on health financing from WHO, including the 2014 report Making fair choices on the path to universal health coverage by the Consultative Group on Equity and Universal Health Coverage, WHO's Health Financing Progress Matrix for assessing country health financing systems, WHO's annual Global Health Expenditure Report, and other guiding documents;

(PP15) Recognizing the need to improve coordination of global health actors to support the priorities, systems and plans of countries for UHC and stronger health systems, in line with the Lusaka Agenda that provides a path towards a joint long-term vision of domestically-financed health systems for UHC to leave no one behind;

(PP16) Recognizing that the number of households facing financial hardship or foregoing care is likely to be underreported because data collection on financial protection is weak;

(PP17) Recognizing the need for response and financial support to countries in conflict to restore medical infrastructure, support critical medical supplies, and facilitate access to healthcare services for the population;

(PP18) Noting the need for sustainable financing to increase access to medicines,

(OP)1. URGES Member States[29] in accordance with national context and priorities:

(1) to implement, strengthen and align policies and reforms, including relevant social protection mechanisms to tackle the causes of poor financial protection and improve access to healthcare services without financial hardship, including prioritizing the poor and others at risk of financial hardship, through reducing out-of-pocket expenditure, where applicable, focusing particularly on government revenue as the primary source of financing, while leveraging external financing to enhance government revenues and also strengthen health systems;

(2) to prioritize pooling of government funds, including revenue from direct and indirect taxes, and levies, where applicable, and mandatory health insurance contributions, in order to reduce fragmentation and out-of-pocket expenditure at the point of care;

(3) to prioritize, as appropriate, health in public budgets through strong national and regional political leadership and commitment such as through the Abuja Declaration, to drive health system efficiency and effective utilization of resources, strengthen public financial management (PFM) systems, including through digitalization whilst supporting overall domestic resource mobilization as the predominant source of health financing including for UHC and the recommended target of allocating an additional 1% of gross domestic product or more for primary healthcare as contained in UNGA Resolution A/RES/74/2 (2019),

[29] And where applicable, regional economic integration organizations.

and consider introducing and increasing taxes on tobacco, sugar and alcohol, as a non-distortionary and tax source that reduces risk factors for NCDs as appropriate in national context;

(4) to strengthen their own domestic and regional R&D, manufacturing capacities and regulatory frameworks to achieve resilient health systems, and attract private investment with adequate safeguards to ensure transparency and accountability to protect public interest, and economic growth;

(5) to focus domestic resources on an affordable package of essential health benefits, based on evidence and developed through inclusive and transparent processes supported by health technology assessment, that inform budget and health financing reforms including revenue raising, pooling of resources and strategic purchasing and the facilitation of other effective and cost-effective interventions to deliver significant health outcomes with limited resources;

(6) to strengthen the role of the WHO in setting normative guidance on effective priority-setting approaches including evidence-informed health technology assessment which can inform budget and purchasing reforms;

(7) to develop and implement policies and reforms to address fragmentation and promote coherent and aligned health financing systems, across health programmes, including progressive health insurance coverage schemes, and pandemic prevention preparedness and response financing, in order to ensure that budgets flow to priority health needs to leave no one behind and reduce financial hardship;

(8) to strengthen, and as necessary, establish institutional capacities, as well as national data collection and reporting systems, for routine monitoring and reporting of domestic and external health resource tracking and financial protection, that are integrated with appropriate national financing and budget data systems and leverage machine-learning, AI, and digital technologies based on ethical standards and digital principles to enhance decision-making;

(9) to design and streamline processes to transition smoothly and sustainably from external assistance for health to sufficiently robust domestic financing for health including through progressive integration of vertical funding flows into domestic public financial management and procurement systems, including through instruments such as SWAps and Health Compacts;

(10) to consider providing additional financial support, as appropriate, for the work of WHO on health financing and economics in advancing universal health coverage; and

(11) to deliver on commitments on domestic health spending and to advance the Addis Ababa Action Agenda, including, as applicable, the commitment by many developed countries to achieve the UN target of 0.7% of gross national income for ODA, by providing more effective financing for health that is aligned to national priorities;

(OP)2. ENCOURAGES Member States, global health initiatives, philanthropic agencies, international and regional financing institutions and mechanisms, consistent with their respective mandates:

(1) to finance domestic priorities with consideration of favourable terms, aligned with country planning, budgetary processes, monitoring and evaluation cycles and to progressively channel their funds through public financial management systems, and to report progress through national routine expenditure tracking processes, including national health accounts where

appropriate while improving their coordination and transparency in support of domestic priorities; and

(2) to explore innovative sources of financing and also to engage constructively in negotiations in multilateral fora to support making progress on bridging the gap in health financing, including through concessional loans for health financing for developing countries and those affected by conflict;

(OP)3. REQUESTS the Director-General:

(1) to maintain WHO's mandate in health financing and strengthen its roles in providing support to countries as a critical prerequisite for UHC;

(2) to prepare a bi-annual report on health expenditures and the state of Global Health Financing to be presented at a WHO-convened meeting in 2026, 2028, and 2030 with Member States, regional institutions, other United Nations organizations, international development partners, International Financial Institutions (IFIs), foundations, academia and civil society organizations and other stakeholders in line with FENSA, as applicable;

(3) to support the improvement in the quality and availability of data, the timeliness and transparency of tracking of domestic and external financing flows, trends and sustainability for health over time, including through national health accounts where appropriate, and to monitor alignment and impact of health spending on domestic budgets, and on progress towards health-related SDGs, with a particular focus on primary healthcare, forgone care, out-of-pocket spending and financial protection, pandemic prevention, preparedness and response, development assistance, insurance-related contributions, and working with Ministries of Health and Finance, MDBs, OECD, GHIs, NGOs, and other stakeholders in line with FENSA as applicable including leveraging AI and digital technology;

(4) to develop, as appropriate, and update evidence, guidance, and tools on health financing and economics, and support Member States in their efforts to build capacity to design and implement health financing policies and reforms, and financial mechanisms, which support progress to UHC, including on revenue raising and pooling, public financial management strengthening, financial protection, design and strategic purchasing of priority benefit packages, effective implementation of health technology assessments and procurement of cost-effective commodities, with a focus on leaving no one behind, and support better coordination, collaboration and alignment of partners, regional and international institutions in providing long-term, reliable support;

(5) to strengthen and elevate WHO's existing, dedicated observatory function to monitor and report on development assistance and domestic financing flows for health to increase the visibility and transparency of financing and financial protection trends in terms of volume and efficiency, assess and evaluate their impact, generate knowledge and expertise, leveraging the national health accounts and other sources of data, and boosting regional and country-level capacity and leadership on health financing to support developing countries, in partnership with United Nations organizations, international development partners, International Financial Institutions (IFIs), foundations, academia and civil society organizations and other stakeholders, in line with FENSA as applicable; and

(6) to support as requested by Member States, the development of prioritized national health financing road maps, to mobilize technical assistance and

financial resources to strengthen national health financing systems and to improve the coordination and collaboration of development partners, UN agencies, IFIs including the World Bank, civil society and the private sector, in line with FENSA as applicable.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[30]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:

1.2.1. Countries enabled to develop and implement equitable health financing strategies and reforms to sustain progress towards universal health coverage

1.2.2. Countries enabled to produce and analyse information on financial protection, equity and health expenditures and to use this information to track progress and inform decision-making

1.2.3. Countries enabled to improve institutional capacity for transparent decision-making in priority-setting and resource allocation, and analysis of the impact of health in the national economy

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:

Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:

Not applicable.

4. Estimated time frame (in years or months) to implement the decision:

Six years (from May 2025 to May 2031).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:

US$ 79.61 million.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:

US$ 12.37 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:

Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:

US$ 26.15 million.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:

US$ 41.09 million.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions

– **Financial resources available to fund the decision in the current biennium:**
  US$ 7.84 million.

[30] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic “bridge” between results structures can be provided as needed.

– **Remaining financing gap in the current biennium:**
US$ 4.53 million.

– **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Resource mobilization efforts are continuing.

Table. Breakdown of estimated resource requirements (in US$ millions)[a]

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	0.70	0.23	0.59	0.58	0.19	0.35	2.26	4.89
	Activities	0.37	0.37	0.37	0.37	0.37	0.49	5.15	7.47
	Total	1.06	0.60	0.96	0.95	0.56	0.84	7.41	12.37
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	1.45	0.47	1.22	1.21	0.39	0.73	11.88	17.36
	Activities	0.77	0.77	0.77	0.77	0.77	1.01	3.94	8.79
	Total	2.22	1.24	1.99	1.98	1.16	1.74	15.82	26.15
B.4. Future bienniums cost of resources to be planned	Staff	2.26	0.73	1.91	1.89	0. 61	1.14	18.84	27.39
	Activities	1.20	1.20	1.20	1.20	1.20	1.57	6.15	13.70
	Total	3.45	1.93	3.11	3.09	1.81	2.72	24.99	41.09
B.1. Total planned costs required to implement the decision									79.61

[a] The row and column totals may not always add up, owing to rounding.

The fourth draft decision, which contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly, on strengthening medical imaging capacity, proposed by Armenia, Brazil, Burkina Faso and Cameroon, read:

The Executive Board, having considered the report by the Director-General,[31]

Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following resolution:

The Seventy-eighth World Health Assembly,

(PP1) Having considered the report by the Director-General;

(PP2) Recognizing that medical imaging is vital for the diagnosis and treatment of numerous communicable diseases, noncommunicable diseases (NCDs), traumatic injuries and other health conditions, including gastrointestinal and gynecological conditions;

(PP3) Considering that medical imaging requires traceable, cost-effective medical technology with consumables and accessories, associated trained health workforce,

[31] Document EB156/6.

knowledge of clinical procedures, patient information, affordable access, patient management, patient preparation, interpretation and reporting;

(PP4) Recognizing that medical imaging for diagnosis and treatment, both conventional as well as interventional, refers to medical devices using ionizing radiation (such as computerized tomography scanners and positron emission tomography (PET)), non-ionizing radiation (such as ultrasound and magnetic resonance imaging (MRI)) and hybrid imaging modalities (such as PET MRI);[32]

(PP5) Noting that the optimal use of medical imaging services in many countries is affected by, among other things, the limited availability of affordable and cost-effective medical imaging technologies, reduced access in remote and rural areas, shortage of trained health workforce and lack of effective or implementable policies, plans and guidelines;

(PP6) Highlighting the need to improve equitable access to safe and effective medical imaging globally, particularly to enhance detection, diagnosis, treatment, monitoring and understanding of diseases, both communicable and NCDs;[33]

(PP7) Noting that the burden of cancer and other NCDs is rising and recognizing that medical imaging is essential for appropriate cancer detection and therapy, including surgery, radiotherapy and chemotherapy;

(PP8) Acknowledging that in 2021 of all neurological conditions, stroke was the leading cause of disability adjusted life years with the largest burden on developing countries;

(PP9) Confirming that medical imaging can contribute to reductions in mortality, morbidity and incidence through early detection and monitoring of many neurological conditions such as multiple sclerosis, nervous system cancers, neurodegenerative disorders[34] and stroke, including through rapidly distinguishing between haemorrhagic and ischemic stroke and determining treatment such as thrombolysis and mechanical thrombectomy;

(PP10) Taking into account that equitable access to medical imaging for early diagnosis and management can reduce lifelong consequences from infectious diseases which contribute to global morbidity and mortality, with particular emphasis on individuals at risk especially among those in vulnerable situations and those that are hard to reach;

(PP11) Noting that accurate medical imaging can minimize unnecessary surgical interventions and optimize complex medical interventions;

(PP12) Recognizing that medical imaging is essential in emergencies, road traffic crashes and disasters by helping emergency medical responders to quickly assess injuries, identify critical conditions and prioritize care and can aid surgical interventions including in traumatic brain and spinal cord injuries;

(PP13) Recognizing that access to medical imaging equipment:

[32] https://www.who.int/activities/strengthening-medical-imaging.

[33] Updated Appendix 3 of the WHO Global NCD Action Plan 2013–2030.

[34] Intersectoral global action plan on epilepsy and other neurological disorders.

(a) is highly inequitable globally and limited in many developing countries;

(b) requires medical technologies, as well as specific infrastructure, health workforce training and operating costs, that might not be available or affordable;

(c) is part of effective universal health coverage;

(d) contributes to health systems to support early diagnosis of certain diseases, trauma, and injuries as well as monitor health conditions such as pregnancy and its complications and to facilitate timely patient referrals to care;

(PP14) Recognizing the added value in using medical ultrasound in obstetric care and to diagnose multiple diseases in a safe and cost-effective manner;35

(PP15) Acknowledging that conventional radiology (such as chest x-ray) can support early and cost-effective diagnosis of pneumonia, which is the single largest infectious cause of death in children worldwide,36 as well as other health conditions;

(PP16) Considering the level of variance and diversity in the practice of medical imaging and the lack of harmonized guidance on selection and use of medical imaging equipment and related technology;

(PP17) Considering also that research using medical imaging equipment is critical and requires special precautions and maintenance to avoid harm related to exposure to radiations;

(PP18) Recognizing that the regulation of medical imaging radiation is fragmented or weak in some countries;37

(PP19) Recalling resolution WHA25.57 (1972)38 on development of the medical use of ionizing radiation as well as resolution WHA76.5 (2023)39 on strengthening diagnostics capacity;

(PP20) Considering the importance of recognizing the essential roles of medical imaging in diagnosis and treatment of diseases, including interventional radiology and the emerging theranostics and integrating medical imaging in healthcare policies,

(OP)1. URGES Member States,[40] considering their national context and circumstances:

(1) to promote appropriate and continued access to quality, safe, affordable and cost-effective medical imaging capacity, by implementing appropriate policies, strategies, programmes, norms and standards;

(2) to promote sustainable investment in imaging equipment and infrastructure, maintenance, and quality management systems;

(3) to commit to adequate education and continuous training of health workforce involved in medical imaging, including through the WHO Academy and other WHO technical platforms as well as training of referring physicians on justification and appropriate use in accordance with up-to-date evidence-based recommendations;

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[35] https://www.who.int/publications/i/item/9789241548540.

[36] https://www.who.int/health-topics/pneumonia#tsab=tab_1.

[37] Atlas of medical devices 2022.

[38] https://iris.who.int/bitstream/handle/10665/91991/WHA25.57_eng.pdf?sequence=1&isAllowed=y.

[39] https://apps.who.int/gb/ebwha/pdf_files/WHA76/A76_R5-en.pdf.

[40] And, where applicable, regional economic integration organizations.

(4) to develop strategies to improve medical imaging capacity and encourage that medical imaging services are included in the national health sector strategic plans to achieve universal health coverage;
(5) to improve affordable and equitable access to medical imaging services, including by through digital health, to reach rural and remote areas for early detection of communicable and NCDs;
(6) to consider the medical imaging technologies that are selected in the WHO Priority Medical Devices list, presented in WHO Medical Devices information system (MeDevIS)[41] be included in national lists of medical devices for diagnostic or treatment, for benefit packages or reimbursement,[42] and if needed, perform health technology assessments for their incorporation and considering internationally accepted standards;
(7) to perform needs assessments, feasibility studies and investment cases before procurement (including donation, acquisition or leasing)[43] and budget decisions are made regarding operating costs of medical imaging equipment and maintenance, and if needed increase the availability of medical imaging equipment, as appropriate, to manage multiple diseases;
(8) to promote the use of health technology management practices, with the support of biomedical engineers, medical physicists and trained related professionals in all the phases of the life cycle of technologies, including procurement, installation, maintenance, calibration and safe use towards the optimization of the medical imaging capacity;
(9) to consider the incorporation of new medical imaging technologies that are cost effective, safe and affordable, easy to use and sustainable for operation, maintenance and disposal with sound management of waste and the prevention of pollution with respect to the environment;
(10) to include medical imaging in national diagnostics and treatment lists, as appropriate, taking into account that many medical imaging technologies can be used for diagnostics and treatment purposes;
(11) to commit to the safe and secure use of diagnostic imaging technologies by applying basic safety standards to protect against the dangers arising from exposure to ionizing and non-ionizing radiation, ensuring the safety of patients, health workers, and the public;
(12) to improve coordination between national regulatory bodies on the authorization of medical imaging services;
(13) to facilitate adaptation of best available practices on imaging services to the national context, including training of the health workforce by health authorities and professional societies, based on international norms and standards;
(14) to promote quality-improvement programmes in medical imaging services, which should ultimately also aim at making quality of care transparent and visible;
(15) to raise awareness of risk mitigation and management in medical imaging, including contrast media side-effects and magnetic field safety;

[41] https://www.who.int/activities/prioritizing-medical-devices and https://medevis.who-healthtechnologies.org/.

[42] https://www.who.int/data/gho/data/indicators/indicator-details/GHO/availability-of-national-list-of-approved-medical-devices-for-procurement-or-reimbursement.

[43] Medical device donations: considerations for solicitation and provision. Second edition.

(16) to promote proper disposal of imaging devices and radioactive materials in accordance with international guidelines on traceability;
(17) to work towards increasing efficiency, affordability, safety and cost-effectiveness of imaging technologies use, including through collecting and integrating data on appropriate use, availability and functionality of medical imaging equipment and services, as appropriate;
(18) to consider integrating technological advances, such as telehealth, teleradiology, clinical decision support (CDS), artificial intelligence and specific software applications, into radiology information systems for patient records, in compliance with applicable international standards and protocols for medical imaging, including ethical aspects, security, and confidentiality data;

(OP)2. REQUESTS the Director-General:
(1) to provide technical assistance to Member States, in order to improve access to safe, affordable and effective medical imaging globally, especially in developing countries, and to enhance detection and treatment of diseases and health conditions towards universal health coverage and response to emergencies, including, as appropriate, on:
(a) guidance on selecting, incorporating and procuring medical imaging equipment;
(b) promotion of the safe use of medical imaging equipment; and
(c) development of comprehensive strategies and policies, to strengthen medical imaging capacity, in line with national health sector strategic plans;
(2) to continuously update the WHO Priority Medical Devices List and its electronic version of medical devices information system (MeDevIS)[44] regarding medical imaging equipment, its related nomenclature, consumables, calibration, technical specifications, traceability, preventive maintenance and training material, level of healthcare use and relation to clinical guidelines, to serve as a reference to Member States and relevant stakeholders, as per decision WHA75(25) (2022)[45] and for consideration by Member States when national lists of medical devices or essential diagnostics are developed;
(3) to provide technical guidance on continuous quality improvement for medical imaging services delivery, including health workforce required to deliver medical imaging services;
(4) to coordinate collection and integration of data on availability and functionality of medical imaging equipment and services, to be presented in the Global Health Observatory[46] and WHO Global Atlas of medical devices[47] or related databases, as appropriate, in alignment with IAEA, UNSCEAR and other related agencies;
(5) to promote affordability and sustainability of cost-effective medical imaging capacity and interventions;

[44] https://medevis.who-healthtechnologies.org/.

[45] https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75(25)-en.pdf.

[46] https://www.who.int/data/gho/data/themes/topics/indicator-groups/indicator-group-details/GHO/medical-equipment.

[47] https://www.who.int/publications/i/item/9789240062207.

(6) to evaluate innovative medical imaging technologies to be included in the WHO compendia of innovative health technologies for low-resource settings;[48]
(7) to perform horizon scanning to identify emerging and innovative medical imaging technologies;[49]
(8) to promote mutual support, assistance and cooperation among all stakeholders in line with FENSA, as applicable to increase access to medical imaging capacity, particularly in developing countries;
(9) to ensure that medical imaging technologies are included in global diagnostic initiatives;[50]
(10) to support education and continuous training of health workforce involved in medical imaging, including through the WHO Academy and other WHO technical platforms;
(11) to report on progress in the implementation of this resolution to the World Health Assembly in 2027, then in 2029 and 2031.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[51]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:
1.3.1. Provision of authoritative guidance and standards on quality, safety and efficacy of health products, essential medicines and diagnostics lists

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:
Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:
Not applicable.

4. Estimated time frame (in years or months) to implement the decision:
Seven years (2025–2031).[52]

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:
US$ 14.57 million.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:
US$ 0.79 million.

[48] https://www.who.int/publications/i/item/9789240095212.

[49] https://www.who.int/activities/who-foresight---monitoring-emerging-technologies-and-building-futures-thinking.

[50] Diagnostics - Global.

[51] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic “bridge” between results structures can be provided as needed.

[52] Costing estimated up to 2030.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:
Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:
US$ 5.39 million.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:
US$ 8.39 million.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions

– **Financial resources available to fund the decision in the current biennium:**
US$ 0.61 million.

– **Remaining financing gap in the current biennium:**
US$ 0.18 million.

– **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Discussion with potential donors is continuing, as well as with various non-State actors in official relations with WHO related to imaging, such as international societies of radiology, of ultrasound and of nuclear medicine, that are very supportive of this draft decision and are aware of the gaps in medical imaging in low- and middle-income countries.

Table. Breakdown of estimated resource requirements (in US$ millions)[a]

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	0.06	0.05	0.04	0.05	0.04	0.05	0.13	0.43
	Activities	0.02	0.02	0.02	0.02	0.02	0.02	0.23	0.36
	Total	0.08	0.07	0.07	0.07	0.07	0.07	0.36	0.79
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	0.61	0.27	0.41	0.25	0.44	0.30	0.70	2.98
	Activities	0.23	0.23	0.23	0.23	0.23	0.23	1.04	2.41
	Total	0.84	0.49	0.64	0.47	0.67	0.52	1.74	5.39
B.4. Future bienniums cost of resources to be planned (2028–2029, 2030)	Staff	0.95	0.41	0.64	0.38	0.69	0.46	1.09	4.63
	Activities	0.36	0.36	0.36	0.36	0.36	0.36	1.62	3.76
	Total	1.31	0.77	1.00	0.74	1.04	0.82	2.71	8.39
B.1. Total planned costs required to implement the decision									14.57

[a] The row and column totals may not always add up, owing to rounding.

The representative of NORWAY, expressing concern about the limited and inequitable progress towards universal health coverage, supported WHO's efforts to advance health systems

reform through primary healthcare and emphasized the need to ensure social participation through transparent, inclusive and fair decision-making processes. Better coordination, transparency and accountability in external financing for universal health coverage were needed to support countries' priorities, plans and capacity development, in line with the Lusaka Agenda, and should be a key priority, including at the third high-level meeting of the United Nations General Assembly on universal health coverage in 2027.

An evidence-based approach was essential to improve financing and focus resources where they were most needed. As such, her Government had sponsored the draft decision on strengthening national capacities in evidence-based decision-making for the uptake and impact of norms and standards and the draft decision on strengthening health financing globally. A review of programme budget priorities, including how to deal with resolutions, was timely in the light of the current financial constraints faced by the Organization.

The representative of CANADA emphasized the importance of access to safe and affordable vaccines, medicines, technologies and essential health services, including comprehensive sexual and reproductive health services and mental health services, as well as prevention, access to screening, and treatment of noncommunicable diseases. The fourth high-level meeting of the United Nations General Assembly on the prevention and control of non-communicable diseases in 2025 would provide an opportunity to promote integrated health and public health system approaches to improve health for all.

In terms of priorities to be supported by the Secretariat in preparation for the third high-level meeting of the United Nations General Assembly on universal health coverage in 2027, it was important to build on the decisions contained in the outcome documents from previous high-level meetings, to ensure an integrated approach to the priorities for universal health coverage and the meaningful participation of the entire global health community. She highlighted the importance of primary healthcare and gender-responsive, community-driven and integrated people-centred health services. Health systems should be supported by a competent health workforce, adequate health infrastructure, enabling legislative and regulatory frameworks, and sufficient and sustainable funding. She condemned attacks on healthcare facilities and personnel during armed conflicts.

Opportunities for efficiencies should be identified in order to accelerate progress towards achieving universal health coverage. Stronger multisectoral collaboration and alignment across global health initiatives were also needed to better support country leadership and plan towards universal health coverage, with the Lusaka Agenda playing an important role in such efforts and a stronger focus on primary healthcare, health systems strengthening, and reducing transaction costs on countries. The draft decision on strengthening health financing globally was therefore timely, and she requested that her Government be added to the list of sponsors.

The representative of BRAZIL recognized the progress made towards universal health coverage, but acknowledged the need for further efforts to address health inequalities and ensure financial protection for all. Investment in health was urgently needed, including in primary and specialized care, new technologies, and training of health and care workers. The Secretariat should focus on supporting Member States in developing the public funding and reform of health systems. In that context, his Government had sponsored the draft decision on strengthening medical imaging capacity and the draft decision on rare diseases. A comprehensive, equitable and sustainable approach was essential to address challenges related to universal health coverage and close gaps in access, leaving no one behind.

The representative of AUSTRALIA said that strong primary healthcare systems were the cornerstone of universal health coverage. To achieve target 3.8 of the Sustainable Development

Goals, domestic actions should be enhanced, including with regard to the coordinated provision of high-quality, affordable, accessible, disability-inclusive and age- and gender-responsive services without discrimination. Health systems must focus on prevention and early intervention at the primary care level. He supported regional efforts to build stronger, inclusive and sustainable health systems and strengthen primary healthcare. In terms of how Member States could advance health systems reform through a primary healthcare approach, he observed that efforts to assert the primacy of primary healthcare were continually hindered by political challenges, even for countries with a well-developed primary healthcare system. The importance of primary healthcare must therefore be reinforced, ensuring health equity and leveraging technology through a coordinated approach.

The representative of COSTA RICA said that an in-depth analysis on the financial sustainability of health systems should have been included in the report. Information concerning specific strategies and innovative financing models was also needed, including their current coverage and long-term viability, as well as concrete strategies to tackle the projected shortfall in health and care workers by 2030, and a more detailed analysis of their geographical distribution. Indicators on quality of care, user satisfaction and clinical results were also required to track progress. Moreover, information should have been provided on how technological innovations, including telemedicine and artificial intelligence, could accelerate progress towards universal health coverage, especially in the context of limited resources. The topic of health resilience also required further attention.

Strategies on emergency preparedness and continuity of services during crises were also needed, as was an in-depth analysis of barriers faced by various groups and strategies to overcome them. In addition, further information and strategies should have been provided on improving intersectoral coordination and community participation. Technical tools should be developed to facilitate implementation of universal health coverage at the national level, with mechanisms for exchanging good practices. Technical and financial support should be provided to developing countries for the implementation of such strategies.

The representative of ISRAEL highlighted the importance of advancing health system reforms, including in areas such as prevention, digital health, community-based services and patient-centred approaches. Long-term strategic planning and effective national financing systems were also essential. To achieve universal health coverage, sufficient public spending must be ensured through a whole-of-government approach. Additional resources should be mobilized for the effective use of digital health, which played an essential role. The pricing of medication should also be addressed. Furthermore, reforming the training of doctors would contribute to efforts to tackle the challenges related to the health workforce. In preparation for the third high-level meeting on universal health coverage, the Secretariat should work on the development of a mechanism to address financing for strategic planning for hospitals and community-based treatment, taking into account cultural and economic differences among Member States.

The representative of the DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA noted that, while significant progress had been made towards universal health coverage, much remained to be done. WHO should promote and facilitate the achievement of tangible deliverables, including through legislative action. She therefore supported WHO's engagement with the Inter-Parliamentary Union. It was crucial to strengthen health and care services in central and regional areas to enable access to essential and quality medical services for all. In preparation for the third high-level meeting on universal health coverage, the Secretariat should support Member States with their priorities and promote engagement with parliaments regarding national

legislation on universal health coverage, the availability of primary healthcare and improvements in the quality of health and care.

The representative of the REPUBLIC OF KOREA recognized the importance of primary healthcare as an effective tool for realizing universal health coverage. In terms of key priorities to be supported by the Secretariat in preparation for the third high-level meeting on universal health coverage, a greater focus should be placed on strengthening community-based primary healthcare capacities. Access to healthcare services should also be improved, including through telemedicine and other technologies that could support primary healthcare institutions in providing customized medical services and preventing and diagnosing diseases at an early stage. Country-level efforts were vital to reduce the burden of medical costs and improve the affordability of healthcare services for vulnerable populations. Describing the action taken in his country, he highlighted the importance of sharing experience among Member States.

The representative of MOROCCO, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that tailored approaches to strengthening primary healthcare were essential to address the unique challenges and diverse characteristics of the countries in his Region. WHO's operational framework for primary healthcare provided a strong foundation for harmonizing national health strategies, while regional strategies such as the Regional Operational Strategic Plan and other flagship initiatives would contribute to ensuring that primary healthcare remained central to achieving universal health coverage.

To scale up primary healthcare, the Member States in the Region were expanding comprehensive service delivery, enhancing core public health functions, promoting sustainable health financing, investing in financial protection mechanisms, and building workforce capacity and infrastructure. Innovative approaches, such as leveraging digital health solutions, fostering community engagement, increasing multisectoral collaboration and integrating emergency preparedness into primary healthcare were essential. Highlighting the importance of strengthening governance, financial sustainability and community-based health interventions to accelerate progress, he called on the Secretariat to support Member States in operationalizing primary healthcare strategies through tailored action plans.

The representative of POLAND, speaking on behalf of the European Union and its Member States, said that the candidate countries Türkiye, North Macedonia, Montenegro, Serbia, Albania, Ukraine, the Republic of Moldova, Bosnia and Herzegovina and Georgia aligned themselves with her statement. She expressed deep concern that progress in achieving universal health coverage by 2030 remained off track. It was essential to keep universal health coverage high on the agenda despite budgetary constraints and other national priorities, and to invest in primary healthcare, in line with the Lusaka Agenda.

Public health functions should be integrated into primary healthcare systems to ensure equitable, adaptable, person-centred, resilient and quality health services. To that end, urgent action was required in five key areas: investing in the health workforce, including through sustained investments in education, innovation, training and retention and initiatives such as the WHO Academy; strengthening community engagement through social participation, including in the design, delivery and evaluation of health services; scaling up financial protection to eliminate impoverishing out-of-pocket health expenditures through efficient, innovative, equitable and sustainable financing mechanisms; strengthening timely and reliable health expenditure data, analysis and tracking of universal health coverage progress to inform policy design; and implementing a multifaceted and cross-sectoral approach, including by integrating digital health solutions, building climate-resilient systems and managing noncommunicable diseases within

primary care. By working together, Member States and stakeholders could deliver on the promise of universal health coverage.

The representative of QATAR called for strengthened technical support for digital transformation in primary healthcare, with a focus on artificial intelligence, telemedicine and predictive analysis. Global policy exchange platforms for noncommunicable diseases should be expanded, and a global artificial intelligence and digital health team should be established to ensure the ethical and harmonized use of such technologies in health systems. It was also important to support regional dialogue on universal health coverage in preparation for the third high-level meeting on universal health coverage. Her Government had sponsored the draft decision on rare diseases in view of their global impact and the need for a comprehensive global action plan to address the issue.

The representative of BARBADOS expressed support for efforts to reorient health systems towards a primary healthcare approach. It was necessary to strengthen multisectoral collaboration at the national level and enhance engagement with key stakeholders to accelerate progress towards the achievement of universal health coverage through quality primary healthcare, in line with the Lusaka Agenda. Domestic workplans on universal health coverage should be aligned to the Fourteenth General Programme of Work, 2025–2028 and be tailored to the national context, with universal health coverage serving as the goal for reform. It was essential to strengthen primary healthcare, eliminate inefficiencies, acknowledge the impact of climate change on achieving universal health coverage and build health system resilience.

The representative of THAILAND highlighted the impact of rare diseases, which must be addressed through universal health coverage. To achieve target 3.8 of the Sustainable Development Goals, it was crucial to expand primary healthcare coverage and increase public funding. Achieving and sustaining universal health coverage would require the prioritization of interventions and medicines through evidence-based health technology assessments to ensure optimal use of resources. Social participation was important for good governance and to ensure that citizens' voices were heard. In addition, digital health and the integration of artificial intelligence would help to expand service coverage and bridge the digital divide. Her Government wished to be added to the list of sponsors of the four draft decisions under consideration.

The representative of BRUNEI DARUSSALAM said that primary healthcare must be strengthened to ensure that universal health coverage remained viable, sustainable and resilient. Efforts should shift beyond treatment towards disease prevention, and from a reactive system to one that empowered people to take charge of their health. Digital innovations and technology driven by artificial intelligence would play a key role in enhancing the ability of doctors and nurses to deliver efficient and equitable care, personalizing and optimizing healthcare. Retaining healthcare professionals, ensuring their well-being and investing in education, training and career development must be a priority. WHO's support should be adapted and responsive to national contexts, with better data, stronger monitoring mechanisms and targeted technical support that reflected the realities of Member States. At the third high-level meeting on universal health coverage, emphasis should be placed on action, not just commitments. Member States should work together, share best practices and implement policies to make universal health coverage a reality for all.

The representative of BULGARIA said that sustainable financing was required to address the global shortage of health workers, alongside continuous training and assessment of knowledge and skills, competitive remuneration, career development opportunities and safe working conditions. Health systems reform could be advanced by expanding the primary healthcare

approach as the fastest, most effective and equitable path to universal health coverage and the provision of comprehensive health services for all. In preparation for the third high-level meeting on universal health coverage, the Secretariat's priorities should include strengthening the monitoring of progress towards universal health coverage; promoting investment in primary healthcare and sustainable health systems in line with the national context; addressing inequalities caused by financial barriers; and improving health workforce training and retention programmes.

The representative of UKRAINE said that her Government had sponsored the draft decision on strengthening health financing globally in the light of the importance of ensuring sustainable and equitable health financing to achieving universal health coverage. Strong political leadership, strategic investments and innovative financing mechanisms were necessary to strengthen healthcare systems. She emphasized the need for global solidarity in health financing, especially in conflict-affected regions, where medical infrastructure and access to care were severely impacted. Her Government looked forward to working with partners to advance implementation of that draft decision.

The representative of CAMEROON, speaking on behalf of the Member States of the African Region, said that budgetary constraints and the impact of vertical funding flows hindered the integration of services into primary healthcare in many countries in the Region. She welcomed the technical support provided by the Secretariat, including in documenting best practices for implementing primary healthcare, and called for strengthened engagement to promote primary healthcare through policies, strategies, regulatory frameworks, reinforced governance and more extensive reforms based on evidence. Data and monitoring should also be strengthened to assess the situation of universal health coverage within health systems. She called on Member States to implement resolution WHA72.2 (2019) on primary healthcare, resolution WHA76.4 (2023) on preparation for the high-level meeting of the United Nations General Assembly on universal health coverage, and decision WHA77(16) (2024) on updates and future reporting: strengthening integrated, people-centre health services. She urged Member States to support the draft decision on strengthening national capacities in evidence-based decision-making, and the draft decision on strengthening health financing globally.

Measures were needed to address the shortage of global health and care workers. Moreover, political will must be accompanied by financial commitments to reorient health systems towards primary healthcare, with a focus on community health. The effectiveness of health financing must be improved, including by mobilizing and allocating additional resources to primary, secondary and tertiary healthcare so as to ensure adequate funding.

The representative of TOGO said that progress towards universal health coverage could be advanced by shifting from disease-focused to person-centred health systems. The Secretariat should encourage Member States to implement a whole-of-system approach to health, with health included in all policies and with a strong emphasis on equity and community participation. Political will should be matched by financial engagement in order to reorient health systems towards primary healthcare.

The representative of ETHIOPIA emphasized the need for sustained political commitment and adequate financing to reorient health systems towards primary healthcare, while enhancing the health impact of investments. The draft decision on strengthening national capacities in evidence-based decision-making highlighted the importance of addressing systemic barriers to effective implementation of clinical and public health guidance and would serve as a strategic tool to optimize investments and achieve better health outcomes. The draft decision on strengthening

health financing globally would help to reinforce implementation of the Lusaka Agenda and enhance WHO's support, particularly in addressing financial hardship; her Government wished to be added to the list of sponsors of that draft decision. She underscored the importance of strengthening medical imaging capacity. Prudent decision-making was necessary when considering the adoption of new resolutions in line with available resources.

The representative of the REPUBLIC OF MOLDOVA said that sustained investments in primary healthcare, financial protection and workforce development were critical in achieving universal health coverage and overcoming barriers to access and affordability. She welcomed WHO's knowledge-sharing initiatives and technical support and highlighted the ongoing challenges to achieving universal health coverage. She supported efforts to prioritize health financing and eliminate impoverishing health expenditures, and regional strategies on health workforce investment to address the current shortage. Efforts to advance universal health coverage by strengthening primary healthcare systems, expanding financial protection, enhancing digital health initiatives, fostering international partnerships, improving health workforce recruitment and retention, investing in modern medical infrastructure, and expanding disease prevention and screening were also positive. The Secretariat should continue to provide support in preparation for the third high-level meeting on universal health coverage.

The representative of SLOVAKIA said that urgent action was needed to improve health system resilience, with a focus on primary healthcare. Investment in health workforce capacity and enhanced social participation were also necessary. Technical support should be provided to scale up digital health solutions, applying ethical artificial intelligence technologies and ensuring patient safety. Contextualized clinical guidelines should also be developed. Noting the importance of sustainability, he expressed support for innovative financing mechanisms, such as regional pooled procurement systems, and highlighted the need to eliminate financial barriers to essential health services. He urged WHO to strengthen its normative guidance on health financing models in line with national contexts, while national budgets should be aligned with universal health coverage objectives. Monitoring and evaluation were also key to advancing progress. He supported the draft decision on rare diseases and the draft decision on strengthening national capacities in evidence-based decision-making.

He called on WHO to integrate universal health coverage strategies beyond 2030 into broader global development agendas, reinforcing links with economic growth, education and equity. At the regional level, knowledge exchange platforms should be facilitated, and capacity-building initiatives should be developed in line with the regional context. At the country level, technical support was needed for primary healthcare reform, the development of digital health strategies and workforce planning. Furthermore, a global action plan should be developed, with clear milestones. Greater investment in cost-effective technologies and equitable partnerships would also help to advance progress.

The representative of the FEDERATED STATES OF MICRONESIA said that context-specific approaches, a skilled workforce and multisectoral support were required to achieve universal health coverage, modelled on the principles of primary healthcare. Partners should continue to support national capacities in relation to disease outbreak response, training of human resources, and access to healthcare and financing. Increased investment was needed in telehealth and digital health, access to diagnostics and vaccines, and for activities to tackle the impact of climate change on the health infrastructure.

The representative of SENEGAL outlined the measures implemented in his country to strengthen primary healthcare towards universal health coverage and the achievement of the

related Sustainable Development Goals. Primary healthcare was key to achieving universal health coverage by providing accessible, quality services focused on prevention, especially for the most vulnerable populations. Member States should increase investment in robust, adequately financed primary healthcare systems, ensuring their integration into public policies in order to guarantee the right to health for all without risk of financial ruin.

Mr Ibrahim took the Chair.

The representative of CHILE supported efforts to reorient health systems towards universal health coverage through a primary healthcare approach and described the strategies implemented in her country in that regard. Noting the importance of reducing financial barriers and tackling health inequities, she highlighted the need to strengthen political commitment, increase budgetary allocations towards primary care and develop financial protection policies. Strategies that took account of social and environmental determinants of health and innovation in the provision of primary healthcare services were also necessary. Those elements should be taken into consideration at the third high-level meeting on universal health coverage in 2027. Public financing should form the core of primary healthcare funding, with a focus on broadening the fiscal space and pooling funds, as recognized in the draft decision on strengthening health financing globally. In addition, rare diseases should be prioritized to ensure equity and inclusivity. She expressed support for the draft decision on strengthening national capacities in evidence-based decision-making.

The representative of SOMALIA drew attention to the challenges faced by his country in achieving universal health coverage due to decades of conflict, fragility and climate-induced crises. Despite those challenges, progress had been made. His Government was committed to rebuilding its health system and called on the international community to support it on its journey towards universal health coverage.

The representative of LEBANON said that the global survey to assess health systems for universal health coverage should capture the barriers and enablers in each region and focus on achievable ways of making progress at the country level before 2030. Increased advocacy was needed to raise governments' awareness of the need to prioritize primary healthcare and of the long-term benefits of primary care services on the economy. Societal resistance to seeking primary healthcare services could be altered by ensuring the presence of a skilled health workforce, especially in remote areas. Advancing prevention and promotion activities and providing a comprehensive benefit package of essential health services, including mental health services, would also be a positive step, including in reducing inequities in access to care. She expressed support for the way forward presented in the report and called for a more innovative method of promoting the primary healthcare approach, which could include risk monitoring and mandatory screening programmes, with incentives for participants. Given the length of time for the benefits of a primary healthcare approach to become apparent, primary healthcare investments must be sustained, even before they had a visible effect on universal health coverage.

The representative of MALDIVES said that a multisectoral approach was required to achieve universal health coverage, encompassing early disease identification, preventive measures and the removal of financial and geographical barriers. The Secretariat should provide tailored support to Member States in the development and implementation of primary healthcare-focused policies and programmes; facilitate knowledge-sharing and collaboration through the establishment of platforms; strengthen monitoring and evaluation frameworks by developing robust indicators and data collection mechanisms to track progress and identify areas for improvement; and advocate

for increased investment in primary healthcare initiatives, including from donors and development partners. Her Government looked forward to contributing to the development of the road map for the third high-level meeting on universal health coverage.

The representative of MEXICO[53] described the action taken by his Government towards ensuring free-of-charge, quality universal health coverage, with primary healthcare serving as the cornerstone of such efforts. In preparation for the third high-level meeting on universal health coverage in 2027, his Government had shared seven areas for further consideration with the Secretariat, including reducing inequalities, financial protection, the health workforce and primary healthcare.

The representative of LUXEMBOURG[53] expressed support for the action on rare diseases set out in the related draft decision, particularly on improving access to diagnosis and newborn testing for rare conditions, networks of patients' associations and training of healthcare personnel. Innovative, fair and sustainable national financing systems and international cooperation were needed to reduce the economic obstacles to access to healthcare services. Data on health expenditure should be enhanced and progress on universal health coverage should be accelerated.

The representative of NIGERIA[53] noted that, in a context of stalled progress on universal health coverage, the effective deployment of financial resources was critical; the draft decision on strengthening health financing globally had been proposed to address that issue. The additional funding constraints faced by WHO made it particularly important to support measures that would provide overall funding support and improve transparency and accountability, and the effectiveness of health financing flows globally and within Member States. He called on Member States to support the adoption of the draft resolution on strengthening health financing globally.

The representative of SINGAPORE[53] said that she strongly supported the advancement of universal health coverage through a primary healthcare approach. The Secretariat should support Member States to design patient-centred integrated care as part of health systems reform and support the adoption of digital health to reach vulnerable populations, as an element of resilient primary healthcare. The Secretariat should prioritize financial protection tools and innovative funding models to reduce inequities. The sharing of best practice, cost-effective interventions and cross-sectoral collaboration would help Member States to achieve transformative reforms. In preparation for the third high-level meeting on universal health coverage planned for 2027, the Secretariat should focus on workforce development, digital health and financial protection to advance universal health coverage globally.

The representative of SLOVENIA[53] emphasized that WHO was best placed to enable collaboration and the sharing of innovative solutions and good practices for primary healthcare. The Secretariat should support networks of Member States to combine resources and speed up progress on universal health coverage. Including interested civil society partners in such networks would add value without significant expenditure. Social participation should be retained as a cross-cutting priority at all levels and programmes in order to build trust and facilitate the development of more equitable guidelines, policies, tools and programmes. . Those who were furthest behind, including those living with rare diseases, must be taken into consideration in universal health coverage.

[53] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of THE SAVE THE CHILDREN FUND, speaking at the invitation of the CHAIR, said that she was also speaking on behalf of Women in Global Health, Inc., The Royal Commonwealth Society for the Blind – Sightsavers, the International Planned Parenthood Federation, World Vision International, the International Federation of Medical Students' Associations, Women Deliver, Inc., Amref Health Africa, CBM Christoffel-Blindenmission Christian Blind Mission e.V., the International Pharmaceutical Students' Federation and the Global Health Council. Achieving universal health coverage required action to reduce inequalities, strengthen primary healthcare, and enhance the health workforce. She welcomed the development of a road map to the 2027 third high-level meeting on universal health coverage. To implement the draft decision on strengthening health financing globally, Member States would need to strengthen health systems through a primary healthcare approach and develop child-sensitive and shock-responsive social protection systems; improve financial protection for vulnerable populations; enhance support to resource-constrained countries; develop cost-effective and gender-transformative packages for maternal, child and adolescent health; and strengthen the rights and working conditions of the healthcare workforce.

The representative of HAITI[54] highlighted that the disparities in health spending between and within countries were an obstacle to the achievement of universal health coverage. She called for investment in the strengthening of health systems, particularly in vulnerable countries. Taiwan[55] could help to achieve universal health coverage and should be included in all WHO technical meetings, activities and mechanisms, and should be invited to participate in the Health Assembly as an observer.

The representative of EL SALVADOR[54] said that capacity-building was needed at the community level to boost resilience and implement a One Health approach, alongside the use of new technologies and skills development for the healthcare workforce, particularly in primary healthcare. Improvements were also needed in the services offered by hospitals. Looking to the third high-level meeting on universal health coverage in 2027, he called for the adoption of an approach focused on eliminating diseases, thereby ensuring the more effective use of technical and financial resources.

The representative of FRANCE[54] noted that investment was needed to strengthen human resources for health and address the healthcare workforce shortage and said that the WHO Academy should be fully utilized in that regard. Social protection must be expanded to tackle catastrophic or impoverishing healthcare expenditure. The financing framework for universal health coverage should be revised to improve coordination between existing mechanisms and to ensure sustainable financing of national systems through public subscription and innovative financing such as taxes on products known to increase the risk of noncommunicable diseases. With a view to the third high-level meeting on universal health coverage in 2027, he encouraged the Secretariat to continue supporting Member States in promoting primary healthcare. Sustainable, clear international financing was needed to achieve universal health coverage, including by implementing the Lusaka Agenda.

The representative of MALAYSIA[54] said that demographic change, the rise in communicable and noncommunicable diseases and increased health costs due to inflation presented challenges to achieving universal health coverage. The primary healthcare approach required expanded access to quality health services, the retention of trained healthcare workers, and increased health

[54] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[55] World Health Organization terminology refers to "Taiwan, China".

sector funding. Mobile and digital healthcare services were needed to reach remote and marginalized populations. Integrated health services should be promoted, alongside targeted preventive strategies and early interventions at the primary healthcare level.

With a view to the third high-level meeting on universal health coverage in 2027, efforts were needed to strengthen financial protection for universal health coverage and eliminate impoverishment due to health costs. She welcomed the initiative to monitor financial protection developed by the Regional Office for the Western Pacific, which could inform evidence-based policy development. The action plan proposed in the draft decision on rare diseases would support universal health coverage by promoting the integration of rare disease initiatives in broader efforts for health systems strengthening. She called for future reports to provide more details of key Secretariat activities and achievements concerning Member States and additional information on initiatives such as the Health Impact Investment Platform.

The representative of the NCD ALLIANCE, speaking at the invitation of the CHAIR, said that she was also speaking on behalf of The Royal Commonwealth Society for the Blind – Sightsavers, HelpAge International, the International Society of Nephrology, the International Diabetes Federation, the Multiple Sclerosis International Federation, PATH, World Cancer Research Fund International, the International Association for Hospice and Palliative Care, Inc., Vital Strategies, Inc., the World Heart Federation, the International Association for Suicide Prevention, the World Federation of Societies of Anaesthesiologists, the World Hepatitis Alliance, Alzheimer's Disease International and The Fred Hollows Foundation. Although she welcomed the draft decisions on strengthening health financing globally and on strengthening national capacities in evidence-based decision-making, stronger commitments were needed in the context of an increasing and inequitable burden of noncommunicable diseases. Member States should accelerate efforts towards achieving universal health coverage by including noncommunicable disease prevention, diagnosis and care, and palliative services in national health benefit packages, and aligning and integrating noncommunicable disease services with other global health priorities. Member States should engage with civil society and people living with noncommunicable diseases to ensure that universal health coverage remained people-centred. Accountability mechanisms and inclusive public health data were essential. Sustained resources were needed for universal health coverage and to implement WHO's guidance on cost-effective interventions. She called for an ambitious global financing target that prioritized catalytic resource mobilization and the implementation of domestic duties on tobacco, sugar-sweetened beverages and alcohol. Implementation of the 2023 political declaration of the high-level meeting on universal health coverage would provide momentum for progress ahead of the third high-level meeting on universal health coverage in 2027.

The representative of PARAGUAY[56] observed that increasing healthcare coverage would reduce catastrophic health spending that affected families around the world; that called for greater international cooperation. She advocated for the inclusion of the Republic of China, Taiwan,[57] in WHO technical meetings and activities, and called for its participation in the Health Assembly as an observer.

The representative of the PHILIPPINES[56] said that strengthened financing for primary healthcare was needed to deliver and sustain healthcare services. Commitment and decisive action were needed from Member States to accelerate progress towards universal health coverage, including by increasing public financing for health and collaborating with multisectoral

[56] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[57] World Health Organization terminology refers to "Taiwan, China".

stakeholders. Innovative financing mechanisms should be used to fill gaps and external financing should be aligned with related strategies and plans. A robust health and care workforce that was equitably distributed across areas of need in the healthcare system would be essential to accelerating progress on universal health coverage. The Secretariat should prioritize the delivery of universal health coverage by supporting finance strategies, multisectoral engagement and healthcare workforce strengthening.

The representative of TÜRKIYE[58] called for the lack of progress to trigger each country to redouble efforts to achieve universal health coverage by 2030 through the primary healthcare approach. At the national level, greater investment was needed in the health and care workforce, education and training, and digital health solutions. The Secretariat should continue to support Member States to redouble their efforts, including by tracking progress on the 2023 political declaration of the high-level meeting on universal health coverage and preparing for the third high-level meeting in 2027.

The representative of the CENTRAL AFRICAN REPUBLIC[58] called for greater investment by WHO in improving access to primary healthcare, particularly given that 90% of the sub-Saharan population had no access to essential healthcare. The establishment of the WHO Academy was welcome, but ongoing professional training should be undertaken in the countries and regions, and be adapted to local situations in order to strengthen national health systems.

The meeting rose at 18:35.

[58] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Fifth meeting

Wednesday, 5 February 2025, at 10:05

Chair: Dr J.X. Walcott (Barbados)

Pillar 1: One billion more people benefiting from universal health coverage (continued)

1. Universal health coverage: Item 6 of the agenda (continued)

- **Primary healthcare** (document EB156/6) (continued)

The CHAIR recalled that the Board had before it four draft decisions, on strengthening national capacities in evidence-based decision-making for the uptake and impact of norms and standards, on rare diseases: a global health priority for equity and inclusion, on strengthening health financing globally and on strengthening medical imaging capacity, all of which respectively contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly.

The representative of SOMALIA urged Member States to support the draft decision on rare diseases to ensure equitable access to diagnosis, treatment and care. He described the situation in his country in that regard, paying particular attention to his Government's efforts to integrate rare disease services into primary healthcare, and called for global solidarity to support health system strengthening in fragile countries.

The representative of CHINA noted with regret that some representatives, in disregard of the relevant provisions of the Rules and Procedures, insisted on making statements that were outside the scope of the agenda item under discussion. He expressed opposition to any infringement of his country's sovereignty. The Secretariat should support Member States in accelerating the implementation of regional primary healthcare initiatives; enhancing people-centred integrated health systems in line with national realities; and monitoring and adjusting the provision of primary healthcare services to priority groups and the allocation of resources to ensure effective service delivery. With support from WHO, his Government would act on the political commitment to accelerate universal health coverage, actively participate in developing a road map for the third high-level meeting of the United Nations General Assembly on universal health coverage and share its experiences on achieving universal health coverage through a primary healthcare approach. His Government wished to be added to the list of sponsors of the draft decisions on strengthening national capacities in evidence-based decision-making and on strengthening medical imaging capacity.

The representative of BELARUS,[1] highlighting efforts to strengthen universal health coverage at the national level, said that his Government could not support the participation of Taiwan[2] as an observer at the Health Assembly. The approach to that issue should be guided by the one-China principle and United Nations General Assembly resolution 2758 (XXVI) (1971), which set out the right of the People's Republic of China to represent all of China, including the island of Taiwan.[2]

The representative of PANAMA,[1] noting the importance of a people-centred, life-course approach to primary healthcare and integrated health services, said that lessons learned from the coronavirus disease (COVID-19) pandemic could be applied to transform health systems, including self-care guidelines and evidence-based skills frameworks for health and care workers. It was necessary to develop integrated health service networks and strengthen information systems and health risk management. Promoting resilient health systems would foster sustainable access to innovative, high-quality health services focused on individuals, families, communities and the environment. She expressed support for the draft decisions on strengthening health financing globally and on strengthening national capacities in evidence-based decision-making.

The representative of SPAIN[1] outlined a plan implemented by his Government to strengthen primary healthcare. Rare diseases should be made a global health priority, and achieving universal health coverage required ensuring access to essential health services, without discrimination or financial hardship, for people affected by such diseases. While the financial landscape was complex, the consensus built through work on the draft decision on rare diseases showed that there was broad support to take action on that issue. It would be important to leverage the Organization's comparative advantage as the only organization able to drive forward a global action plan to improve the quality of life of millions of people affected by rare diseases. He expressed appreciation for the remaining draft decisions.

The representative of the WORLD FEDERATION OF NUCLEAR MEDICINE AND BIOLOGY, speaking at the invitation of the CHAIR, said that he was also speaking on behalf of the International Society of Radiology, the Global Diagnostic Imaging Healthcare IT and Radiation Therapy Trade Association, Humatem, the International Alliance of Patients' Organizations, the International Federation on Ageing, the International Federation for Medical and Biological Engineering, the International Federation of Surgical Colleges Limited, the International Organization for Medical Physics, The International Society for Quality in Health Care Company Limited by Guarantee, The International Society of Radiographers and Radiological Technologists, the Multiple Sclerosis International Federation, RAD-AID International, Inc., The International Society of Paediatric Oncology, the Thalassaemia International Federation, the World Federation for Ultrasound in Medicine and Biology, The World Medical Association, Inc., and the World Stroke Organization.

He welcomed the draft decision on strengthening medical imaging capacity, highlighting the importance of increasing equitable and timely access to medical imaging capacity in low- and middle-income countries through a comprehensive health system approach. While the burden of noncommunicable diseases was rising and disproportionately affected low- and middle-income countries, access to medical imaging and nuclear medicine in such countries was limited. Timely and equitable access to medical imaging and nuclear medicine brought economic benefits and should be an essential component of WHO's primary healthcare and universal health coverage initiatives. The Secretariat should coordinate with IAEA and Member States to develop and implement strategies for introducing and maintaining appropriate imaging equipment, workforce

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[2] World Health Organization terminology refers to "Taiwan, China".

training, radiation safety and quality assurance at the national level. Such strategies should complement strategies on in-vitro diagnostics and other diagnostic clinical procedures. It would be crucial to agree on the provision of the budgetary support required to improve access to medical imaging.

The representative of KUWAIT[3] expressed appreciation for WHO's efforts to promote international cooperation in health. His Government was working to promote primary healthcare as the fastest and most effective way to achieve universal health coverage and was committed to strengthening cooperation with international health organizations and regional partners with the aim of exchanging expertise.

The representative of JAPAN[3] said that accelerated efforts were needed to achieve universal health coverage by 2030. Universal health coverage required health systems to be strengthened, including through sustainable health financing; to that end, it would be important to enhance coordination, reinforce the financial base for health and ensure stable domestic financial resources. The draft decision on strengthening health financing globally was aligned with the objectives of the universal health coverage knowledge hub soon to be launched in his country in coordination with WHO and the World Bank.

The representative of SOUTH AFRICA[3] said that adopting a primary healthcare approach to health systems reform would be the most effective and efficient way to make health systems more resilient to shocks and crises. Strengthening health systems by strengthening the health and care workforce would help to achieve universal health coverage. Investment and action would be required in order to ensure universal access to high-quality essential health services. She called for increased investment in universal health coverage and an emphasis on the importance of domestic resource mobilization, international financing mechanisms and the role of multilateral organizations in supporting the efforts of Member States. In preparation for the third high-level meeting on universal health coverage, she encouraged the Secretariat to draw on the Lusaka Agenda to guide financing discussions, promote regional and international collaboration and advocate for innovative financing solutions to ensure the sustainability of universal health coverage globally.

The representative of the RUSSIAN FEDERATION[3] said that, in preparation for the third high-level meeting on universal health coverage, it would be appropriate to note the historic contribution made by the Soviet Union in developing the primary healthcare model used in many countries. He described efforts to enhance primary healthcare and the treatment of rare diseases at the national level. His Government wished to be added to the list of sponsors of the draft decision on rare diseases.

The representative of THE INTERNATIONAL SOCIETY OF PAEDIATRIC ONCOLOGY, speaking at the invitation of the CHAIR and also on behalf of Childhood Cancer International, the International Association for Hospice and Palliative Care, Inc., the International Pediatric Association, the International Society of Nephrology and the International Agency for the Prevention of Blindness, called for the adoption of the draft decision on rare diseases, stressing its importance for the millions of children with life-altering rare conditions. It should be implemented in an ambitious and pragmatic manner while pursuing global health equity and ensuring synergy with relevant WHO programmes, including those addressing severe rare diseases in children and initiatives promoting access to clinical trials and research. Integrated efforts on rare diseases should span the

[3] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

patient pathway and promote equitable and sustainable access to care while integrating socioeconomic and psychosocial support to address the lifelong impact on paediatric patients and their families. A coordinated approach could foster multiplier effects; for instance, investment in childhood cancer diagnosis and treatment had been identified as a cost-effective intervention for overall health systems strengthening. A global action plan on rare diseases, implemented in coordination with relevant initiatives, would accelerate life-enhancing progress and foster efficiency, sustainability and the potential to harness the transformative power of universal health coverage.

The representative of BANGLADESH[4] said that rising out-of-pocket health costs and stagnancy in the reduction of maternal mortality would hinder progress in universal health coverage. He requested the Secretariat to provide disaggregated information on its efforts to support Member States in implementing national reforms. Strengthened health expenditure data, analysis and tracking was a good policy tool, and a similar approach should be applied to international financial assistance to reduce fragmentation in health financing. He would welcome further information on the pooled procurement mechanisms described in paragraph 13 of the report, specifically the kind of medicines selected, the selection criteria used, whether novel medicines were included and whether procurement was monitored. The Secretariat should provide information on its work on debt restructuring in line with the Lusaka Agenda and on facilitating the alignment of health organizations such as Gavi, the Vaccine Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria to support primary healthcare at the country level. To enhance transparency, it would be useful to receive further information on the Health Impact Investment Platform via the WHO website. If the Secretariat could not provide the information requested at the current session of the Board, it would be helpful to receive a report containing that information at the Seventy-eighth World Health Assembly. Turning to the draft decision on rare diseases, he called on the Secretariat to provide insight as to how Member States could facilitate access to vaccines, therapeutics, diagnostics and other health services within the framework of a global action plan on rare diseases.

The representative of INDIA[4] said that strengthening primary healthcare was key to achieving universal health coverage and described interventions implemented by his Government in that regard. Given the pivotal role of digital health in advancing universal health coverage, the Secretariat should prioritize that issue at the third high-level meeting on universal health coverage. Leveraging digital health technologies could enhance access to high-quality, affordable and timely healthcare services, ensuring equitable and inclusive health outcomes for all. More information would be welcome on the Health Impact Investment Platform, particularly regarding the projects that would receive funding through the Platform.

The representative of GERMANY[4] said that universal health coverage provided the foundations for resilient health systems and pandemic preparedness. While her Government had supported the development of the draft decisions under consideration, it was crucial to assess their cost implications and any new actions required and to identify essential programmes and prioritize their continuation. She cautioned against adopting new resolutions before the Board had concluded its discussions of the budgetary implications and prioritization process and requested the Secretariat to provide guidance on the next steps in that regard.

To achieve universal health coverage, essential health services must be accessible to all, especially the most vulnerable, and universal access to sexual and reproductive health and rights must be made a reality. Expanding health financing and social protection systems based on

[4] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

solidarity and equity would be key to reducing out-of-pocket payments and ensuring access to health services. Efficient and sustainable financing mechanisms for universal health coverage and social protection must be established, primarily through domestic resources.

The representative of the UNITED REPUBLIC OF TANZANIA[5] said that achieving universal health coverage required embracing primary healthcare in health promotion and disease prevention through a holistic, people-centred approach. To accelerate the achievement of universal health coverage, it was necessary to strengthen the community health workforce through integrated programmes; mobilize resources using innovative health financing mechanisms; leverage digital health and medical technologies, especially in remote areas; promote joint research and knowledge-sharing to address emerging health challenges; and advocate for policies promoting universal health coverage and strengthened governance and accountability. Her Government remained committed to working with WHO and partners to prioritize primary healthcare reforms and achieve universal health coverage by 2030, an approach that should receive due attention at the third high-level meeting on universal health coverage.

The representative of BURUNDI[5] welcomed WHO's efforts to promote universal health coverage in the African Region and highlighted a number of measures implemented in her country to that end. To achieve universal health coverage, the quality and quantity of human resources should be strengthened. Her Government recognized the Government of the People's Republic of China as the only legal government representing the whole of China, in keeping with United Nations General Assembly resolution 2758 (XXVI).

The representative of NAMIBIA[5] noted that a lack of financial protection remained a critical barrier to universal health coverage. There was a need for strong political leadership and increased financial investment in primary healthcare. The Secretariat should support Member States in converting political commitments into actionable policies and comprehensive primary healthcare-centred reforms driven by robust advocacy and evidence-based strategies. Ahead of the third high-level meeting on universal health coverage, the Secretariat should prioritize developing frameworks to measure and address health equity and financial risk protection and conduct comprehensive evaluations of current health system reforms to guide policy-making and investment.

The representative of PAKISTAN[5] said that his Government remained committed to the progressive realization of universal health coverage. The draft decision on rare diseases addressed an important gap in combating the spread of such diseases. The Secretariat was requested to share steps that Member States could take to improve access to medical countermeasures for rare diseases pending the development of a related draft global action plan.

The participation of Taiwan[6] in WHO's work was an issue that had been settled by United Nations General Assembly resolution 2758 (XXVI) and resolution WHA25.1 (1972). It was important to remember that the Board was a technical body and WHO was a specialized agency of the United Nations. Politicizing the Organization's discussions detracted from vital public health issues. Member States should avoid dwelling on issues that had been conclusively resolved.

The representative of RARE DISEASES INTERNATIONAL, speaking at the invitation of the CHAIR and also on behalf of the World Federation of Hemophilia, the International Agency for the

[5] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[6] World Health Organization terminology refers to "Taiwan, China".

Prevention of Blindness, the International Alliance of Patients' Organizations, the International Hospital Federation and the Council for International Organizations of Medical Sciences, said that the draft decision on rare diseases represented a significant milestone in achieving universal health coverage. Despite growing recognition of the importance of addressing rare diseases, millions of people continued to face barriers to timely diagnosis, treatment and care. A comprehensive and coordinated global action plan on rare diseases would be essential to addressing diagnosis and treatment gaps. A draft global action plan should provide Member States with a strategic framework to integrate rare diseases into national health priorities; promote equity by fostering collaboration to address cross-border challenges and support sustainable innovation in diagnostics and therapeutics; and strengthen health systems by driving progress in data collection, research and capacity-building. WHO should dedicate the necessary financial and technical resources to develop a global action plan in collaboration with Member States, civil society and the rare diseases community. Insufficient investment could undermine the potential of the draft decision to drive transformative change. Addressing rare diseases was not only a health issue but also a matter of equity and human rights.

The representative of INDONESIA,[7] providing an overview of her Government's efforts to achieve universal health coverage, underscored the importance of ensuring equitable access to high-quality integrated healthcare services through collaboration with the private sector; securing sustainable financing to promote effective resource allocation and financial protection for all; and integrating digital health interventions to enhance efficiency, transparency and data-driven decision-making.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND[7] said that attaining universal health coverage, including strengthening health financing reforms and sexual and reproductive health and rights, was fundamental to achieving health for all and a key part of WHO's core mandate. Strengthening primary healthcare was the foundation for delivering equitable access to services through national health systems. Her Government wished to be added to the list of sponsors of the draft decision on strengthening national capacities in evidence-based decision-making, with the recognition that the Organization needed to undertake robust prioritization to address its pressing financing challenges.

The representative of ZAMBIA[7] said that the COVID-19 pandemic had shown that more needed to be done to break down barriers to equitable access to essential diagnostic, preventive and therapeutic products. Multilayered interventions were required at all levels to address persisting and complex structural issues related to the financing of medical research and development, health financing, technology transfer and healthcare supply chains and ensure an intellectual property rights ecosystem that was supportive of public health. Deliberate and active support for the local production of health products would improve timely access to such products where they were needed most. It would be crucial to move beyond a pathological and biological view of health to a human-centred approach, with health considered a human right.

The representative of the DOMINICAN REPUBLIC[7] said that her Government wished to be added to the list of sponsors of the draft decision on strengthening national capacities in evidence-based decision-making.

The Observer of GAVI, THE VACCINE ALLIANCE, welcomed the draft decision on strengthening health financing globally. Immunization was a key component of primary healthcare

[7] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

and lowered overall healthcare costs by preventing disease. Gavi was committed to strengthening health systems through country-driven partnerships in line with the Lusaka Agenda. To advance universal health coverage, Member States should prioritize health in public budgets, provide essential health services to zero-dose children and underserved communities and expand and fairly compensate the health workforce, including community health workers, while addressing gender inequities.

The representative of the EUROPEAN SOCIETY FOR MEDICAL ONCOLOGY, speaking at the invitation of the CHAIR, urged Member States to adopt the draft decision on rare diseases; strengthen the delivery of care for patients with rare cancers and rare molecular alterations of more common cancers; include rare cancers in national cancer control plans; enable robust global data collection and sharing to attain a deeper clinical representation of rare cancers and facilitate research; allocate sufficient resources to the development of basic, clinical and translational research on rare cancers; facilitate clinical trials to address inequality and inequity in access to innovative treatments and precision medicine; and build collaborative efforts for shared responsibility to improve outcomes for all people living with rare cancers.

The representative of the INTERNATIONAL SOCIETY ON THROMBOSIS AND HAEMOSTASIS, INC., speaking at the invitation of the CHAIR, said that blood clot prevention was essential to high-quality care and universal health coverage. Venous thromboembolism was the leading cause of hospital-associated adverse events globally, yet prevention was simple and cost-effective, and the relevant medicines were on the WHO Model List of Essential Medicines. Prioritizing hospital-associated venous thromboembolism prevention within the framework of universal health coverage could save lives, reduce healthcare costs and improve outcomes.

The representative of the GLOBAL SELF-CARE FEDERATION, speaking at the invitation of the CHAIR, said that self-care complemented primary healthcare, enhanced disease prevention, strengthened resilience against pandemics and noncommunicable diseases, reduced environmental stressors and boosted healthcare efficiency. As a cornerstone of sustainable health systems, self-care eased financial burdens and ensured long-term viability, allowing better resource allocation to specialized care and infrastructure. A WHO-led global action plan could provide structured guidance, promote best practices and help policy-makers to optimize self-care to advance universal health coverage.

The representative of KNOWLEDGE ECOLOGY INTERNATIONAL, INC., speaking at the invitation of the CHAIR, said that the cost of implementing the draft decision on rare diseases posed a challenge at a time of severe funding issues. One inexpensive measure could be to circulate a survey among Member States on compliance with resolution WHA72.8 (2019) on improving the transparency of markets for medicines, vaccines, and other health products, including questions on progress in collecting and publishing data on units of medicines sold, prices, sales revenue, cost of trials and subsidies related to research and development for specific products. That information would help to evaluate the extent of disparities regarding access and the impact of rare diseases on healthcare budgets. The Secretariat could also solicit and publish proposals from the public on challenges and opportunities regarding the delinking of drug development incentives from high prices and monopolies.

The representative of the WELLCOME TRUST, speaking at the invitation of the CHAIR, said that the draft decision on strengthening global health financing should help to better align global health financing with country-led trajectories towards universal health coverage; forge strong links to the Lusaka Agenda, particularly its five key shifts for the long-term evolution of the global health financing ecosystem; target the partners required to drive reforms; and be translated into

coherent and ambitious actions by Member States and non-State actors. The ambition and support driving the draft decision should reflect the size of the global health financing challenge and the urgent need to make the global ecosystem efficient, effective and equitable, while taking into account the increasing health impacts of climate change.

The representative of the INTERNATIONAL SOCIETY OF PHYSICAL AND REHABILITATION MEDICINE, speaking at the invitation of the CHAIR, said that universal health coverage included rehabilitation, which was crucial to addressing the growing burden of noncommunicable diseases and injuries and the challenge posed by ageing populations. Rehabilitation enabled individuals to achieve and maintain optimal health and function, thereby reducing health inequities, supporting inclusive societies and boosting economic productivity. Countries should allocate sufficient resources to strengthen the provision of rehabilitation services and the availability of skilled professionals at all levels of health systems.

The representative of the MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION, speaking at the invitation of the CHAIR, expressed concern that billions of people had been driven into poverty owing to catastrophic health spending and called on Member States to prioritize increased political investment in universal health coverage, focusing on ensuring financial protection for the most vulnerable. Given the high mortality rate of sepsis and its associated healthcare costs, she urged Member States to prioritize the integration of sepsis into national universal health coverage packages.

The representative of the WORLD ORGANIZATION OF FAMILY DOCTORS, speaking at the invitation of the CHAIR, said that family doctors were essential to the delivery of holistic primary healthcare and their community insight facilitated early intervention, chronic disease management and health promotion. Despite their critical role in improving survival rates and reducing hospitalizations and reliance on emergency services, family doctors were often under-resourced. Ensuring universal access to trained family doctors was vital for high-quality, safe and sustainable health systems. Member States should prioritize family medicine specialization and develop strategies to recruit and retain family doctors.

The representative of FDI WORLD DENTAL FEDERATION, speaking at the invitation of the CHAIR and also on behalf of the International Association for Dental Research, said that initiatives to strengthen financial protection and expand access to high-quality integrated care were needed to address the catastrophic out-of-pocket health costs often reported in managing oral diseases. Universal health coverage programmes should incorporate a basic package of essential oral health services at the primary care level, including timely access to specialized oral healthcare. National research on universal health coverage should assess progress on oral health for all. Member States should integrate oral disease prevention and self-care practices into national self-care policies, supported by research assessing their effectiveness.

The representative of the INTERNATIONAL LACTATION CONSULTANT ASSOCIATION, speaking at the invitation of the CHAIR, emphasized the need to expand essential health services in primary healthcare settings, especially for maternal health. Increasing global breastfeeding rates could prevent thousands of deaths among mothers and children and reduce the risk of several noncommunicable diseases. Member States were therefore urged to include skilled lactation care, free at the point of contact, in primary healthcare services; invest in appropriate training for physicians, nurses and midwives; and support the development of a skilled lactation care workforce. Increased investment in breastfeeding protection and counselling would improve the health of mothers and babies and reduce overall healthcare costs.

The representative of THE WORLDWIDE HOSPICE PALLIATIVE CARE ALLIANCE, speaking at the invitation of the CHAIR, said that palliative care was critical to managing noncommunicable diseases in primary healthcare settings and should be included by Member States in universal health coverage planning. Noting that the palliative care needs of low- and middle-income countries were not being met, he encouraged Member States to consider allocating funding for palliative care in their contributions to the United Nations multi-partner trust fund to catalyse country action for non-communicable diseases and mental health.

The representative of the PUBLIC SERVICES INTERNATIONAL, speaking at the invitation of the CHAIR, stressed that investing in the health and care workforce was crucial to delivering high-quality and accessible healthcare for all. Governments must ensure public funding for primary healthcare systems while maintaining robust safeguards against private for-profit extraction. Decent work, fair remuneration, social protection and a safe environment for health and care workers were required to retain workers and address workforce shortages, particularly in underserved areas. Member States should grant formal recognition to community health workers and secure their rights along with those of other public essential health workers. Governments should involve trade unions in policy-making through effective social dialogue.

The representative of the DRUGS FOR NEGLECTED DISEASES INITIATIVE, speaking at the invitation of the CHAIR, said that vulnerable populations, including those affected by neglected tropical diseases, must be prioritized in efforts to achieve universal health coverage. Noting the limitations of existing tools for those diseases, he said that research and development could enhance universal health coverage through the creation of affordable, effective tools tailored to patient needs and suitable for primary healthcare settings. At the third high-level meeting on universal health coverage, Member States should address medical innovation and the delivery of essential health tools to address unmet needs. Member States should seek research and development synergies and integrate access programmes relating to various diseases.

The representative of MOVENDI INTERNATIONAL, speaking at the invitation of the CHAIR, said that many of the burdens and costs borne by health systems were avoidable, and diseases caused by alcohol were becoming more prevalent in many countries, placing a heavy strain on families, health services and economies. Greater attention to alcohol policy and taxation could reduce healthcare costs and increase revenue for investments in universal health coverage. A more ambitious focus on alcohol policy best buys would drive progress towards universal health coverage.

The representative of the INTERNATIONAL BABY FOOD ACTION NETWORK, speaking at the invitation of the CHAIR, said that strong safeguards against conflicts of interest were needed to prevent health-harming industries from undermining efforts towards universal health coverage. Prevention was critical and started with optimal feeding during the early years of life. Noting that many baby foods were high in free sugars, she encouraged Member States to participate in meetings of the Codex Alimentarius Commission to ensure adherence to WHO recommendations in the development of new standards for baby foods. Marketing legislation must cover all products marketed for children, including plant-based formulas, bottles and teats.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of the CHAIR, said that, while nurse-led healthcare models expanded access to high-quality, cost-effective care, chronic underinvestment prevented such models from achieving their full potential and hindered progress toward universal health coverage. Governments were urged to make bold, sustained investments in nursing and primary healthcare. Universal health coverage could not be achieved without urgent action to educate, protect and retain the nursing workforce.

The representative of the ISLAMIC REPUBLIC OF IRAN[8] said that it would be important to continue taking a realistic approach to achieving universal health coverage at the international level and highlighted the need for international cooperation to bridge the gap between developing and developed countries. He expressed appreciation for the work done to develop the draft decision on rare diseases, emphasizing the importance of a holistic, patient-centred approach in addressing the needs of people living with rare diseases and a focus on enhancing their functioning and removing barriers to health, education and employment. Strengthened cooperation at all levels was needed to ensure unhindered, equitable and timely access to affordable, high-quality medicines for all people living with rare diseases.

Discussions on health financing should take into account challenges faced by countries targeted by unilateral coercive measures. There should be clear pathways to ensure access to financing to enhance universal health coverage in such countries.

The representative of STICHTING HEALTH ACTION INTERNATIONAL, speaking at the invitation of the CHAIR, said that a firm legal and financial base for primary care was a prerequisite for universal health coverage. The third high-level meeting on universal health coverage should address the root causes of the lack of global progress. Renewed energy and a sense of urgency was needed from all stakeholders. The Secretariat should continue providing technical assistance to governments and advocate for more affordable and accessible medicines and health technologies. Stakeholders should address climate change when formulating policies and public interventions aimed at strengthening health systems.

The representative of ECUADOR[8] said that an intersectoral approach involving governments, civil society and international organizations was needed to achieve universal health coverage and described national efforts to reach that goal. She called on the Secretariat to strengthen its support to help Member States to improve the quality and coverage of health services.

The representative of GUINEA-BISSAU[8] provided an overview of his Government's efforts to boost universal health coverage, noting in particular its progress in eliminating trachoma.

The representative of ZAMBIA[8] underscored the importance of holding focused discussions on technical matters in line with the WHO Constitution. Politicizing discussions served only to derail the Organization's efforts to focus on substantive and impactful issues. Her Government recognized the one-China principle, acknowledged that the Government of the People's Republic of China was the sole legal government representing the whole of China and supported that Government's efforts regarding national reunification. The Government of China must be able to safeguard its national sovereignty and territorial integrity.

The representative of the BOLIVARIAN REPUBLIC OF VENEZUELA[8] said that her Government recognized only one legitimate government representing the People's Republic of China and considered Taiwan[9] to be part of that country in line with the one-China principle. As WHO was a specialized agency composed of sovereign States, the participation of that region in the Organization's work should be aligned with United Nations General Assembly resolution 2758 (XXVI) and resolution WHA25.1. She expressed support for the call not to politicize the Board's work.

[8] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[9] World Health Organization terminology refers to "Taiwan, China".

The representative of ZIMBABWE expressed support for the one-China principle, recognizing that Taiwan[10] was an inalienable part of China's territory.

The REGIONAL DIRECTOR FOR THE WESTERN PACIFIC, speaking on behalf of all six regions of WHO, said that progress on the commitments made at the second high-level meeting on universal health coverage was off track, and inequalities between and within countries continued to grow. Reorienting health systems around a primary healthcare approach was the fastest and most effective, efficient, equitable and inclusive path to universal health coverage. All WHO Regions had made significant achievements towards advancing universal health coverage. It would be crucial to build on those achievements, address critical challenges in the health workforce and galvanize the support of the global health ecosystem to promote universal health coverage, particularly in areas of the highest need, such as fragile, conflict-affected and vulnerable settings. The regional offices were enhancing the support provided to Member States through initiatives such as the Health Impact Investment Platform and the International Health Partnership for Universal Health Coverage and remained committed to supporting countries to achieve health for all by 2030.

The ASSISTANT DIRECTOR-GENERAL (Universal Health Coverage/Life Course) said that the Secretariat shared concerns regarding the stagnancy of progress on universal health coverage and its human cost. He took note of the call to address rare diseases and the clear guidance provided on the way forward with respect to the third high-level meeting on universal health coverage, noting the emphasis on the need for a primary healthcare approach; financing and financial protection; interventions to address the workforce gap, especially regarding community health workers and nurses; efforts to harness artificial intelligence, digital health and data; and tailored approaches, particularly in fragile, conflict-affected and vulnerable settings.

He welcomed the guidance received on stepping up work on medical imaging and on strengthening national capacities in evidence-based decision-making and expressed his appreciation to the sponsors of the relevant draft decisions. He acknowledged the views expressed on the need to harness the power of social participation with a view to leaving no one behind, noting that WHO's work in that regard must include sexual and reproductive health and rights interventions.

Health financing and financial protection underpinned the entire universal health coverage agenda. The decline in global health financing had been compounded by economic headwinds, competing priorities, slowing economic growth and the debt servicing burden. He expressed appreciation to the Member States that had taken the lead on the draft decision on strengthening health financing globally. Specific questions raised by Member States would be addressed by the Secretariat on a bilateral basis.

The Secretariat would shape the road map to the third high-level meeting on universal health coverage in line with Member States' suggestions and would roll out a global survey to assess systems for primary healthcare and universal health coverage to provide a basis for future work in that regard. In addition, the Secretariat would continue its networking efforts in order to strengthen universal health coverage partnerships, which were key to its ability to provide tailored support, and would work to develop a global action plan on rare diseases that addressed barriers highlighted by Member States and ensured the dignity of people affected by such diseases. Efforts towards improving medical imaging, including work on the WHO list of priority medical devices as well as normative work and training, would be advanced by the Secretariat in coordination with Member States and partners. He stressed that the goal of leaving no one behind could not be achieved without the full financing of the Organization and its vital work on health financing.

[10] World Health Organization terminology refers to "Taiwan, China".

The CHAIR took it that the Board wished to note the report contained in document EB156/6.

The Board noted the report.

The representative of SWITZERLAND, echoing the sentiments expressed by the representative of Germany on the need to assess the cost implications of draft resolutions and decisions, requested that consideration of the draft decisions should be suspended pending the outcome of informal consultations on the matter.

The representatives of BULGARIA and POLAND expressed support for the request made by the representative of Switzerland.

The CHAIR took it that the Board wished to suspend consideration of the item pending the outcome of the broader discussion on the costing implications of resolutions and decisions recommended by the 156th session of the Executive Board for adoption by the Seventy-eighth World Health Assembly.

It was so agreed.

(For the adoption of decisions, see the summary record of the eighteenth meeting, section 2.)

2. Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases: Item 7 of the agenda (document EB156/7)

- **Reducing the burden of noncommunicable diseases through strengthening prevention and control of diabetes**
- **Oral health**
- **Comprehensive mental health action plan 2013–2030**
- **Global strategy to accelerate the elimination of cervical cancer as a public health problem and its associated goals and targets for the period 2020–2030**

The CHAIR invited the Board to consider the report contained in document EB156/7 and provide guidance with respect to the questions set out in paragraph 41 of the document. The Board was also invited to consider five draft decisions under the item. The first draft decision, which contained a draft decision to be submitted to the Seventy-eighth World Health Assembly, on a dedicated report on mental health for WHO's governing bodies, proposed by Albania, Armenia, Bangladesh, Belgium, Brazil, Chile, the Dominican Republic, Ecuador, Finland, France, Georgia, Jamaica, Latvia, Mexico, the Kingdom of the Netherlands, Panama, Peru, the Philippines, Romania, Spain and Ukraine. The draft decision read:

The Executive Board, having considered the report by the Director-General,[11]

Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following decision:

The Seventy-eighth World Health Assembly,

(PP1) Having considered the report by the Director-General;

(PP2) Having recognized Member States' increased concerns over, and attention to, mental health as a public health priority, as evidenced by decision WHA74(14) (2021) on mental health preparedness for and response to the COVID-19 pandemic, and resolution WHA77.3 (2024) on strengthening mental health and psychosocial support before, during and after armed conflicts, natural and human-caused disasters and health and other emergencies;[12]

(PP3) Acknowledging the preferences expressed by numerous Member States to give appropriate space for Member States to plan, discuss and review the Secretariat's and Member States' work on mental health;

(PP4) Acknowledging WHO's expanded framework for addressing noncommunicable diseases, including mental health, which integrates prevention, early detection, treatment and control strategies that are tailored to these priority areas, fostering a more comprehensive and sustainable response to noncommunicable diseases globally,[13]

(OP)1. Decided to request the Director-General to submit annual reports to the Health Assembly, through the Executive Board, on the implementation of the decision and resolutions on mental health,[14,15,16] separately from the consolidated reporting on noncommunicable diseases as required by decision WHA72(11) (2019).

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[17]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:
1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:
Not applicable.

[11] Document EB156/7.

[12] Resolution WHA77.3.

[13] Document A75/10 Add.8.

[14] Decision WHA74(14).

[15] Resolution WHA77.3.

[16] Resolution WHA66.8 (2013).

[17] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic "bridge" between results structures can be provided as needed.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:
Not applicable.

4. Estimated time frame (in years or months) to implement the decision:
Six years (2026–2031).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:
US$ 0.95 million.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:
US$ 0.14 million (decision to be implemented in 2026; however, preparatory work may be needed in 2025).

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:
Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:
US$ 0.27 million.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:
US$ 0.54 million.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions

- **Financial resources available to fund the decision in the current biennium:**
  US$ 0.14 million.
- **Remaining financing gap in the current biennium:**
  Zero.
- **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
  Not applicable.

Table. Breakdown of estimated resource requirements (in US$ millions)

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.14
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.14
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	0.04	0.04	0.03	0.04	0.04	0.04	0.04	0.27
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	0.04	0.04	0.03	0.04	0.04	0.04	0.04	0.27
B.4. Future bienniums cost of resources to be planned	Staff	0.08	0.08	0.06	0.08	0.08	0.08	0.08	0.54
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total	0.08	0.08	0.06	0.08	0.08	0.08	0.08	0.54
B.1. Total planned costs required to implement the decision									0.95

The second draft decision, which contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly, on promoting and prioritizing an integrated lung health approach, proposed by Bangladesh, Brunei Darussalam, China, Egypt, Ghana, Guatemala, Japan, Kuwait, Malaysia, Palestine, Qatar, Romania, Thailand and Vanuatu. The draft decision read:

> The Executive Board, having considered the report by the Director-General,[18]
>
> Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following resolution:
>
> > The Seventy-eighth World Health Assembly,
> >
> > (PP1) Noting with deep concern that in 2021, communicable and noncommunicable lung diseases, including COVID-19, were among the leading causes of mortality, causing over 18 million deaths globally;
> >
> > (PP2) Recognizing the critical importance of addressing both communicable and noncommunicable diseases that affect the lungs, including tuberculosis, pneumonia, influenza, COVID-19, chronic obstructive pulmonary disease, pulmonary fibrosis, asthma and lung cancer,[19] and the need to strengthen primary healthcare in the context of an integrated approach towards attainment of universal health coverage; and acknowledging that pulmonary diseases and other noncommunicable diseases often share the same risk factors, requiring a horizontal preventive approach;

[18] Document EB156/7.

[19] Political declaration of the high-level meeting on universal health coverage (2023). United Nations General Assembly resolution 78/4.

(PP3) Stressing the importance of comprehensive infection prevention and control measures to reduce the risk of transmission of tuberculosis, COVID-19, pneumonia, and other airborne infectious diseases, particularly in high-burden, low-income settings, and recognizing the critical role of addressing risk factors and determinants, including poor and crowded living conditions, poor ventilation and others;

(PP4) Acknowledging indoor and outdoor air pollution, whose root cause is predominantly socioeconomic in nature,[20] and its linkage with social and environmental determinants of health as one of the leading risk factors for lung diseases,[21] especially in developing countries that are disproportionately impacted, as well as the need for multisectoral engagement and action to promote lung health, prevent new cases of disease and reduce exacerbations of respiratory conditions;

(PP5) Recognizing that radon exposure is one of the leading causes of lung cancer after smoking in countries with known data, and acknowledging the lack of prevention and mitigation actions for radon exposure, as well as limited public awareness concerning radon risks;

(PP6) Reemphasizing that over 45% of tobacco-related deaths are due to lung diseases, totalling 3.3 million deaths in 2021,[22] and acknowledging that exposure to second-hand smoke causes cancer and that vaping aerosols can be harmful to lung health, which underscores the importance of primary care services for prevention of tobacco smoking, particularly tobacco and vaping control;

(PP7) Noting the substantial contribution of workplace exposures to the burden of both infectious and chronic respiratory diseases;

(PP8) Acknowledging the impact of stigma associated with lung cancer, tuberculosis and chronic obstructive pulmonary disease on access to early detection and access to treatment, noting advances in lung screening and its effectiveness in reducing mortality rates in high-risk populations;[23,24]

(PP9) Recalling United Nations General Assembly resolution 74/2 (2019) and its commitment to strengthen efforts to address noncommunicable diseases as part of universal health coverage, and the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases[25] and the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases of 2018,[26] which reaffirms the primary role and responsibility of governments in responding to the challenge of noncommunicable diseases by developing adequate national multisectoral and participative responses for their prevention and control, and the Rio Political Declaration on Social Determinants of Health (2011), considering that health inequalities are an important aspect for respiratory diseases;

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[20] See resolution WHA68.8 (2015).

[21] WHO ambient air quality database, 2022 update: status report. Geneva: World Health Organization; 2023.

[22] Institute for Health Metrics and Evaluation. Global Burden of Disease study, 2021 data.

[23] Stigma experiences in people with chronic obstructive pulmonary disease: an integrative review. Int J Chron Obstruct Pulmon Dis. 2021.

[24] Interventions to reduce lung cancer and COPD-related stigma: a systematic review. Annals of Behavioural Medicine 2024; 58 (11) 729-740.

[25] United Nations General Assembly resolution 66/2 (2011).

[26] United Nations General Assembly resolution 73/2 (2018).

(PP10) Recognizing resolution WHA72.2 (2019) on primary healthcare, in which the Health Assembly urged Member States to implement the commitments of the Declaration of Astana, resolution WHA60.26 (2007) on workers' health: global plan of action, through which Member States were urged to work towards full coverage of all workers with essential interventions and basic occupational health services for primary prevention of occupational and work-related diseases and injuries, and the significant progress of the global action plan for the prevention and control of noncommunicable diseases 2013–2020, endorsed by the Health Assembly in resolution WHA66.10 (2013), including the 2022 update of Appendix 3 to the WHO global action plan on the prevention and control of noncommunicable diseases 2013–2020, endorsed by the Health Assembly in decision WHA76(9) (2023), and the adoption of the related implementation road map 2023–2030 through decision WHA75(11) (2022), as well as the WHO global strategy on health, environment and climate change, noted through decision WHA72(9) (2019), resolution WHA68.8 (2015), entitled "Health and the environment: addressing the health impact of air pollution" and its road map, welcomed by the Health Assembly in decision WHA69(11) (2016), and resolution WHA70.12 (2017) on cancer prevention and control in the context of an integrated approach;

(PP11) Recalling resolution WHA71.3 (2018) on preparation for a high-level meeting of the General Assembly on ending tuberculosis, which reaffirmed commitment to end the tuberculosis epidemic by 2030, and the resulting political declaration of the high-level meeting on the fight against tuberculosis (2023),[27] as well as resolution WHA67.1 (2014) on the global strategy and targets for tuberculosis prevention, care and control after 2015, which set ambitious targets for reducing tuberculosis incidence and mortality; and emphasizing the importance of the WHO multisectoral accountability framework for tuberculosis to enable universal access to good-quality services, and to address all determinants and drivers of tuberculosis, such as poverty, inequalities, undernutrition, HIV, noncommunicable diseases, inadequate housing and living conditions, as an integral part of the universal health coverage agenda, including in the context of health and humanitarian emergencies;

(PP12) Recalling also resolution WHA76.5 (2023) on strengthening diagnostics capacity, resolution WHA72.8 (2019) on improving the transparency of markets for medicines, vaccines, and other health products, the global strategy and plan of action on public health, innovation and intellectual property, adopted by the Health Assembly through resolution WHA61.21 (2008) and resolution WHA67.22 (2014) on access to essential medicines;

(PP13) Reaffirming resolution WHA73.1 (2020) on COVID-19 response, which emphasized the need for equitable access to quality, safe, efficacious, effective, and affordable diagnostics, therapeutics, medicines and vaccines for the COVID-19 response consistent with the provisions of relevant international treaties, including the provisions of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) and the flexibilities within the Doha Declaration on the TRIPS Agreement and Public Health;

(PP14) Noting resolution WHA72.6 (2019) on global action on patient safety, which is crucial in the management of both communicable and noncommunicable lung diseases;

[27] See General Assembly resolution 78/5.

(PP15) Recalling the WHO Framework Convention on Tobacco Control and reaffirming the principles of primary healthcare as the basis for strengthening health systems;

(PP16) Building on the successes of the integrated approaches to disease management, including WHO's existing instruments such as the Practical Approach to Lung Health (PAL), the Package of Essential Noncommunicable Disease Interventions (PEN) and the Integrated Management of Childhood Illness (IMCI) in improving health outcomes, and their potential for integrated lung health programmes,

(OP)1. URGES Member States,[28] considering national context and priorities, and in alignment with relevant policies on addressing communicable, noncommunicable and occupational lung diseases:

(1) to develop integrated national policy for an integrated approach to lung health, encompassing both communicable and noncommunicable lung diseases, through multisectoral collaboration, multidisciplinary collaboration and by incorporating whole-of-government and whole-of-society approaches, ensuring engagement from all relevant sectors including health, environment, labour, education, and finance;

(2) to incorporate an integrated approach to lung health into primary healthcare services towards the attainment of universal health coverage, inclusive of comprehensive lung health services, with effective referral pathways to secondary and tertiary care, when appropriate;

(3) to strengthen awareness of the health impacts of air pollution and enhance national air quality standards and monitoring capacity;

(4) to create and enforce adequate regulations protecting workers from occupational risk factors impacting lung health;

(5) to strengthen existing, or establish new, comprehensive integrated approach lung health programmes including:

(a) strengthening health promotion, primary preventive services – particularly tobacco and vaping control, reducing indoor and outdoor air pollution exposure – and vaccination programmes for preventable respiratory infections;

(b) updating or developing evidence-based clinical and public health guidelines for cost-effective measures for early detection, diagnosis, and treatment of communicable and noncommunicable lung diseases, including the use of innovative technologies;

(c) updating or developing evidence-based information mechanisms for policy-making and programme monitoring, evaluation and learning;

(6) to strengthen national capacities for an integrated approach on lung health, considering adaptation of relevant existing and evidence-based WHO tools to create an evidence-based and cost-effective integrated lung health package of interventions suitable for all patients, according to their individual needs;

(7) to improve access to and affordability and availability of safe, effective and quality medicines, vaccines and health technologies using the WHO Model List of Essential Medicines and the WHO Model List of Essential In Vitro Diagnostics with an emphasis on cost-effectiveness, sustainable allocation of resources, and evidence-based approaches including by increasing national capacities, and with

[28] And, where applicable, regional economic integration organizations.

a focus on building effective regulatory systems, manufacturing capacities and/or procurement strategies and policies for fair pricing to address both communicable and noncommunicable lung diseases, including tuberculosis, pneumonia, influenza and COVID-19, as well as chronic obstructive pulmonary disease, asthma, pulmonary fibrosis and lung cancer;

(OP)2. REQUESTS the Director-General:

(1) to map existing strategies, road maps and WHO normative work and instruments relating to relevant lung conditions and risk factors, which would help to inform an integrated lung health approach and identify existing gaps and needs in addressing prevention, diagnosis and treatment of and rehabilitation from communicable and noncommunicable diseases;

(2) to provide an initial report with recommendations and key components to further strengthen an integrated lung health approach, to consider steps to improve implementation of existing strategies and plans in the context of an integrated lung health approach and to consider new initiatives, including a framework for tracking implementation of such strategies, plans and new proposals with clear measurable targets in consultation with Member States and other relevant stakeholders in line with the Framework of Engagement with Non-State Actors, as applicable, and to submit the report for consideration by the Eightieth World Health Assembly in 2027;

(3) to collaborate with relevant stakeholders in line with the Framework of Engagement with Non-State Actors, as applicable, to mobilize commitment and resources, build capacity, and foster collaborative research on the integrated lung health approach;

(4) to support Member States in strengthening their primary healthcare systems to effectively deliver integrated lung health services to strengthen universal health coverage, promoting a life-course approach to lung health;

(5) to strengthen the capacity of the Secretariat to support the implementation of cost-effective interventions and country-adapted models of care for both communicable and noncommunicable lung diseases, including tuberculosis, pneumonia, influenza, and COVID-19, as well as chronic obstructive pulmonary disease, asthma, pulmonary fibrosis and lung cancer;

(6) to report on progress made in implementing this resolution to the Eightieth World Health Assembly in 2027 and the Eighty-first World Health Assembly in 2028.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[29]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:

1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary healthcare strategies and comprehensive essential service packages

1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results

3.2.1. Countries enabled to address risk factors through multisectoral action

3.3.1. Countries enabled to address environmental determinants of health, including climate change

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:

Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:

Not applicable.

4. Estimated time frame (in years or months) to implement the decision:

Six years (2025–2030).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:

US$ 12.48 million.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:

US$ 1.98 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:

Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:

US$ 4.10 million.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:

US$ 6.40 million.

[29] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic “bridge” between results structures can be provided as needed.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions

– **Financial resources available to fund the decision in the current biennium:**
US$ 1.98 million.

– **Remaining financing gap in the current biennium:**
Zero.

– **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Not applicable.

Table. Breakdown of estimated resource requirements (in US$ millions)[a]

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	0.23	0.26	0.19	0.26	0.18	0.20	0.36	1.68
	Activities	0.02	0.02	0.02	0.02	0.02	0.02	0.21	0.30
	Total	0.25	0.28	0.20	0.27	0.20	0.21	0.57	1.98
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	0.48	0.54	0.39	0.53	0.38	0.41	0.75	3.49
	Activities	0.03	0.03	0.03	0.03	0.03	0.03	0.43	0.61
	Total	0.51	0.57	0.42	0.56	0.42	0.44	1.18	4.10
B.4. Future bienniums cost of resources to be planned	Staff	0.75	0.85	0.61	0.83	0.60	0.64	1.17	5.44
	Activities	0.05	0.05	0.05	0.05	0.05	0.05	0.67	0.96
	Total	0.80	0.89	0.66	0.88	0.65	0.68	1.84	6.40
B.1. Total planned costs required to implement the decision									12.48

[a] The row and column totals may not always add up, owing to rounding.

The third draft decision, which contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly, on reducing the burden of noncommunicable diseases through promotion of kidney health and strengthening prevention and control of kidney disease, proposed by Armenia, Burkina Faso, Chile, Ecuador, Georgia, Guatemala, Malaysia, Mexico, the Federated States of Micronesia, Nauru, Panama, Romania, Somalia, Spain, Thailand, Ukraine and Vanuatu. The draft decision read:

The Executive Board, having considered the report by the Director-General,[30]

Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following resolution:

The Seventy-eighth World Health Assembly,
(PP1) Having considered the report by the Director-General;

[30] Document EB156/7.

(PP2) Recognizing the right of every human being, without distinction of any kind, to the enjoyment of the highest attainable standard of physical and mental health;

(PP3) Reaffirming our collective commitment to reduce premature mortality from noncommunicable diseases (NCDs) by one-third, and achieving the targets in the WHO global action plan for the prevention and control of NCDs 2013–2030 (WHA66.10 (2013) and WHA72(11) (2019)) as committed to in the Political Declarations of the three High-Level Meetings of the General Assembly on the Prevention and Control of NCDs (A/RES/66/2; A/RES/68/300; A/RES/73/2), including the nine voluntary global targets to prevent and control NCDs to be achieved by 2025, through effective health promotion and diseases prevention, resilient health systems, an adequate, well trained and committed health workforce, universal health coverage (UHC) and people-centred health services as well as the need to promote access and maintain essential NCD services in emergencies and humanitarian settings (A/RES/78/4);

(PP4) Reaffirming our commitment to accelerate the implementation of the 2019 and 2023 Political Declarations of the High-Level Meetings of the General Assembly on UHC, by providing financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and cost-effective essential medicines and vaccines for all; [A/RES/74/2 and A/RES/78/4];

(PP5) Recognizing that approximately 674 million people live with chronic kidney disease, comprising 9% of the global population[31] and concerned that kidney disease is one of the fastest-growing causes of death globally and is projected to become the fifth leading cause of death by 2050, with a projected 33% increase in age-standardized death rate and a 28% increase in age-standardized disability-adjusted life years (DALYs) if no action is taken;

(PP6) Recalling resolution WHA77.4 on increasing the availability, ethical access, and oversight of the transplantation of human cells, tissues, and organs, which urges countries to adopt preventive strategies and incorporate transplantation into the continuum of care of non-communicable and other diseases that may lead to the need for transplantation in accordance with their national contexts, and that requests the Director-General to support Member States in implementing the elements of the Resolution, particularly through the design of a Global Strategy on Donation and Transplantation.

(PP7) Concerned that access to kidney care is highly inequitable worldwide, especially in resource-limited settings where kidney disease often goes undiagnosed and untreated, leaving millions at risk of death;

(PP8) Concerned that in many developing countries, including Small Island Developing States, individuals bear heavy financial burdens needing to pay out-of-pocket for kidney care, as only a small percentage of these countries provide coverage for kidney replacement therapy (dialysis and transplantation), making kidney disease the leading cause of catastrophic health expenditure;

(PP9) Concerned that kidney disease significantly impacts economies and societies, requires complex management, and contributes disproportionately to national healthcare costs;

(PP10) Recognizing that kidney disease affects many individuals with common risk factors and it is present in 1 in 5 people with hypertension and occurs in 4 of 10

[31] Including but not restricted to social, environmental, commercial, and economic determinants.

people with diabetes, contributing to 1 in 10 deaths attributed to hypertension and accounting for a substantial proportion of morbidity and mortality related to diabetes;

(PP11) Aware that cost-effective medications for kidney disease are now available, and continue to be developed, and can dramatically reduce morbidity and mortality from kidney disease as well as other NCDs that often coexist with kidney disease, such as hypertension, diabetes, and cardiovascular disease (A74/A/CONF./5), but concerned that these highly effective medicines, as well as diagnostics and consumables necessary for the spectrum of kidney care, are unaffordable or unavailable in many developing countries;

(PP12) Recognizing that kidney disease is a preventable, but potentially fatal consequence of many infections in adults, adolescents and children, including malaria, dengue fever, HIV, tuberculosis, hepatitis, sepsis, COVID-19, diarrheal illnesses, and neglected tropical diseases;

(PP13) Recognizing that kidney disease is a significant risk factor for, and consequence of, hypertensive disorders of pregnancy (impacting 1 in 10 pregnancies) and that both kidney disease and hypertensive disorders of pregnancy are associated with maternal mortality, and preterm and low-birth-weight neonates, who are at higher risk of kidney disease;

(PP14) Recognizing that kidney health is strongly impacted across the life course by all determinants[32] of health, environmental factors, and climate change, most disproportionately affecting developing countries and Small Island Developing States;

(PP15) Recognizing the urgent need to address, where appropriate, the social and environmental determinants of health, including climate change, to control the epidemic of chronic kidney disease of unknown origin which disproportionately affects young people in agricultural communities, which places kidney disease among the top four causes of death in some regions;

(PP16) Recognizing that the majority of people living with kidney disease have multiple comorbidities requiring specialized care across sectors to manage various health issues effectively, and that kidney disease significantly impacts mental health, causing stress, anxiety, and depression, which further contribute to the decline in their health-related quality of life;

(PP17) Acknowledging that efforts have been made to strengthen services for treating NCDs in emergencies (document A75/10 Add.2 – Annex 4) but recognizing that persons living with kidney disease remain highly vulnerable in humanitarian settings, especially those living on dialysis or with kidney transplants;

(PP18) Recognizing the importance of public awareness, health literacy, patient education and empowerment, community engagement, and policy action in controlling risk factors for, and improving outcomes in individuals affected by kidney disease;

(PP19) Emphasizing the importance of integrating kidney health and the spectrum of kidney care into broader and holistic strategies for preventing and controlling NCDs and recognizing the need for multisectoral approaches (document EB154/7);

(PP20) Considering that among the different types of kidney replacement therapies, kidney transplantation should be the preferred option for medically eligible patients with kidney failure, who should be systematically considered for this kind of

[32] Including but not restricted to social, environmental, commercial, and economic determinants.

treatment in accordance with their national context, as it provides better survival and quality of life at a lower cost and environmental impact compared to dialysis; and

(PP21) Acknowledging that World Kidney Day is celebrated annually on the second Thursday of March to increase public awareness and engagement, enhance global understanding, and work towards global solidarity and action by Member States to promote kidney health,

(OP)1. URGES Member States,[33] in accordance with their national context and priorities, to:

(1) invest in health systems to integrate prevention, early detection, and management of kidney disease into national health policies and inclusion of kidney management into UHC benefit packages, with the aim to provide financial risk protection and universal access to the full spectrum of quality and sustainable kidney care services (to progressively include peritoneal and hemodialysis, kidney transplantation, and conservative kidney care) (EB154(7)) delivered by an adequately trained health workforce, to all individuals without any discrimination, with particular emphasis on those at risk, in vulnerable and marginalized situations, including Indigenous Peoples (WHA76.16 (2023)), pregnant women, and children (WHA77.5 (2024)) and to ensure that all patients have equitable access to appropriate care;

(2) promote multisectoral and multi-stakeholder collaboration, with appropriate governmental oversight, to develop and support the progressive provision of comprehensive, uninterrupted and sustainable kidney care services and with appropriate regulation to ensure quality of service delivery;

(3) strengthen interventions to address the determinants[34] of key risk factors for kidney disease, through the fullest application of WHO “Best Buys” interventions, and using a total risk approach with the aim to control diabetes and hypertension and prevent or delay progression of chronic kidney disease to end stage kidney failure, as well as providing policy, education, public awareness campaigns, and
community-based interventions, aligning with the targets set out in the WHO global action plan for the prevention and control of NCDs 2013-2030 (WHA66.10 and WHA72(11));

(4) strengthen and integrate the monitoring of kidney disease burden, access to care, quality of care and morbidity and mortality outcomes into national health information systems, to inform policy decisions and guide research;

(5) strengthen country institutional capacity to conduct health intervention and technology assessments to guide the progressive scale-up of cost-effective and sustainable government health programs to address kidney disease in a comprehensive manner;

(6) take measures to promote progressive access to kidney replacement therapy, of which kidney transplantation is preferred, enabling timely referral for transplantation, as well as by implementing interventions to maximize the availability of organs for clinical use aligned with the WHO Guiding Principles on human cell, tissue and organ transplantation;

[33] And, where applicable, regional economic integration organizations.

[34] Including but not restricted to social, environmental, commercial, and economic determinants.

(7) promote multisectoral collaboration and actions to address all determinants[56] of NCDs risk factors , including the impacts of climate change, which lead to chronic kidney disease, and foster partnerships with professional organizations, civil society, advocacy groups, and the private sector to strengthen health promotion, increase public awareness of kidney diseases and its determinants, improve health literacy by providing accessible, high-quality, patient-friendly information and education;

(8) promote regional collaboration, in line with existing exchange formats where applicable, particularly in regions with similar epidemiological profiles, with an aim to share best practices, resources, and expertise in preventing and managing kidney disease; and

(9) support research on kidney disease to advance the understanding of etiologies and risk factors specific to regions, countries and local context, and to develop responsive implementation strategies for prevention and control of kidney disease, treatments, and technologies.

(OP)2. REQUESTS the Director General:

(1) to advance kidney disease as an NCD of increasing global priority, in addition to cancer, cardiovascular diseases (heart disease and stroke), diabetes and respiratory diseases, as well as mental health, which have been recognized as the major causes of death and disability;

(2) to provide technical support to Member States, upon request, to strengthen and improve the design, assessment, and implementation of national policies for preventing and managing kidney disease across all relevant disease programs, including monitoring and evaluation of kidney care program implementation and outcomes, to improve quality and access to care.

(3) to provide technical support to Member States, upon request, to strengthen implementation of the WHO “Best Buys” to address all determinants[35] of NCD which contribute to chronic kidney diseases, and to strengthen integration of comprehensive kidney care into UHC benefit packages;

(4) to support Member states, upon request, to strengthen information systems (including civil registries and vital statistics) to produce evidence, *inter alia* including risk factors, kidney disease prevalence, access to kidney care, unmet healthcare needs, and associated morbidities and mortality, particularly in developing countries and Small Island Developing States; to inform policy and program development, guide research and promote the establishment and maintenance of kidney disease registries;

(5) to facilitate the sharing of knowledge, best practices, clinical guidelines, evidence-based interventions for preventing and managing kidney disease and experiences in addressing major risk factors, including diabetes and hypertension; support strengthening of education and training and retention of a multidisciplinary kidney workforce;

(6) to develop and share guidance for sustainable financing for CKD prevention, diagnostics, and treatment, prioritizing equitable access to comprehensive kidney care and financial risk protection, especially in developing countries and Small Island Developing States;

[35] Including but not restricted to social, environmental, commercial, and economic determinants.

(7) to support Member States to maintain uninterrupted treatment of people living with kidney disease during health emergencies and in all humanitarian settings; and

(8) to report to the Health Assembly on progress in implementing the present resolution, including achievements, challenges and recommendations for further action as part of the consolidated reporting on the progress achieved in the prevention and control of NCDs, with biennial reports to be submitted to the Health Assembly through the Executive Board in 2027, 2029 and 2031.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[36]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:

1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary healthcare strategies and comprehensive essential service packages

1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results

1.2.1. Countries enabled to develop and implement equitable health financing strategies and reforms to sustain progress towards universal health coverage

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:

Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:

Not applicable.

4. Estimated time frame (in years or months) to implement the decision:

Seven years (2025–2031).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:

US$ 16.27 million.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:

US$ 2.57 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:

Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:

US$ 5.35 million.

[36] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic “bridge” between results structures can be provided as needed.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:
US$ 8.35 million.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions

– **Financial resources available to fund the decision in the current biennium:**
Zero.

– **Remaining financing gap in the current biennium:**
US$ 2.57 million.

– **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Given that there are currently no human nor financial resources available to respond, the Secretariat would have to suspend any activities requested for the current biennium and launch a dedicated resource mobilization plan for future bienniums.

Table. Breakdown of estimated resource requirements (in US$ millions)[a]

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	0.15	0.18	0.13	0.12	0.14	0.14	0.32	1.19
	Activities	0.11	0.11	0.11	0.11	0.11	0.11	0.74	1.39
	Total	0.26	0.29	0.24	0.22	0.24	0.25	1.06	2.57
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	0.32	0.38	0.27	0.24	0.28	0.30	0.67	2.46
	Activities	0.22	0.22	0.22	0.22	0.22	0.22	1.54	2.88
	Total	0.55	0.61	0.50	0.46	0.51	0.52	2.21	5.35
B.4. Future bienniums cost of resources to be planned	Staff	0.50	0.59	0.42	0.37	0.44	0.46	1.05	3.85
	Activities	0.35	0.35	0.35	0.35	0.35	0.35	2.40	4.50
	Total	0.85	0.94	0.77	0.72	0.79	0.81	3.44	8.35
B.1. Total planned costs required to implement the decision									16.27

[a] The row and column totals may not always add up, owing to rounding.

The fourth draft decision, which contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly, on primary prevention and integrated care for sensory impairments including vision impairment and hearing loss, across the life course, proposed by Bangladesh, Georgia, Hungary, Japan, The Federated States of Micronesia, Panama, Romania, Somalia and Slovakia. The draft decision read:

The Executive Board, having considered the report by the Director-General,[37]

[37] Document EB156/7.

Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following resolution:

The Seventy-eighth World Health Assembly,

(PP1) Having considered the report by the Director-General;

(PP2) Having considered the World report on vision[38] and the World report on hearing[39] and recalling resolutions WHA66.4 (2013) on a global action plan 2014–2019 towards universal eye health,[40] WHA70.13 (2017) on prevention of deafness and hearing loss,[41] WHA73.4 (2020) on integrated people-centred eye care, including preventable vision impairment and blindness,[42] United Nations General Assembly resolution 75/310 entitled "Vision for Everyone: accelerating action to achieve the Sustainable Development Goals",[43] resolution WHA72.12 (2019) on primary healthcare,[44] the endorsement of the first-ever global targets for refractive error and cataract surgery at the Seventy-fourth World Health Assembly;[45]

(PP3*)* Recalling the United Nations Convention on the Rights of Persons with Disabilities[46] and the UN Decade of healthy ageing (2021–2030), endorsed by the World Health Assembly and proclaimed by the United Nations General Assembly;

(PP4) Recognizing that at least 2.2 billion individuals are affected by vision impairment and 1.5 billion individuals by hearing loss, and noting that the prevalence of such impairments (including sensory disabilities)[47] is projected to rise due to population growth, ageing demographics, and changes in lifestyle patterns; [48,49]

(PP5) Expressing concern regarding the increasing impact of additional risk factors, including extended exposure to digital devices, excessive noise levels in occupational, domestic, and recreational settings, and also insufficient time spent outdoors during childhood, contributing to sensory impairments;

(PP6) Acknowledging that the incidence and prevalence of unaddressed vision impairment and hearing loss remains disproportionately high in low- and middle-income countries (LMICs), Small Island Developing States (SIDS), and settings affected

[38] WHO World report on vision (2019).

[39] WHO World report on hearing (2021).

[40] Resolution WHA66.4 (2013).

[41] Resolution WHA70.13 (2017).

[42] Resolution WHA73.4 (2020).

[43] United Nations General Assembly resolution 75/310.

[44] Resolution WHA72.12 (2019).

[45] Document WHA74/9 Add.3.

[46] Convention on the Rights of Persons with Disabilities, 24 January 2007. United Nations General Assembly resolution 61/106 (2007).

[47] The term "sensory impairments" refers to all grades of impairments that affect one or more of the sensory functions, ranging from mild vision and hearing impairments to blindness and deafness. The United Nations Convention on the Rights of Persons with Disabilities recognizes "that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others" (Preambular paragraph (e)) and acknowledges the importance of addressing barriers in society in order to support participation.

[48] WHO World report on vision (2019).

[49] WHO World report on hearing (2021).

by different emergencies, often due to limited or inadequate access to affordable, equitable, and quality essential health and care services and health products;

(PP7) Recognizing also that many of the causes of vision impairment and hearing loss can be effectively prevented through access to primary care services and strengthened universal health coverage and other public health interventions, such as vitamin A supplementation, immunization, provision of corrective lenses and provision of hearing aids and implants, prevention of ocular trauma, measures to mitigate noise exposure and ototoxicity, as well as the timely detection and effective management of eye disease or otitis media;

(PP8) Aware that recent technological advancements that facilitate the screening and detection of vision impairment and hearing loss, including their underlying conditions, across all age groups and diverse settings, and recognizing the availability of cost-effective and quality interventions, including cataract surgery and assistive technologies such as spectacles, hearing aids, implants, and rehabilitative services as well as reasonable accommodations, such as sign language interpreters, Braille literacy, which can reduce the barriers to active participation in society for those with sensory impairments;

(PP9) Expressing concern over the significant impact of unaddressed vision impairment and hearing loss which in interaction with barriers in society, can affect daily communication, child development, educational achievement, employment opportunities, social integration, and participation, and the overall financial well-being of affected individuals; further recognizing the established link between sensory impairment, cognitive decline, and dementia, and noting the estimated economic impact, exceeding US$ 980 billion annually, for unaddressed hearing loss[50] and US$ 410.7 billion for unaddressed vision impairment globally;[51]

(PP10) Acknowledging that the economic impact posed by hearing loss or vision impairment is attributable to loss of productivity, stigma, and social exclusion posed when these impairments remain unaddressed;

(PP11) Expressing additional concern about barriers to the availability, affordability, and accessibility of eye, vision, ear, and hearing care services, particularly at the community and primary healthcare levels, including limited public awareness, shortage of trained health personnel, inadequate infrastructure and policies, inadequate sustainable financing, high out-of-pocket costs for care resulting in significantly lower intervention coverage, especially within underserved communities and individuals experiencing social, economic, or systemic disadvantages. Further noting the lack of comprehensive inclusion of relevant services in national health benefit packages and universal health coverage, and insufficient data for relevant national monitoring, and evaluation frameworks;

(PP12) Recalling that persons with disabilities include those who have one or more long-term physical, mental, intellectual, psychosocial, or sensory impairments, which in interaction with various environmental, financial, legal, and attitudinal barriers in society, including discrimination and stigmatization, may hinder their full and effective participation in society on an equal basis with others, and may limit their access to essential health and care services, including eye, vision, ear and hearing care,

[50] McDaid D, Park AL, Chadha S. Estimating the global costs of hearing loss. Int J Audiol. 2021 Mar;60(3): 162-170. doi: 10.1080/14992027.2021.1883197. Epub 2021 Feb 16. PMID: 33590787.

[51] Burton MJ, Ramke J, Marques AP, et al. The Lancet Global Health Commission on Global Eye Health: vision beyond 2020. Lancet Glob Health. 2021;9(4):e489-e551. doi:10.1016/S2214-109X(20)30488-5.

as well as recalling the need for reliable, comparable, and disaggregated data by disability;

(PP13) Recognizing that eye, vision, ear, and hearing care encompasses health promotion, prevention, identification, treatment, and rehabilitation for eye and ear conditions, as well as interventions for hearing loss or vision impairments;

(PP14) Noting that integration of evidence-based policies, including for eye, vision, ear, and hearing care can provide significant benefits for individuals with sensory impairments and disabilities, by enhancing language and communication, supporting social connection, educational attainment, and employment opportunities, while also reducing the risk of cognitive decline, and yielding an estimated return of approximately US$ 20 for every dollar invested in prevention and care;[52,53]

(PP15) Reaffirming the commitments to action outlined in previous resolutions, including WHA70.13 on prevention of hearing loss and deafness; WHA73.4 on integrated people-centred eye care, including preventable vision impairment and blindness;[54] WHA74.8 on the highest attainable standard of health for persons with disabilities;[55] WHA76.6 on strengthening rehabilitation in health systems[56] and WHA71.8 on improving access to assistive technology;[57]

(PP16) Recalling the Draft Implementation Roadmap 2023–2030,[58] for the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2030,[59] and aligning efforts with the Sustainable Development Goals 3 and 4,* which recognize needs and equitable access to quality healthcare and education for all including persons with disabilities;

(PP17) Noting with concern that eye and ear diseases as well as vision impairment and hearing loss are commonly not sufficiently addressed within the primary healthcare frameworks that span the entire life cycle thus leaving significant gaps in service provision for those affected;

(PP18) Reaffirming the obligation to provide health and care services based on free, prior and informed consent and respecting and promoting human rights, dignity, autonomy, and legal capacity, and to respect the diversity and needs of persons with disabilities, including through education and training for health and care workforce, and the promulgation of ethical standards for public and private health and care services;

(PP19) Appreciating the longstanding and continued efforts made by the WHO Secretariat, Member States and international partners to prevent and address eye and ear diseases and mitigate the impact of vision impairment and hearing loss, while

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[52] Tordrup D, Smith R, Kamenov K, et al. Global return on investment and cost-effectiveness of WHO's HEAR interventions for hearing loss: a modelling study. Lancet Glob Health. 2022;10(1):e52-e62. doi:10.1016/S2214-109X(21)00447-2.

[53] Transforming Lives: An Investment Case for Eye Health, The Fred Hollows Foundation.

[54] Resolution WHA73.4 (2020).

[55] Resolution WHA74.8 (2021).

[56] Resolution WHA76.6 (2023).

[57] Resolution WHA71.8 (2018).

[58] Draft implementation road map for NCDs 2023–2030.

[59] Global action plan for the prevention and control of noncommunicable diseases 2013–2020.

*disassociation by Argentina.

acknowledging the urgent need for widespread, sustained and focused public health actions to strengthen efforts to prevent hearing loss and vision impairment,

(OP)1. URGES Member States,[60] in line with their own national context and priorities:

(1) To adopt or adapt and implement the recommendations outlined in the *World report on vision* and *World report on hearing*, incorporating comprehensive eye, vision, ear and hearing care across the life course as a core element within national health plans, as appropriate and primary healthcare initiatives as part of achieving Universal health Coverage (UHC);

(2) To support individuals with vision impairments, hearing loss, and sensory disabilities by promoting access to comprehensive and integrated health and care services, including eye, vision, ear, and hearing care throughout their lives, with emphasis on equitable access to assistive technologies, rehabilitation services, and inclusive communication features such as access to sign language and interpretation, captioning, and other accessibility features;

(3) To integrate systematic vision and hearing screening and early intervention services within health and care services across the life course, focusing on high-risk populations;

(4) To expand, where relevant, the availability of, and build the capacity of qualified human resources to deliver eye, vision, ear, and hearing care by education and training healthcare workers at the primary level, fostering innovative practices and service delivery approaches;

(5) To adopt regulations on the scope of practice and competencies to ensure a high quality of care across the continuum of care;

(6) To set and implement policies, in line with WHO published norms and standards, for the provision and use of protective equipment, and control of noise in occupational settings, at entertainment venues, and through personal audio systems, as well as for control of ototoxic medicines and chemicals;

(7) To ensure the integration of eye, vision, ear, and hearing care into national health benefit packages and services and strengthen the sustainability of financing mechanisms for spectacles, hearing aids, and implants, by incorporating into health benefit packages and services, and provisions for underserved communities, where necessary;

(8) To undertake high-quality public health research on eye, vision, ear and hearing care;

(9) To strengthen monitoring and evaluation of eye, vision, ear, and hearing care services and assistive technologies, through appropriate surveillance and monitoring systems, including integrating indicators for monitoring eye, vision, ear, and hearing care services and assistive technologies within national health information systems, as appropriate, surveys and quality assurance programmes and health technology assessment;

(10) To ensure that social integration and economic policies should seek to reduce inequalities, promote access to basic social services, education, lifelong learning opportunities for all and health and care services, including for mental health and psychosocial well-being, eliminate discrimination, increase the participation and integration and inclusion of social groups, particularly persons with sensory impairments and disabilities;

[60] And, where applicable, regional economic integration organizations.

(OP)2. CALLS UPON relevant partners, including intergovernmental and nongovernmental organizations, the private sector, organizations of persons with disabilities and their representative organizations, and academia:

(1) To provide, in collaboration with Member States, technical support for the national implementation of the recommendations contained in the *World Report on Vision* and *World Report on Hearing*, including the development and implementation of evidence-based and evidence-informed guidelines and policies;

(2) To support Member States through, among others, encouraging public–private partnerships that are aligned with national plans, legislation, and priorities, to expand eye, vision, ear, and hearing care coverage in countries, while ensuring that such care is accessible, sustainable, affordable, and of high-quality and respecting data privacy;

(3) To support monitoring efforts for eye, vision, ear, and hearing care, including through data sharing on health products across the value chain and the promotion of consumer protection-related best practices for audio-visual personal products; and

(4) To strengthen coordination and multisectoral approaches involving Member States, WHO, multilateral institutions, civil society organizations, private sector entities, organizations of persons with disabilities and their representative organizations and the active engagement from communities at large, for equitably expanding access to eye, vision, ear and hearing care;

(OP)3. REQUESTS the Director-General:

(1) to provide technical support to Member States for integrating eye, vision, ear, and hearing care into primary healthcare as part of efforts to achieve universal health coverage and improve the effective coverage of hearing aids, implants and spectacles among the affected population;

(2) to provide guidance for integration of vision and hearing screening and early intervention services into school-based and occupational-based programmes and other relevant public health and NCD approaches across the life course approach;

(3) to work in collaboration with Member States and industry partners, in line with FENSA, as applicable, for the adoption of relevant norms and standards for safe vision and listening and to drive behaviour change in the target population for the prevention of hearing loss and vision impairments including, where relevant, through implementing “MyopiaEd” and the Make Listening Safe initiative;

(4) continue the annual observance of both World Hearing Day and World Sight Day, to raise awareness on sensory impairments including eye, vision, ear and hearing care, while also reducing stigma associated with vision impairment and hearing loss and the use of assistive devices;

(5) strengthen global collaboration for eye, vision, ear, and hearing care through the World Hearing Forum and the SPECS 2030 Initiative;

(6) coordinate data collection to monitor global progress, including progress toward the 2030 eye, vision, ear, and hearing care targets;

(7) create guidance on how to integrate eye, vision, ear, and hearing care into overall public financing systems (beyond the health sector alone) and take into account the specific needs of persons with disabilities, in particular with sensory disabilities;

(8) report back on progress in the implementation of this resolution to the World Health Assembly in 2027, 2029 and 2031.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[61]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:
1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary healthcare strategies and comprehensive essential service packages

1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:
Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:
Not applicable.

4. Estimated time frame (in years or months) to implement the decision:
Six years (2025–2030).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:
US$ 18.35 million.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:
US$ 2.90 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:
Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:
US$ 6.03 million.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:
US$ 9.42 million.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions

- **Financial resources available to fund the decision in the current biennium:**
  US$ 1.90 million.
- **Remaining financing gap in the current biennium:**
  US$ 1.00 million.
- **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
  US$ 1.00 million will be mobilized from donors.

[61] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic “bridge” between results structures can be provided as needed.

Table. Breakdown of estimated resource requirements (in US$ millions)[a]

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	0.26	0.21	0.18	0.11	0.19	0.20	1.05	2.19
	Activities	0.09	0.09	0.09	0.09	0.09	0.09	0.15	0.71
	Total	0.36	0.30	0.27	0.20	0.28	0.29	1.20	2.90
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	0.55	0.43	0.36	0.23	0.39	0.41	2.18	4.55
	Activities	0.19	0.19	0.19	0.19	0.19	0.19	0.32	1.49
	Total	0.74	0.63	0.56	0.42	0.59	0.60	2.49	6.03
B.4. Future bienniums cost of resources to be planned	Staff	0.86	0.68	0.57	0.35	0.61	0.64	3.40	7.10
	Activities	0.30	0.30	0.30	0.30	0.30	0.30	0.50	2.32
	Total	1.16	0.98	0.87	0.65	0.92	0.94	3.89	9.42
B.1. Total planned costs required to implement the decision									18.35

[a] The row and column totals may not always add up, owing to rounding.

The fifth draft decision, which contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly, on world cervical cancer elimination day, proposed by Armenia, Bangladesh, Botswana, Egypt, Ethiopia, Jamaica, Lesotho, Nigeria, Palestine, the Philippines, Rwanda, South Africa, the United Republic of Tanzania and Zambia. The draft decision read:

> The Executive Board, having considered the report by the Director-General,[62]
>
> Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following resolution:
>
> > The Seventy-eighth World Health Assembly,
> >
> > (PP1) Having considered the report by the Director-General;
> >
> > (PP2) Recalling resolution WHA73.2 (2020) which, inter alia, adopted the Global strategy to accelerate the elimination of cervical cancer as a public health problem, urged Member States to take actions to accelerate the elimination of cervical cancer through the prevention including with vaccination, detection and treatment, including holistic systems approach to cervical cancer programme, called upon international organizations and stakeholders to prioritize activities to eliminate cervical cancer through prevention, including with vaccination, detection and treatment, requested the Director-General to support Member States to implement the Global strategy and strengthen stakeholder engagement to achieve the 2030 targets;
> >
> > (PP3) Recalling the 2030 Agenda for Sustainable Development, especially Goal 1 (End poverty in all its forms everywhere), Goal 3 (Ensure healthy lives and promote

[62] Document EB156/7.

well-being for all at all ages), Goal 5 (Achieve gender equality and empower all women and girls) and Goal 10 (Reduce inequality within and among countries);

(PP4) Recognizing every human beings' right to the enjoyment of the highest attainable standard of physical and mental health without discrimination;

(PP5) Recognizing also the importance of prioritizing health of women and girls especially those living with HIV and addressing the associated stigmas, gender inequality and barriers to accessing healthcare services related to cervical cancer; by promoting universal access to sexual and reproductive healthcare services, HPV vaccination, cervical cancer screening, and treatment, as part of an integrated healthcare system, in accordance with national priorities and contexts;

(PP6) Recognizing the disproportionate burden on women living with HIV, who are more likely to develop cervical cancer;

(PP7) Recognizing that cervical cancer is preventable and treatable and curable if detected early and adequately treated yet it remains among the most common causes of cancer-related morbidity and death in women across the world, can increase infertility, with a disproportionate burden in developing countries;

(PP8) Recognizing also the efforts of WHO, including its regional and national offices, the International Agency for Research on Cancer (IARC), and other international organizations in strengthening the capacity of frontline health workers through training in screening and treatment techniques, as well as education on vaccines;

(PP9) Recognizing the need to promote access to cervical cancer screening services, potentially including the availability of the self-sampling that may offer a sense of empowerment and participation;

(PP10) Recognizing that HPV is the leading cause of cervical cancer in women and can also lead to other cancers in men and women and that despite the availability of vaccines, vaccination coverage against HPV in girls under 15 years is far from the goal of 90% by 2030;

(PP11) Recognizing that effective primary (HPV vaccination) and secondary prevention approaches (screening for, and treating precancerous lesions) can prevent most cervical cancer cases;

(PP12) Emphasizing that HPV vaccination, screening and treatment of pre-cancer lesions are very cost-effective strategies to prevent cervical cancer;

(PP13) Recognizing that boosting public awareness, access to information and services are important elements for prevention and control of diseases across the life course;

(PP14) Noting the historic nature of resolution WHA73.2, the first-ever resolution to pursue the global elimination of a cancer, and the accompanying launch of the Global strategy to accelerate the elimination of cervical cancer as a public health problem on 17 November 2020;

(PP15) Noting the positive responses in all regions to the launch of the global strategy, as well as sustained advocacy, planning, action and health promotion activities that have continued on 17 November each year to mark the same day, thereby encouraging community collaboration, promoting cervical cancer prevention early detection and treatment services, and maintaining attention on the importance of solidarity across countries in pursuit of the world's first elimination of a cancer,

(OP)1. URGES Member States:

(1) to designate 17 November as the World Cervical Cancer Elimination Day to be observed each year beginning from November 2025, in order to further stimulate and sustain global efforts toward cervical cancer elimination;

(2) to enable sufficient/adequate resources to expand healthcare services for cervical cancer elimination efforts, in accordance with national priorities and contexts, and in the context of achieving universal health coverage; and

(3) to promote and support the annual commemoration of World Cervical Cancer Elimination Day to achieve equitable access for universal health coverage;

(OP)2. REQUESTS the Director-General:

(1) to utilize World Cervical Cancer Elimination Day to continue strengthening stakeholder engagement, in line with FENSA as applicable, for coordination, innovation and resource mobilization towards supporting Member States' efforts to eliminate cervical cancer pursuant to WHA73.2 and applicable mandates;

(2) to continue highlighting Member States' efforts to accelerate the elimination of cervical cancer as a public health problem and to strengthen population-based cancer registries and employ cervical cancer vaccination and screening registries needs to measure progress towards the elimination targets, including through measurable progress toward elimination and emphasizes that a key measure in ensuring early and easily, accessible HPV vaccination; and

(3) to coordinate efforts and engage across all three levels of WHO, including at the regional level, with the aim of harmonizing activities, fostering collaboration and maximizing the impact of awareness and prevention campaigns to eliminate cervical cancer;

(OP)3. RECOMMENDS stakeholders and/or partners:

(1) to enhance multilateral and international collaboration in the promotion of knowledge, safe, affordable and quality services, healthcare products and interventions for all to accelerate the elimination of cervical cancer as a public health problem in line with the achievement of UHC, and other related regional commitments, taking into account any conflict of interests; and

(2) and international and regional organizations and bodies concerned with or dedicated to cervical cancer elimination in utilizing World Cervical Cancer Elimination Day, to deepen their support and engagement with Member States' in achieving relevant goals, in accordance with national priorities and contexts;

(OP4). RESOLVES, in line with OP1(1), that 17 November will be World Cervical Cancer Elimination Day and will be observed each year beginning from November 2025, in order to further stimulate and sustain global efforts toward cervical cancer elimination.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[63]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:

1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary healthcare strategies and comprehensive essential service packages

1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results

1.3.2. Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems

4.2.1. Leadership, governance and external relations enhanced to implement GPW 13 and drive impact in an aligned manner at the country level, on the basis of strategic communications and in accordance with the Sustainable Development Goals in the context of United Nations reform

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:

Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:

Not applicable.

4. Estimated time frame (in years or months) to implement the decision:

Five years (pursuant to resolution WHA73.2 (2020), in which the Seventy-third World Health Assembly adopted the global strategy to accelerate the elimination of cervical cancer as a public health problem).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:

Zero.

The work required to implement the decision has already been costed under resolution WHA73.2. (see document WHA73/2020/REC/1, Annex 3).

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:

Not applicable.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:

Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:

Not applicable.

[63] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic “bridge” between results structures can be provided as needed.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:
Not applicable.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions
- **Financial resources available to fund the decision in the current biennium:**
  Not applicable.
- **Remaining financing gap in the current biennium:**
  Not applicable.
- **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
  Not applicable.

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GPW 13: Thirteenth General Programme of Work, 2019–2025.

The representative of QATAR, speaking on behalf of the Member States of the Eastern Mediterranean Region, highlighted the high level of mortality associated with noncommunicable diseases in the Region. Diabetes and cervical cancer required urgent action, and despite progress in tobacco control and trans-fat elimination, significant gaps remained. Mental health and psychosocial support services were underfunded, with considerable treatment gaps in low- and middle-income countries. Rising obesity, insufficient physical activity, air pollution and climate change had compounded the regional noncommunicable disease burden, and multiple emergencies had widened inequities. Those challenges would intensify as populations aged.

To achieve target 3.4 of the Sustainable Development Goals on noncommunicable diseases and mental health, Member States must strengthen primary healthcare systems to deliver integrated people-centred services to address noncommunicable diseases and mental health and must scale up efforts to reform mental health systems through evidence-based interventions. Structured programmes, such as therapeutic education for patients with diabetes, and guidance on integrating mental health services into primary healthcare were much needed. Sensory impairments should be prioritized with the support of practical WHO technical guidance tailored to country contexts. Regional mental health initiatives should be strengthened to ensure continuity of care in all settings. Multisectoral partnerships were essential to addressing determinants of health and must work towards implementation of the latest WHO best buys for noncommunicable diseases. There was a need for enhanced cervical cancer elimination strategies and investment in sustainable financing and surveillance systems to build resilience. The fourth high-level meeting of the United Nations General Assembly on the prevention and control of non-communicable diseases would provide a pivotal opportunity to reaffirm political commitment, drive transformative action and advance health equity and resilience across the Region.

The representative of MOROCCO, describing measures implemented in his country to tackle noncommunicable diseases and improve oral health, called for increased investment in mental health, better management of human and material resources and the integration of mental health into general healthcare through an inclusive and holistic approach. The Secretariat should support Member States in preparing for the fourth high-level meeting on the prevention and control of noncommunicable diseases and work to intensify the fight against noncommunicable diseases and strengthen mental health globally.

The representative of the REPUBLIC OF KOREA expressed concern regarding the lack of improvement in some noncommunicable disease and mental health indicators. The Secretariat

should more actively support Member States in preparing for the fourth high-level meeting by enhancing data collection and analysis capacities to identify gaps regarding indicators and their causes. In addition, the Secretariat should strengthen its technical support for the development and implementation of national action plans and advocate for increased domestic political support. He described his Government's efforts to address noncommunicable diseases and mental health at the national level.

The representative of UKRAINE said that the draft decision on mental health reporting underscored the importance of addressing mental health as a global public health priority, particularly given its profound impact on societal well-being and sustainable development. In the light of the continued impact of Russian aggression on her country, she expressed appreciation to the Secretariat and Member States for their efforts to implement resolution WHA77.3 (2024) on strengthening mental health and psychosocial support before, during and after armed conflicts, natural and human-caused disasters; and health and other emergencies. Kidney disease was a growing public health challenge that should be met with strengthened prevention, diagnosis and treatment, equitable healthcare access, international cooperation and sustainable financing.

The representative of THAILAND said that noncommunicable disease prevention required efforts to address exposure to risks, especially commercial determinants of health such as tobacco, alcohol and unhealthy diets. The draft political declaration of the fourth high-level meeting should focus on increasing investment in oral health; accelerating and scaling up the implementation of national oral health plans; establishing a global coalition for oral health; addressing the commercial determinants of health, particularly industry interference and marketing strategies for health-harming products; increasing financing and the full application of best buys; and introducing innovative financing for health promotion.

Kidney disease greatly reduced quality of life and incurred catastrophic health expenditure; it was therefore crucial to prevent its root causes. Since there was no safe alcohol consumption limit, WHO should lead by example and become an alcohol-free organization. She expressed support for all the draft decisions.

The representative of BRAZIL, noting that addressing noncommunicable diseases required coordinated global efforts, called for strengthened technical discussions and information-sharing to help Member States in aligning national interventions with global strategies on noncommunicable diseases. Member States should embrace a comprehensive and collaborative approach to accelerate progress on noncommunicable diseases. The fourth high-level meeting provided an opportunity to identify gaps, exchange best practices and reinforce commitments to improve prevention and treatment strategies. Mental health should be integrated into preparedness, response and recovery efforts to ensure that vulnerable populations received the necessary support.

He expressed support for the draft decision on lung health and called for oral health to be prioritized as an integral element of national strategies on noncommunicable disease control, highlighting his Government's efforts to address those issues at the national level. Cancer prevention and control required integrated policies promoting healthy environments and lifestyles while reinforcing regulatory measures to reduce exposure to risk factors. His Government therefore wished to be added to the list of sponsors of the draft decision on world cervical cancer elimination day. Greater attention should be paid to rare noncommunicable diseases, and coordinated regional efforts were needed to ensure equitable access to medicines and comprehensive care for persons living with rare diseases.

The representative of BRUNEI DARUSSALAM said that the mental health agenda should be reoriented through a health systems approach to incorporate well-being and a focus on reaching the unreached. Mental health support and care should become part of everyday life and be reinforced in family and community settings. He called for sustained cervical cancer prevention and control efforts to counter challenges including high vaccine costs and anti-vaccination campaigns and encouraged the Secretariat to continue supporting Member States in expanding access to vaccines and screening technologies, particularly in underserved communities.

The draft decision on lung health would support efforts to address several communicable and noncommunicable diseases. Strengthening health systems by introducing integrated lung health services into primary healthcare could improve access to treatment and facilitate the provision of comprehensive care. Addressing exposure to second-hand smoke and vaping among young people required continued multisectoral collaboration.

The Secretariat could play a crucial role in converting ideas into transformative action by enhancing tailored technical support provided to Member States, sharing best practices and strengthening tools to help Member States to effectively monitor progress on global strategies, taking into account financing considerations. To maximize impact, sustainable financing was needed to address the care gap; noncommunicable diseases and mental health services should be integrated into primary healthcare systems; and the root causes of noncommunicable diseases, such as commercial determinants and inequity, should be tackled and healthy environments promoted.

The representative of CHILE outlined her Government's comprehensive approach to tackling noncommunicable diseases. The draft decision on mental health reporting sought to ensure that the necessary attention would be paid to both noncommunicable diseases and mental health, with the recognition that the topics were interconnected and an integrated approach to health systems strengthening was required. The fourth high-level meeting would be an opportunity for Member States to renew their commitment in that regard. Discussions at that meeting should focus on strengthening sharing of successful experiences and integrated care models; promoting specific frameworks to scale up healthcare access programmes; and developing technical support mechanisms for the implementation of cost-effective interventions.

The representative of NORWAY said that the fourth high-level meeting would provide an opportunity for Member States to renew their commitment to the prevention and treatment of noncommunicable diseases. Multisectoral work and cooperation with civil society was needed to achieve common goals in that regard. Implementation of cost-effective policies to prevent and reduce noncommunicable diseases should be scaled up in line with the WHO best buys, and access to healthcare should be increased to reduce major risk factors such as tobacco, alcohol and sugar consumption. She expressed support for the draft decision on mental health reporting, which should cover all aspects of the comprehensive mental health action plan 2013–2030, and suggested that mental health should continue to be included in the Secretariat's report on noncommunicable diseases as part of the "5 x 5 NCD agenda". While she supported the aim of the draft decisions on specific diseases, she cautioned against fragmenting work on noncommunicable diseases as their risk factors were interrelated and benefited from a holistic approach. It was vital to integrate noncommunicable diseases into primary healthcare and universal health coverage, boost health promotion and address the commercial determinants of health.

The representative of POLAND, speaking on behalf of the European Union and its Member States, said that the candidate countries North Macedonia, Montenegro, Albania, Ukraine, the Republic of Moldova, Bosnia and Herzegovina and Georgia as well as Armenia aligned themselves with her statement. Collective work was needed to get back on track to reduce premature

mortality from noncommunicable diseases. Adopting an impactful, evidence-based and rights-based political declaration on noncommunicable diseases would give impetus to WHO-led noncommunicable disease prevention and control efforts. The 2025 Nutrition for Growth Summit would provide an opportunity to address malnutrition. Implementing cost-effective and evidence-based solutions to address noncommunicable diseases required the political will to prioritize public health and technical know-how. Given the current budgetary constraints, it was crucial to prioritize the continuity of essential programmes and avoid additional strain; the Secretariat should therefore assess the impact and financial implications of adding new world health days and recommend a sustainable approach.

To achieve shared goals, she called for multisectoral collaboration to create supportive environments by addressing the determinants of health through social participation with public and private actors, while stressing the need to safeguard the integrity of public health policy and remain attentive to possible influence from commercial and other interests. Action on preventable risk factors common to noncommunicable diseases was necessary. Implementing public health interventions promoting health literacy, stress management, healthy diets, adequate physical activity and a pollution-free environment, as well as tobacco, nicotine and alcohol control policies, would contribute towards reducing health inequalities. Trends in addressing noncommunicable diseases and their risk factors should be monitored and progress evaluated, with quantified national objectives guiding priorities and policies, and the impact of interventions could be measured using existing initiatives. A comprehensive care continuum approach should be adopted, taking into account the rising prevalence of multimorbidity linked to demographic shifts. Primary healthcare should be strengthened to scale up health promotion, prevention, screening, early detection, management and timely treatment and support self-management in coordination with a community approach. Universal health coverage frameworks should centre on primary healthcare and prevent catastrophic out-of-pocket spending. Access to innovative and effective medications should be enhanced for all through collaboration with public and private partners.

The representative of MALDIVES provided an overview of his Government's efforts to address diabetes, oral health and cervical cancer. Ahead of the fourth high-level meeting, the Secretariat was encouraged to strengthen technical support for the expansion of community-based mental health services, ensuring access for underserved populations; provide guidance on single-dose human papillomavirus vaccination strategies and scale up DNA-based human papillomavirus screening; facilitate discussions on integrating essential services for noncommunicable diseases into health benefit packages; and promote the exchange of best practices to support national and regional efforts to control noncommunicable diseases.

The representative of BULGARIA said that the Secretariat could support Member States by providing benchmark analyses on key indicators for noncommunicable diseases and assisting in capacity-building to train health workers in innovations in noncommunicable disease prevention and control. He called for deepened dialogue and exchange of good practices regarding cancer screening programmes, multisectoral strategies for integrated care, progress monitoring and risk management tools, digital solutions and artificial intelligence. The outcomes of the fourth high-level meeting could serve as a guide for achieving sustainable progress and strengthening national measures and resource mobilization and could shine a spotlight on the social and economic determinants of health. A whole-of-government, whole-of-society approach was key to global progress on noncommunicable diseases and mental health. The Secretariat could further support Member States by providing guidelines and innovative tools, such as digital monitoring platforms. National programmes could be strengthened through regional and global cooperation with the participation of experts from Member States.

The representative of SWITZERLAND underscored the importance of mental health, particularly among young people and children, and the need to provide comprehensive mental health and social support services integrated into local structures. It was crucial to bridge the gap between mental and physical health; combat stigma; consider the close connection between mental health and addiction; target at-risk groups; and recognize the complex relationship between social isolation, substance use disorders and mental health disorders. An integrated approach across all relevant health services was needed to ensure coordination in treatment provision.

The representative of SOMALIA expressed concern about the increasing global chronic kidney disease burden and described the situation in his country, noting that vulnerable populations were disproportionately affected. To address that challenge, primary healthcare should be strengthened and kidney health services should be integrated into essential packages of health services focusing on early detection and management of hypertension and diabetes. He requested the Secretariat to support the development of national guidelines for kidney disease prevention and management, tailored to country contexts; enhance capacity-building programmes for health workers on noncommunicable diseases and kidney health; call for increased funding for global health initiatives to support kidney health programmes in fragile settings; explore innovative financing mechanisms, including public–private partnerships, to expand access to life-saving treatments; support research into the kidney disease burden in his country to inform evidence-based interventions; and strengthen health information systems to better track noncommunicable disease indicators and monitor progress. Member States were called on to provide the necessary resources and technical support to strengthen kidney health services, especially in fragile and conflict-affected settings.

The representative of ISRAEL said that more needed to be done to prevent diabetes and called for a greater emphasis on promoting healthy lifestyle habits, especially proper nutrition and physical activity, in early childhood. As oral healthcare was not always sufficiently incorporated into universal health coverage systems, it would be vital to convince lawmakers and decision-makers of the importance of oral health over the coming decade and reform oral health services, budgets and health worker training. Despite disparities within and among countries, the world possessed the tools to eliminate cervical cancer; the global health community must therefore advance the cervical cancer elimination agenda, taking cultural issues into account and making care accessible to all. Regarding mental health, he endorsed the statements made by the representatives of Chile, Norway and Switzerland and called for further discussions on the matter.

The representative of ETHIOPIA, speaking on behalf of the Member States of the African Region, said that the rising noncommunicable disease burden in the Region had been addressed through health promotion and prevention measures with a primary healthcare approach. Such efforts included the implementation of the Global Diabetes Compact, capacity-building interventions to promote oral health and mental health and activities aimed at cervical cancer elimination. However countries faced challenges including increasing alcohol and tobacco use; limited funding, data, human resources and capacity, especially at the primary healthcare level; and a lack of a comprehensive support system for the implementation of national strategies.

He underscored the need for meaningful participation at the fourth high-level meeting and an enhanced focus on equitable and affordable access to diagnostics and therapeutics as well as sustainable financing. More emphasis should be placed on adequate engagement, robust evidence, contextualization and intensive communication ahead of that meeting. Sustained political will was needed, and realistic targets with innovative and adequate funding modalities should be adopted.

Member States in the Region remained committed to accelerating the response to noncommunicable diseases through actionable policies and strategies and coordinated multisectoral efforts addressing the social and commercial determinants of health. He called for greater collaboration and support for enhanced financing, equitable access to medicines and technologies, evidence-based decision-making and the scaling-up of national services and essential healthcare packages. He asked for the Member States of the African Region to be added to the list of sponsors of the draft decision on world cervical cancer elimination day and expressed support for the remaining draft decisions.

The representative of TOGO said that noncommunicable disease prevention and control should be strengthened and integrated into primary healthcare. Outlining her country's efforts to tackle noncommunicable diseases, she called on the Secretariat to improve governance, leadership and partnerships, increase funding for the fight against noncommunicable diseases and strengthen the people-centred, multisectoral approach needed for their prevention.

The representative of the DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA highlighted the importance of strengthening primary healthcare, which allowed for the effective monitoring and timely diagnosis and treatment of noncommunicable diseases and mental health. It was necessary to adopt a whole-of-society and whole-of-country approach to facilitate early detection and treatment of noncommunicable diseases, while allocating sufficient health workers to the primary healthcare level and strengthening their capacities. Health promotion and public awareness-raising of noncommunicable disease prevention, management and control should be prioritized, especially as the global population was ageing. The Secretariat should consider including other metabolic disorders in addition to diabetes, in interventions aimed at reducing the noncommunicable disease burden; provide Member States with appropriate support to implement the global strategy to accelerate the elimination of cervical cancer as a public health problem; introduce evidence-based interventions for oral health promotion; and closely monitor incidences of oral diseases, disaggregating the resulting data by age. He reaffirmed his Government's support for the one-China principle.

The representative of BARBADOS described his Government's efforts to eliminate cervical cancer. Small island developing States faced challenges in implementing the global strategy to accelerate the elimination of cervical cancer as a public health problem, such as limited financial and human resources, geographical barriers to access, vaccine hesitancy, cultural sensitivities regarding sexual health and screening, and integration with HIV/AIDS services. He emphasized the need for sustainable financing mechanisms, strengthened laboratory networks and regional cooperation. The Secretariat should continue working with Member States and development partners to support small island developing States in achieving elimination targets by building resilient health systems and improving access to essential technologies.

The representative of SENEGAL expressed appreciation for WHO's leadership role in the fight against noncommunicable diseases and provided details of measures implemented at the national level, in particular interventions aimed at addressing cervical cancer.

The representative of AUSTRALIA said that further investment in modifying individual risk behaviours would be necessary to achieve successful outcomes regarding noncommunicable diseases and encouraged the Secretariat to work with Member States to keep noncommunicable diseases at the forefront of the global health agenda. Discussions at the fourth high-level meeting would benefit from the participation of non-State actors and should culminate in the adoption of a political declaration that could serve as a road map to advance the global response to noncommunicable diseases over the next five years. The political declaration should include clear

and measurable targets to be tracked annually, allowing for efforts to be reoriented where required. The Secretariat should produce an annual report on the implementation of decisions and resolutions concerning mental health.

The representative of CAMEROON provided an overview of measures taken by his Government to reduce the national noncommunicable disease burden, particularly by strengthening diabetes prevention and control.

The representative of LESOTHO encouraged the Board to adopt the draft decision on world cervical cancer elimination day. The adoption of resolution WHA73.2 (2020) on the global strategy to accelerate the elimination of cervical cancer as a public health problem had reinforced the urgent need for coordinated global action. Designating 17 November as world cervical cancer elimination day would promote the scaling-up of services; strengthen global advocacy, accountability and political commitment; ensure sustained attention and resource mobilization; and highlight the importance of prioritizing the health of vulnerable and marginalized communities.

The representative of the FEDERATED STATES OF MICRONESIA described the situation in his country, noting in particular a lack of trained specialists in oral health and mental health and the challenges faced in combating cervical cancer. He expressed the hope that the establishment of the Global Coalition on Oral Health would lead to improvements in services, service integration, knowledge-sharing and policy development, tailored to the realities of small island developing States, and called for technical and financial support to expand human papillomavirus immunization programmes. Addressing noncommunicable diseases required an integrated approach grounded in universal health coverage and primary healthcare. Ensuring access to essential medicines, an adequate skilled workforce and robust health infrastructure would be key to maximizing impact.

The representative of SLOVAKIA said that a road map with measurable milestones and an accountability mechanism were urgently needed, and the Organization was uniquely positioned to take the lead in that regard. Mental health, behavioural and cultural insights, social determinants of health, migrant health and climate health should be integrated into efforts addressing noncommunicable diseases. Greater cooperation was needed to address disparities in prevention services and treatment, especially for cancers, and in sustainable financing for diabetes and cardiovascular care.

Many sensory impairments were preventable and treatable, yet unaddressed hearing and vision loss significantly contributed to disabilities and health inequities. Investment in prevention and care for sensory impairments could yield substantial economic returns, reducing healthcare costs and boosting workforce productivity. Adopting the draft decision on sensory impairments would reinforce WHO’s leadership, advance disability-inclusive health policies and promote health equity, economic resilience and; sustainable development worldwide.

The representative of SLOVENIA[64] underscored the importance of addressing the commercial determinants of health. In the social media era, it was difficult to address the marketing and sale of alcohol, tobacco and unhealthy foods to minors, and social media addiction and a related lack of physical activity had emerged as challenges. The Secretariat and Member States must invest in identifying new marketing practices and in understanding behavioural and cultural aspects of health and the impact of social media on young people’s mental health. In that

[64] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

regard, it would be important to explore the potential of social participation – especially the participation of young people – and the opportunities offered by the adoption of a community approach, engagement in advocacy, the use of artificial intelligence and intersectoral cooperation. At a time of growing digitalization and misinformation, increased health literacy was crucial to addressing growing inequalities in access to prevention and treatment services. While it was the Secretariat's role to identify, evaluate and promote innovative solutions, it was for countries to implement them and make investments on the basis of WHO evidence. The Organization should lead by example and avoid serving alcohol at WHO events. Her Government wished to be added to the list of sponsors of the draft decision on sensory impairments.

The representative of TÜRKIYE[65] called for greater cooperation and effective strategies to accelerate progress on noncommunicable diseases and mental health and noted the importance of adopting a multisectoral approach. The Secretariat could play a crucial role by providing technical guidance, sharing data and enhancing cooperation among Member States. In addition, the Secretariat should provide Member States with information on socioeconomic impacts, digital health solutions, innovative approaches and links between mental health and noncommunicable diseases. To ensure a rapid and effective response to crises, the Secretariat should increase cooperation with countries to build resilience in health systems and should further strengthen its operational role during crisis responses.

The fourth high-level meeting would provide an opportunity to make health policies on noncommunicable diseases more inclusive and equitable, strengthen monitoring and evaluation systems and scale up community-based health interventions. Noting that greater solidarity and WHO-led cooperation were needed to tackle global threats, she expressed hope that the meeting would provide a holistic perspective on current challenges and future action on noncommunicable diseases.

The representative of GUATEMALA[65] highlighted the prevalence and ill effects of chronic kidney disease, such as high healthcare costs, especially in developing countries. The draft decision on kidney health stressed the need to prioritize the topic on the public health agenda and emphasized the importance of promotion, prevention and access to affordable, high-quality care, particularly in developing countries and among vulnerable populations.

The representative of MEXICO[65] said that, to achieve target 3.4 of the Sustainable Development Goals, it was essential to adopt a comprehensive approach to support people living with noncommunicable diseases, improve epidemiological evidence and develop effective strategies for emergency situations. Primary healthcare should be strengthened to improve the identification of people affected by risk factors that could lead to complications and hospitalization. Control and treatment systems should be improved, focusing on nutrition, anthropometric assessments, eye examinations and glycated haemoglobin testing. A community-based, intercultural, rights-based, gender-responsive and life-course approach should be taken when integrating mental health and addiction into primary healthcare. He outlined his Government's efforts to address mental health and cervical cancer.

The meeting rose at 13:00.

[65] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Sixth meeting

Wednesday, 5 February 2025, at 14:45

Chair: Dr J.X. Walcott (Barbados)

Pillar 1: One billion more people benefiting from universal health coverage (continued)

1. **Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases:** Item 7 of the agenda (document EB156/7) (continued)

    - **Reducing the burden of noncommunicable diseases through strengthening prevention and control of diabetes** (continued)

    - **Oral health** (continued)

    - **Comprehensive mental health action plan 2013–2030** (continued)

    - **Global strategy to accelerate the elimination of cervical cancer as a public health problem and its associated goals and targets for the period 2020–2030** (continued)

The CHAIR recalled that the Board had before it five draft decisions, on a dedicated report on mental health for WHO's governing bodies, on promoting and prioritizing an integrated lung health approach, on reducing the burden of noncommunicable diseases through promotion of kidney health and strengthening prevention and control of kidney disease, on primary prevention and integrated care for sensory impairments including vision impairment and hearing loss, across the life course, and on world cervical cancer elimination day.

The representative of ETHIOPIA said that establishing a world cervical cancer elimination day would accelerate coordinated action on a range of interventions including screening, early detection and treatment. Enhanced support, partnership and collaboration were needed to that end. The other draft decisions were also highly relevant; clear next steps should be set out for their implementation.

The representative of LEBANON called for urgent multisectoral action to address noncommunicable diseases. Mental healthcare must be integrated into primary healthcare and universal health coverage. It was also important to develop secondary care services. Efforts must continue to protect the human rights of individuals living in prison-like institutions owing to a lack of appropriate community-based mental health services, and to work towards their deinstitutionalization. Protecting human rights, especially in conflict situations, was essential for protecting mental health.

The representative of CHINA said that his Government wished to be added to the list of sponsors of the draft decisions on primary prevention and integrated care for sensory impairments including vision impairment and hearing loss, across the life course; on world cervical cancer elimination day; on promoting and prioritizing an integrated lung health approach; and on a dedicated report on mental health for WHO's governing bodies. He asked the Secretariat to provide data on global mortality trends for noncommunicable diseases over the past five years. The Secretariat should strengthen its work on noncommunicable diseases and mental health and promote their integration into primary healthcare and universal health coverage. It would be important to draw attention to those topics in the political declaration of the fourth high-level meeting of the United Nations General Assembly on the prevention and control of non-communicable diseases; he requested an update on preparations for that meeting, including details of the dates, scope, format and organizational arrangements. Addressing noncommunicable diseases required multisectoral collaboration, with a focus on strengthening early screening, diagnosis and treatment. Continuous improvements to the integrated disease prevention and treatment model would promote ongoing capacity-building and enhance prevention and control.

The representative of COSTA RICA described a number of measures implemented in his country to address noncommunicable diseases, including obesity, and to promote mental health.

The representative of ITALY[1] highlighted the importance of creating community-based, recovery-oriented psychiatric services; strengthening rehabilitation and reintegration of patients into society; promoting more inclusive services; and increasing resources to promote access to psychological treatments for all, especially young people. She welcomed the proposal to separate reporting on mental health from consolidated reporting on noncommunicable diseases, as that would give Member States appropriate space to plan, discuss and review work on mental health.

The representative of IRELAND[1] described his Government's efforts to improve oral health and mental health, and to address diabetes. Reorienting health systems to meet the challenges posed by increased life expectancy, including the growing noncommunicable disease burden, would require a shift in mindset towards a person-centred and integrated approach to care. The political declaration at the fourth high-level meeting must reflect that goal and have a strong grounding in scientific evidence and human rights.

The representative of FINLAND[1] said that measures to promote mental health were an essential element of the noncommunicable disease agenda. Taxing products with a negative public health impact could be an effective way to reduce health inequalities and improve population health while generating revenue for States.

The representative of INDONESIA,[1] outlining national measures to address noncommunicable diseases, said that the fourth high-level meeting would be an opportunity for renewing political commitments and ensuring that they were matched with concrete actions, measurable targets and effective monitoring. Underinvestment and widening inequities in the health sector must be rectified, and the socioeconomic determinants of health tackled as an integral element of efforts to address noncommunicable diseases. To that end, Member States needed timely access to financial and technical resources; tailored capacity-building initiatives, including data collection; and robust policy guidance reflecting the latest evidence.

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of FRANCE[2] said that vulnerable populations were disproportionately affected by oral diseases, which contributed to social and health inequalities. National policies must be developed to integrate oral health into primary healthcare throughout the life course, and health systems should be strengthened to ensure access to dental care for all. Increased international cooperation was needed to facilitate sharing of best practices and support the development and implementation of oral health programmes. Further research into effective, evidence-based interventions was also necessary, as were educational activities and training for health workers on the importance of oral health, including through the WHO Academy. The Secretariat should develop recommendations for integrating oral health into all public health strategies and promoting innovation in prevention and care. It should also support the mobilization of communities, schools and civil society in oral health prevention, promotion and education activities.

The representative of PARAGUAY[2] suggested that the Secretariat could hold consultations involving governments, international organizations and civil society to identify local, regional and global priorities regarding noncommunicable diseases. It should also promote technical discussions addressing noncommunicable disease prevention and control and the integration of mental health into public health policies, with a focus on risk factors, primary healthcare strategies and training in global best practices. The outcomes of the fourth high-level meeting should be used to translate commitments into concrete actions, enabling countries to adapt global strategies and develop contextualized and evidence-based national plans that met the specific needs of their populations. WHO should continue to promote efforts to align policies and strategies with international commitments and the Sustainable Development Goals.

The representative of BOTSWANA,[2] noting that noncommunicable diseases placed a heavy burden on health systems and economies, called on the Secretariat to support national and regional research on noncommunicable diseases and make the case for investment and multistakeholder collaboration. It should also support Member States in developing and implementing informed and funded national oral health strategies.

The representative of NAMIBIA[2] said that cervical cancer remained a critical public health challenge, particularly in Africa, with the high cost and poor availability of human papillomavirus vaccine constituting a significant barrier to health. A lack of reliable data owing to shortcomings in cancer registries made it harder to conduct assessments and reach underserved populations. Strengthened partnerships were needed to secure global pricing agreements for vaccines and testing to promote equitable access, while screening and treatment should be prioritized as part of universal health coverage benefit packages. More generally, the Secretariat should improve data collection and utilization to inform policy-making on noncommunicable diseases, track progress made since the third high-level meeting and inform contributions to the fourth high-level meeting, including the development of high-level indicators.

The representative of SOUTH AFRICA[2] said that cervical cancer was a major cause of death in Africa, a problem exacerbated by the high HIV/AIDS burden in southern Africa. The prevalence of cervical cancer reflected the inequities affecting poorer women and vulnerable communities. Establishing a world cervical cancer elimination day would demonstrate solidarity and enhance equity for women and girls across the world.

[2] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of PERU[3] highlighted the importance of joint efforts in the fight against noncommunicable diseases, calling for technical support programmes and additional coordination meetings to promote effective national strategies, especially on cancer prevention and control. Updated technical guidance should also be provided to ensure the uninterrupted delivery of accessible dental services, notably to vulnerable populations and during emergencies. Such measures would improve equity and resilience in health systems. The regional committees should establish standing meetings to make timely decisions regarding health strategies and policies in line with evolving realities in Member States. Greater inclusivity, resilience and flexibility in health systems could only be achieved through technical cooperation, capacity-building and continuous dialogue.

The representative of SPAIN[3] said that, to keep noncommunicable diseases high on the global health agenda beyond the fourth high-level meeting, a health equity approach must be incorporated into all policies, taking into account assessments of health impacts and the social and commercial determinants of health. It would be essential to explore national and global strategies to prevent suicide; regulate alcohol consumption through pricing and labelling; tackle obesity through health taxes and responsible marketing; increase breastfeeding rates; and address low-prevalence diseases. To maximize the impact of the high-level meeting, its conclusions must be translated into commitment and concrete actions.

His Government supported the draft decision on mental health reporting, as mental health must constitute a key element of the global health agenda. It also welcomed the draft decision on reducing the burden of noncommunicable diseases through promotion of kidney health and strengthening prevention and control of kidney disease, particularly the recognition of transplantation as the preferred form of kidney replacement therapy. Initiatives centred on equity, solidarity and efficiency were needed to ensure access to that vital treatment. In addition, his Government wished to be added to the list of sponsors of the draft decision on sensory impairments.

The representative of GERMANY[3] expressed concern regarding the proposals to introduce new world health days and reporting obligations, which would place further strain on the Organization's long-term costs and workload. She welcomed the proposal by the Secretariat to avoid recommending resolutions at the present session of the Board and to allow prioritization in line with the programme budget and the Fourteenth General Programme of Work, 2025–2028, in advance of the Seventy-eighth World Health Assembly. In that connection, she requested information on the number of WHO staff currently working on noncommunicable diseases and on the resources available.

Preparations for the fourth high-level meeting should focus on prevention across the life course, including lifestyle-related risk factors and health literacy. Reducing the effects of climate change was another important task for WHO, as it was increasing the incidence of many noncommunicable diseases, leading to avoidable mortality. A holistic, multisectoral approach was needed to strengthen health systems and address physical and mental health needs. The Secretariat should support Member States in strengthening surveillance of noncommunicable diseases and their risk factors, especially among children and adolescents. The exchange of high-quality data would be key to improving prevention and care.

The representative of URUGUAY[3] described steps taken in her country to promote physical activity and address oral health, mental health and cervical cancer.

[3] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of PORTUGAL[4] outlined a number of interventions implemented in his country to combat noncommunicable diseases through strengthened prevention and control measures. The fourth high-level meeting must deliver an ambitious political declaration that would promote prevention, early detection and equitable access to care.

The representative of BANGLADESH[4] said that WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2030 had proved useful in shaping national policies and plans. Stringent measures were needed to combat tobacco use, and consolidated global efforts were required to address dietary and nutritional risk factors for noncommunicable diseases. In that regard, WHO should be an alcohol-free organization. Welcoming the draft decision on world cervical cancer elimination day, he urged Member States to facilitate access to affordable vaccines, therapeutics and diagnostics to achieve elimination targets in low- and middle-income countries. It was also important to enhance awareness of mental health and make associated services available to all, especially young people.

The representative of PANAMA[4] called on Member States to renew their commitment to achieving target 3.4 of the Sustainable Development Goals and fully implementing the WHO Framework Convention on Tobacco Control. Greater political will was required to administer funding and deliver universal health coverage to individuals living with noncommunicable diseases, including mental health disorders. Prioritizing interventions would contribute towards healthy, productive and happy ageing. WHO focal points and regional and country offices should be involved in preparations for the fourth high-level meeting, as joint work would lead to more effective implementation of plans in the context of the comprehensive global monitoring framework for the prevention and control of noncommunicable diseases. She expressed support for the draft decisions on lung health and on world cervical cancer elimination day.

The representative of KUWAIT[4] described a number of measures implemented in his country to prevent and control noncommunicable diseases including diabetes and cervical cancer.

The representative of INDIA[4] said that high mortality rates, especially in low- and middle-income countries, demonstrated the urgent need for global collaboration to combat noncommunicable diseases. A holistic approach to prevention and control was required, with a particular focus on addressing the growing burden of metabolic syndrome. Although it was important to enhance tertiary care services, health promotion and prevention strategies, including lifestyle modifications, were critical to tackling noncommunicable diseases.

The representative of the UNITED REPUBLIC OF TANZANIA[4] provided details of measures taken in his country to address noncommunicable diseases. Adopting a holistic approach could make decision-making more inclusive and engaging, leading to better prevention and control of diseases. The Secretariat should continue to provide policy guidance and technical support for the development of relevant strategies; build capacities through training and knowledge exchange; strengthen data and surveillance systems; and facilitate global and regional collaboration.

The representative of DENMARK[4] expressed the hope that the fourth high-level meeting would result in an ambitious political declaration that responded to the needs of persons living with, or at risk of developing, noncommunicable diseases and poor mental health. Mental health was constantly challenged by stigma, discrimination, conflict, pandemics and natural hazards, and

[4] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

should feature more prominently in discussions and reporting. Particular attention should be paid to the mental health and well-being of children and adolescents.

The representative of NIGERIA[5] welcomed the support for the draft decision on world cervical cancer elimination day and described steps taken by his Government on that issue.

The representative of ALBANIA,[5] outlining measures taken in her country to address mental health, said that dedicated reporting on the subject would support implementation of the comprehensive mental health action plan 2013–2030 by enabling Member States to review the Secretariat's work in that area.

The representative of BELGIUM[5] expressed strong support for WHO's critical work on the commercial determinants of health, which was vital in countering commercial activities that undermined progress in noncommunicable disease prevention. Describing her Government's efforts to respond to the challenges posed by the sale of disposable e-cigarettes, she urged Member States to focus on the commercial determinants of heath and prioritize public health over economic interests as they prepared for the fourth high-level meeting.

The representative of the PHILIPPINES[5] said that, to accelerate progress towards target 3.4 of the Sustainable Development Goals, the Secretariat's technical support must be enhanced by country-specific consultations with a view to identifying gaps and best practices and developing innovative strategies. The Secretariat could assist Member States in embedding WHO strategies on topics such as diabetes, mental health and oral health into health systems.

Discussions at the fourth high-level meeting should emphasize the importance of primary care, focusing on health promotion and risk reduction, community-based services, equitable access and essential medicines, and lead to a bold and transformative political declaration. Attention should also be paid to improving data collection capacities in health systems and conducting evaluations to refine strategies. The meeting was an opportunity to strengthen global solidarity and support low- and middle-income countries. Multisectoral, multistakeholder dialogue at the regional and global levels could bring together governments, the private sector and civil society to identify sustainable solutions, assess support for strategy implementation and share guidance on resource mobilization. Her Government wished to be added to the list of sponsors of the draft decision on sensory impairments.

The representative of HAITI[5] said that the global increase in stress, anxiety and depression represented a growing burden on mental health services, while insecurity and climate change were increasingly generating humanitarian emergencies in countries like his. Noting that Taiwan[6] had supported his country in combating noncommunicable diseases, he called for its participation in the activities of the Health Assembly as an observer. Health financing should be channelled towards health systems strengthening, primary healthcare, universal health coverage, mechanisms to improve financial protection and the development of emergency preparedness plans addressing communicable and noncommunicable diseases. It was also essential to address underlying social, economic, commercial and environmental risk factors.

The representative of SINGAPORE[5] said that Secretariat support through technical briefings, capacity-building workshops and multistakeholder dialogue would be vital in preparations for the fourth high-level meeting. A transformative political declaration with measurable goals could

[5] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[6] World Health Organization terminology refers to "Taiwan, China".

accelerate progress towards the Sustainable Development Goals, especially target 3.4. Aligning Member States' efforts with WHO strategies required actionable frameworks; he therefore expressed support for the comprehensive mental health action plan 2013–2030 and the global strategy to accelerate the elimination of cervical cancer as a public health problem. Increased investment in primary healthcare and noncommunicable disease prevention was essential. Prioritizing universal health coverage and addressing the social determinants of health would generate equitable and sustainable outcomes for all.

The representative of the KINGDOM OF THE NETHERLANDS,[7] highlighting WHO's capacity to anchor mental health initiatives within health systems, said that mental health and psychosocial support must be at the centre of efforts to respond to humanitarian emergencies. Early intervention in both emergency and non-emergency contexts prevented long-term conditions and supported sustainable recovery, especially among individuals with pre-existing conditions. Given its unique importance, mental health should be discussed under a dedicated agenda item to do justice to the complexity of both noncommunicable diseases and mental health.

The representative of ZAMBIA[7] said that the fourth high-level meeting provided a unique opportunity to reinvigorate efforts to reduce premature mortality from noncommunicable diseases and mental health disorders. In the lead-up to that meeting, there should be a focus on enhancing prevention capacities and addressing issues such as the high cost of vaccines and other health inputs. It would also be necessary to consider how to bolster political commitment, scale up cost-effective and high-impact interventions, and strengthen health systems to ensure equitable access to high-quality healthcare. Given the high cervical cancer incidence and mortality in low- and middle-income countries, she welcomed the draft decision on world cervical cancer elimination day.

The representative of MALAYSIA[7] welcomed efforts to make a case for Member State investment in the prevention and control of noncommunicable diseases. The draft decision on lung health was particularly relevant given the slow progress in tackling respiratory conditions and the challenges encountered by patients in navigating disease-specific programmes; its adoption would promote coordinated efforts to address the issue across WHO programmes. Her Government also supported the draft decisions on kidney health and world cervical cancer elimination day. A whole-of-government and whole-of-society approach was needed to implement a multifaceted strategy on noncommunicable diseases. To that end, she called for renewed, action-oriented political commitment at the fourth high-level meeting.

The representative of EL SALVADOR[7] called for sustained and efficient financing for the management of noncommunicable diseases. Chronic kidney disease of non-traditional origin was a particular concern in the Region of the Americas; increased cooperation was needed on the issue, and on chronic kidney disease more generally, to promote early detection and improve treatments for late-stage disease. The support provided by WHO/PAHO, notably through cervical cancer elimination programmes and the HEARTS in the Americas initiative, should be used as a model for addressing the other noncommunicable diseases under discussion.

The representative of the DOMINICAN REPUBLIC[7] welcomed the support for the draft decision on mental health reporting and asked to be added to the list of sponsors of the draft decision on world cervical cancer elimination day.

[7] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of the RUSSIAN FEDERATION[8] said that, despite the closure of the WHO European Office for the Prevention and Control of Noncommunicable Diseases in Moscow, his Government would continue to support countries and organizations in implementing modern approaches to the prevention and control of noncommunicable diseases. Outlining several national measures in that regard, he asked to be added to the lists of sponsors of the draft decisions on lung health, world cervical cancer elimination day and kidney health.

The representative of ECUADOR[8] said that her Government would join global efforts to address noncommunicable diseases at the fourth high-level meeting and recognized the importance of WHO's role in promoting cooperation, resource mobilization and strategic dialogue. Describing measures implemented in her country to address cervical cancer, she called for continued work towards elimination and asked to be added to the list of sponsors of the associated draft decision. Her Government also wished to be added to the list of sponsors of the draft decision on sensory impairments.

The representative of COLOMBIA[8] said that mental health and social connection should occupy a relevant place in the discussions of the Organization. Her Government therefore wished to be added to the list of sponsors of the draft decision on dedicated mental health reporting.

The Observer of PALESTINE described the situation in the Gaza Strip, noting the severe impact of fear, grief and uncertainty on the mental health of Palestinian children. Greater efforts were needed to support the mental health of all Palestinians in the occupied Palestinian territory.

The Observer of GAVI, THE VACCINE ALLIANCE, highlighted the important role of immunization in preventing noncommunicable diseases, noting that human papillomavirus vaccine was a particularly powerful tool in efforts to eliminate cervical cancer. As they prepared for the fourth high-level meeting, Member States should strengthen immunization systems within primary healthcare to reduce the infectious disease burden and prevent noncommunicable diseases, and expand equitable access to human papillomavirus vaccine.

The representative of IAEA drew attention to her organization's work to support Member States in integrating radiation medicine services into national cancer control plans. It had also worked with WHO to publish guidance on establishing comprehensive cancer centres.

The representative of the EUROPEAN SOCIETY FOR MEDICAL ONCOLOGY, speaking at the invitation of the CHAIR, urged Member States to prioritize cancer prevention and control and optimization of the cancer workforce during the fourth high-level meeting, which should result in a political declaration that fully addressed the needs of patients with cancer. All populations should be able to access comprehensive, safe and affordable services that addressed quality of life, side effects and toxicity and were delivered by well-trained, well-resourced healthcare professionals.

The representative of THE WORLD MEDICAL ASSOCIATION, INC., speaking at the invitation of the CHAIR, underscored the urgent need to address noncommunicable diseases through targeted investment in universal health coverage, including prevention, primary care, access to essential medicines and evidence-based policies grounded in equity and sustainability. Investment in a well-trained and adequately equipped health workforce was also vital and must be prioritized in the political declaration of the fourth high-level meeting.

[8] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of ALZHEIMER'S DISEASE INTERNATIONAL, speaking at the invitation of the CHAIR, expressed concern that dementia had been excluded from the focus areas identified in advance of the fourth high-level meeting, particularly given the increased prevalence and associated economic costs of the disease. WHO should ensure that the issue was fully incorporated into the discussions.

The representative of the INTERNATIONAL AGENCY FOR THE PREVENTION OF BLINDNESS, speaking at the invitation of the CHAIR, urged Member States to support the draft decision on prevention and care for sensory impairments. Most sensory impairments could be prevented or corrected through access to primary care services, screening, health promotion, assistive technologies and rehabilitation. An integrated approach could strengthen health systems through the delivery of people-centred care, reducing long-term costs, improving population health and enhancing economic productivity.

The representative of the INTERNATIONAL SOCIETY OF NEPHROLOGY, speaking at the invitation of the CHAIR, said that she was also speaking on behalf of the World Hypertension League, the International Diabetes Federation and the International Society on Thrombosis and Haemostasis, Inc. Highlighting the importance of integrating kidney care into national strategies and strengthening health systems to promote comprehensive care, she urged Member States to prioritize kidney health and support the relevant draft decision.

The representative of STICHTING HEALTH ACTION INTERNATIONAL, speaking at the invitation of the CHAIR, called for accelerated action to achieve target 3.4 of the Sustainable Development Goals and ensure access to medicines, care and support for noncommunicable diseases. He encouraged Member States to improve the availability and affordability of quality-assured insulin and devices used to manage diabetes, develop person-centred health policies and ensure transparency in device markets.

The representative of the UNION FOR INTERNATIONAL CANCER CONTROL, speaking at the invitation of the CHAIR, urged Governments to develop costed national cancer control plans with time-bound targets. Cancer-related actions should also be discussed during the fourth high-level meeting. He encouraged Member States to support the draft decision on lung health and applauded the proposal to establish a world cervical cancer elimination day.

The representative of the NCD ALLIANCE, speaking at the invitation of the CHAIR, called on Member States to deliver a strong political declaration at the fourth high-level meeting. The declaration should seek to accelerate implementation of measures on noncommunicable diseases, integrate interventions into universal health coverage benefit packages, mobilize investment and ensure accountability through regular reporting on targets. Efforts should also be made to include civil society in the discussions and avoid conflicts of interest.

The representative of MÉDECINS SANS FRONTIÈRES INTERNATIONAL, speaking at the invitation of the CHAIR, called on WHO to support initiatives to increase human papillomavirus vaccination and screening and access to treatment for cervical cancer, and to ensure access to affordable oral and long-acting injectable medicines for psychosis. It should also address the unequal standard of diabetes and hypertension care between high-income countries and low- and middle-income countries, by improving access to insulin and glucose monitoring tools and type 2 diabetes medications.

The representative of the MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION, speaking at the invitation of the CHAIR, called on Member States to further prioritize political and financial

investment in the prevention and control of noncommunicable diseases in women. She highlighted the need for more effective women-centred innovations in the prevention, diagnosis and treatment of noncommunicable diseases, and encouraged closer collaboration with the Equity 2030 Alliance.

The representative of the INTERNATIONAL PHARMACEUTICAL STUDENTS' FEDERATION, speaking at the invitation of the CHAIR, highlighted the essential role played by pharmacists in noncommunicable disease prevention and management. WHO and Member States should leverage pharmacy students and professionals in primary healthcare settings, integrate healthcare students into national plans and policies on noncommunicable diseases and expand pharmacy services, especially in low- and middle-income countries.

The representative of the INTERNATIONAL FEDERATION OF PHARMACEUTICAL MANUFACTURERS AND ASSOCIATIONS, speaking at the invitation of the CHAIR, underscored the importance of a life-course approach to tackling noncommunicable diseases in the light of the growing pressures placed on healthcare systems by chronic conditions and comorbidities, and their risk factors. She urged Member States to embrace innovation, mobilize investment and ensure accountability ahead of the fourth high-level meeting.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIR, called for accelerated action to address noncommunicable diseases. WHO and Member States should prioritize vulnerable populations to address health inequities, integrate mental health into strategies on noncommunicable diseases and engage young people in noncommunicable disease prevention and policy-making.

The representative of FDI WORLD DENTAL FEDERATION, speaking at the invitation of the CHAIR, said that public health measures to prevent and manage oral diseases should be included in the political declaration of the fourth high-level meeting. The comprehensive global monitoring framework for the prevention and control of noncommunicable diseases should include targets on the prevalence of the main oral diseases, access to essential oral healthcare and measures to reduce free sugar intake. Research would play an essential role in achieving those targets.

The representative of the WORLD COUNCIL OF CHURCHES, speaking at the invitation of the CHAIR, drew attention to the limited availability of newer biological therapies for cervical cancer, especially in developing countries. Since it was unethical to provide screening without access to treatment, Member States should enhance local production of therapies by implementing evidence-based regulatory changes and utilizing the flexibilities offered by the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) to lower costs and improve accessibility. The Secretariat should promote equitable access to therapies for all.

The representative of THE INTERNATIONAL SOCIETY OF PAEDIATRIC ONCOLOGY, speaking at the invitation of the CHAIR, said that the incorporation of childhood cancer in best buy interventions indicated the multiplier potential of investment in that area, which should be explicitly included in the preparations for the fourth high-level meeting and the resulting political declaration.

The representative of the MEDICINES PATENT POOL FOUNDATION, speaking at the invitation of the CHAIR, said that his organization was leveraging voluntary licensing and technology transfer to expand access to innovative products for the management of noncommunicable diseases such as type 2 diabetes and obesity. Collaboration with WHO and Member States would be needed to create a favourable environment for licensing.

The representative of THE WORLDWIDE HOSPICE PALLIATIVE CARE ALLIANCE, speaking at the invitation of the CHAIR, said that chronic obstructive pulmonary disease and lung cancer should not be neglected in preparations for the fourth high-level meeting. Palliative care should be introduced in the early stages of chronic lung disease and understood as an integral part of treatment. It was essential to ensure the availability of opioids and effective management of pain and breathlessness for patients with lung disease.

The representative of KNOWLEDGE ECOLOGY INTERNATIONAL, INC., speaking at the invitation of the CHAIR, called on WHO to investigate measures that could improve access to affordable generic versions of glucagon-like peptide-1 receptor agonists, such as a pooled buyout of patent rights. WHO should also develop a strategy to implement resolution WHA72.8 (2019) on improving the transparency of markets for medicines, vaccines and other health products. The data gathered following implementation could be used to improve equity and design cost-effective innovation incentives.

The representative of the WORLD HEART FEDERATION, speaking at the invitation of the CHAIR, called on Member States to address the social and commercial determinants of health by regulating marketing of unhealthy foods; integrate diabetes and cardiovascular disease prevention, diagnostics and management into universal health coverage benefit packages; implement the WHO package of essential noncommunicable (PEN) disease interventions for primary healthcare, the Global Hearts Initiative and the PEN-Plus strategy; and scale up efforts to implement the Global Diabetes Compact. They should also adopt a strong, actionable political declaration at the fourth high-level meeting.

The representative of WORLD CANCER RESEARCH FUND INTERNATIONAL, speaking at the invitation of the CHAIR, called for the adoption of an ambitious and achievable political declaration at the fourth high-level meeting. Ahead of the discussions, Member States should work with non-State actors and the Secretariat towards evidence-based implementation of best buy interventions on noncommunicable diseases, avoiding influence from health-harming industries.

The representative of the INTERNATIONAL LACTATION CONSULTANT ASSOCIATION, speaking at the invitation of the CHAIR, urged Member States to recognize the role of breastfeeding in preventing noncommunicable diseases such as obesity, type 1 and type 2 diabetes, hypertension and cardiovascular diseases in later life. Investing in skilled lactation care would reduce noncommunicable diseases and address health inequalities.

The representative of MOVENDI INTERNATIONAL, speaking at the invitation of the CHAIR, expressed regret that alcohol policy interventions had not been integrated into United Nations Sustainable Development Cooperation Frameworks, despite their effectiveness in preventing noncommunicable diseases. Such gaps should be addressed at the fourth high-level meeting by mainstreaming alcohol policy at the country level and within the United Nations system, and securing a dedicated space for the SAFER initiative.

The representative of the INTERNATIONAL BABY FOOD ACTION NETWORK, speaking at the invitation of the CHAIR, said that any political declaration adopted at the fourth high-level meeting must be evidence-based, grounded in human rights and mindful of the need to avoid conflicts of interest and undue influence.

The representative of THE CARTER CENTER, INC., speaking at the invitation of the CHAIR, stressed the importance of integrating mental health into the noncommunicable disease agenda ahead of the fourth high-level meeting. Calling for greater investment in mental healthcare and

high-quality, accessible services as part of universal health coverage, he underscored the importance of adequate resources for necessary medications, a strong workforce, cross-sectoral policies to support prevention and treatment, and up-to-date legal frameworks to promote human rights-based, community-centred care.

The REGIONAL DIRECTOR FOR AFRICA, speaking on behalf of all WHO regions, said that, despite progress made since the third high-level meeting, noncommunicable diseases remained a leading cause of premature death globally. Cardiovascular diseases were the most prevalent, especially in low- and middle-income countries. Member States across all regions were prioritizing prevention, risk reduction and strengthened healthcare services, with an emphasis on primary healthcare.

In the European Region, the Advisory Council on Innovation for Noncommunicable Diseases was aligning strategies between countries in the east and west, focusing on cardiovascular disease prevention, digital health and childhood obesity. In the South-East Asia Region, the SEAHEARTS initiative had reached over 60 million people, addressing tobacco use, salt reduction, trans-fat elimination and hypertension and diabetes management. Efforts in the Western Pacific Region had focused on strengthening primary care, risk reduction, early detection and research. Access to primary healthcare systems and data monitoring were being expanded in the Region of the Americas through the WHO/PAHO Better Care for Noncommunicable Diseases Initiative in response to a rise in deaths from noncommunicable diseases owing to population growth and ageing.

In 2022, the WHO Regional Office for Africa had co-hosted a strategic dialogue on noncommunicable diseases with the Governments of Ghana and Norway, securing high-level policy commitments and leading to the official launch of the Global Noncommunicable Disease Compact 2020–2030. All Member States of the African Region had adopted the WHO PEN and the PEN-Plus strategy, focusing on severe childhood noncommunicable diseases. Advocacy by the Regional Office, including engagement with international foundations, had contributed to the first International Conference on PEN-Plus in Africa. In 2023, human papillomavirus vaccination coverage in the Region had reached 40%, and 28 countries had included human papillomavirus vaccine in their immunization schedules.

The fourth high-level meeting offered a critical opportunity to mobilize resources, reaffirm commitments and accelerate progress towards the goal of reducing premature deaths from noncommunicable diseases by one third. It was vital to maintain momentum through sustained investment and a collective response. An integrated, collaborative approach to addressing risks and opportunities, coupled with a focus on primary healthcare and person-centred care, could be transformative in that regard.

The ASSISTANT DIRECTOR-GENERAL (Universal Health Coverage/Communicable and Noncommunicable Diseases) drew attention to some of the essential areas of work identified during consultations in preparation for the fourth high-level meeting. These included the need to strengthen national participatory evidence-based coordination mechanisms and promote multisectoral and multistakeholder actions, including through meaningful engagement of civil society and people living with noncommunicable diseases and mental health conditions. Efforts to address noncommunicable diseases and mental health should be integrated into public financing by design, and supported by targeted development assistance. Greater attention should be paid to addressing the commercial practices that were driving noncommunicable diseases and worsening mental health outcomes, while engaging responsibly with the private sector and protecting public health from undue influence. Investment in integrated primary healthcare with equitable access to health products and technologies would also be crucial, and must be complemented by capacity-building in the health and care workforce to support multimorbidity-responsive primary

care with a person-centred approach. The opportunities afforded by digital health, artificial intelligence and data collection tools should be maximized at the country and global levels.

He applauded Member States for their commitment to cervical cancer elimination and welcomed the call for strengthened noncommunicable disease surveillance and monitoring. A new Mental Health Atlas survey was being conducted and would indicate progress against objectives and targets since the coronavirus disease (COVID-19) pandemic. The *Global status report on alcohol and health and treatment of substance use disorders*, published in 2024, provided a comprehensive overview of alcohol consumption, alcohol-related harm, policy responses and treatment capacities. An implementation toolkit for the intersectoral global action plan on epilepsy and other neurological disorders 2022–2031, containing actions, tools and resources for policy-makers, had also been published in 2024, as had the report *Improving access to medicines for neurological disorders*. While the Secretariat assessed how best to respond to the requests made in the draft decisions, it would continue providing guidance, frameworks and road maps for integrated strategies concerning noncommunicable diseases, and using its convening role to enhance impact at the country level.

The ASSISTANT DIRECTOR-GENERAL (Universal Health Coverage/Healthier Populations) welcomed the calls for greater attention and investment to be channelled towards prevention and promotion, risk factors, health determinants and safe and healthy environments. There were several cost-effective, evidence-based interventions that could be used in the fight against noncommunicable diseases, such as health taxation. The fourth high-level meeting offered an opportunity to drive change and reshape noncommunicable disease prevention and control as the foundation of universal health coverage, including through innovative country-level interventions. The points raised by Member States regarding measures to address noncommunicable disease risk factors, including climate change, would be reflected in WHO's work in line with the prioritization exercise in the context of the Fourteenth General Programme of Work, 2025–2028.

The DIRECTOR (Evaluation) said that an evaluation of world health days would be completed within the coming month, and Member State perspectives would be taken into account in the management response. The recently completed mid-term evaluation of the WHO global coordination mechanism on the prevention and control of noncommunicable diseases contained relevant information on the multisectoral interventions under discussion and would prove useful in guiding WHO's work. A decentralized evaluation of the United Nations Interagency Task Force on the Prevention and Control of Non-communicable Diseases would be available within two weeks and would also provide valuable lessons for the Organization.

The CHAIR took it that the Board wished to note the report contained in document EB156/7.

The Board noted the report.

The CHAIR took it that the Board wished to suspend consideration of the draft decisions pending the outcome of the broader discussion on the costing implications of resolutions and decisions recommended by the 156th session of the Executive Board for adoption by the Seventy-eighth World Health Assembly.

It was so agreed.

(For the adoption of decisions, see the summary record of the eighteenth meeting, section 3.)

2. Mental health and social connection: Item 8 of the agenda (document EB156/8)

The CHAIR drew attention to a draft decision, which contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly, on fostering social connection for global health: the essential role of social connection in combating loneliness, social isolation and inequities in health, proposed by Chile, Ecuador, Japan, Kenya, Mexico, Morocco, Panama, Paraguay, Spain, Sweden and Vanuatu. The draft decision read:

> The Executive Board, having considered the report by the Director-General,[9]
>
> Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following resolution:
>
> > The Seventy-eighth World Health Assembly,
> >
> > (PP1) Having considered the report by the Director-General;
> >
> > (PP2) Reaffirming the principle set forth in the WHO Constitution, which defines health as a state of complete physical, mental and social well-being, not merely the absence of disease, and recognizing that social health is an integral yet often overlooked dimension of overall health;
> >
> > (PP3) Considering that social connection is [both a structural and individual (DEL)] Social Determinant of Health, and can be interlinked to other social, economic and environmental determinants, creating cumulative health vulnerabilities.
> >
> > [PP3 alt Chair proposal] Considering that social connection is Social Determinant of Health, and can be interlinked to other social, economic and environmental determinants, creating cumulative health vulnerabilities.
> >
> > (PP3bis) Acknowledging that digital technologies have a profound and complex impact on social connection which needs to be better understood and regulated to minimize social disconnection while leveraging its role in strengthening social connections [for Health (ADD) (DEL)].
> >
> > (PP3bis alt Chair proposal) Acknowledging that digital technologies have a profound and complex impact on social connection which needs to be better understood and regulated to minimize social disconnection while leveraging its role in strengthening social connections for Health and well-being.
> >
> > (PP4) [Recognizing that social disconnection takes the form of social isolation and loneliness, rejection or exclusion, which when chronic, negatively affects physical and mental health, life expectancy, and well-being.
> >
> > (PP4 alt Chair proposal) Recognizing that social connection is an umbrella term describing how people relate and interact with each other and that social isolation and loneliness, when chronic, are forms of social disconnection, that negatively affect physical and mental health, life expectancy, and well-being.
> >
> > [PP4bis Chair proposal] Noting that structural inequalities can exacerbate loneliness and social isolation and recognizing that these conditions are not experienced equally by all, with certain groups – such as women, children, youth, Indigenous Peoples, persons with disabilities, older adults, those living in poverty and those exposed to gender-based violence – being disproportionally affected.
> >
> > (PP4ter] Noting that data on social disconnection, social isolation and loneliness, particularly on their prevalence, drivers, and its impact on health and well-being remain scarce, particularly in developing countries; (ADD)]

[9] Document EB156/8.

(PP5) Recalling resolution WHA62.14 (2009) on reducing health inequities through action on the social determinants of health.

(PP6) Recalling resolution WHA65.8 (2012) on the Outcome of the World Conference on the Social Determinants of Health. (RESERVE)

(PP6bis)(Proposal) Recalling resolution WHA71.8 (2018) that recognizes that access to assistive devices is essential for persons with disabilities to participate fully in society including the ability to connect socially. (RETAIN – Chair)

(PP7) Recalling also resolution WHA 74.16 (2021) on the Social Determinants of Health, which calls for reducing health inequities and inequalities and the unequal distribution of health resources within and between countries, and which emphasizes support for the 2030 Agenda for Sustainable Development.

(PP8) [Recalling resolution 70/1 (2015) of the United Nations General Assembly which adopted the 2030 Agenda for Sustainable Development, an action plan for people, planet and prosperity, leaving no one behind and the strengthening of universal peace and access to justice. (DEL)(RETAIN as drafted)]

(PP9] [Recognizing that quality social connection contributes to the achievement of the Sustainable Development Goals, particularly Goal 3: Ensure healthy lives and promote well-being for all at all ages; and Goal 10, which aims to reduce inequalities within and between countries; while also recognizing that [many (DEL)] / [other (ADD) global public health goals [will (DEL] [may (ADD)] remain unattainable without a focus on social connection. (RESERVE) (RETAIN as drafted)]

(PP9 alt Chair proposal) Recognizing that positive social connections contributes to the achievement of the Sustainable Development Goals, particularly Goal 3: Ensure healthy lives and promote well-being for all at all ages; and Goal 10, which aims to reduce inequalities within and between countries; while also recognizing that other global public health goals could remain unattainable without a focus on social connection.

(PP10] Noting that quality/positive social connection, can prevent and reduce social isolation and loneliness, enhancing physical and mental health and extending lifespans, and also contributes to support healthy behaviours.

(PP10bis] In contrast, social disconnection, specifically social isolation and loneliness, are associated with cardiovascular disease, and mental health conditions, including depression, dementia and other types of cognitive decline, and have adverse impacts on individuals, communities and societies.

(PP11) [Recognizing (DEL)] [Noting (ADD)] the [deep (DEL)] impact of loneliness and social isolation felt worldwide, that was exacerbated during the COVID-19 pandemic, affecting all [age groups (DEL)] [people (ADD)], [but in particular youth, adolescents, women and girls, older persons, and persons with disabilities (DEL (with listing included in PP4), (with listing included in PP4))].

(PP11 alt Chair proposal) Recognizing the impact of loneliness and social isolation felt worldwide, that was exacerbated during the COVID-19 pandemic, affecting all.

(PP12) Recognizing the centrality of promoting quality social connection and social participation, and addressing social isolation and loneliness, rejection or exclusion [and its interlinkages with other vulnerabilities (RESERVE)], [for the reduction of inequities and inequalities in health and well-being (RESERVE)], [particularly for the most vulnerable (DEL) (RETAIN)].

(PP13) [Recognizing that addressing the social determinants of health, [including structural inequalities (RETAIN)], involves actions to address [the social, [cultural, economic, [technological (ADD)] and political (DEL)] [environmental (ADD) (DEL)] (DEL]

factors that shape social connections and can prevent and respond to social isolation and loneliness.

(PP13 alt Chair proposal) Recognizing that addressing the social determinants of health involves actions to address the factors that shape social connections and can prevent and respond to social isolation and loneliness.

(PP13bis) [Recognizing the role of [the (ADD)] family, as the [natural and (ADD)] fundamental group of society and the natural environment for the growth and well-being of all its members, and of family-oriented policies, which can contribute to promote social connection and reduce social disconnection; (ADD) (RESERVE)]

(PP14 alt) Emphasizing that [culture (DEL)] [[cultural, religious, and spiritual values (ADD) (DEL)] plays a [foundational (DEL) (RETAIN)] [important (ADD)] role [which individuals and communities establish identity, purpose, and connection with one another, families and communities, and important for promotion of social connection, through better (ADD)] in social inclusion [and harmonization (ADD) (DEL] [cohesion, and understanding; (ADD)];
(Relevant reports will be in footnote)

(PP14 alt 2 Chair proposal) Emphasizing that cultural values play an important role in the promotion of social connection, through better social inclusion and cohesion.

(PP15) [Acknowledging (DEL)] [Noting (ADD)] the progress of the World Health Organization's Commission on Social Connection, [as well as the importance of the Commission continuing its work (RESERVE – pending costing)].

(PP15 alt Chair proposal) Noting with appreciation the progress of the World Health Organization's Commission on Social Connection, as well as the importance of the Commission continuing its work.
Note by SEC: Commission mandate finishes in Nov 2026.

(OP)1. URGES Member States,[10] taking into account national contexts and priorities:

(a) to develop evidence-based policies, programmes and strategies on social connection and/or integrate these issues within existing and new health policies, programmes and strategies, including those that target the social determinants of health;

(b) to develop or strengthen [where applicable (ADD)], public awareness campaigns to emphasize the importance of quality [(DEL quality)] / positive social connection for mental and physical health and overall well-being, while seeking to reduce the stigma around loneliness at all life stages;

(c) to [Endeavor to (add), support () or consider ()] [Establish (indicators on loneliness, and/or social isolation and social connection, taking into account such factors as (ADD)] including [(delete)] gender- and age-[(add specific] responsive (support) (delete responsive, support ()) and disability (support mention of 3 factors] (all relevant factors () – inclusive indicators, (delete ())] strengthen (ADD) national health and social monitoring systems to assess and address the impact of social connection and disconnection on public health outcomes.

(c alt Chair proposal) to strengthen national health and social monitoring systems to assess and address the impact of social connection and disconnection on public health outcomes, including, as appropriate, disability, age- and gender-specific indicators

[10] And, where applicable, regional economic integration organizations.

(c bis) to develop and incorporate indicators, [as appropriate add ()] on digital technology and digital environments to assess and address their impact on social human interactions (combine with C ().
(c bis alt Chair proposal) to develop and incorporate indicators, as appropriate, on digital technology and digital environments to assess and address their impact on social connection.
(d) to develop, implement, and evaluate [ADD where appropriate, ()] the currently best available evidence-based strategies that promote social connection to reduce social isolation and loneliness, [taking into consideration the specificities of groups facing particular vulnerabilities delete ()] [(Delete vulnerability, use Age, disability and race rather than vulnerabilities () support], and integrate, [Move where appropriate ()], into health promotion, disease prevention, and recovery and management programmes as well as into health emergencies prevention, preparedness and response plans.
(d alt Chair proposal) to develop, implement, and evaluate the currently best available evidence-based strategies that promote social connection to reduce social isolation and loneliness taking into consideration the specificities of groups facing particular vulnerabilities; and integrate them into health promotion, disease prevention, management and recovery programmes as well as into health emergencies prevention, preparedness and response plans.
(e) to promote, support and disseminate evidence and research, including studies related to the social determinants of health and research on the impact of digital technologies and social media platforms on social connection, loneliness and social isolation with a focus on their impact on health outcomes to inform policy and practice. [This research should also examine use of digital and social media platforms for their positive and negative impact on social isolation and loneliness as well as examine variations across different religions, cultures, social values, populations, life stages, age groups, among other aspects [and include a gender analysis (delete blue text)].
(e alt Chair proposal) to promote, support and disseminate evidence and research, including studies related to the social determinants of health and research on the impact of digital technologies and social media platforms on social connection, loneliness and social isolation with a focus on their impact on health outcomes to inform policy and practice.
(f) to create [and strengthen a social infrastructure that creates (delete), support] a supportive environment at all levels, through cross-sectoral collaborations, including partnerships with NPOs, [at all levels – international, regional and local del ()] – and initiatives that foster social interactions, inclusivity, and mutual support, including through social participation.
(f alt Chair proposal) to create a supportive environment at all levels, through cross-sectoral collaborations and initiatives that foster social interactions, inclusivity, and mutual support, including through social participation.
(g) prioritize support for culture [Revise : Strengthen collaboration between culture and health sectors to promote social inclusion ADD support in promoting social inclusion [ADD (harmonization, cohesion, support cohesion].
[alt g promoting the role of cultural values in strengthening social connection and fostering social inclusion support]
(g alt Chair proposal) strengthen collaboration between culture and health sectors to promote social inclusion and cohesion.

(h) to develop a strategy that promotes the safe and responsible use of digital technology, including social media and artificial intelligence, to advance social connectedness.

(OP)2. ENCOURAGES international, intergovernmental and [other non-state actors, including (ADD)] / [nongovernmental organizations (DEL)]/[other non-state actors (ADD], as well as private sector, academia, donors and civil society, to work with Member States and the Secretariat to:

(OP2 alt Chair proposal) ENCOURAGES international, intergovernmental and non-state actors, including private sector, academia, donors and civil society, to work with Member States and the Secretariat to:

(a) address the determinants of social disconnection and promote [high quality (retain (), Delete and replace with positive (Support () or supportive ()] social connection;

(b) support the exchange and dissemination and impact assessment of knowledge, information and best practices related to high quality/positive social connection, loneliness and social isolation and physical and mental health and well-being;

(c) contribute to the enhancement of supportive environments for social connection, and leverage technologies and innovations that promote social connection and address social isolation and loneliness;

(d) promote the development of strategies, learning from those already under way, filling knowledge gaps, stimulating research on the subject, favouring synergies between countries.

(OP)3. REQUESTS the Director-General:

(a) to include social connection and [related (ADD)] actions [which can (ADD)] [to (DEL)] prevent and respond to loneliness and social isolation, as a [key (DEL)] [important (ADD)] component in the WHO's public health agenda, research priorities, and capacity-building initiatives across WHO divisions and the three levels of the Organization.

(b) to [facilitate (DEL)] [Support (ADD)] the development of evidence-based guidelines for governments on promoting and sustaining quality social connections, as well as addressing social isolation and loneliness at the individual, community, regional, and national levels, [targeting at transformative approaches that address the root causes of [gender (DEL)] inequalities with attention to socially constructed barriers and needs (DEL) (RETAIN)].

(b alt Chair proposal) to facilitate the development of evidence-based guidelines for governments on promoting and sustaining positive social connections, as well as addressing social isolation and loneliness, particularly those groups most affected, at the individual, community, regional, and national levels.

(c) to develop recommendations to assess/for assessment of the scale and distribution of social disconnection. (ADD)] Develop [in consultation with Member States (DEL) (RETAIN)] [valid, reliable, and globally comparable methods to assess the scale and distribution of social disconnection and [work with Member States to (ADD)] track progress towards improving social connection over time.

(c alt Chair proposal) to develop, in cooperation with Member States, as appropriate, valid, reliable, and globally comparable methods to assess the scale

and distribution of social disconnection and track progress towards improving social connection over time.
(c bis proposal) to [Develop recommendations for successful and healthy integration of digital technologies in people`s daily lives, recognizing that digital technologies and digital environments are important determinants of health and a public health approach is required for reducing digital impact on social isolation while promoting their use as tools to fight loneliness and isolation (ADD)(RESERVE)]
(c bis alt Chair proposal) to develop recommendations for successful and healthy integration of digital technologies for reducing negative impact on social connection while promoting their use as tools to tackle loneliness and isolation.
(d) [Develop, in consultation with Member States, [and within existing resources (ADD), (RESERVE)] a WHO Global Strategy and action plan to address social isolation and loneliness and foster social connection that links with and leverages other relevant WHO frameworks (RESERVE)(DEL)]
(e) to provide technical assistance and capacity-building support to Member States [upon request (ADD)] in designing and implementing policies and interventions that enhance social connections, including through social participation.
(f) to provide technical assistance, to the extent possible and [upon request (ADD)], to integrate social connection, and prevent social isolation and loneliness in efforts to deliver universal [health (ADD)] coverage and primary [health (ADD)] care, and the strengthening and resilience of health systems, including to prevent, prepare and respond to health challenges.
(f alt Chair proposal) to provide technical assistance, to the extent possible, and upon request, to integrate social connection, and prevent social isolation and loneliness in efforts to deliver universal health coverage and primary healthcare, and strengthen health systems, including to prevent, prepare and respond to health challenges.
(g) to support with technical assistance to mobilize national and international resources to strengthen intersectoral work and local development with a view to strengthening social connection and reducing social isolation and loneliness.
(h) [Extend the mandate of the WHO Social Connection Commission through 2028. (RESERVE)]
(i) to develop, in conjunction with the Member States, [mechanisms that encourage the evaluation of intersectoral and sectoral (DEL] [methodologies to assess effectiveness of (ADD)] policies and programmes that promote physical and mental health and well-being based on social connection.
(j) to collaborate with Member States [at the UN bodies (ADD)], [the Secretary-General of the United Nations (DEL)] and other specialized agencies belonging to the United Nations, [in the definition of essential messages (DEL)] on social connection, social isolation and loneliness, as a social determinant of health inequalities, [and in their incorporation into the process of preparation for future United Nations conferences [as a key component for the achievement of the Sustainable Development Goals (DEL) (RETAIN)] (DEL) (RETAIN)].
(j alt Chair proposal) to collaborate with Member States, the Secretary-General of the United Nations and other specialized agencies belonging to the United Nations, in the development of a coherent narrative on social connection, social isolation and loneliness, as a social determinant of health.

(k) to report on the implementation of this resolution to the 79th World Health Assembly in [2026]/[2027 ()], through the Executive Board at its 158th session, and subsequently to report on the progress of the work associated with this resolution at the [81st]/[82nd ()] [and 83rd (DEL)] sessions of the World Health Assembly, in 2028 and 2030 respectively.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[11]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:
3.1.1. Countries enabled to address social determinants of health across the life course

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:
Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:
Not applicable.

4. Estimated time frame (in years or months) to implement the decision:
Six years (2025–2030).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:
US$ 38.77 million.[12]

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:
US$ 5.24 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:
Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:
US$ 12.67 million.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:
US$ 20.86 million.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions
– **Financial resources available to fund the decision in the current biennium:**
US$ 1.50 million.

[11] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic “bridge” between results structures can be provided as needed.

[12] The draft decision text as at 3 February 2025 was used for the costing. A consensus on the decision text has not yet been reached. Further consultations are planned, which may lead to adjustments in the text and thus also affect the costing.

– **Remaining financing gap in the current biennium:**
US$ 3.74 million.

– **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
The WHO Foundation launched the “Health Online collective” on 22 January 2025 to support fundraising on social connection. The Government of Sweden has supported this work since its inception and the Republic of Korea recently committed funds for activities in the current biennium. Donors leading in this area will be approached to ascertain their interest in collaboration.

Table. Breakdown of estimated resource requirements (in US$ millions)[a]

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	0.17	0.15	0.12	0.15	0.12	0.13	0.83	1.66
	Activities	0.15	0.15	0.15	0.15	0.15	0.15	2.68	3.58
	Total	0.31	0.30	0.27	0.30	0.27	0.28	3.51	5.24
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	0.34	0.31	0.25	0.32	0.25	0.27	1.72	3.46
	Activities	0.57	0.57	0.57	0.57	0.57	0.57	5.82	9.21
	Total	0.91	0.87	0.81	0.89	0.82	0.83	7.54	12.67
B.4. Future bienniums cost of resources to be planned	Staff	0.54	0.48	0.38	0.50	0.40	0.42	2.68	5.40
	Activities	1.17	1.17	1.17	1.17	1.17	1.17	8.42	15.47
	Total	1.71	1.65	1.56	1.67	1.57	1.59	11.10	20.86
B.1. Total planned costs required to implement the decision									38.77

[a] The row and column totals may not always add up, owing to rounding.

A representative of POLAND, speaking on behalf of the European Union and its Member States, said that the candidate countries North Macedonia, Montenegro, Serbia, Albania, Ukraine, the Republic of Moldova, Bosnia and Herzegovina, Georgia and Armenia aligned themselves with the statement. Social connection helped to build resilience in individuals and societies and played a crucial role in the development of social, mental and physical health. She welcomed the increased awareness of its importance, noting that the draft decision represented one of several initiatives marking the beginning of global efforts to protect and promote long-neglected key social determinants of health.

Poor mental health, social isolation and loneliness had an impact on social and physical health, physical and cognitive development, life expectancy and well-being, and disproportionately affected adolescents, persons with disabilities, older persons and persons in vulnerable situations. Those issues must therefore be recognized as a critical global public health priority and tackled through a comprehensive and multisectoral approach. A health equity and gender equality perspective must be incorporated in that regard, with inclusive and tailored interventions implemented at all levels.

Highlighting measures taken by the European Union to promote mental health through enhanced social integration and participation, she underscored the need for evidence-based policies, programmes and strategies at all levels. Strengthening social connection would require multistakeholder commitment and collaboration among actors in government, healthcare, social work, education, the private sector and civil society. Health and social monitoring systems should include indicators on loneliness and social isolation, and public awareness of those issues must be increased.

A representative of MOROCCO, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the coronavirus disease (COVID-19) pandemic had highlighted the need to strengthen work on mental health and social connection. The Region was witnessing rapid social, demographic, political and technological changes, such as the rise of social media and remote working, a significant increase in the number of internally displaced persons, refugees and migrants, a decline in extended family structures and greater longevity. A lack of social connection posed a serious risk to the mental and physical health of individuals and wider society, and the impact on health systems, education, employment and the economy could negatively affect development efforts. Social connection must therefore be prioritized in development and humanitarian programmes.

Promising solutions had emerged to address loneliness and isolation, and strengthen social ties. Scaling up those solutions would require a strategic shift by Member States, which must integrate measures to enhance social connection into national policies, mobilize resources and track progress on the issue. Without proper attention, mental health issues could hinder individuals' ability to participate in society. Given that many people experiencing mental health problems lacked access to the services they needed, investment in mental health systems would be critical to improving social connections. He agreed that, as part of work to prioritize social connection within the public health agenda, the Secretariat should encourage governments to incorporate it into public health frameworks and policies; develop guidance for Member States; and work with other United Nations organizations and international stakeholders to develop globally comparable metrics to monitor social connection trends.

A representative of ZIMBABWE, speaking on behalf of the Member States of the African Region, said that key challenges affecting social connection and mental health included rapid changes in the use of technology, changes in social and family structures, increased internal and international migration and accelerated urbanization. Life transitions such as retirement, the loss of loved ones and changes in living conditions could contribute to stress-related mental health problems, while the impact of conflicts, health emergencies and humanitarian crises were affecting social functioning in the Region.

The WHO Regional Office for Africa had developed several frameworks addressing the social determinants of mental health and innovative approaches to support the mental health of older adults by addressing the gap in mental health skills, reducing social isolation and suicide rates and empowering older adults to remain active in their communities. The Secretariat should assist African countries in developing and scaling up effective, traditional, culturally acceptable and accessible interventions to enhance social connection. Member States also required support in developing social connection policies and integrating relevant interventions into existing national policies and frameworks. Greater investment was needed to strengthen mental health support systems, particularly at the community and primary care levels, and mental health and psychosocial support in emergency contexts. Further research should be carried out to identify successful interventions.

A representative of NORWAY said that all sectors of society were responsible for preventing loneliness and social isolation by creating an inclusive environment. Attention must be paid to fighting the stigma surrounding those issues, and research should be conducted to develop innovative, evidence-based measures to address them, with the involvement of people experiencing loneliness. The links between loneliness and health conditions, including mental health conditions, and premature death were well established. Structural and social factors were significant mental health determinants. Measures to address loneliness, mental health and well-being should be integrated with efforts to improve intersectoral policies and investment across all sectors of government.

A representative of CHILE called for increased multisectoral collaboration with a view to promoting social connection and strengthening systems to facilitate the implementation of evidence-based interventions. The work done thus far would guide efforts towards a more inclusive and sustainable approach. Noting that consensus had not yet been reached on the content of the draft decision owing to time constraints, she urged Member States to continue demonstrating their commitment during intersessional consultations on the matter. Given the scope of the problem, the severity of its effects and the potential for scalable solutions, social isolation merited further discussion at the Health Assembly.

A representative of BULGARIA, outlining his Government's efforts to adopt a multisectoral approach to mental health, said that mental health was often overshadowed by physical health, leading to inadequate resource provision, stigma and a lack of comprehensive mental health strategies. Improving social connection should be adopted as a public health priority. To that end, it was important to promote cross-sectoral collaboration; develop strategic plans to strengthen social connections, especially among people in marginalized situations; and implement actions to prevent and tackle loneliness and social isolation. Political support for the implementation of such measures would be vital. He agreed that the areas of action proposed in the report provided an appropriate focus for the Secretariat's work.

A representative of CANADA welcomed the proposed areas of action and expressed support for the adoption of a life-course approach to mental health and social connection, particularly given how those phenomena were experienced by older adults. Since social connection was being proposed as a new or expanded area of work for the Secretariat, it was important to consider the topic from a costing perspective. Given its cross-cutting nature, work on social connection should be embedded in other areas of the United Nations system and the global health architecture and in upstream and structural efforts outside of the health sector. In that regard, she encouraged Member States to share information on their strategic approaches to social connection and describe how they integrated the issue into existing policies, frameworks and intersectoral work.

A representative of the REPUBLIC OF KOREA, describing national measures to assess and tackle social isolation, noted that tailored, multisectoral policy approaches were needed to address the causes of loneliness and withdrawal, which varied across population groups and life stages. Further evidence on the link between social connection and health, and opportunities to share experience would enhance Member States' engagement on the issue. WHO and other organizations in the United Nations system should demonstrate greater interest in the topic, including by holding high-level meetings, to secure political leadership and advocacy on social connection and mental health.

A representative of the REPUBLIC OF MOLDOVA said that many contemporary challenges were leaving their mark on mental health, especially among children, thereby increasing pressures on mental health services. In her country, an increase in the refugee population following the

outbreak of war in Ukraine had increased demand for mental health services. She expressed support for the areas of action proposed by the Secretariat, highlighting the need to incorporate social connection into national health strategies, enhance multisectoral collaboration and scale up research and data collection to identify effective interventions, especially for marginalized populations. WHO should work with other United Nations organizations to ensure that social connection was recognized as a critical factor in the achievement of the Sustainable Development Goals. The Secretariat should provide clear technical guidance to help Member States to integrate social connection into public health policies, mobilize resources to support implementation and foster strong regional and global collaboration.

A representative of the DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA underscored the importance of building resilient communities through social connection and encouraged the Secretariat to develop strategies to that end. It would be useful to explore opportunities for integrating mental health support into community-based initiatives to promote early intervention and prevention. The Secretariat and Member States should examine how to balance technology use and social connection, taking into account the potential benefits and drawbacks of digital communication. Targeted investments were needed to integrate mental health systems into community-based primary healthcare. WHO should therefore mobilize resources through engagement with international partners and stakeholders.

A representative of THAILAND expressed support for the draft decision. Highlighting factors that could contribute to loneliness, including urbanization, technological shifts and changes in family structure, she said that older adults and adolescents were especially vulnerable and should be prioritized along with other at-risk populations, such as persons with substance abuse disorders. Social media and other media platforms could prove useful in promoting awareness, reducing loneliness and facilitating access to mental health services. Online and offline social and community engagement was also vital to promote mental well-being and prevent social isolation.

A representative of BRAZIL said that, owing to structural inequalities, loneliness was not experienced in the same way by all. Specific public policies should therefore be developed to address different societal groups, such as the prison population, women and girls, people of African descent, Indigenous Peoples, older people and domestic violence survivors. Beyond the particular risks to young people highlighted in the report, technology habits had an impact on all areas of life; they should be regarded as new determinants of health and their relationship with loneliness and social isolation closely monitored. She supported the draft decision, noting the particular need for indicators on digital technologies and environments, and recommendations for the healthy integration of digital technologies into daily life, which should be supported by an ethical commitment to quality of life and take into account mental health.

A representative of TOGO expressed support for the priority measures proposed in the report. She agreed that the Secretariat and Member States should implement multisectoral strategies and establish partnerships to support social connection and promote mental health. Further investment was needed to strengthen mental health support, particularly at the community and primary healthcare levels, and mental healthcare and psychosocial support in emergencies and crises.

A representative of CHINA described a number of national measures to promote mental health, highlighting the importance of a whole-of-society approach. His Government would continue to support the Secretariat's work on mental health and social connection, in particular by helping developing countries to improve their mental health service provision.

A representative of BRUNEI DARUSSALAM echoed the need for a whole-of-society approach, observing that the health sector must work with the education, labour, urban planning and digital technology sectors to foster inclusion and catalyse research. Community-driven initiatives, social prescribing programmes and digital innovations could help to strengthen social ties, particularly among those most vulnerable to isolation. WHO must work closely with other organizations in the United Nations system and beyond to address social disconnection as a global, multifaceted challenge.

A representative of MOROCCO emphasized the negative impact of social isolation on physical and mental health and among all societal groups, describing his Government's efforts to integrate social connection into the national development model. The Secretariat should take note of the outcomes of the second meeting of the WHO Commission on Social Connection and recognize social connection as a key determinant of public health. He expressed support for the draft decision, underscoring the need for a global action plan on social connection; the systematic integration of social connection into all public health policies, especially those linked to mental health, ageing and noncommunicable diseases; further research into the impact of social isolation and loneliness; and the creation of a global coalition for social health bringing together governments, institutions and civil society.

A representative of the UNITED STATES OF AMERICA, noting that the engagement of all members of the global community was needed to reach shared goals concerning mental health, urged Member States to support the meaningful participation of Taiwan[13] in WHO and its work and to call for the resumption of its participation as an observer at the World Health Assembly.

A representative of SENEGAL described his Government's efforts to implement the comprehensive mental health action plan 2013–2030 at the national level and to address social isolation, drawing attention to the importance of community-based services and support.

A representative of CAMEROON said that addressing mental health and social connection constituted a major contemporary challenge requiring multisectoral coordination. Despite the surge in mental health issues in all societal groups, the topic had received low levels of investment, risking a rise in mental health disorders. Outlining steps taken in her country to address the problem, she welcomed, in particular, Member States' commitment to combating drug dependence.

A representative of AUSTRALIA said that certain groups faced an increased risk of disconnection and loneliness, and action to reduce social isolation and loneliness played a key role in achieving better health and well-being for all. He expressed the hope that the forthcoming report of the WHO Commission on Social Connection would provide evidence and set a comprehensive agenda for addressing social isolation and loneliness.

A representative of BARBADOS said that the poor recognition and treatment of mental health challenges was particularly alarming in the case of young people, given their vulnerability to social exclusion, discrimination, stigma, educational difficulties, risk-taking behaviours, physical ill-health and human rights violations. The impact of the COVID-19 pandemic on the vulnerable economies of small island developing States had significantly affected the mental health of both children and adults, notably in the educational context. His Government had sought to address that problem by enhancing mental health services in schools and communities.

[13] World Health Organization terminology refers to "Taiwan, China".

A representative of LESOTHO said that challenges such as stigma, lack of access to services and socioeconomic inequalities continued to hinder progress in addressing mental health. Describing her Government's efforts in that regard, she called on the Secretariat and development partners to provide enhanced technical and financial support for low- and middle-income countries. International collaboration was vital in tackling the social determinants of mental health; efforts should continue to place mental well-being at the heart of sustainable development.

The meeting rose at 17:40.

Seventh meeting

Wednesday, 5 February 2025, at 18:10

Chair: Dr M. Manaouda (Cameroon)

Pillar 1: One billion more people benefiting from universal health coverage (continued)

1. Mental health and social connection: Item 8 of the agenda (document EB156/8) (continued)

The CHAIR recalled that the Board had before it a draft decision on fostering social connection for global health: the essential role of social connection in combating loneliness, social isolation and inequities in health.

The representative of SOMALIA said that the report's focus on the mental health of marginalized groups was welcome, especially as it aligned with his government's priorities. Member States should prioritize mental health in humanitarian responses and the global health agenda and ensure sustainable and predictable funding for mental health services. The recommendations on leveraging digital technologies to enhance social connection and mental health support were also welcome. WHO was urged to increase investment in mental health services and to support countries in building resilient and inclusive health systems.

The representative of COSTA RICA outlined the actions taken by his country at the national level to address mental health. He said that Costa Rica was grateful for the technical assistance it had received to strengthen its health system, particularly from PAHO and UNICEF.

The representative of SLOVAKIA said that WHO was uniquely positioned to set global standards on social connection through contextualized evidence-based guidelines, support policy integration by helping Member States to incorporate social connection into their national frameworks, facilitate cross-sectoral collaboration to protect vulnerable and marginalized populations and advance research and innovation through international and intersectoral cooperation. He asked how WHO would integrate social connection into its country profile framework; which key indicators it would include in the global monitoring framework; how it would develop a practical toolkit to support Member States in implementing scalable social connection initiatives; and how it would ensure adaptability across regions and national contexts. WHO must lead the way in making social connection a public health priority, ensuring it was embedded in global, regional and national policies.

The representative of ETHIOPIA said that efforts to integrate social connection into policies and strategies should take into account cultural values and social fabric, and must be relevant and responsive to local needs and contexts. Experience-sharing, benchmarking and multisectoral collaboration were to be encouraged.

The representative of TÜRKIYE[1] said that her country recommended that the Secretariat should: prepare a strategy document on developing mental health services, taking cultural diversity into account; increase family involvement and community-based support in mental health services; promote national strategies on young people's mental health; promote digital health technologies and create a global strategy on their dissemination; develop global policies on the link between gender equality and mental health and scale up programmes to combat violence against women; launch global compacts to address cultural and social stigmas; and establish global programmes to provide psychological support in health crises and after disasters.

The representative of FINLAND[1] said that shifting the focus towards prevention of loneliness and social isolation was essential. The provision of adequate health-related and social support measures for at-risk groups, such as sexual and gender minorities, children and young people, older adults, persons with disabilities and migrants, was vital. Cross-sectoral cooperation was required to address the determinants of mental health, including in relation to employment practices and working conditions. Achieving a well-being economy called for a whole-of-society approach and national and international collaboration.

The representative of MEXICO[1] said that it was essential to strengthen measures on social connection and mental health in all areas of WHO's work. The draft resolution contained within the draft decision would strengthen measures to address social connection as a public health problem and promote international cooperation and research to move towards equity in health outcomes.

The representative of GERMANY[1] said that the cost implications of the actions suggested in the draft resolution contained within the draft decision should be assessed and prioritized in accordance with the draft Proposed programme budget 2024–2025 and the Fourteenth General Programme of Work, 2025–2028. She requested information on the number of people working on the issue at WHO and the available resources.

Social health could only be tackled through multisectoral strategies, in view of the link between social connection and physical and mental health. Mental health promotion was often effective in environments shared by people of all ages and social backgrounds. Evidence-based policy recommendations on the causes and consequences of loneliness and social isolation, and how to reach those affected, would be vital. Increased public awareness was important, especially for the most vulnerable; children and adolescents should be taught early about resilience and how to strengthen their coping skills.

The representative of CUBA[1] reiterated her Government's firm support for the one-China principle; Taiwan[2] was an inalienable part of Chinese territory. United Nations General Assembly resolution 2758 (XXVI) (1971) and resolution WHA25.1 (1972) provided the legal basis for WHO in that regard. Her country's position was shared by the overwhelming majority of the international community. Cuba supported the efforts of China to bring about national reconciliation.

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[2] World Health Organization terminology refers to "Taiwan, China".

The representative of PARAGUAY[3] said that awareness-raising campaigns for governments and health professionals would help to strengthen social connection and mental health initiatives. Intersectoral cooperation, particularly at the community level, was key, as was working together with international organizations, governments and the private sector to integrate social connection and mental health into policies promoting community well-being, training for health professionals in identifying social needs, and strengthening health information systems to collect data on social relationships and their impact on health. The creation of inclusive public spaces would facilitate interaction and community participation, and the inclusion of mental health and social connection in educational programmes would boost understanding. Investment in research into the impact of social connection on vulnerable populations and the promotion of inclusion, especially in difficult contexts, was needed.

The representative of ITALY[3] said that the production of clear, evidence-based, operational WHO guidance for policy-makers and practitioners about how best to counter social isolation would be valuable. Health and social services should be reoriented towards proactive community services, alongside investment to train professionals. Her Government would welcome more guidance and best practices in that regard. WHO guidance, capacity-building and training tools should be adaptable to regional contexts.

The representative of SLOVENIA[3] said that evidence-based language should be used to recognize that there was no safe limit for alcohol consumption. Alcohol was a major contributor to mental health disorders and its role in exacerbating social isolation and loneliness should be explicitly acknowledged. He called for better WHO guidance on how to address the growing public health challenge of substance-use disorders. Scientific analysis showed that peer support, mutual aid and self-support programmes were low-cost and effective interventions for addiction recovery. Such community-based models also fostered social connection.

The representative of FRANCE[3] said that the prioritization of mental health and social connection in the Fourteenth General Programme of Work, 2025–2028 was welcome, and the growing investment in international forums on mental health commendable. WHO was encouraged to: promote initiatives to strengthen long-term social cohesion and community engagement, especially in respect of crisis situations; support training programmes for health professionals on the importance of social connection to mental health, with the WHO Academy playing a key role; and promote multisectoral partnerships, particularly with other entities of the United Nations system.

The representative of COLOMBIA,[3] heeding the Secretariat's call through its evidence-based report for action to be taken to tackle social disconnection, described measures implemented by her Government to address the social determinants of mental health in different development contexts and throughout the life cycle.

The representative of JAPAN[3] said that declining populations, low birth rates, ageing societies and late or non-marriage were among the factors that made loneliness and social isolation more common. In Japan, a dedicated government department had been established to tackle those issues, among other measures.

The representative of SPAIN[3] said that multisectoral studies into social disconnection in vulnerable populations could help in developing measures tailored to their needs. Social

[3] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

infrastructure played a crucial role in promoting social connection; public spaces such as libraries, parks and community centres encouraged interaction and intervening in such spaces reduced dependence on digital devices, ensuring they were complementary rather than substitutes for social interaction. Health protection strategies, especially in relation to young people and use of the internet and social media, should therefore be included in the draft resolution contained in the draft decision. Social connection could also be improved through non-health-related sectors, such as education, the digital environment and urban planning, including integrating social connection principles into urban development to foster well-being through accessible and inclusive spaces.

The representative of SINGAPORE[4] said that nurturing family and intergenerational connections, helping older persons to connect digitally, spending time outdoors and providing barrier-free access to amenities improved mental health and reduced dementia risk. In view of budgetary constraints, the issues of social connectedness and social isolation could be integrated into existing WHO work on ageing, the public health response to dementia and mental health. Experience-sharing and partnerships between the Secretariat and Member States would strengthen the global mental health landscape.

The representative of ECUADOR[4] said that the adoption of effective policies on mental health and social connection had been hindered by the lack of accurate data on the impact of the coronavirus disease (COVID-19) pandemic on loneliness and isolation and limited social infrastructure, such as a lack of community spaces. Insecurity had exacerbated the situation. Only through a coordinated and integrated approach could public health strategies be improved and the challenges of social isolation and loneliness be addressed.

The representative of OMAN[4] outlined initiatives taken by the country's Ministry of Health to promote mental health and social connection. He stressed the need to continue developing and implementing programmes and initiatives, with increased use of modern technologies, and expand the scope of services to reach all population groups.

The representative of PANAMA[4] said that strategies on mental health and social connection must take into account the impact of information, communication and relationship technologies on social dynamics. Research and the dissemination of its results were crucial to informed decision-making and the implementation of actions suited to the demographic, epidemiological and cultural profiles of Member States. Her Government urged the Secretariat to: include social connection as a cross-cutting theme in public health and existing frameworks; boost the technical capacities of Member States; and strengthen multilateral and bilateral cooperation and experience-sharing.

The representative of BANGLADESH[4] said that Member States should adopt national policies and programmes to maintain and strengthen the social fabric and family bonds. Cultural and physical activities should be promoted, particularly for children, to boost social cohesion. WHO actions on mental health should be tailored to the social and cultural sensitivities of populations, with particular attention to conflict and poverty-stricken areas of the world. The social and economic determinants of the health of vulnerable populations must be addressed, and the value of social connection should be taken in consideration when designing healthy working environments and promoting healthy lifestyles.

[4] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of NAMIBIA[5] urged the Secretariat to adapt WHO strategies to the social and cultural contexts of Member States, including by utilizing local knowledge and traditions to foster community initiatives that enhanced social networks, especially in rural areas where isolation was prevalent. He also urged the Secretariat to champion multisectoral strategies that drew on the strengths of different sectors to support social connection among vulnerable populations. Aligning social connection efforts with the Sustainable Development Goals, particularly Goal 3, was essential to address systemic factors contributing to social isolation.

The representative of NIGERIA[5] said that social connection was key to improving health among all age groups. He described some national measures taken to that end, including the creation of a task force for the decriminalization of attempted suicide. Nigeria urged the Secretariat to conduct ongoing research to understand the impact of social media on various age groups.

The representative of MALAYSIA[5] said that there was a lack of comprehensive global data on loneliness and social relationships, with limited research on developing countries, and no universally agreed definitions of social connection, loneliness or social isolation. The lack of standardization led to variation in data collection, hindering the ability to compare findings and establish global trends. The Secretariat could conduct more robust and cross-regional studies, inclusive of cultural and social contexts, in order to develop evidence-based policies. It should work with Member States to develop social connection policies tailored to their demographic, cultural and social norms. WHO should also include the role of faith-based organizations in public health to help countries to develop more inclusive, community-driven health initiatives.

The representative of EGYPT[5] said that his country continued to support the one-China principle and urged Member States to avoid politicizing the work of the Executive Board.

The representative of the RUSSIAN FEDERATION[5] said that his country had taken various measures to strengthen mental healthcare at the national level. It was important for WHO to remain within the parameters of its mandate when developing proposals on mental health and social connection.

The Russian Federation recognized that Taiwan[6] was an inalienable part of Chinese territory, with the Government of China its only representative. The work of China in international organizations was carried out in accordance with the one-China principle, and all issues relating to Taiwan[7] should be approached by WHO in line with that principle. The participation of Taiwan[7] at meetings of WHO governing bodies was an internal matter for China.

The representative of INDONESIA[5] said that building an evidence base on the risk factors of social isolation and its impact on personal health and well-being would help to understand the scope of the issue and mobilize effective interventions. To ensure that interventions were relevant and sustainable, WHO should to take into account national contexts and local values, including cultural and religious ones, when formulating strategies to promote social connection and developing related indicators. The role of the family remained central to well-being.

The representative of the INTERNATIONAL ASSOCIATION FOR HOSPICE AND PALLIATIVE CARE, INC., speaking at the invitation of the CHAIR, said that the global compassionate

[5] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[6] World Health Organization terminology refers to “Taiwan, China”.

communities' movement promoted social health by addressing the unmet needs of isolated and chronically or terminally ill people. The compassionate communities' model created care ecosystems that fostered a sense of ownership and support for persons with palliative care needs, and the Neighbourhood Network in Palliative Care model addressed issues such as access to long-term care, workforce fatigue and shortages, and catastrophic out-of-pocket spending. Adopting such models provided a cost-effective way of supporting social connection.

The representative of THE WORLD MEDICAL ASSOCIATION, INC., speaking at the invitation of the CHAIR, said that evidence-based strategies were needed to strengthen community-based mental health services, prioritize suicide prevention and reduce stigma, with a focus on reaching marginalized populations. Multisectoral collaboration and culturally appropriate interventions to ensure equitable, quality care for all were vital.

The representative of THE CARTER CENTER, INC., speaking at the invitation of the CHAIR, said that mental health should be treated as a global health and development priority, with holistic, cross-sectoral approaches to improve social connection, inclusion and access to care. Investment in health systems was critical, including to address gaps in the size and quality of the mental health workforce and improve service delivery. Prevention and promotion through the media, school-based health programmes and peer support could also help to address the mental health crisis.

The representative of the NCD ALLIANCE, speaking at the invitation of the CHAIR, said that Member States were encouraged to strengthen collaboration between the WHO workstreams on noncommunicable diseases and mental health. Such work would ensure that mental health and neurological conditions remained central to policies on noncommunicable diseases, including in relation to alcohol. It could also enhance reporting mechanisms, encouraging greater alignment and coherence for an integrated agenda on noncommunicable diseases.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of the CHAIR, said that mental disorders and social isolation affected workforce sustainability, patient safety and care quality. She urged Member States to invest in nurses' mental health and well-being, and recommended the integration into national policies of its Guidelines on Mental Health Nursing. Addressing the mental health crisis required urgent action on workforce shortages, with nurses, the largest part of the mental health workforce, key to transforming care and strengthening health systems.

The representative of STICHTING HEALTH ACTION INTERNATIONAL, speaking at the invitation of the CHAIR, said that the European Union's migration policy had created a global health emergency with devastating mental health consequences. Member States and the WHO Secretariat were urged to: end detention and border violence; establish safe and healthy migration pathways; adopt stronger, evidence-based language that acknowledged the impact of migration policies on mental health; and ensure access to mental healthcare and medical treatment.

The representative of THE WORLDWIDE HOSPICE PALLIATIVE CARE ALLIANCE, speaking at the invitation of the CHAIR, said that social work, psychology, psychiatry and chaplaincy were part of quality interdisciplinary work to provide palliative care services to patients and families. Since social connection was essential to adjusting to loss, hospice and palliative care programmes were aimed at providing bereavement support to families based on their needs. Counselling and mental health services needed to be better integrated into medical care in all health systems.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIR, said that her organization called on WHO to: include people with lived experience in shaping inclusive policies and programmes; scale up investment in research and data collection; integrate mental health and social connection into universal health coverage and primary healthcare; include mental health in all policies to address social determinants; and develop targeted interventions for marginalized groups.

The representative of the INTERNATIONAL LACTATION CONSULTANT ASSOCIATION, speaking at the invitation of the CHAIR, said that investment in breastfeeding could be an effective strategy to improve mental health and social connection. Breastfeeding hormones had protective effects on maternal and infant mental health, could prevent postnatal depression and contributed to a secure attachment. Responsive breastfeeding and caregiving in the first 1000 days of life supported optimal brain development, laying down pathways used for trusting relationships.

The representative of MOVENDI INTERNATIONAL, speaking at the invitation of the CHAIR, said that the alcohol industry should be recognized as a commercial determinant of mental ill health and social isolation. Alcohol contributed to depression, anxiety and suicide, and alcohol-use disorder was a global crisis that deepened social disconnection. Addressing the role of alcohol in mental ill health and social isolation was critical to building stronger, healthier and more connected societies.

The REGIONAL DIRECTOR FOR SOUTH-EAST ASIA, speaking on behalf of all six regions of WHO, said that social isolation and loneliness were pervasive problems that demanded collective action. Risk was increased by excessive technology use and urban environments. Insufficient social connection was linked to increased mortality rates, higher risk of stroke and cardiovascular disease, global dementia risk and higher rates of anxiety, depression and suicide. Significant life changes put older adults at heightened risk. Social disconnection also had far-reaching impacts on education, employment and the economy. Research into social isolation and loneliness had yielded promising strategies, but further synthesis of evidence was needed to distil clear, actionable recommendations for policy-makers and practitioners.

The ASSISTANT DIRECTOR-GENERAL (Health Emergency Intelligence and Surveillance Systems) said that work to strengthen data on social isolation and expand the available evidence base was ongoing. Metrics were being developed to monitor progress, taking into account the Organization's current financial situation. The nature and complexity of the issue required cross-cutting, multisectoral approaches. Moving forward, WHO's work on mental health and social connection would be guided by the Fourteenth General Programme of Work, 2025–2028 and programme budget priorities.

The CHAIR took it that the Board wished to note the report contained in document EB156/8.

It was so agreed.

The CHAIR took it that the Board wished to conclude the discussion and suspend consideration of the draft decision on fostering global health to allow for intersessional consultations.

It was so agreed.

2. Communicable diseases: Item 9 of the agenda (document EB156/9)

- **Global road map on defeating meningitis by 2030** (document EB156/10)

The CHAIR invited the Board to consider the reports contained in documents EB156/9 and EB156/10, and drew attention to two draft decisions. The first draft decision, which contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly, on accelerating the eradication of dracunculiasis (Guinea-worm disease) proposed by Angola, Cameroon, Chad, China, the Russian Federation and South Sudan, read:

> The Executive Board, having considered the report by the Director-General,[7]
>
> Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following resolution:
>
> > The Seventy-eighth World Health Assembly,
> > (PP1) Having considered the report by the Director-General;
> > (PP2) Recalling previous resolutions WHA39.21 (1986), WHA42.29 (1989), WHA44.5 (1991), WHA50.35 (1997), WHA57.9 (2004) and WHA64.16 (2011) on the elimination and eradication of dracunculiasis;
> > (PP3) Noting the significant progress made towards the eradication of dracunculiasis, with human cases reduced from an estimated 3.5 million in 1986 to only 13 in 2024 (provisional) – a reduction of over 99% since the global initiative began;
> > (PP4) Acknowledging that, due to the detection of animal infections, the definition of worldwide eradication of dracunculiasis was revised in 2023 by the International Commission for the Certification of Dracunculiasis Eradication to be the confirmed absence of the emergence of adult female worms in humans and animals for three consecutive years or longer at the global level;
> > (PP5) Noting that the emergence of dracunculiasis in animals, especially domestic dogs, since 2012 has complicated eradication efforts, but that dog infections have declined annually since 2019;
> > (PP6) Appreciating the role of health ministers in coordinating successful efforts to eliminate dracunculiasis from 17 countries and to obtain the certification of elimination from 200 countries, areas and territories, including 188 WHO Member States, with only six countries still to be certified to date;
> > (PP7) Acknowledging the commitment by countries in which dracunculiasis is endemic, including the Abu Dhabi Declaration on the Eradication of Guinea Worm Disease (2022)[8] and the N'Djamena Declaration on interrupting the transmission of dracunculiasis;[9]
> > (PP8) Recognizing that dracunculiasis persists due to infections in animals and a lack of access to safe water and healthcare services, which is further aggravated by other factors such as health and humanitarian emergencies and cross-border

[7] Document EB156/9.

[8] NTDs and milestones: World NTD Day 2023. In: WHO/Home/News [website]. Geneva: World Health Organization; 2025.

[9] Three Central African countries commit to global eradication of Guinea-worm disease. In: WHO/Campaigns [website]. Geneva: World Health Organization; 2025.

movement, and that this, together with insufficient surveillance and community ownership, poses a potential risk to eradication goals;

(PP9) Reaffirming WHO's commitment to achieving the complete eradication of dracunculiasis, in line with the global targets of control and elimination set by the road map for neglected tropical diseases 2021–2030;

(PP10). Recognizing that strong cross-border collaboration, coordination, and information-sharing among Member States, including the effective implementation of a multisectoral approach, are essential to interrupting the transmission of dracunculiasis,

(OP)1. ENDORSES the strategy for Member States in which dracunculiasis is endemic:

(1) to maintain community-based surveillance, especially in endemic and at-risk communities;

(2) to carry out proactive tethering of domestic animals in endemic communities;

(3) to bury aquatic waste in endemic and at-risk communities to prevent consumption by animals and resulting infections;

(4) to effectively treat drinking-water by distributing cloth and pipe filters and support education in endemic and at-risk communities;

(5) to apply temephos on a monthly basis to unsafe sources of drinking water in endemic communities;

(6) to provide sources of safe drinking water to affected communities;

(7) to ensure that guinea-worm specimens are laboratory confirmed and that rewards for reporting human dracunculiasis cases and for reporting and tethering infected animals are paid promptly; and

(8) to require human and animal dracunculiasis to be an immediately reportable disease and reports to be submitted from all endemic areas on at least a monthly basis;

(OP)2. URGES Member States, taking into account, and in line with, national context and priorities:

(1) to recommit to the eradication of guinea worm, regardless of host, by incorporating dracunculiasis, where appropriate, into national, regional and local surveillance systems in affected countries;

(2) to offer political support to the remaining countries in which the disease is endemic; and

(3) to continue providing and advocating for financial and technical support;

(OP)3. CALLS ON Member States with endemic or at-risk populations:

(1) to conduct ministerial visits to endemic communities to assess programme performance;

(2) to intensify cross-border collaboration, including joint surveillance, coordination, and information-sharing mechanisms, particularly in regions with highly mobile populations;

(3) to collaborate with regional and international partners to address challenges related to political instability, animal infections and resource constraints;

(4) to prioritize safe water access and hygiene education, in coordination with UNICEF and other partners, in endemic areas and areas at risk for dracunculiasis transmission; and

(5) to enhance capacity-building at the national and subnational levels to ensure rapid detection and response to human and animal infections, including through a multisectoral approach;

(OP)4. CALLS ON past, present, and new donors to continue to provide financial assistance to the eradication efforts;

(OP)5. REQUESTS the Director-General:

(1) to continue to provide technical support, and facilitate financial assistance, to Member States in their eradication efforts;

(2) to support the coordination of cross-border initiatives to rapidly detect and eliminate remaining dracunculiasis, including through a multisectoral approach;

(3) to continue to submit annual reports to the Health Assembly on the progress made and remaining challenges in the eradication of dracunculiasis; and

(4) to present certification of eradication certificates to the remaining endemic countries when eligible at future sessions of the Health Assembly.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[10]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:
1.1.2. Countries enabled to strengthen their health system to deliver on condition- and disease-specific service coverage results

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:
Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:
Not applicable.

4. Estimated time frame (in years or months) to implement the decision:
Seven years (2025–2031).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. **Total planned costs required to implement the decision, in US$ millions:**
US$ 35.11 million (up to 2030).

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:
US$ 5.55 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:
Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:
US$ 11.55 million.

[10] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic “bridge” between results structures can be provided as needed.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:
US$ 18.01 million.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions

- **Financial resources available to fund the decision in the current biennium:**
  US$ 1.5 million.
- **Remaining financing gap in the current biennium:**
  US$ 4.05 million.
- **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
  Continued mobilization efforts are ongoing, including with The Carter Center, the Gates Foundation and the Children's Investment Fund Foundation. Steps are similarly being taken to look for additional Member State financial contributions to allow the Secretariat to deliver on its mandate to support Member States in eradicating this debilitating disease. Action is also being taken to mobilize resources within WHO for this purpose.

Table. Breakdown of estimated resource requirements (in US$ millions)[a]

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	1.37	0.00	0.00	0.00	0.22	0.00	0.78	2.38
	Activities	2.15	0.00	0.00	0.00	0.35	0.00	0.67	3.18
	Total	3.52	0.00	0.00	0.00	0.58	0.00	1.45	5.55
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	2.85	0.00	0.00	0.00	0.47	0.00	1.62	4.94
	Activities	4.47	0.00	0.00	0.00	0.73	0.00	1.40	6.61
	Total	7.32	0.00	0.00	0.00	1.20	0.00	3.02	11.55
B.4. Future bienniums cost of resources to be planned	Staff	4.45	0.00	0.00	0.00	0.73	0.00	2.53	7.71
	Activities	6.98	0.00	0.00	0.00	1.14	0.00	2.19	10.31
	Total	11.42	0.00	0.00	0.00	1.87	0.00	4.72	18.01
B.1. Total planned costs required to implement the decision									35.11

[a] The row and column totals may not always add up, owing to rounding.

The second draft decision, which contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly, on skin diseases as a global public health priority, proposed by Côte d'Ivoire, the Federated States of Micronesia, Nigeria and Togo, read:

The Executive Board, having considered the report by the Director-General,[11]

Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following resolution:

The Seventy-eighth World Health Assembly,

(PP1) Having considered the report by the Director-General;

(PP2) Recalling Member States' commitment to achieve universal health coverage, including access to essential healthcare services for all;

(PP3) Acknowledging that skin diseases encompass a wide range of conditions, including infectious, inflammatory-autoimmune disorders, congenital dermatosis, chronic and rare conditions, malignant skin tumours, and climate and environmental sensitive dermatology conditions, which often remain undiagnosed and untreated, particularly in developing countries;

(PP4) Highlighting the efforts to prevent, improve early detection and treatment of, reduce the burden of, eliminate, and raise awareness of various types of skin diseases and conditions;

(PP5) Recalling the relevant resolutions pertaining to some skin diseases: WHA57. (2004) (Surveillance and control of *Mycobacterium ulcerans* disease [Buruli ulcer]); WHA60.13 (2007) (Combatting leishmaniasis); WHA64.16 (2011) (Eradication of dracunculiasis); WHA66.12 (2013) (Neglected tropical diseases); WHA67.9 (2014) (Psoriasis); WHA69.21 (2016) (Mycetoma); WHA75.20 (2022) (The global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections;

(PP6) Recalling other relevant resolutions such as WHA69.19 (2016) (Global strategy on human resources for health: workforce 2030); WHA68.7 (2015) (Antimicrobial resistance); WHA69.25 (2016) (Addressing the global shortage of medicines and vaccines); WHA76.5, (2023) (Strengthening diagnostics capacity); WHA76.6 (2023) (Strengthening rehabilitation in health systems); WHA77.18 (2024) (Climate change and health aspects of global public health);

(PP7) Concerned about discrimination and violence against persons affected by skin diseases and their families;

(PP8) Concerned that the prevalence of emerging infectious diseases is increasingly reflected through skin manifestations and noting the importance of recognizing these signs as critical indicators for early detection and response to public health challenges;

(PP9) Acknowledging that the resulting economic, social and emotional consequences of skin diseases cause stigma and discrimination and can lead to mental health comorbidities, particularly depression and anxiety, exacerbating the physical effects of the conditions[12,13] and affect human development across the entire life course;

[11] Document EB156/9.

[12] Seth D, Cheldize K, Brown D, Freeman EF. Global burden of skin disease: inequities and innovations. Curr Dermatol Rep. 2017;6:204–10. doi:10.1007/s13671-017-0192-7.

[13] Ahmed A, Leon A, Butler DC, Reichenberg J. Quality-of-life effects of common dermatological diseases. Semin Cutan Med Surg. 2013;32(2):101–9. doi: 10.12788/j.sder.0009. PMID: 24049968.

(PP10) Concerned that awareness and knowledge of skin diseases is generally low across all levels of society, which delays diagnosis and treatment, and that the lack of routine surveillance may underestimate the burden of skin diseases, especially in hard-to-reach communities;

(PP11) Noting that the Global Burden of Disease Study 2021 identified 4.69 billion incident cases of skin and subcutaneous diseases, responsible for 41.9 million DALYs and forming one of the top 10 causes of disability;[14]

(PP12) Acknowledging that the majority of the skin diseases burden in any community is caused by about 10 common general skin diagnoses and that, with the essential medicines, the right training and support, local health teams could effectively care for these patients;

(PP13) Mindful that, given the inadequate numbers of health and care workers, including specialist practitioners, efforts to strengthen the health and care workforces in primary healthcare settings should ensure competencies to provide services related to dermatology, including managing common skin diseases and timely referral of complex cases;

(PP14) Recognizing that the impact of skin diseases can hinder progress towards Universal Health Coverage, and emphasizing the need to strengthen health systems to improve primary care for skin conditions, improving access for all individuals to necessary care so that no one is left behind;

(PP15) Acknowledging the existence of WHO normative documents to guide Member States to address this resolution: Fourteenth General Programme of Work, 2025–2028 (GPW 14); strategic framework for integrated control and management of skin-related neglected tropical diseases; global leprosy strategy 2021–2030; global action plan for the prevention and control of noncommunicable diseases 2013–2030 and Comprehensive Mental Health Action Plan 2013–2030,

[14] GBD 2021 Diseases and Injuries Collaborators. Global incidence, prevalence, years lived with disability (YLDs), disability-adjusted life-years (DALYs), and healthy life expectancy (HALE) for 371 diseases and injuries in 204 countries and territories and 811 subnational locations, 1990–2021: a systematic analysis for the Global Burden of Disease Study 2021. Lancet. 2024;403(10440):2133–2161.

(OP)1. URGES Member States, according to national context, resources and priorities to:

(1) dedicate adequate resources and prioritize skin diseases and their comorbidities, particularly those in specific global initiatives, through integrated efforts to prevent, detect and treat them within national health programmes including health promotion measures and Universal Health Coverage policies;

(2) strengthen national surveillance, data collection and mapping of skin diseases to promote targeted interventions;

(3) strengthen competency-based education for the health workforce in primary healthcare settings in the identification and management of skin diseases and their comorbidities, as well as self-care education when appropriate for patients and their families, thus empowering them with skills to enhance long-term outcomes;

(4) strengthen laboratory diagnostic capacities to provide accurate and affordable diagnosis of skin diseases, contain antimicrobial resistance and detect emerging skin diseases, including those related to environmental factors, and using basic and advanced methodologies (e.g. immunology, histopathology and microbiology);

(5) promote equitable access to cost effective, affordable and high-quality treatment, especially to essential medicines and wound care materials, as appropriate, to reduce out-of-pocket payments;

(6) take measures to integrate services for skin diseases into current disability, rehabilitation and mental health policies;

(7) consider innovative integrated service delivery models, including telemedicine platforms and training for digital assessments, to strengthen dermatology services, especially in remote and hard-to-reach areas;

(8) accelerate efforts to achieve the skin NTD road map targets by 2030, with as a central strategy through integrated approaches;

(9) support as appropriate the formation and sustainability of skin disease patient support organizations and enhance their active engagement in policy and programme implementation;

(10) promote research on skin diseases in collaboration with academic and research institutions as appropriate;

(OP)2. CALLS UPON the international community and relevant stakeholders including, inter alia, international organizations, bodies of the specialized agencies of the United Nations system, donors, nongovernmental organizations, foundations and research institutions:

(1) to support Member States and WHO in implementing the resolution;

(2) to support advocacy efforts to highlight the medical, social, economic and public health burden of skin diseases;

(3) to cooperate at the global, regional and national levels to reduce stigma, discrimination and mental health problems caused by skin diseases, as well as those resulting from mental disorders;

(4) to foster collaboration among these organizations, academia, civil society and the private sector to advance access to affordable prevention tools, diagnostics and treatments of all skin diseases to reduce the financial burden to the patients and families as well as to governments;

(5) to support institutions in the promotion of social interactions and acceptance, including tackling stigma;

(OP)3. REQUESTS the Director-General:

(1) to develop a results-based, needs-oriented and capabilities-driven Global Plan of Action on public health responses to skin diseases within existing resources, as feasible, ensuring a coordinated approach across all three levels of WHO with the full participation of Member States and in consultation with other relevant stakeholders in line with FENSA, as applicable; with clear goals and targets – for consideration by the Eightieth World Health Assembly, through the Executive Board;

(2) to support Member States, upon their request, to develop or revise, and implement national plans and strategies on skin diseases, covering areas such as:

(a) capacity-building and training for healthcare professionals and workers on skin diseases, including through the WHO Academy and other technical training platforms, and identification of centres of excellence, including WHO Collaborating Centres, in various WHO regions;

(b) digital technologies, in adherence with relevant national guidelines, and assistance to healthcare workers in managing skin diseases with the support of remote specialists including by promoting the availability of relevant data for the development and testing of such technologies;

(c) diagnostic capacity and surveillance for skin diseases;

(d) multidisciplinary research on high-quality, safe, effective and affordable diagnostics and treatments, and promoting their equitable access as well as research into their social and economic impacts;

(e) environmental factors, including climate change, and their effect on the prevalence, spread and control of skin diseases;

(f) emerging and reemerging infectious diseases and their impact on the prevalence, spread and control of skin diseases, with an emphasis on strengthening surveillance systems for early detection and monitoring, to improve response times and prevent potential outbreaks;

(g) sustainable prevention strategies to reduce the burden of skin diseases through comprehensive approaches that may include UV protection with regards to skin cancers, access to basic water supply, sanitation, and hygiene, and One Health approach to reducing transmission of certain skin diseases such as lymphatic filariasis, onchocerciasis, cutaneous leishmaniasis, tungiasis as feasible;[15,16,17]

(3) to report on progress in the implementation of this resolution to the World Health Assembly in 2027, 2029, and 2031.

[15] https://pmc.ncbi.nlm.nih.gov/articles/PMC10674387/.

[16] Cutaneous Leishmaniasis in Pakistan: a neglected disease needing one health strategy - PubMed.

[17] https://www.who.int/publications/i/item/9789240051423.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[18]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:
1.1.1. Countries enabled to provide high-quality, people-centred health services, based on primary healthcare strategies and comprehensive essential service packages

1.1.2. Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:
Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:
Not applicable.

4. Estimated time frame (in years or months) to implement the decision:
Six years (2025–2030).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:
US$ 19.19 million.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:
US$ 3.03 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:
Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:
US$ 6.31 million.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:
US$ 9.85 million.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions
- **Financial resources available to fund the decision in the current biennium:**
  US$ 2 million.
- **Remaining financing gap in the current biennium:**
  US$ 1.03 million.

[18] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic "bridge" between results structures can be provided as needed.

– **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
The adoption of the decision would facilitate ongoing efforts to mobilize additional resources to implement it. Governments and current partners may increase their commitment by providing additional funding. New partners will also be sought.

Table. Breakdown of estimated resource requirements (in US$ millions)[a]

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	0.31	0.26	0.22	0.26	0.22	0.24	0.50	2.00
	Activities	0.15	0.15	0.15	0.15	0.15	0.15	0.16	1.03
	Total	0.45	0.40	0.37	0.41	0.37	0.38	0.66	3.03
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	0.64	0.53	0.46	0.55	0.46	0.49	1.03	4.17
	Activities	0.30	0.30	0.30	0.30	0.30	0.30	0.33	2.14
	Total	0.94	0.83	0.76	0.85	0.76	0.79	1.37	6.31
B.4. Future bienniums cost of resources to be planned	Staff	1.00	0.83	0.72	0.86	0.72	0.77	1.61	6.50
	Activities	0.47	0.47	0.47	0.47	0.47	0.47	0.52	3.34
	Total	1.47	1.30	1.19	1.33	1.19	1.24	2.13	9.85
B.1. Total planned costs required to implement the decision									19.19

[a] The row and column totals may not always add up, owing to rounding.

The representative of YEMEN, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the draft decision on diseases as a global health priority and the Secretariat's efforts to promote an integrated approach to skin diseases were welcome. Malaria, tuberculosis and HIV were prevalent in the region, exacerbated by population movements, climate change, conflict and political instability. The region's high rates of cutaneous leishmaniasis and sexually transmitted infections indicated deficiencies in testing and treatment, and vulnerability to emerging threats. The regional hepatitis C burden had been reduced through testing and treatment, and vaccinations and other preventive measures had curbed the incidence and mortality rate of bacterial meningitis caused by primary pathogens. However, inequity in vaccination coverage, limited diagnostic capacities and inadequate surveillance remained major obstacles. Fostering collaboration, empowering communities and strengthening national capacities were crucial to tackling communicable diseases. Inadequate surveillance and response hindered full understanding of the mpox burden; strengthening high-level advocacy for resource mobilization and information-sharing, and ensuring implementation of the Director-General's recommendations were vital to that end.

The representative of the REPUBLIC OF KOREA said that increasing access to healthcare could strengthen Member States' capacity to treat skin conditions and eliminate mpox. Strengthening laboratory capacities to identify diseases and using artificial intelligence-based

screening, such as the WHO Skin NTDs app, were cost-effective measures. Country-specific campaigns to raise awareness of skin diseases should also be implemented, in addition to more comprehensive immunization programmes in African meningitis belt countries. Standardized guidelines and frameworks for improved surveillance of sequelae, including neurological complications, and long-term impact assessments would be important.

The representative of NORWAY said that aggressive mpox outbreaks in recent years had shown an unmet need for action in the area of skin diseases. Her Government supported the global road map on defeating meningitis by 2030, given the global situation, particularly in low-income countries. The road map must be made visible and efforts to achieve its goals supported by Member States. To address health inequities, global access was needed to affordable vaccines against bacterial meningitis.

The representative of CHINA said that her Government firmly opposed the statements made by certain countries in violation of the Rules of Procedure of the Executive Board, United Nations General Assembly resolution 2758 (XXVI) (1971) and resolution WHA25.1 (1972).

Commending the Secretariat's action on mpox, she said that her Government wished to be added to the list of sponsors of the draft decision on skin diseases as a global public health priority. She stressed the importance of implementing government-led, intersectoral and comprehensive response mechanisms that harnessed public participation to prevent and control infectious diseases. Countries' economic, cultural, healthcare and epidemiological situations should be taken into account when implementing strategies and frameworks. It was to be hoped that WHO would play a leading technical role in the research and application of vaccines, medicines and other medical countermeasures.

The representative of BRAZIL said that initiatives to eliminate communicable diseases required integrated, collaborative strategies between countries. The new Global Coalition for Local and Regional Production, Innovation and Equitable Access – a Group of 20 initiative – would promote equity in health through access to vaccines, treatments, diagnostic tools and health technologies, with a focus on neglected diseases and population groups. The development of technological platforms would allow production to be reoriented when needed, in order to play a critical role in endemic and pandemic situations.

The representative of MOROCCO said that the challenges of communicable diseases should be addressed through collective action, tailored to national contexts. The One Health approach should be strengthened by developing integrated strategies on combating communicable and other emerging diseases. Improvement in the detection of, and rapid response to, communicable diseases would require investment in laboratory infrastructure and early diagnostic tools, as well as training and public-awareness programmes to combat stigma and encourage early diagnosis and detection. Integrated primary healthcare, with follow-up of sexually transmitted infections and skin diseases in routine medical consultations, was vital. Supporting universal health coverage and improving access to treatment were key. Immunization and clear, harmonized guidelines on diagnosis, treatment and care were crucial to combating meningitis.

The representative of CAMEROON, speaking on behalf of the Member States of the African Region, said that a regional framework, which had been adopted to implement the global road map on defeating meningitis by 2030, was aimed at containing outbreaks of bacterial meningitis in Africa by 2030. He called on the Secretariat to: mobilize the necessary resources and involve partners and donors to support the implementation of national strategies to defeat meningitis throughout Africa; ensure sufficient stocks of, and access to, vaccines for the most affected populations, in order to combat seasonal outbreaks; and strongly advocate for and support the

introduction of the MenAfriVac and pentavalent vaccines into an expanded immunization programme.

The representative of SENEGAL said that it was vital to employ case-by-case monitoring of meningitis throughout the health system, promote early detection and mapping of at-risk areas, and provide capacity-building for care providers and rapid diagnostic tests. Molecular research into meningitis and improved training for laboratory workers were key. Also critical were the inclusion of meningococcal conjugate vaccines in expanded routine vaccination programmes and improved coverage of pentavalent and conjugate vaccines.

The representative of COSTA RICA said that international efforts to combat communicable diseases could be strengthened through mechanisms to exchange scientific information. There should also be regional education programmes to inform patients and foster understanding. Regarding mpox, mechanisms must be sought to facilitate access to small quantities of vaccines so that countries, particularly those with small populations and middle-incomes, could immunize their at-risk populations and have supplies to tackle possible outbreaks.

He asked the Secretariat to provide more detail on local coordination, training of health personnel and monitoring strategies to ensure the effective implementation of the global road map on defeating meningitis by 2030. On collaboration and leadership, further information on how to ensure effective coordination between the key players was requested. On financing and sustainability, clear financing strategies and an emphasis on initial investment were needed; low-income countries might require additional support to mobilize resources. Member States should also have more information on how to integrate meningitis into the primary healthcare system, particularly on training health personnel in diagnosis and treatment. Access to meningitis vaccines in all countries affected must be guaranteed. On capacity-building, it would be helpful to know how the use of manuals and workshops to support countries in implementing national plans would be measured in practice. On the mid-term evaluation scheduled for 2025, a standardized monitoring system to ensure that consistent data across regions was needed.

The representative of THAILAND said that her country called for accurate information dissemination on mpox to allay public concerns, and for equitable vaccine solutions and urgent research into targeted treatment. The support of Gavi, the Vaccine Alliance in providing meningococcal vaccines to affected countries was appreciated. With regard to enhancing data-collection efforts at the national level, WHO should develop a heat map of meningitis cases and fatality rates to prioritize the allocation of financial resources, vaccines and diagnostic tools. Expressing support for the draft decision on skin diseases as a global health priority, she said that embracing artificial intelligence and telemedicine could improve diagnostics and treatment, reduce burdens and enhance global cooperation.

(For continuation of the discussion, see the summary record of the eleventh meeting, section 2.)

Rights of reply

The representative of CHINA, speaking in exercise of the right of reply, said that the United States of America and a few other countries had made erroneous remarks on issues concerning Taiwan,[19] thereby violating the sovereignty and territorial integrity of China. His Government wished to remind Member States of the provisions of the Cairo Declaration of 1943, the Potsdam

[19] World Health Organization terminology refers to “Taiwan, China”.

Declaration of 1945, United Nations General Assembly resolution 2758 (XXVI) (1971) and resolution WHA25.1 (1972). Countries making oppositional statements had previously made agreements with China on the basis of the one-China principle. Taiwan,[20] as a province of China, had no basis, justification or right to participate in the World Health Assembly in any form.

The representative of the UNITED STATES OF AMERICA, speaking in exercise of the right of reply, said that efforts to isolate Taiwan[20] from the global health community prevented the international community from benefiting from Taiwanese experience, technical expertise and resources, including lessons learned from the COVID-19 pandemic. Taiwan[20] had been an observer in the World Health Assembly from 2009 to 2016; United Nations General Assembly resolution 2758 (XXVI) (1971) did not preclude the meaningful participation of Taiwan[20] in the United Nations system and could not be used as the basis for its exclusion.

The representative of CHINA, speaking in exercise of the right of reply, said that the central Government attached great importance to the health and welfare of the people of Taiwan[20] and had made appropriate arrangements for their participation in WHO activities. The World Health Assembly had repeatedly rejected proposals on Taiwan;[20] challenging the consensus of the vast majority of Member States would thus only disrupt the Assembly's work.

The meeting rose at 20:05.

[20] World Health Organization terminology refers to "Taiwan, China".

Eighth meeting

Thursday, 6 February 2025, at 10:05

Chair: Dr J.X. Walcott (Barbados)

1. Report of the Standing Committee on Health Emergency Prevention, Preparedness and Response: Item 5 of the agenda (document EB156/5)

The CHAIR invited the Board to consider the report contained in document EB156/5. The Board also had before it the proposed amendments to the terms of reference of the Standing Committee on Health Emergency Prevention, Preparedness and Response, as contained in Appendix 2 to the report, and the possible extension of the mandate of the Standing Committee beyond the closure of the Seventy-eighth World Health Assembly under item 26.3 of the agenda.

The CHAIR OF THE STANDING COMMITTEE ON HEALTH EMERGENCY PREVENTION, PREPAREDNESS AND RESPONSE said that, at its fifth meeting, the Standing Committee had been updated on poliovirus and had reviewed the proposed extension of the Polio Eradication Strategy 2022–2026, to 2029. An update had also been provided on mpox, including on the development of an African continental plan to tackle its spread. The Standing Committee's first extraordinary meeting had been held within 24 hours of the declaration of mpox as a public health emergency of international concern.

The Standing Committee had been informed about continuing work to strengthen the global architecture for health emergency preparedness, response and resilience, including in relation to financing and the implementation plan for the amended International Health Regulations (2005). Health emergencies presented regional and global challenges, particularly in relation to financing. The Standing Committee had also participated in the Secretariat's review of the Committee's functioning and impact.

The representative of CANADA said that the Standing Committee had been envisioned as an agile guidance mechanism for the Executive Board and the Director-General following the declaration of a public health emergency of international concern and as a forum for Member States and the Secretariat to improve engagement and oversight concerning the WHO Health Emergencies Programme. In that regard, it remained valuable to have a Member State-led mechanism that could convene extraordinary meetings rapidly, particularly given that Rule 6 of the Rules of Procedure of the Executive Board did not require the Director-General to brief the Board when convening a special session.

Since the establishment of the Standing Committee, the global health security architecture had changed significantly, and it was necessary to consider existing oversight mechanisms and those that would enter into force prior to the 158th session of the Board. The Standing Committee should therefore continue to operate until that session of the Board, in order to identify existing gaps in the global health security architecture and determine whether a Member State-led committee was the best option for filling those gaps. Given the lack of time available at governing

bodies meetings to discuss reports on WHO's responses to health emergencies, those reports should also be submitted to the Standing Committee, underscoring that the Standing Committee was open to all Member States. The Standing Committee remained an appropriate forum to discuss health emergency prevention, preparedness and response.

The representative of LESOTHO, speaking on behalf of the Member States of the African Region, said that the Standing Committee was critical to strengthening global health security and ensuring an effective, coordinated response to health emergencies. Intersecting crises, such as climate-related food insecurity, population displacement and disease outbreaks, posed a significant threat to health security, particularly in disadvantaged regions, and underscored the need for a comprehensive approach to health emergency preparedness and response. Mpox continued to affect vulnerable communities in the African Region due to limited access to diagnostic and other healthcare infrastructure. Improved strategies were needed to better understand zoonotic spillover and track cases of communicable disease transmission. Member States and development partners should work together to tackle health threats, including mpox, which should retain its status as a public health emergency of international concern.

The representative of the REPUBLIC OF KOREA expressed his appreciation for WHO's immunization and surveillance activities to support poliovirus eradication. It was vital to continue monitoring both poliovirus and mpox trends, and the Secretariat and health authorities should work closely to ensure the smooth implementation of the mpox global strategic preparedness and response plan. It was to be hoped that work to strengthen the global architecture for health emergency preparedness, response and resilience would be closely aligned with the amended International Health Regulations (2005), and he looked forward to further discussions in that regard. In the light of concerning reports of attacks on healthcare services, continuous humanitarian healthcare support should be provided to address health threats and inequities affecting civilians in conflict areas.

The representative of TOGO welcomed the update on current work to strengthen health emergency prevention, preparedness and response and on the 44 graded emergencies currently occurring globally. She appreciated the essential work of the Standing Committee in reinforcing global health security and facilitating an effective and coordinated response to health emergencies. Member States and partners should collaborate in a spirit of equity and solidarity to tackle health threats.

The representative of BULGARIA said that global public health emergencies required rapid, appropriate and coordinated action, and the Standing Committee drew on the highest possible expertise to ensure clear communication and to monitor and control diseases. The global architecture for health emergency prevention, preparedness and response should be strengthened and operationalized through regional and global cooperation and consultations with Member States. To that end, existing governance mechanisms, such as the International Health Regulations (2005), should be leveraged, and global initiatives should complement national initiatives. He supported using existing funding mechanisms and mobilizing additional resources from Member States and other stakeholders to finance health emergency response efforts. It was necessary to discuss how to ensure that representatives of other entities of the United Nations system could participate in Standing Committee meetings.

The representative of the DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA said that epidemics of diseases such as cholera and dengue were spreading in some regions, in addition to the lingering impacts of the coronavirus disease (COVID-19) pandemic, public health emergencies of international concern and more frequent climate-related natural disasters. Without improved

partner engagement, intersectoral collaboration and workforce training, the socioeconomic and public health impacts of those complex health emergencies would worsen. The Secretariat should step up its negotiations with donors to secure more predictable and sustainable funds and allocate adequate resources to ensure the implementation of the mpox global strategic preparedness and response plan. Member states should share best practices for responding to health emergencies.

He welcomed the proposed amendments to the Standing Committee's terms of reference and standard operating procedures. The terms of reference should include measures to prevent pandemics, such as developing vaccines and medicines but should not overlap with those of other bodies, including the negotiating bodies for the International Health Regulations (2005) and the pandemic agreement. The Standing Committee, whose mandate should be extended and continuously updated, should play a crucial role in health emergency preparedness and response rather than operating as an information body.

The representative of CHINA said that the amended standard operating procedures for the Standing Committee's extraordinary meetings would enhance efficiency and ensure the full participation of its members in those meetings. Since its establishment, the Standing Committee had carried out its mandate but had also encountered challenges. She therefore supported the review of its operations and effectiveness.

The representative of NORWAY, speaking on behalf of the Nordic and Baltic countries, expressed concerns about extending the mandate of the Standing Committee beyond the closure of the Seventy-eighth World Health Assembly in May 2025. First, the number of challenges that the Standing Committee had encountered outnumbered its benefits. It had not provided any recommendations or guidance concerning the WHO Health Emergencies Programme and Member States were not familiar with key aspects of the Programme. Secondly, its mandate and functions overlapped with those of other committees, such as the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme. Although it was useful to convene the Standing Committee at short notice following the declaration of a public health emergency of international concern, it was also possible to convene the Board in such circumstances. Thirdly, the benefits of the Standing Committee did not justify the cost for the Secretariat to prepare and service Standing Committee meetings.

The representative of YEMEN, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that health emergencies were increasing due to climate-related disasters, disease outbreaks and conflict. Lack of resources, obstacles to implementation and attacks on health facilities presented key challenges, particularly in the Eastern Mediterranean Region. A focus on prevention, surveillance and equitable access to medical tools was needed to ensure the health security of his country and the broader Region. WHO must improve its technical and financial support to enable countries to strengthen weak health systems and respond to the consequences of conflicts, climate change and recurring disease outbreaks. He condemned in the firmest terms all attacks on healthcare facilities and called for the creation of stronger international accountability and protection mechanisms. There should also be greater investment in community-centred approaches to preparedness and response, along with increased funding to fill resource gaps in regions experiencing simultaneous emergencies.

The representative of BRUNEI DARUSSALAM said that collective action to tackle health emergencies was needed more than ever, and efforts should focus on evaluating and strengthening the global health emergency framework. He supported the Standing Committee's call for a broader consultative process to enhance governance and operational effectiveness, which would increase inclusivity and transparency, and thereby foster trust and collaboration

among Member States. While the Standing Committee's structured approach to meetings and its regular updates on global health emergencies had been effective, it failed to provide guidance and recommendations to the Board in its reports. The Standing Committee could enhance its effectiveness and align with its terms of reference by improving engagement, expert involvement and document review timelines. Its potential could be further maximized by refining its terms of reference and facilitating decision-making. Although its mandate overlapped with that of other oversight bodies, it provided added value by streamlining information and providing actionable insights. He therefore supported extending the mandate of the Standing Committee beyond the closure of the Seventy-eighth World Health Assembly. To tackle limited resources, workforce shortages and the complexities of multisectoral collaboration, capacity-strengthening initiatives should be prioritized, particularly for small developing countries.

The representative of CHILE welcomed the progress made in critical areas, including the strengthening of the global health emergency architecture. The high number of graded emergencies worldwide and of people requiring humanitarian assistance underscored the importance of that work. She expressed support for the proposed amendments to the Standing Committee's terms of reference and the standard operating procedures for extraordinary meetings, which would strengthen the Standing Committee's ability to respond to public health emergencies of international concern. The mpox global strategic preparedness and response plan and the medical countermeasures access and allocation mechanism were of particular interest to her Government, while WHO's work on the Africa continental plan alongside the Africa Centres for Disease Control and Prevention demonstrated the importance of regional collaboration.

Her delegation was open to holding the sixth meeting of the Standing Committee on 14 and 15 April 2025 and supported the proposal to broaden the consultation for the review of the Standing Committee to include Member States that were not part of the Standing Committee and key stakeholders outside of WHO. Such an approach would enrich the review process and strengthen the legitimacy of recommendations. It was important to focus on national capacity-building and ensure sustainable financing for emergency preparedness and response activities. She supported the proposed extension of the mandate of the Standing Committee until the 158th session of the Board.

The representative of BARBADOS thanked WHO for spearheading the mpox response and for providing Member States with institutional knowledge and technical expertise to manage new and emerging outbreaks. Climate change altered the prevailing communicable disease landscape, particularly for vector-borne diseases such as dengue. Meanwhile, progress in improving sanitation and access to drinking water should be leveraged to eradicate gastroenteritis.

The representative of the FEDERATED STATES OF MICRONESIA said that the work of the Standing Committee was critical and should be strengthened to ensure that it could respond to evolving situations. He supported expanding participation in Standing Committee meetings, extending the mandate of the Standing Committee beyond the closure of the Seventy-eighth World Health Assembly and amending the terms of reference and the standard operating procedures for extraordinary meetings.

The representative of SLOVAKIA expressed appreciation for the constructive dialogue at Standing Committee meetings and support for the proposed amendments to its terms of reference. While he acknowledged that it was critical to respond effectively to continuing and emerging health crises, he recommended that, in the light of current challenges and the expected reallocation of funding, the Standing Committee should pause its activities, unless a public health emergency of international concern was declared, or the Director-General or the Board requested

otherwise. In addition, dedicated expert working groups should be formed to ensure science- and evidence-based analyses, recommendations and guidance from the Standing Committee. The membership of the Standing Committee should be broadened beyond the Executive Board to increase inclusion and strengthen global health governance.

The representative of BELGIUM[1] said that effective health emergency prevention and preparedness required WHO to assess new or re-emerging health threats quickly and thoroughly and to direct and coordinate work at the national and subnational levels. In turn, Member States must share essential information about health risks, continuing outbreaks and scientific collaboration. Discussions on the impact of the announced withdrawal of the United States of America from WHO should focus more on the impact on collaboration, particularly in terms of information sharing, and on health emergency preparedness and global health. He asked the Secretariat to share its view on the matter and to provide information on how it planned to mitigate the possible impact of the United States' decision.

The representative of FRANCE[1] said that the Standing Committee facilitated coordination between WHO headquarters, WHO regional offices and Member States, had improved transparency and accountability and had helped to implement the lessons learned from the COVID-19 pandemic. The Standing Committee had already demonstrated its value, particularly during its first extraordinary meeting. He expressed the hope that an international accord on pandemic prevention, preparedness and response would be adopted at the Seventy-eighth World Health Assembly.

The representative of SINGAPORE[1] said that the Standing Committee had fulfilled its mandate of ensuring rapid information sharing between the Secretariat and Member States. However, to strengthen its role in providing guidance on the WHO Health Emergencies Programme, it should engage with the Programme's leadership to provide specific recommendations for after-action reviews of previous health emergencies. In addition, to strengthen the Standing Committee's engagement with Member States that were not members of the Standing Committee, discussions about region-specific health emergency matters could be held through the regional offices prior to Standing Committee meetings. Sufficient preparation and time for consultation would ensure the effectiveness of the Standing Committee, and she supported extending its mandate.

The representative of PANAMA[1] said that she supported the proposed amendments to the Standing Committee's terms of reference. The large number of graded emergencies currently under way represented a significant challenge and required a response that was underpinned by regional and global solidarity. She called on the Executive Board to redouble its efforts to protect health workers in dangerous or politically unstable areas. The Standing Committee must have access to sufficient resources, including technical resources, and reach its full potential. It was important to extend its mandate, boost efficiency and broaden Member State participation.

The Observer of PALESTINE expressed appreciation for the discussions held at the fifth meeting of the Standing Committee, particularly in relation to addressing health sector challenges during emergencies, work carried out in the occupied Palestinian territory in that regard and lessons that could be learned from complex humanitarian and health emergencies. The Standing Committee should continue to report on health emergencies, particularly in areas experiencing armed conflict and in complex humanitarian settings, and provide recommendations

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

in its reports to the Executive Board. Member States and observers should be encouraged to participate in the Standing Committee's meetings.

The representative of OMAN[2] said that the Secretariat should work with Member States to ensure that conflict-induced emergencies were not neglected, by developing early warning systems, establishing effective communication channels between governments and response teams and conducting joint simulation exercises among Member States. It was essential to develop a comprehensive plan for mechanisms to supply and equitably distribute resources, which would help to ensure more effective support for response efforts. Continued solidarity was critical to mitigating the severity and impact of the challenges that many countries faced in mobilizing adequate resources.

The representative of NIGER[2] said that, in the light of continuing and widespread humanitarian, climate and security challenges, the work of the Standing Committee was more important than ever. It should continue to be inclusive, in order to ensure comprehensive, rational and efficient management in view of financial constraints. The Standing Committee had proven its worth and Member States must continue contributing to its work.

The representative of BANGLADESH[2] said that Member States should take a stand against attacks on hospitals and health services in areas affected by war and conflict. He requested that the Secretariat, alongside the international community and partners, continue to support the displaced Rohingya people in his country until they could return to Myanmar. The Standing Committee's terms of reference should provide for a process by which countries affected by health emergencies could express their needs.

(For continuation of the discussion, see the summary record of the sixteenth meeting, section 4.)

Pillar 2: One billion more people better protected from health emergencies

2. WHO's work in health emergencies: Item 15 of the agenda (document EB156/18)

The CHAIR invited the Board to consider the report contained in document EB 156/18, in particular the guiding questions set out in paragraph 30. He also drew attention to a draft decision, which contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly, on strengthening the evidence-base for public health and social measures proposed by Brazil, China, Georgia, Norway, Qatar, Romania, Singapore, Spain and Zambia, which read:

> The Executive Board, having considered the report by the Director-General,[3] under Pillar 2: WHO's work in health emergencies,
>
> Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following resolution:
>
> > The Seventy-eighth World Health Assembly,
> > (PP1) Having considered the report by the Director-General;

[2] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[3] Document EB156/7.

(PP2) Noting that public health and social measures (PHSM) refer to non-pharmaceutical measures implemented by individuals, communities, governments and institutions to reduce the risk and scale of epidemic- and pandemic-prone infectious disease transmission;

(PP3) Acknowledging the relevance of PHSM to the amended International Health Regulations (2005) adopted through resolution WHA77.17 (2024);

(PP4) Recalling the temporary recommendations of the International Health Regulations Emergency Committee regarding the COVID-19 pandemic to States Parties on the continuous use of evidence-informed and risk-based PHSM and the temporary recommendations of the International Health Regulations Emergency Committee regarding the upsurge of mpox 2024 to States Parties on addressing research gaps including the effectiveness of public health interventions;

(PP5) Recalling resolution WHA58.5 (2005) which calls on Member States to make effective use of appropriate and effective PHSM that may protect the general public from the influenza virus;

(PP6) Acknowledging the importance of PHSM in preventing and controlling infectious diseases, especially those with epidemic- and pandemic potential, that PHSM are the first, and sometimes the only, interventions available, and that appropriate PHSM are essential throughout an epidemic or pandemic;

(PP7) Noting that it can be difficult to anticipate who may be most at risk of experiencing adverse health and socioeconomic consequences during future epidemics and pandemics, as well as to possible adverse effects of PHSM, and that building a stronger and robust evidence base for PHSM can help to improve our understanding and better inform approaches to minimize such adverse consequences;

(PP8) Recognizing that, despite the critical role of PHSM in preventing and controlling epidemics and pandemics, advanced research and detailed data on the effectiveness and impact of PHSM is limited;

(PP9) Acknowledging the importance of expanding the evidence base to inform the implementation of PHSM that are targeted, effective, appropriate, equitable, adapted to local contexts, proportionate to the type, scale and severity of the specific risks and hazards, and that aim to maximize public health benefits, whilst minimizing their adverse consequences;

(PP10) Acknowledging the importance of increasing our understanding of the drivers and barriers, including behavioural factors, that prevent or enable national implementation and community and individual adherence to PHSM, including through social participation, effective risk communication, community engagement and infodemic management;

(PP11) Recognizing the inherent challenges in conducting research on PHSM due to their complex, multisectoral nature and that national research, ethical and legal frameworks do not necessarily provide for research on PHSM;

(PP12) Recalling resolutions WHA58.34 (2005) acknowledging that high-quality, ethical research and the generation and application of knowledge are critical to achieving internationally agreed health-related development goals and WHA63.21 (2010) outlining WHO's role and responsibilities in health research;

(PP13) Recalling resolution WHA74.7 (2021) on strengthening WHO preparedness for and response to health emergencies, which requests the Director-General to, in consultation with Member States, develop a global framework to generate, monitor, compare and evaluate research and policies on public health and social interventions and assess their broader impact in order to harness global

knowledge and expertise and to translate evidence into effective health emergency and preparedness policies;

(PP14) Recognizing that research on PHSM should be well designed, methodologically rigorous, and well implemented in accordance with applicable ethical guidelines and taking into account social and cultural sensitivities, and that this research could benefit from appropriate robust digital health ecosystems that are in accordance with applicable legal frameworks and facilitate seamless data exchange, data compatibility, integration, and application across healthcare systems;

(PP15) Noting also that research and evaluations of PHSM are likely to be most informative and supportive of fair and effective implementation when carried out in various settings, in countries at all levels of income categories, and include research participants from the populations that the intervention is targeted towards, including those that are under-represented and from various cultural backgrounds;

(PP16) Underlining the importance of equity and transparency in research on PHSM, including sharing of information, in line with national laws and protocols, on the results of PHSM research, including both positive and negative findings;

(OP)1. URGES Member States,[4] as appropriate and in accordance with national laws priorities and contexts:

(1) to support, as appropriate, the development and strengthening of national PHSM research capabilities and quality-control frameworks for research on PHSM;

(2) to build capacity for PHSM research to inform cross-sectoral decision-making and implementation by inter alia integrating research on PHSM, as appropriate, as a component of public health emergency training program curricula;

(3) to encourage an agile response to opportunities to gather evidence on the effectiveness, impact and consequences of PHSM as well as through systematic monitoring and evaluation of PHSM policies during health emergencies;

(4) to consider integrating models of behavioural and social change and decision-making into research on PHSM, including through social participation, whilst taking a whole-of-government and whole-of-society approach to PHSM research;

(5) to share data generated from PHSM research, as well as monitoring and evaluation of PHSM applied during public health emergencies, systematically and transparently, as appropriate and in line with applicable legal frameworks and policies on data protection and supported by robust digital health ecosystems that facilitate seamless data exchange where relevant;

(6) to encourage research funding agencies to consider supporting well-designed PHSM research that is robust, conducted in various settings, takes into account equity principles, seeks to include research participants from the populations the intervention is likely to affect most and monitors adverse consequences, in order to produce actionable evidence to inform public health policy, practice and decision-making;

(7) to support national and regional ethics committees and regulatory authorities in enabling efficient governance processes that focus on the fundamental scientific and ethical principles underpinning population-based intervention research, including PHSM intervention research and trials;

[4] And, where applicable, regional economic integration organizations.

(8) to support the highest level of human research subject protections, including personal data protection and minimizing risks to participants;
(9) to review and, if necessary, consider revising legislation to support and enable timely and agile PHSM research;
(10) to consider how proportionate, relevant and context-specific PHSM research can be integrated into pandemic prevention, preparedness and response plans;
(11) to work with WHO and relevant stakeholders, including regional partners, to strengthen the evidence base for PHSM, as appropriate;

(OP)2. REQUESTS the Director-General:
(1) to support Member States, upon request, in addressing methodological, legal and ethical considerations in order to strengthen and improve PHSM research;
(2) to collate, review and update existing guidance as needed on best practices for PHSM research, including recommendations on key data that would facilitate their interpretation in different settings as well as for monitoring adverse consequences;
(3) to support Member States, as appropriate, in developing study protocols that are ready for use in different settings and make available ethical guidelines for PHSM research, including trials, monitoring or programme evaluation that Member States can adapt to their own settings;
(4) to present a substantive report outlining progress in the activities requested of the Director-General in this resolution for consideration by the Seventy-ninth World Health Assembly in 2026 through the Executive Board at its 158th session.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[5]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:
2.2.1. Research agendas, predictive models and innovative tools, products and interventions available for high-threat pathogens

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:
Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:
Not applicable.

4. Estimated time frame (in years or months) to implement the decision:
Not defined. Costing to be estimated up to 2030.

[5] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic “bridge” between results structures can be provided as needed.

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:
US$ 18.13 million.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:
US$ 2.87 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:
Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:
US$ 5.96 million.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:
US$ 9.30 million.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions

- **Financial resources available to fund the decision in the current biennium:**
  US$ 0.90 million.
- **Remaining financing gap in the current biennium:**
  US$ 1.97 million.
- **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
  Discussions are ongoing with selected Member States that have strong strategic and technical interests in this draft decision.

Table. Breakdown of estimated resource requirements (in US$ millions)[a]

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	0.31	0.26	0.22	0.26	0.22	0.24	0.82	2.33
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.54	0.54
	Total	0.31	0.26	0.22	0.26	0.22	0.24	1.36	2.87
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	0.64	0.53	0.46	0.55	0.46	0.49	1.71	4.84
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	1.12	1.12
	Total	0.64	0.53	0.46	0.55	0.46	0.49	2.83	5.96
B.4. Future bienniums cost of resources to be planned	Staff	1.00	0.83	0.72	0.86	0.72	0.77	2.66	7.55
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	1.75	1.75
	Total	1.00	0.83	0.72	0.86	0.72	0.77	4.41	9.30
B.1. Total planned costs required to implement the decision									18.13

[a] The row and column totals may not always add up, owing to rounding.

The representative of TOGO, speaking on behalf of the Member States of the African Region, commended WHO's progress in strengthening health emergency preparedness, response and resilience. The climate crisis had a profound impact on global health, particularly in humanitarian settings and, in the light of the increasing incidence of climate-related health emergencies, she urged the Secretariat to establish a permanent system to support the response to such emergencies. She outlined the health emergencies that her Region had experienced, the progress made and remaining challenges. She called on the Secretariat to establish a comprehensive platform for health workers involved in health emergencies, leverage artificial intelligence and technology to improve risk monitoring and assessments, increase collaboration through strengthened networks and partnerships and improve primary healthcare to stop the spread of vaccine-preventable diseases.

The representative of SENEGAL said that the increase in the number and complexity of emergencies, many of which were caused by extreme hydrometeorological events, was concerning. Member States must work more closely to improve prevention, detection and response strategies, and consider data on the health-related impact of climate change when designing national public health policies and carrying out epidemiological surveillance. Strengthening and coordinating rapid response and emergency medical teams was important to improve emergency responses. His Government stood ready to work with other Member States and international partners to strengthen global health security.

The representative of POLAND, speaking on behalf of the European Union and its Member States, said that the candidate countries North Macedonia, Montenegro, Serbia, Albania, Ukraine and the Republic of Moldova, as well as Armenia and Georgia, aligned themselves with her statement. Health emergencies, which were becoming more frequent and longer-lasting, generated long-term social and economic impacts, increased health inequalities and hindered progress towards achieving the Sustainable Development Goals. Armed conflicts and the triple planetary crisis spurred migration, strained health systems and increased health insecurity. Despite WHO's support for crisis-affected countries, funding gaps and significant budgetary earmarking hindered emergency preparedness and response efforts, and the Organization's financing may worsen with the withdrawal of its single largest donor country. It was in the collective interest to ensure that WHO had the financial and human resources necessary to carry out its mission. The WHO Health Emergencies Programme was crucial to that mission, and she welcomed its ongoing reorganization and streamlining.

The threats posed by zoonoses continued to evolve, and it was essential to be able to assess risks and respond swiftly and comprehensively through coordinated and proactive international action and the One Health approach. The European Union and its Member States remained committed to the successful conclusion of the work of the Intergovernmental Negotiating Body to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response. Links with regional offices must be enhanced to adapt core health emergency responses to regional specificities, and she welcomed the strategy and action plan on health emergency preparedness, response and resilience in the WHO European Region. Outlining the work that the European Union had carried out alongside WHO, she expressed her commitment to health security. Prevention and preparedness saved lives, while transparency ensured that resources were used efficiently.

The representative of AUSTRALIA, underscoring the importance of ensuring that all populations and potential partners were included in WHO's work, commended WHO for its central role in coordinating and responding to concurrent, acute and protracted health emergencies and for its efforts to support Member States to strengthen emergency preparedness and response. He

acknowledged the finding of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme that the increase in WHO operations was not financially sustainable. Discussions to determine areas of focus should therefore be realistic, and an appropriate balance should be struck between preparedness and response activities. The Secretariat should implement the Standing Committee's recommendations to leverage on-the-ground partners through the cluster system, work with the strengths of the WHO Health Emergencies Programme and bolster training across the Organization, particularly at the country level.

He encouraged Member States to continue making voluntary contributions to the WHO Health Emergencies Programme. While the establishment of an access and allocation mechanism for mpox medical countermeasures was commendable, it was essential to conclude a pandemic agreement that established a global supply chain and logistics network. He appreciated WHO's ongoing efforts to support Member States in strengthening national emergency prevention, preparedness and response capacities and urged the Secretariat to continue to monitor and report attacks on medical personnel, units and transport in line with resolution WHA73.8 (2020) on strengthening preparedness for health emergencies: implementation of the International Health Regulations (2005).

The representative of BRAZIL said that dengue and other Aedes-borne arboviral diseases – the spread of which was facilitated by climate change – presented challenges in areas beyond health, including education, social communication, basic sanitation and other social determinants of health. It was essential to address limited access to healthcare and medical supplies, including vaccines, in outbreak areas. She supported WHO's call for sustainable funding and enhanced international coordination to combat dengue and other health emergencies. She acknowledged WHO efforts to strengthen surveillance, preparedness and response, and to develop a global surveillance system. It was to be hoped that the necessary US$ 55.5 million could be mobilized to bolster global response capabilities.

The declaration of mpox as a public health emergency of international concern had underscored the need for greater solidarity to ensure equitable access to countermeasures. The pandemic agreement must therefore include meaningful provisions to guarantee access to vaccines, treatments and diagnostics during pandemics, public health emergencies of international concern and at the onset of disease outbreaks.

Concerning the draft decision, increased knowledge of the implementation and impact of public health and social measures across different contexts and populations would be crucial to improving preparedness and responses to future public health threats.

The representative of ISRAEL said that the report should include a clearer overview of emergency operations, the allocation of resources to the various programmes and measurable goals and achievements. To streamline processes and increase transparency, the current agenda item should cover all health emergencies; the health situation in one country alone should not be singled out under a separate agenda item. There was no transparent, updated overview concerning the funds allocated under the programme of assistance to the Syrian Arab Republic. Similarly, the report did not explain how WHO planned to implement programmes in Yemen or how many people those programmes would reach. More detailed information was also needed in the report on the health emergency programme in Sudan. Furthermore, including examples of successful cooperation could increase willingness to provide financing.

The representative of the REPUBLIC OF MOLDOVA said that the impact of emergencies required global cooperation and the prioritization of resources. Current humanitarian needs, such as those arising from the illegal and unjustified war in Ukraine, were concerning. She called on all

interested parties to urgently support the WHO Health Emergencies Programme, while all Member States should contribute to the WHO Contingency Fund for Emergencies and other financing mechanisms. She supported WHO's commitment to fostering preparedness and resilience at the national, regional and global levels; greater collaboration between Member States was vital to ensure efficient, effective and equitable emergency responses. Member States should embrace regional and global agendas to that end.

The representative of BULGARIA said that her Government prioritized health security and continued to support the work of the Intergovernmental Negotiating Body in the hope that a meaningful and implementable agreement could be reached. Emerging health threats required cross-cutting tools and innovative solutions, and the inability to deal with adverse factors put the global community at risk. Member States should prioritize sustainable funding. She supported the conduct of studies on non-pharmaceutical measures to accumulate evidence, optimize anti-epidemic activities and counter disinformation. The WHO Regional Office for Europe's risk communication and community engagement resources could help to protect health during early responses to health threats. The European Centre for Disease Prevention and Control and the Global Outbreak Alert and Response Network had established a pool of experts ready to respond to health emergencies. Maintaining such regional mechanisms could improve response times to emerging hazards.

The representative of LEBANON, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that a third of the health emergencies recorded worldwide in the year 2024 had occurred in her Region, with outbreaks of measles, cholera, dengue and other diseases fuelled by conflict, fragility, disrupted surveillance and control systems and the effects of climate change. The most devastating humanitarian crises had unfolded in the occupied Palestinian territory, Sudan and Lebanon. Attacks on healthcare, two thirds of which had occurred in her Region, had become an unacceptable norm – the sanctity of health and healthcare must be preserved. Recovery from the damage inflicted on health systems could take decades, and she urged Member States to ensure that such efforts remained a priority. Applauding the bravery and sacrifice of frontline health workers, she welcomed the recent ceasefire agreements in Lebanon and the Gaza Strip and expressed the hope that similar progress could be made in Sudan. Collective efforts should focus on preventing wars, upholding international humanitarian law and protecting human rights, as well as on providing support to those experiencing the most unbearable situations. The Secretariat should strengthen cooperation with partners through existing coordination platforms, such as the Regional Health Alliance, and replicate such mechanisms in other regions.

The representative of CHINA, noting with appreciation WHO's work in coordinating the response to emergencies, said that the Secretariat should clearly specify how it intended to use funds when launching appeals for public health emergency responses and emphasize how those funds would save lives and meet the health needs of vulnerable populations. The Secretariat should also communicate with Member States and partners to increase transparency, facilitate dialogue on funding strategies and coordinate resources and actions when exploring sustainable financing solutions.

Community and primary healthcare systems, and the enhancement of their capacity, were key to health emergency prevention, detection and response. To that end, the Secretariat should make policy recommendations, develop guidelines and provide low-capacity developing countries with technical support and resources to detect, diagnose and report diseases. Global health organizations should improve the coordination of financing, technology and human resources.

Meanwhile, Member States should enhance solidarity and cooperation to ensure that resources were directed to where they were most needed.

The representative of the REPUBLIC OF KOREA, highlighting that her Government had recently made voluntary contributions to the WHO Contingency Fund for Emergencies, said that the amendments to the International Health Regulations (2005) were critical to reshaping the global health landscape, and the conclusion of an inclusive and implementable pandemic agreement would be equally significant. The recent outbreak of novel influenza pathogens underscored the persistent threat of pandemics. Collective action by the Secretariat and Member States could help to build a more robust and resilient response to future pandemics. In that regard, international mechanisms to ensure the equitable distribution of vaccines, antiviral agents and medical equipment should be strengthened. It was important to enhance information sharing and leverage artificial intelligence-powered predictive modelling to improve pandemic forecasting. Global health disparities must be reduced through technology transfers and capacity-building initiatives between developed and developing countries.

The representative of the DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA said that emergency preparedness, resilience and response efforts required a whole-of-government and whole-of-society approach, along with government commitment and guidance. It was important to remain persistently alert to the risk of an epidemic and build national emergency responses and anti-epidemic capacity at any cost. The Secretariat should enhance its technical and logistical support and mobilize resources, with a view to strengthening health emergency preparedness and response and mitigating impacts.

The representative of SWITZERLAND expressed concern that certain WHO programmes that responded to acute health needs were at immediate risk. The recent hiring freeze meant that the Organization was already losing experts, many of whom were highly specialized and played key roles in pandemic influenza immunization, surveillance and preparedness. She asked how the Secretariat would protect vital work in those important areas and in other essential functions. Her Government would continue to provide support in that area.

The work of emergency medical teams coordination cells was appreciated but could be streamlined by ensuring that country offices provided support to active coordination cells and helped to build the capacity of national emergency medical teams at the request of health ministries. Those efforts would increase resilience within communities and health systems and ensure a more effective response to future crises.

The representative of NORWAY said that WHO's work was critical to providing life-saving healthcare and strengthening pandemic preparedness and response. Her Government condemned the unacceptable attacks on health workers and facilities, which must be protected. Parties to conflicts should comply with international humanitarian law and ensure that basic civilian needs were met. All donors should prioritize the WHO Health Emergencies Programme.

The draft decision aimed to promote the generation and sharing of evidence for more effective and evidence-informed decision-making and implementation, taking into account different contexts and populations. Efforts had been made to align the draft decision with the Fourteenth General Programme of Work, 2025–2028. She would welcome further discussions on how to avoid overburdening the Secretariat, given the large number of draft decisions and resolutions proposed during the current session of the Executive Board.

The representative of COSTA RICA said that the actions outlined in the report to strengthen response capacities should be implemented at the national and international levels.

Epidemiological surveillance, interinstitutional coordination and health infrastructure should be strengthened to respond effectively to public health emergencies.

To secure more sustainable and efficient financing for health emergencies, collaboration with other international organizations should be increased, opportunities to work with the private sector and nongovernmental organizations should be explored, and sources of funding should be diversified. The process to prioritize funds for health emergencies and vulnerable populations should be transparent in order to build trust.

To enhance cooperation with Member States and partner organizations, the WHO Incident Management System should be strengthened and information should continue to be exchanged in real time through platforms such as the Event Information Site for national IHR focal points. Efforts to build national and regional surveillance, prevention and response capacities should continue, as should the adoption of a One Health approach to tackling complex emergencies. Prevention measures should be prioritized, with a view to reducing costs, improving response efficiency and fostering health system resilience, including at the community level.

The representative of BARBADOS said that it was essential to ensure that WHO was able to respond promptly to health emergencies. The Secretariat should make sure that Member States submitted timely and accurate reports of emerging public health threats. It should also implement the Incident Management System at the subregional level to decrease response times; integrate factors such as human conflict, population displacement, the free movement of people and climate change into health emergency planning and response strategies; prioritize its health emergency work, particularly for small island developing States; and integrate its responses with those of other entities of the United Nations system to maximize resources and outcomes.

The representative of THAILAND expressed her support for the draft decision. The COVID-19 pandemic had highlighted the importance of social participation, regulated research, local adaptability and strong policies to enhance the effectiveness of public health and social measures. Research on such measures should be context specific, aligned with community behaviours and cultural dynamics, and focused on how public trust in governments influenced effectiveness. Robust methodologies and systematic reviews should be adopted to identify effective interventions, including those to counter misinformation and disinformation.

She supported efforts to diversify WHO funding sources for public health emergencies, attract non-traditional donors and secure more flexible voluntary contributions. Through the WHO Foundation, the Organization should aim to replicate the success of UNICEF in raising funds through individual and private sector donations. She supported the Director-General's proposal to establish an endowment fund to sustainably finance emergency preparedness and response efforts.

The representative of BRUNEI DARUSSALAM commended the work carried out through the WHO Health Emergencies Programme, including the WHO Contingency Fund for Emergencies. The effects of climate change, conflicts and infectious disease outbreaks highlighted the fragility of health systems, particularly in humanitarian settings, and underscored the importance of regional solidarity. The increase in attacks on health workers and facilities was concerning, and Member States must ensure their protection in line with international humanitarian law.

Partnerships and coordination with other entities of the United Nations system, international financial institutions and regional organizations should be reinforced, and aligning funding priorities and pooling resources would enhance the effectiveness of emergency operations and reduce duplication of efforts. He echoed the call for further investment in resilient health systems.

The representative of MALDIVES said that climate change, extreme weather events and limited resources intensified the impact of health emergencies in small island developing States. The Secretariat should explore innovative financing solutions, such as a dedicated finance facility for health emergencies; strengthen collaboration with international financial institutions and donors; and ensure the efficient and equitable allocation of funds. Moreover, the Secretariat should increase its efforts to facilitate information sharing, joint planning and coordinated responses; support the development of regional and national emergency response plans that were aligned with the International Health Regulations (2005); and promote cross-sectoral collaboration, including by integrating climate resilience and disaster reduction strategies into health emergency preparedness and response efforts. The establishment of the Pandemic Fund was welcome, and the Secretariat must ensure equitable access to financial resources, particularly for vulnerable countries. She urged the Secretariat to prioritize sustainable financing, enhanced cooperation and resilient health systems in its emergency response efforts.

The representative of LEBANON thanked WHO for the support it had provided during the devasting humanitarian crisis in her country, which had placed further strain on the already fragile health system. She outlined measures to strengthen the national health system and respond to the humanitarian situation, which threatened the public health of Lebanon and neighbouring countries. International solidarity was crucial in tackling such crises. The Secretariat should scale up its financial and technical support to strengthen health systems and should focus on securing sustainable funding in order to deliver essential functions to countries facing crises. Her Government supported the draft decision and wished to be added to the list of sponsors.

The representative of ETHIOPIA said that developing regional resources, including shared stockpiles, teams and cross-border agreements, was critical to providing a unified response to health threats. However, it was also necessary to enhance national health emergency prevention, preparedness and response capabilities and develop a comprehensive emergency workforce platform. She called for more support in deploying WHO-classified teams in the African Region. It was important to build robust networks and partnerships, foster collaboration, share knowledge and disseminate best practices among partners and public health responders at the regional and global levels, including through the WHO Academy and regional training and knowledge hubs for emergency medical teams. Sustainable, predictable and readily available financing for health emergencies was crucial to save lives and maintain essential health services. It was to be hoped that a pandemic agreement with meaningful provisions to operationalize equity would be concluded by May 2025. She endorsed the draft decision.

The representative of the FEDERATED STATES OF MICRONESIA expressed appreciation for the training that WHO had provided to national staff, which should be sustained. Real-time surveillance of global, regional and national emergencies should be prioritized. As part of its standard operating procedures, WHO should ensure that regional stockpiles of emergency assets, supplies and therapeutics were available and could be delivered to emergency areas within 24 hours. The Secretariat should also work directly with national authorities before, during and after emergency responses. The presence of adequately resourced country offices with appropriate technical capacities and skills – particularly in small island developing States – would help to prevent local emergencies from developing into pandemics.

The representative of SOMALIA, outlining the infectious diseases that were prevalent in his country and the challenges that exacerbated outbreaks, recommended that the Secretariat support countries in building health system resilience, particularly in fragile and conflict settings; strengthen national, regional and global coordination mechanisms to ensure timely and effective

responses to emergencies; prioritize emergency preparedness; and work closely with countries to develop and implement comprehensive preparedness plans to address acute and protracted emergencies, with a focus on early detection and response. He called on Member States and international partners to increase funding to ensure that resources were available to address emergencies in the short and long term.

The representative of FRANCE[6] expressed his appreciation for the work of WHO and its partners to respond rapidly to the ever-increasing number of crises. Response efforts required strong coordination among all actors; a whole-of-society approach that included non-State actors; and an approach driven by regional offices and regional coordination mechanisms. He was grateful for the support that the Regional Office for Europe had provided to Mayotte in the wake of Cyclone Chido, which had helped to prevent the spread of waterborne diseases. In the light of the impact that the current budgetary situation would have on the WHO Health Emergencies Programme, he urged the Secretariat to continue to prioritize essential programmes.

The representative of INDONESIA,[6] highlighting the large number of attacks on health workers and facilities recorded in the year 2024, said that international humanitarian law must be upheld and enforced. Critical funding gaps were concerning, and stronger, more coordinated and more sustainable responses were needed to address increasingly complex health challenges. Welcoming the launch of the WHO Health Emergency Appeal for 2025, she called for flexible financing for the WHO Contingency Fund for Emergencies. The Secretariat must help Member States to strengthen health systems, in part by building strong partnerships, and enhance risk assessment, surveillance and early warning systems for emerging outbreaks.

The representative of FINLAND,[6] welcoming the amendments to the International Health Regulations (2005) and looking forward to a meaningful conclusion of the Intergovernmental Negotiating Body process, said that the current financial situation must not affect WHO's work on health emergency response and preparedness. Preventive measures, starting at the community level, should be considered an investment in health and well-being.

The representative of KNOWLEDGE ECOLOGY INTERNATIONAL, INC., speaking at the invitation of the CHAIR and also on behalf of Stichting Health Action International, the World Council of Churches, the World Blind Union and Oxfam, said that it was regrettable that some world leaders appeared to prioritize their industrial and trade goals over health and rejected a multilateral and collegiate approach. Technology transfers were key to scaling up the manufacture of, and access to, medical products and could be achieved by authorizing the use of patented inventions, ensuring access to manufacturing know-how and materials and enforcing the right to access information from regulatory filings. Member States must have legal and policy space to use mandatory measures when voluntary agreements were unavailable or inadequate. Although the current draft of the pandemic instrument contained useful and important provisions on transparency, they fell short of the standards set out in resolution WHA72.8 (2019) on improving the transparency of markets for medicines, vaccines and other health products. The transparency of the negotiations should also be enhanced, with the Intergovernmental Negotiating Body continuing to release a version of the negotiated text daily and to provide a webcast of non-State actor statements for the duration of the plenary sessions. Excessive secrecy in the negotiations contributed to the spread of false narratives and mistrust in WHO.

[6] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of PARAGUAY[7] said that health emergencies must not further entrench inequality. Sustainable and predictable financing was necessary for WHO to guarantee rapid, effective and equitable responses to health emergencies, particularly for developing countries with limited budgets. Introducing mechanisms to respond to emergencies and strengthen health systems required strategic investments in epidemiological surveillance, stockpiles of essential supplies and updates to contingency plans. Coordination between humanitarian actors, governments and the private sector was crucial, while cooperation between countries and organizations helped to promote early warning systems, real-time data-sharing platforms and updates to response protocols. She supported the inclusion of the Republic of China, Taiwan,[8] in WHO technical meetings, activities and work mechanisms.

The representative of MONACO[7] said that it was essential to protect health workers and their efforts through sufficient and sustainable financing. Donors must therefore mobilize resources for the WHO Health Emergencies Programme. Meanwhile, the Secretariat, Member States and humanitarian organizations must strengthen their coordination and collaboration to ensure equitable resource allocation. Building the resilience of health systems, sharing best practices and investing in health surveillance – including early warning systems – would help communities to deal effectively with emergencies and protect the most vulnerable.

The representative of SPAIN[7] said that, in the light of the announced withdrawal of the main financial contributor to the WHO Health Emergencies Programme and the increased frequency of health emergencies, it was crucial to intensify efforts to secure funding and ensure coordination. Doing so would ensure that healthcare continued to be provided, particularly to populations affected by armed conflict. He condemned attacks on health facilities, which violated international law and deepened humanitarian crises.

Sustainable, timely and predictable funding was necessary to develop, strengthen and maintain basic capacities within Member States. It was also necessary to promote the effective use of existing financial instruments established under the International Health Regulations (2005) and create the Coordinating Financial Mechanism under the Regulations. Essential initiatives, such as emergency medical teams, should not be affected by financial challenges. The successful conclusion of an ambitious and equitable international pandemic treaty would be key to improving coordination at the global level and to strengthening the resilience of communities and health systems. He urged Member States to adopt a flexible and constructive approach to negotiations.

The representative of GERMANY[7] commended WHO staff for their work to tackle health emergencies in extremely challenging conditions. The decision of the United States of America to withdraw from WHO had major implications for WHO's core functions, particularly those concerning global health security, and immediately affected expertise and funding. WHO should take all measures necessary to secure flexible and sustainable funding for severely underfunded functions, and she requested further information from the Secretariat about how it would address funding gaps. A strong pandemic agreement was paramount to upholding global health security functions and to health emergency prevention, preparation and response. Maintaining and prioritizing work in health emergencies was in Member States' collective and national interest. She called on Member States to increase their commitments to the WHO Contingency Fund for Emergencies and acknowledged the importance of the work conducted by the WHO Hub for

[7] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[8] World Health Organization terminology refers to "Taiwan, China".

Pandemic and Epidemic Intelligence. To tackle current challenges, it was essential to pool expertise and ensure inclusivity.

The representative of NAMIBIA[9] commended the Secretariat for its agile and robust support for Member States in responding to health emergencies and welcomed the establishment of 10 public health emergency operations centres across Africa. The Secretariat must collaborate with relevant stakeholders, including the World Bank and the IMF, to support developing countries in addressing their international debt burden. Facilitating debt restructuring reforms would help to build a more solid financial foundation for Member States, improve health outcomes and resilience against health emergencies and enable African countries to allocate more resources to domestic health.

The representative of the INTERNATIONAL FEDERATION OF PHARMACEUTICAL MANUFACTURERS AND ASSOCIATIONS, speaking at the invitation of the CHAIR and also on behalf of Global Diagnostic Imaging Healthcare IT and Radiation Therapy Trade Association, the Global Self-Care Federation, the International Pharmaceutical Federation, the International Alliance of Patients' Organizations and the International Generic and Biosimilar Medicines Association, said that disease outbreaks in the year 2024 had demonstrated the need to strengthen health systems, enhance surveillance mechanisms, improve regulatory procedures, remove trade barriers and develop accurate forecasts to guide the scaling-up of production. Equitable access to vaccines, diagnostics and treatments must be ensured while safeguarding innovation. WHO should direct its limited resources towards normative, policy and technical guidance and engage with all key stakeholders and experts. The private sector should be consistently and systematically included in WHO health emergency initiatives and discussions.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND[9] acknowledged the increasing funding required for WHO to respond to graded and ungraded emergencies and the need to effectively prioritize resources for critical responses. It was important to support mechanisms that empowered the Secretariat to respond to evolving priorities and address dynamic challenges, such as vaccine shortages and climate-related crises. Her Government was committed to working with international partners towards a pandemic accord that enhanced global health security and recognized the value of the One Health approach and the importance of zoonotic disease preparedness. It was also important to draw on expertise from around the world to build global health resilience.

The representative of BANGLADESH[9] expressed alarm at the large number of attacks against health workers and facilities, which were unacceptable. The calls from developing countries to increase funds to tackle future health emergencies had not been heeded, despite the large number of people requiring humanitarian assistance. The absence of legally binding commitments to provide new and additional financial resources in the current draft of the pandemic agreement was a collective failure. It was essential to design a transparent, effective and accountable system that included commitments to share monetary and non-monetary benefits, including access to vaccines, therapeutics and diagnostics. A flexible donor fund could help to ensure predictable financing for the WHO Health Emergencies Programme. It was essential to support vulnerable populations during health emergencies to protect global health.

[9] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of PANAMA[10] called on Member States to redouble their efforts to conclude a pandemic agreement that would enter into force rapidly, enabling the Conference of the Parties to continue working on guidelines, annexes and protocols. Agreements and strategic partnerships between financial institutions, development organizations and the private sector should be used to establish a multilateral emergency fund with sustainable contributions that could be activated immediately. Audits, monitoring and accountability would ensure the transparent use of that fund and support for vulnerable populations. It was essential to foster international cooperation through enhanced communication between Member States; draw on standardized protocols and platforms to share best practices and lessons learned and to develop guidelines to allocate resources effectively; and avoid duplication and ensure the interoperability of surveillance and response systems. Ensuring resilient systems, guaranteeing access to essential services and protecting health workers and community leaders were essential to emergency prevention, preparedness and response.

The representative of PAKISTAN,[10] noting that conflict and the effects of climate change were aggravating health emergencies, expressed his commitment to work with global partners to eradicate poliovirus. He was deeply concerned about the worsening health conditions caused by conflicts, particularly in the Eastern Mediterranean Region. Palestinians continued to suffer physical and psychological trauma and would require long-term support from WHO and global partners. He condemned the deliberate attacks on health infrastructure, including in the Gaza Strip, which underscored the need to protect healthcare facilities and adhere to international humanitarian law. His Government was committed to concluding an equity-based pandemic agreement and looked forward to the effective implementation of the amended International Health Regulations (2005).

The representative of NIGER[10] said that traditional approaches to health investment that targeted specific diseases had a limited impact, with efforts to achieve universal health coverage requiring a more comprehensive and inclusive approach that involved pooling resources. Recent epidemics had demonstrated the vulnerability of health systems and the need for new strategies to strengthen primary healthcare. Health security could be improved by mobilizing communities, raising awareness and ensuring the availability and rational use of high-quality medicines. Primary healthcare was essential to building health system resilience.

The representative of ESWATINI[10] said that the African Region continued to face health crises that stretched already fragile health systems and, while WHO's role in strengthening early warning systems, emergency responses and health system resilience was appreciated, gaps in support persisted. She called for sustainable and predictable financing to support WHO's emergency responses and national preparedness efforts; the equitable and timely distribution of vaccines, diagnostics and treatments; investment in workforce training and the local manufacture of medical products; and regional coordination and enhanced collaboration to better prevent, detect and respond to health threats. Greater global solidarity could protect the health and well-being of all.

The representative of SINGAPORE[10] said that public health and social measures were key to the global response to epidemics at all stages. Through robust research, the effectiveness of such measures could be evaluated to guide policy-making. It was important to share findings and best

[10] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

practices to avoid duplicating efforts, and Member States should tailor measures to their unique circumstances.

The representative of URUGAY,[11] welcoming the amendments to the International Health Regulations (2005) and looking forward to the conclusion of a pandemic agreement, said that cooperation and preparedness were more crucial than ever to tackling health emergencies. She called for increased international cooperation, public health investment and epidemiological surveillance to enhance global resilience to future crises. Protecting health was a global effort.

The representative of the PHILIPPINES[11] said that strengthening core capacities at the national and international levels – including by enhancing surveillance, early warning and rapid response systems – remained crucial to mitigating health emergencies. The Secretariat must continue to support Member States by strengthening international countermeasure-sharing agreements, expanding the One Health workforce and steering the process to earmark funds for the implementation of the International Health Regulations (2005).

The representative of the INTERNATIONAL ASSOCIATION FOR HOSPICE AND PALLIATIVE CARE, INC., speaking at the invitation of the CHAIR, said that she was also speaking on behalf of HelpAge International, the International Federation of Surgical Colleges Limited, the Union for International Cancer Control, the World Federation of Societies of Anaesthesiologists and The Worldwide Hospice Palliative Care Alliance. To prevent suffering during health emergencies, it was essential to guarantee secure supply chains, stockpile essential medicines and ensure that emergency response teams were trained to use them. Member States should also invest in anaesthesia and intensive care services that could provide medical oxygen; basic pain and palliative care services staffed by trained personnel; community-based mental health services; sustainable cancer care; and support and essential medicines for vulnerable groups. Member States and WHO emergency response teams should have adequate supplies of oral and injectable essential medicines in formulations for all ages, prepare health workers to administer those medicines safely and conduct public health information campaigns to provide evidence-based information about essential medicines.

The representative of the GLOBAL HEALTH COUNCIL, speaking at the invitation of the CHAIR, said that she was also speaking on behalf of Association Africaine des Centrales d'Achats de Médicaments Essentiels, the European Association for Injury Prevention and Safety Promotion, HelpAge International, Humatem, the International Alliance of Patients' Organizations, the International College of Surgeons, the International Federation of Gynecology and Obstetrics, the International Federation of Medical Students' Associations, the International Federation on Ageing, the International Planned Parenthood Federation, The International Society for Quality in Health Care Company Limited by Guarantee, the International Society of Physical and Rehabilitation Medicine, the International Union for Health Promotion and Education, the Multiple Sclerosis International Federation, Public Services International, The Save the Children Fund, The Royal Commonwealth Society for the Blind – Sightsavers, The Task Force for Global Health, Inc., Women Deliver, Inc., Women in Global Health, Inc., the World Federation for Mental Health, the World Federation of Hemophilia and The Worldwide Hospice Palliative Care Alliance.

Health emergencies critically undermined health equity, which disproportionately affected the most vulnerable. Governments and the international community must prioritize at-risk groups; collect data disaggregated by gender, age and disability to inform equity-based responses; ensure inclusivity in crisis response strategies; deliver tailored health interventions to address the unique

[11] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

needs of vulnerable groups; ensure universal health coverage, the uninterrupted delivery of essential medical supplies and access to water, sanitation and hygiene; hold those responsible for attacks on health systems and workers accountable; urge the United Nations and regional and global actors to place the protection of health facilities and workers at the centre of the peace and security agenda; provide frontline health professionals with security training, protective equipment and legal protection; diversify the production of essential health technologies; strengthen the production capacity of low- and middle-income countries; and enhance global funding streams and establish innovative financing tools.

The representative of the NCD ALLIANCE, speaking at the invitation of the CHAIR, said that she was also speaking on behalf of The Royal Commonwealth Society for the Blind – Sightsavers, the International Society of Nephrology, HelpAge International, the International Diabetes Federation, the Multiple Sclerosis International Federation, PATH, the International Society on Thrombosis and Haemostasis, Inc., FDI World Dental Federation, the International Association for Suicide Prevention, the International Rescue Committee, Inc., The Worldwide Hospice Palliative Care Alliance and The Fred Hollows Foundation.

Highlighting the importance of WHO's work on emergency preparedness and noncommunicable diseases, she said that people living with noncommunicable diseases must be recognized as a vulnerable group in health emergencies and humanitarian settings, and essential noncommunicable disease services should be integrated into every stage of the emergency cycle. Member States should collect data disaggregated by sex, age and disability on the prevalence, risk factors and treatment of noncommunicable diseases; ensure uninterrupted health services during emergencies by creating lists of essential medical supplies and tests for noncommunicable diseases; and train the health workforce on the prevention and treatment of noncommunicable diseases. She urged Member States to establish sustainable financing models to integrate noncommunicable disease prevention and treatment into development, humanitarian and health programmes.

The representative of ECUADOR[12] said that preparing for health emergencies and pandemics required comprehensive planning covering early detection, research, communication and technical and financial support from WHO, as well as capacity-building and improved access to cutting-edge technologies. To strengthen the notification of public health events that could constitute health emergences, it was necessary to expand the use of local indicators and improve the quality and timeliness of information, particularly in border areas and at the regional level.

The Observer of GAVI, THE VACCINE ALLIANCE, expressed concern about the increase in humanitarian needs and infectious disease outbreaks, which required coordinated efforts and more funding. Member States should establish predictable funding mechanisms for prevention, preparedness and response; invest in regional manufacturing, health systems and health workers; and prioritize timely and equitable access to vaccines and other resources.

The representative of MÉDECINS SANS FRONTIÈRES INTERNATIONAL, speaking at the invitation of the CHAIR, said that access to healthcare in emergencies required rapid national responses, supported by national coordination, earmarked in-country funding and swift access to life-saving healthcare products. Non-State actors must be allowed to provide emergency healthcare and must receive protection. Member States must uphold the International Health

[12] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Regulations (2005) and receive capacity-building support to ensure the continuity of high-quality healthcare during emergencies.

The representative of the MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION, speaking at the invitation of the CHAIR, said that armed conflicts, disease outbreaks, the effects of climate change and displacement significantly increased the risk that civilians, health workers and peacekeeping forces would contract infections, particularly sepsis. She therefore urged WHO to integrate sepsis into emergency preparedness plans and the pandemic accord.

The representative of ALZHEIMER'S DISEASE INTERNATIONAL, speaking at the invitation of the CHAIR, said that emergencies disproportionately affected people living with dementia and their carers and disrupted diagnostic, treatment, care and support services. WHO should be mindful of the specific needs of people living with dementia and work with national dementia associations in affected areas.

The representative of the INTERNATIONAL PHARMACEUTICAL FEDERATION, speaking at the invitation of the CHAIR, emphasized the need for inclusive and coordinated emergency response systems to protect the most vulnerable populations. He urged WHO to integrate pharmacists into strategies to strengthen health systems, and to empower young people to respond to health emergencies.

The representative of the MEDICINES PATENT POOL FOUNDATION, speaking at the invitation of the CHAIR, highlighted the importance of initiatives to strengthen regional capacity to address emerging threats and the need to ensure access to technology and know-how to build resilient health systems, through programmes such as his organization's mRNA Technology Transfer Programme. Investment in research and development, technology sharing and licensing models to ensure timely and affordable access to countermeasures would be crucial.

The representative of PUBLIC SERVICES INTERNATIONAL, speaking at the invitation of the CHAIR, called for more concerted efforts from Member States to tackle health emergencies, in part by funding public services, strengthening international solidarity and fostering decent working conditions. WHO's work in health emergencies must involve training health and care workers, and establishing partnerships with Member States to improve working conditions during health emergencies. Trade unions were crucial in that regard. WHO must also strengthen the capacity of countries of the global South to produce health technologies and to include intellectual property waiver mechanisms in legislation. The negotiations for a pandemic agreement represented a missed opportunity to introduce legally binding commitments for more financial resources.

The representative of the WORLD HEART FEDERATION, speaking at the invitation of the CHAIR, said that, given the significant challenges faced by people living with noncommunicable diseases in emergency settings, Member States must prioritize health services for noncommunicable diseases in emergency preparedness, response and recovery plans; elevate noncommunicable diseases in the dialogue on global health security; engage meaningfully with civil society and people with lived experience; and strengthen primary healthcare and universal health coverage.

The representative of the INTERNATIONAL LACTATION CONSULTANT ASSOCIATION, speaking at the invitation of the CHAIR, said that, as health emergencies contributed to food insecurity and limited access to reproductive healthcare, emergency preparedness, planning and response efforts should include strategies to protect infant and young child feeding. Providing information on and support for breastfeeding during emergencies secured the food supply for infants and

children and protected them against infection. The Infant Feeding in Emergencies Core Group provided comprehensive guidance that WHO could use in that regard.

The representative of INTERNATIONAL BABY FOOD ACTION NETWORK, speaking at the invitation of the CHAIR, said that the proposed draft Codex guidelines on the application of food labelling measures in emergencies presented a risk for baby foods. Instead, robust, coordinated emergency responses, such as relactation and skin-to-skin contact, should be used to improve infant survival. WHO must ensure that commercial agendas did not influence its emergency guidance and that food distribution did not do unintended harm to mothers and their children.

The meeting rose at 13:00.

Ninth meeting

Thursday, 6 February 2025, at 14:40

Chair: Dr J.X. Walcott (Barbados)

Pillar 2: One billion more people better protected from health emergencies (continued)

1. WHO's work in health emergencies: Item 15 of the agenda (document EB156/18) (continued)

The CHAIR recalled that the Board had before it a draft decision on strengthening the evidence-base for public health and social measures.

The representative of the RUSSIAN FEDERATION[1] said that his Government was ready and equipped to support others in the prevention of, and response to, health emergencies. He highlighted his Government's collaboration with Member States and the Secretariat in previous years, and its intention to develop more diagnostics and countermeasures for infectious diseases. He noted the increasing spread of infectious diseases, particularly in Africa, which posed a serious threat at the regional and global levels. Access to mobile laboratories and rapid testing was vital in emergency situations; standards for their use had been developed in his country in collaboration with the Secretariat.

The DEPUTY EXECUTIVE DIRECTOR (WHO Health Emergencies Programme) welcomed Member States' guidance and noted the comments on WHO's response to humanitarian crises, particularly concerning attacks on healthcare facilities, of which there had been more than 1500 in 2024. He reiterated the call to protect healthcare at all times.

He highlighted the work of the WHO Health Emergencies Programme in the ongoing mpox public health emergency of international concern, and in the Marburg virus disease and Sudan virus disease outbreaks. The current situation in Uganda demonstrated how the work of the WHO Health Emergencies Programme empowered leadership at the national level.

He noted Member States' comments on the deployment of human resources, and artificial intelligence and other new technologies. Advice provided concerning emergency medical teams as part of the health emergency prevention, preparedness, response and resilience framework was welcome. In the light of emerging funding constraints, he recognized the need to ensure that the WHO Health Emergencies Programme remained agile and used resources effectively.

The EXECUTIVE DIRECTOR (WHO Health Emergencies Programme) said that the health emergency prevention, preparedness, response and resilience framework was aligned with the Fourteenth General Programme of Work, 2025–2028. He welcomed Member States' collaboration in building emergency preparedness and response capacity at all levels. Currently deployed to Uganda, he outlined WHO's response activities to tackle the Sudan virus disease outbreak in

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Uganda, which highlighted the investment made at the national and regional levels in recent years. WHO Emergency Response Framework had been implemented, realigning functions in the country office, deploying an incident manager and rapid response staff from the WHO Regional Office for Africa and headquarters, and issuing emergency funding from the WHO Contingency Fund for Emergencies. Pre-positioned supplies to combat viral haemorrhagic fever had been deployed immediately.

He commended the Government's response to the outbreak, which had recognized the importance of community engagement and empowerment, and its collaboration with partners in the field. Emergency medical teams trained in the country had been deployed and two isolation units had been fitted out. To support surveillance and contact tracing, a data system developed by WHO and the Global Outbreak Alert And Response Network had been implemented with trained local staff, alongside a national alert management system. He commended the public health laboratories in Uganda for sequencing the virus and publishing the genetic sequence within 24 hours. WHO had been supporting preparations for the deployment of investigational vaccines and therapeutics in 16 countries potentially affected by Sudan virus disease through the Filovirus Collaborative Open Research Consortium, and he thanked all partners for their contributions. That work had led to the fastest deployment of a countermeasure vaccine for such a dangerous pathogen.

Turning to the Contingency Fund for Emergencies, he thanked all partners for their contributions to that Fund, which had been used to support responses within 24 hours for 22 emergencies in 2023 and 28 emergencies in 2024.

The DIRECTOR (Strategic Planning and Partnership) took note of the comments and questions regarding the impact of the announcement made by the Government of the United States of America concerning its membership of WHO. Currently, funding from the United States accounted for approximately 20% of funding for emergency appeal and acute response activities, and 25% of the core programme of the WHO Health Emergencies Programme. In the light of that immediate withdrawal of funding, the Secretariat was reviewing how to meet its existing humanitarian and acute response obligations on the ground, while safeguarding populations in need and health workers. The core programme of the WHO Health Emergencies Programme had been aligned with the health emergency prevention, preparedness, response and resilience framework and the Fourteenth General Programme of Work, 2025–2028. Within the funding constraints, work at the country level would be prioritized. An update on the prioritization of activities and funding would be provided at the Seventy-eighth World Health Assembly.

The Secretariat would continue to raise financing for the 2025 Health Emergency Appeal, which was currently only 65% funded. Activities would be scaled up or down according to the availability of resources. He also emphasized the importance of contributions to the Contingency Fund for Emergencies, the balance of which was currently US$ 22 million.

The DIRECTOR-GENERAL commended the Executive Director of the WHO Health Emergencies Programme for his work and the leadership demonstrated by those at the highest level in the subregion, which was prone to outbreaks of Marburg and Ebola virus diseases. He recalled the high-level commitment in the response to Marburg virus disease outbreaks in Rwanda and the United Republic of Tanzania, and to the various outbreaks of Ebola virus disease, and the promotion of vital community participation in containment and response activities. He also recognized the leadership of the Deputy Executive Director of the WHO Health Emergencies Programme and the Government of the Democratic Republic of the Congo in the mpox response.

He recognized the importance of WHO's work on norms and standards but said that there had been a shift towards operational activities since the Ebola virus disease outbreak in West Africa in 2014. WHO's operational role complemented rather than duplicated the work of

other organizations, and included the deployment of pre-positioned strategic resources, personnel and emergency funding. The Secretariat had ensured that activities were better coordinated and based on WHO's comparative advantage. In some complex situations, only WHO staff remained because of security risks. Thus, when reviewing priorities, WHO's operational activities were necessary and should be financed.

The current financial situation required a two-fold solution, balancing resource mobilization with efficiency gains. He urged Member States to support the planned 20% increase in assessed contributions and contribute to the WHO investment round, and to encourage private sector donors to provide funding through the WHO Foundation.

The representative of OMAN[2] expressed his Government's sincere gratitude for the work of WHO, especially its Health Emergencies Programme, in responding to health emergencies worldwide. That said, he emphasized the importance of sensitivity when labelling diseases, and urged WHO to consider removing the reference to Sudan in the name used for Sudan virus disease to avoid unnecessary stigmatization.

The CHAIR took it that the Board wished to note the report contained in document EB156/18.

The Board noted the report.

The CHAIR took it that the Board wished to suspend consideration of the draft decision pending the outcome of the broader discussion on the costing implications of resolutions and decisions recommended by the 156th session of the Executive Board for adoption by the Seventy-eighth World Health Assembly.

It was so agreed.

(For the adoption of a decision, see the summary record of the eighteenth meeting, section 9.)

2. Implementation of resolution WHA75.11 (2022): Item 16 of the agenda (document EB156/19)

The CHAIR invited the Board to consider the report contained in document EB156/19 and to provide guidance on the questions set out in the final paragraph of that document.

The representative of UKRAINE welcomed WHO's efforts to implement resolution WHA75.11 (2022) and to respond to urgent health needs in her country. She noted WHO's leadership of the United Nations health cluster in Ukraine and its collaboration to strengthen the national healthcare system and facilitate emergency medical evacuations. Nonetheless, the aggression perpetrated by the Russian Federation continued and the humanitarian and health crisis persisted, including among the 10 million Ukrainians that had been displaced. To ensure the continued strength of WHO's response in addressing urgent healthcare needs, she requested the Secretariat to prepare an updated implementation report for the Seventy-eighth World Health Assembly, containing data for the period from August 2024, and to organize a Member State briefing on the implementation of resolution WHA75.11 prior to that session of the Health

[2] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Assembly. The health impacts – in the region and beyond – of the Russian Federation's aggression against Ukraine should also be reflected in the updated report.

The representative of TOGO, speaking on behalf of the Member States of the African Region, commended the Secretariat's efforts to provide medical and humanitarian assistance to victims in situations of conflict around the world. Any and all obstacles to attaining the highest possible level of health for all must be removed. The Secretariat should continue to mobilize resources and develop partnerships in order to meet the needs resulting from public health emergencies.

The representative of POLAND, speaking on behalf of the European Union and its Member States, said that the candidate countries North Macedonia, Montenegro, Albania, Ukraine, the Republic of Moldova and Georgia, as well as the European Free Trade Association country Norway, member of the European Economic Area, aligned themselves with her statement. She commended WHO's implementation of resolution WHA75.11 and its leadership in responding to the health emergency in Ukraine resulting from the Russian Federation's war of aggression. She condemned the Russian Federation's unprovoked, unjustified and illegal war against Ukraine, which was a violation of international law. The Russian Federation should cease its military actions and respect Ukraine's territorial integrity, sovereignty and independence.

She expressed concern regarding the health impact of the Russian Federation's aggression in Ukraine, which was exacerbated by the destruction of critical infrastructure, the disruption of medical supply chains and the displacement of health workers. WHO's activities in Ukraine had contributed to preserving health services and had supported neighbouring countries and communities hosting Ukrainian refugees; efforts sought to address immediate and long-term health needs. She welcomed activities aimed at strengthening emergency medical services and trauma care capacity, rebuilding damaged facilities, maintaining essential health services and routine immunization programmes, ensuring access to mental health services and strengthening surveillance systems for infectious diseases. She commended WHO's documentation and verification of attacks on healthcare facilities and personnel, which enabled the development of effective strategies to protect healthcare workers and facilities during conflicts.

She called for sustained and adequate funding for WHO's emergency operations in Ukraine, enhanced protection for health and care facilities and workers, improved access to humanitarian health assistance, strengthened coordination mechanisms among international partners, and continued support for building resilient health systems. She supported the request for the Secretariat to prepare an updated implementation report for the Seventy-eighth World Health Assembly.

The representative of AUSTRALIA expressed her Government's ongoing concern regarding the dire health impacts of the Russian Federation's invasion of Ukraine, which was a violation of international law. She condemned the invasion and the reported attacks on health facilities, which were protected under international humanitarian law. The war had caused damage and loss of life, deprived people of necessary care, endangered health workers and increased the risk of infectious disease outbreaks. She expressed appreciation for WHO's support for the response in Ukraine, including through the procurement of essential medicines and medical supplies and the provision of mental health services. She welcomed WHO's continued focus on the mainstreaming of support to address sexual exploitation, abuse and harassment in response operations. She looked forward to receiving an updated report on the implementation of resolution WHA75.11 at the Seventy-eighth World Health Assembly.

The representative of BULGARIA condemned the Russian Federation's systematic destruction of civilian targets in Ukraine, which violated international law and had led to the

severe deterioration of critical healthcare services and increased the risk of infectious disease outbreaks in the country. He noted, in particular, the Russian Federation's attack on the Okhmatdyt children's hospital in Kyiv, and the support provided by his Government in response to that attack.

He expressed support for WHO's role in coordinating the health cluster in Ukraine, which had been highlighted by the implementation of resolution WHA75.11. WHO should continue to support routine immunization, access to essential healthcare and mental health services and the strengthening of surveillance and documentation of infectious diseases. The increase in the number of cases of hepatitis A was a cause of concern, and more vaccines were required. He asked the Secretariat to provide more information on forward-looking contingency planning and supported the request for an updated report on the implementation of resolution WHA75.11 for the Seventy-eighth World Health Assembly and a corresponding Member State briefing.

The representative of CANADA welcomed WHO's coordination of the health cluster and other operational activities, and said that its operational activities in Ukraine had helped to reduce pressure on Ukraine's strained health system. He highlighted the need to provide mental health and psychosocial support and prevent gender-based violence and conflict-related sexual violence. His Government would continue to support recovery and reconstruction efforts in Ukraine in partnership with WHO and other organizations and expressed its support for the ongoing use in Ukraine of the Contingency Fund for Emergencies. Medical and humanitarian personnel must be protected in accordance with international humanitarian law, including through the implementation of United Nations Security Council resolution 2286 (2016). He noted the Secretariat's efforts to track and report attacks on healthcare during emergencies, through the WHO Surveillance System for Attacks on Health Care. He encouraged the Secretariat to continue monitoring and assessing the health impacts of the war in the region and beyond. In that regard, he expressed appreciation for activities undertaken by neighbouring countries, Poland, Moldova, Romania and Czechia, especially the focus on mitigating and preventing gender-based violence, sexual exploitation and harassment. He asked the Secretariat to draft an updated report on the implementation of resolution WHA75.11 and to organize a Member State briefing on the situation in Ukraine prior to the Seventy-eighth World Health Assembly.

The representative of the REPUBLIC OF MOLDOVA condemned the Russian Federation's illegal invasion of Ukraine and expressed concern regarding the increasing number of attacks on health infrastructure and their impact on the health situation in Ukraine. More than one million refugees had entered her country from Ukraine, and her Government had prioritized meeting their health needs. She commended WHO's commitment to the implementation of resolution WHA75.11 and its continuing support for emergency operations in Ukraine. She expressed support for the request for an updated implementation report and a Member State briefing for the Seventy-eighth World Health Assembly. Her Government remained committed to a comprehensive and lasting peace that respected Ukraine's sovereignty and territorial integrity, as a basis for health system recovery.

The representative of NORWAY condemned the Russian Federation's aggression against Ukraine, which violated international law. She expressed concern regarding continued attacks on civilians and civil infrastructure, including healthcare and humanitarian facilities and workers. Her Government was working with international partners to support health in Ukraine, and she commended WHO's critical function in coordinating the health sector's humanitarian response with Ukrainian health authorities and other partners.

The representative of MONACO[3] welcomed WHO's efforts to meet urgent health needs in Ukraine and encouraged WHO to go beyond emergency response to strengthen health system resilience in Ukraine in the light of the ongoing conflict. She called for greater psychosocial and mental health support, especially for children and adolescents in Ukraine and for refugees in neighbouring countries. She expressed concern regarding the worsening health situation and the reported attacks on health infrastructure, including the attack on the Okhmatdyt children's hospital in Kyiv. Parties must respect international humanitarian law and health facilities must be protected.

The representative of FRANCE[3] expressed her Government's ongoing support for the people and Government of Ukraine after three years of the Russian Federation's war of aggression. The resulting health and humanitarian situation should be the focus of international attention; the human cost was unprecedented and the Government of the Russian Federation was solely responsible. Additionally, the aggression had increased the risk of epidemic outbreaks that threatened global health. He welcomed WHO's efforts to respond in that regard. WHO should continue to provide humanitarian assistance and health support, and Member States should demonstrate their support for a cessation of attacks against health facilities and workers and the unhindered movement of WHO staff deployed on the ground. His Government would continue to contribute to WHO's critical efforts in Ukraine. He looked forward to receiving an updated report on the implementation of resolution WHA75.11, and a Member State briefing on the situation prior to the Seventy-eighth World Health Assembly.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND[3] condemned the Russian Federation's unprovoked aggression against Ukraine, which continued to devastate health services and infrastructure across the country. She noted with concern the appalling toll of the conflict on the Ukrainian people. WHO's relentless response to the humanitarian crisis, including the provision of mental health and psychosocial support for Ukrainian healthcare professionals and initiatives to ensure that refugees had access to healthcare services was welcome. She supported the request for an updated report on the implementation of resolution WHA75.11 prior to the Seventy-eighth World Health Assembly. She called on the Russian Federation to uphold its obligations under international law, especially the protection of civilians and health and humanitarian workers.

The representative of JAPAN[3] condemned the Russian Federation's aggression against Ukraine, which infringed upon Ukraine's sovereignty and territorial integrity in violation of international law. He further condemned attacks on healthcare facilities and workers, and expressed concern regarding the challenge of ensuring adequate healthcare in the country. He supported the request for an updated report on the implementation of resolution WHA75.11 and a Member State briefing in time for the Seventy-eighth World Health Assembly.

The representative of ARGENTINA[3] supported the request for an updated report on the implementation of resolution WHA75.11 and a corresponding Member State briefing on the situation prior to the Seventy-eighth World Health Assembly. She further requested the Secretariat to continue assessing the health impacts in the region and beyond of the Russian Federation's aggression against Ukraine, and to include the outcome of those assessments in the updated implementation report.

[3] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of IRELAND[4] expressed her Government's concern regarding the ongoing health impact of the Russian Federation's escalating aggression against Ukraine. Attacks on healthcare facilities and workers were a cause of particular concern. The worsening humanitarian situation had exacerbated the vulnerabilities of women and girls. She commended WHO's efforts to maintain and strengthen the health system in Ukraine in challenging circumstances, especially through the delivery of essential medical supplies and equipment and the facilitation of medical evacuations.

The representative of IAEA acknowledged the challenge in Ukraine of meeting increasing demands for cancer diagnostic, management and treatment services and ensuring the implementation of quality and safety requirements. IAEA would continue to support Ukraine with safe cancer care, radiation therapy and medical imaging through targeted support for priority institutions. IAEA staff had been deployed to five nuclear sites in Ukraine, and nuclear safety and security-related equipment had been provided, alongside occupational health services. IAEA would continue to work with the Ukrainian Government to support ongoing efforts to prevent a nuclear accident during the conflict.

The DEPUTY EXECUTIVE DIRECTOR (WHO Health Emergencies Programme) said that the recovery of the Ukrainian health system was a priority in order to restore health services, strengthen primary healthcare and improve public health surveillance. He called on all parties to adhere to their obligations under international humanitarian law and allow safe and unhindered humanitarian access to meet the health needs of people affected by the war in Ukraine.

The DIRECTOR (Health Emergency Interventions) said that the report on the implementation of resolution WHA75.11 would be updated prior to the Seventy-eighth World Health Assembly. He outlined WHO's operational commitment in Ukraine. Since the report had been published, 164 more attacks had been carried out against healthcare targets. He highlighted the investment in the resilience of the Ukrainian healthcare system and the delivery of necessary medical supplies to 921 health institutions, much of which supported immediate life-saving healthcare on the front lines. Primary healthcare and pre-hospital emergency care structures had been established, medical training had been supported, and mental health and psychosocial support had been provided. However, WHO's activities, including its coordination of the health cluster partners in Ukraine, were at risk if future funding was not secured.

The Board noted the report contained in document EB156/19.

3. Health conditions in the occupied Palestinian territory, including east Jerusalem: Item 17 of the agenda (document EB156/20)

The CHAIR invited the Board to consider the report contained in document EB156/20 and to provide guidance on the questions set out in the final paragraph of that document. She drew attention to a draft resolution, which contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly, on health conditions in the occupied Palestinian territory, including east Jerusalem, proposed by Palestine and Qatar. The draft resolution read:

[4] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The Executive Board,

Having considered the report by the Director-General;[5]

RECOMMENDS that the Seventy-eighth World Health Assembly adopt, mutatis mutandis, the resolution EBSS7.R1 (2023) as is, other than the following textual revisions:

(1) In operative paragraph 5(a) to replace the phrase "submit recommendations in this regard to the 154th session of the Executive Board and to the fourth meeting of the Standing Committee on the Health Emergency Prevention, Preparedness and Response, and to the Seventy-seventh World Health Assembly" with "submit recommendations in this regard to the 158th session of the Executive Board, the seventh meeting of the Standing Committee on the Health Emergency Prevention, Preparedness and Response, and the Seventy-ninth World Health Assembly";

(2) In operative paragraph 5(b) to replace the phrase "prior to the Seventy-seventh World Health Assembly" with "prior to the Seventy-ninth World Health Assembly".

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[6]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:

2.3.1. Potential health emergencies rapidly detected, and risks assessed and communicated

2.3.3. Essential health services and systems maintained and strengthened in fragile, conflict-affected and vulnerable settings

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:

Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:

Not applicable.

4. Estimated time frame (in years or months) to implement the decision:

Five months (January 2025–May 2025).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:

US$ 648.00 million (including US$ 275.00 million for emergency response and US$ 265.00 million for early recovery and rehabilitation, in alignment with the occupied Palestinian territory Operational Response and Early Recovery Plan January–December 2025).

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:

Zero. This decision would be implemented through the emergency operations and appeals budget segment.

[5] Document EB156/20.

[6] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic "bridge" between results structures can be provided as needed.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:
US$ 648.00 million (including US$ 275.00 million for emergency response and US$ 265.00 million for early recovery and rehabilitation).

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:
Not applicable.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:
Not applicable.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions

– **Financial resources available to fund the decision in the current biennium:**
US$ 45.00 million for the continued response within the revised occupied Palestinian territory Operational Response and Early Recovery Plan.

– **Remaining financing gap in the current biennium:**
US$ 603.00 million.

– **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Pledges are in the pipeline; fundraising is continuing.

Table. Breakdown of estimated resource requirements (in US$ millions)

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.2.b. 2024–2025 cost of additional resources	Staff	0.00	0.00	0.00	0.00	52.00	0.00	2.00	54.00
	Activities	0.00	0.00	0.00	0.00	591.00	0.00	3.00	594.00
	Total	0.00	0.00	0.00	0.00	643.00	0.00	5.00	648.00
B.3. 2026–2027 cost of resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.4. Future bienniums cost of resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.1. Total planned costs required to implement the decision									648.00

The representative of QATAR, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, while a ceasefire had been agreed, further negotiations were required and the ceasefire agreement was only the first step towards achieving justice and dignity for Palestinians. Despite the cessation of violence, the suffering continued. In the Gaza Strip,

devastation and disease were widespread, many people were displaced and famine loomed. Many Palestinians had been killed or injured. The health system had collapsed following the destruction or damage of 94% of health facilities. It would take many years and a significant funds to restore the health system and services to pre-conflict levels. She noted that a significant number of attacks had been reported on healthcare facilities in areas of the occupied Palestinian territory outside the theatre of the current war. She urged all parties to respect the ceasefire, ensure unhindered humanitarian access and respect international humanitarian law.

The representative of LEBANON paid tribute to the staff members of WHO and other organizations, including UNRWA, who were working in very difficult conditions. She welcomed the report and WHO's ongoing monitoring of the situation in the occupied Palestinian territory, especially in the Gaza Strip which was subject to the Israeli blockade. Israel's military assault, in violation of international law, had obliterated the health sector in the Gaza Strip. The number of deaths and injuries were high, and Palestinians had experienced epidemics, displacement and starvation. Health facilities had been destroyed, medical workers targeted and humanitarian aid blocked. She welcomed WHO's efforts to support recovery, calling on the Secretariat to scale up its interventions and donors to scale up funding to enable that work to continue. She expressed concern regarding the lasting impact of the humanitarian tragedy on the physical and mental health of Palestinians, especially women and children. The international community should increase pressure on Israel to halt violations of international law, accept a lasting ceasefire and allow unhindered humanitarian access to the Gaza Strip. Only ending the occupation would enable Palestinians to enjoy their basic rights, including the right to health. It was vital to restore confidence in the multilateral system and in international law in general.

The representative of ISRAEL said that the blame placed on his Government was unfounded and spoke out against the politicization of health. His Government had repeatedly proven that terrorist groups had abused medical facilities in the Gaza Strip. Hamas remained the primary cause of civilian suffering in the Gaza Strip. The report, however, did not acknowledge the use of hospitals to store arms and ammunition, hide hostages and commit terror acts against Israel; a practice that many organizations had failed to condemn. Israel attacked only Hamas targets. He called for the implementation of the decision adopted at the Seventy-seventh World Health Assembly, which took a stance against the militarization of hospitals. He highlighted the biased and politicized discussions and reports within the United Nations system. His Government would continue to fight that bias in order to achieve necessary structural reform across that system. It would continue to facilitate the delivery of aid, despite security concerns and Hamas' misuse of that aid. Furthermore, it would continue to fight for the return of all Israeli hostages. He could not support the draft resolution and objected to the agenda item as a whole, calling on the Board to conclude its discussion and prevent the further politicization of health.

The representative of AUSTRALIA welcomed the report and commended healthcare workers and WHO staff working on the ground. Expressing concern regarding the deterioration of health facilities in the Gaza Strip, she welcomed the efforts of WHO and its partners to deliver essential supplies and deploy medical teams. Health facilities and workers must be protected. She welcomed the ceasefire and hostage agreement and urged all parties to respect its terms and implement it in full. Peace was vital to the humanitarian response, and she reaffirmed the importance of safe and unimpeded humanitarian access. She reiterated her Government's call for the release of hostages and protection of civilians and condemned Hamas. The international community should work together to meet the humanitarian needs of the people of the Gaza Strip and to work towards a two-State solution.

The representative of POLAND, speaking on behalf of the European Union and its Member States, said that the candidate countries North Macedonia, Montenegro, Serbia, Albania, Ukraine and the Republic of Moldova aligned themselves with his statement. He thanked the Director-General for his report and welcomed the ceasefire agreement, which should be implemented in full to bring a permanent end to hostilities. The number of civilian casualties and the ongoing lack of food and potable water were deplorable. The health system in the Gaza Strip had been degraded by attacks on healthcare. He supported WHO's efforts to scale up its operations, mobilize critical supplies, organize medical evacuations and support early recovery. Since the ceasefire agreement had increased humanitarian aid flowing into the Gaza Strip, he called for its unimpeded delivery and distribution by United Nations agencies, including UNRWA. He called on all parties to abide by their obligations under international law. The European Union was committed to a just, comprehensive and lasting peace based on the two-State solution. It would support the Palestinian Authority to meet urgent needs and support the reform agenda, and engage with Israel and other partners in the political process. He highlighted the European Union's latest humanitarian aid package for the occupied Palestinian territory and contributions from the Member States of the European Union.

The representative of CANADA welcomed the report and recognized WHO's vital role in the humanitarian and emergency response in Gaza, contingent upon continued health cluster coordination and access to secure and safe spaces to delivery humanitarian aid and essential services. He called for the release of all remaining hostages. While it was encouraging that a ceasefire agreement had been signed, the impact of the conflict and the resulting humanitarian crisis remained devastating, particularly for civilians. He called on all parties to protect civilians and healthcare workers, including through the implementation of United Nations Security Council resolution 2286 (2016). He expressed concern regarding the devastation of the health system in Gaza, and the destruction of medical, water and sanitation infrastructure. He commended WHO's work to integrate protection from sexual exploitation, abuse and harassment into its operations, especially in conflict situations. Support and humanitarian action could only be provided if access was safe and assured. He called on all parties to respect their obligations under international humanitarian law, thus facilitating the passage of humanitarian aid, protecting civilian infrastructure and restoring health to the people of Gaza.

The representative of NORWAY said that the report was both factual and balanced. He expressed concern regarding the health situation in Palestine, especially in the Gaza Strip. The conflict between Israel and Hamas had led to destruction, suffering and death. All parties, including the occupying power, should respect the ceasefire agreement, release any remaining hostages and ensure access to vital aid. He expressed concern regarding the Israeli law preventing UNRWA from operating in Palestine, which would have catastrophic consequences for Palestinians, including for their access to health services. Humanitarian actors' efforts to alleviate suffering should be continued. Israel should adjust its policy to allow access in the Gaza Strip to spare parts labelled for dual use, in order to begin repairs to essential infrastructure. The reconstruction of the healthcare system in Palestine could only take place within the framework of a lasting political solution which facilitated the implementation of a Palestinian State that included the Gaza Strip. Palestinian authorities must have ownership of that process.

The representative of BRAZIL said that, despite the announcement of a ceasefire, his Government remained concerned about the humanitarian crisis in the region. Significant damage had been inflicted on the health system in the Gaza Strip and accounts of famine, diarrhoeal disease, lack of access to physical and mental healthcare services and rising rates of disability and high-risk pregnancy painted a devastating picture of suffering. Noting the report, he commended

WHO's ongoing work, which required sufficient funding. He expressed the hope that the ceasefire announcement would alleviate restrictions on access, security concerns and movement constraints in the Gaza Strip. Recognizing the importance of the two-round vaccination campaign, he asked the Secretariat to report the outcomes of that campaign in the light of the detection of poliomyelitis in the Gaza Strip. He called for measures to address the lack of support for survivors of gender-based violence. It was to be hoped that a permanent cessation of hostilities would allow for the reconstruction of civil infrastructure in the Gaza Strip, including the health system. He therefore requested to be added to the list of sponsors of the draft resolution.

The representative of the DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA expressed appreciation for the report and for WHO's efforts to meet acute health needs in the Gaza Strip. The number of deaths and injuries reported since the start of the massacre was unprecedented. He condemned ongoing violence despite the presence of a ceasefire agreement. He expressed support for the establishment of a Palestinian State and a just solution to the situation in the region.

The representative of YEMEN affirmed his Government's support for the rights of the Palestinian people, in the light of the deteriorating health situation in the Gaza Strip. He welcomed the ceasefire but emphasized that it would not bring an immediate end to the crisis. He noted the collapse of the health system and health, water and sanitation infrastructure, the increasing risk of famine and infectious disease outbreaks, and the lack of access to basic health services, including for vulnerable population groups. He called on the international community to ensure the full implementation of the ceasefire and unhindered humanitarian access. Rebuilding the health system in the Gaza Strip would require significant investment. International humanitarian law must be respected, including ensuring the protection of civilians and health workers. Sustained political commitment was required to reach a comprehensive and just solution to the crisis.

The representative of MALDIVES expressed appreciation for the report and concern regarding the humanitarian situation in the Gaza Strip, which was exacerbated by regular attacks on healthcare facilities and workers as well as patients. The loss of life, widespread displacement and destruction of critical health infrastructure required an urgent and coordinated response. She called on all parties to uphold their obligations under international law to cease attacks on healthcare infrastructure and workers, and ensure the unimpeded delivery and distribution of humanitarian aid. WHO should support enhanced access to mental health services and disease prevention, and mobilize financial and technical resources for rebuilding and to strengthen healthcare capacity. She called for the full implementation of the ceasefire agreement. She expressed support for the draft resolution.

The representative of CHILE said that his Government supported the two-State solution and opposed any forced displacement of the Palestinian people from the Gaza Strip, which would constitute a violation of international law and of Palestinians' legitimate rights. She supported WHO's ongoing work in the region.

The representative of CHINA said that his Government would like to be added to the list of sponsors of the draft resolution. He noted the unprecedented humanitarian crisis in the Gaza Strip, exacerbated by restricted access to food, medicine and vaccines. He welcomed the ceasefire agreement, which should be implemented effectively and should lead to permanent peace in Israel and Palestine. He called on the occupying power to lift restrictions on the entry of humanitarian aid to enable its safe and orderly distribution to the people of the Gaza Strip. Member States should support WHO, UNRWA and other agencies in providing that aid. Health and

humanitarian workers must be protected, especially those providing surgical and immunization services.

The two-State solution was the only possibility of a lasting solution to the situation in Israel and Palestine, and he welcomed international efforts to revive the political process to that end. Any post-war arrangements for the Gaza Strip and the West Bank could only be determined through internal Palestinian consultations, without interference.

The representative of BRUNEI DARUSSALAM acknowledged the catastrophic public health crisis in the occupied Palestinian territory, including east Jerusalem, which had had a severe impact on the health system, while malnutrition and disease outbreaks were exacerbating the suffering. He welcomed the ceasefire agreement, which should lead to a lasting and just peace for the Palestinian people. Peace was not solely the absence of conflict, however, and Palestinians must be allowed to rebuild their lives, including their health system. Member States should ensure that humanitarian assistance reached those in need, that health workers could work safely, and that unhindered access to healthcare was assured, and should support efforts to restore health services.

The representative of SOMALIA said that the ceasefire offered civilians hope, but did not mark the end of the health crisis in the Gaza Strip, where the health system was on the brink of collapse. He noted the lack of access to health services to combat communicable and noncommunicable diseases and the impact of looming famine, limited access to mental health support and reproductive health services, and the low number of medical evacuations. The international community must ensure that the ceasefire was fully implemented and facilitate the unhindered delivery of aid and medical supplies. International humanitarian law should be respected in order to ensure the protection of civilians and health workers. The recovery process in the Gaza Strip would require sustained political will and international commitment, and a just and comprehensive solution.

The representative of the ISLAMIC REPUBLIC OF IRAN[7] recognized the troubling nature of the information provided in the report about the acts committed by Israel and the dire humanitarian conditions in the occupied Palestinian territory. The conflict in the Gaza Strip had not been a legitimate fight against a resistance group, rather it had defied human morality. The actions of Israel – forced displacement, restricted access to food, water, sanitation and healthcare, and the bombardment of civilians – constituted violations of human rights law and international humanitarian law. The support of several Western governments for Israel would not be forgotten. He recognized the number of people killed or injured and the number of hospitals damaged and destroyed. He commended the tireless work of humanitarian relief organizations to deliver aid to the people of the Gaza Strip.

The representative of PAKISTAN[7] acknowledged the unprecedented level of devastation in the occupied Palestinian territory. He condemned attacks on healthcare facilities and workers, in violation of international law, which had resulted in many facilities being unable to operate and a shortage of essential medicines. The deteriorating humanitarian situation had exacerbated food insecurity, malnutrition and disease outbreaks, and the risk of famine remained high. He called for the unhindered delivery of humanitarian aid and safe access for humanitarian and health workers. Recognizing that recovery in the Gaza Strip would require many years of sustained support, he urged WHO to continue its work in the region and to continue to report on the situation to its

[7] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

governing bodies. He requested that his Government be added to the list of sponsors of the draft resolution and reaffirmed his Government's support for the two-State solution.

The representative of COLOMBIA[8] said that the humanitarian crisis in the Gaza Strip was unprecedented and expressed concern regarding the destruction of health infrastructure, attacks against health services, forced displacement and restricted access to potable water, sanitation and healthcare, which had a particular impact on women and children. The mental health impact of the situation on the Palestinian people should not be underestimated. She expressed appreciation to WHO staff who had continued their work in spite of restrictions, risk and constant violations of international humanitarian law. She called for international humanitarian law to be respected, and welcomed the ceasefire agreement. The international community should redouble the provision of humanitarian and technical support through WHO. Her Government would continue to support efforts towards lasting peace in the Gaza Strip.

The representative of ARGENTINA[8] recalled his Government's comments at the Seventy-seventh World Health Assembly and said that his Government did not support the report or the draft resolution. The report did not reflect the facts; it omitted any reference to the number of fatalities resulting from the terrorist attack carried out by Hamas on 7 October 2023 and to the hostages that had not yet been released, who included Argentine citizens. Furthermore, it did not refer to the use of hospitals and ambulances by armed groups. The report did not reflect the full story and had become politicized. That was unacceptable. He urged the Secretariat to produce an accurate, balanced report, with particular reference to WHO's commitment to achieving the release by Hamas of all remaining hostages.

The representative of NAMIBIA[8] commended the health and humanitarian workers who continued to provide essential medical care to affected communities in the occupied Palestinian territory and welcomed the report. He acknowledged the efforts that had led to a ceasefire agreement. The constraints on medical infrastructure had exacerbated the humanitarian situation, and the health system was on the brink of collapse. He urged Member States to continue supporting WHO's work in Palestine, including in the rebuilding process.

The representative of SPAIN[8] expressed his Government's support for staff from WHO and other international organizations working to assist the Palestinian population. He highlighted the vital role played by UNRWA in the provision of basic services to Palestinian refugees in the occupied Palestinian territory. UNRWA would be instrumental in ensuring the implementation of the ceasefire agreement, restoring acceptable health conditions and rebuilding health facilities. He condemned the large number of victims, particularly women and children, and the ongoing health risks linked to attacks on civilian targets, famine, lack of potable water and the lack of humanitarian aid. Attacks against health facilities and efforts to forcibly displace the Palestinian population from the Gaza Strip were a violation of international humanitarian law. Recognizing the challenging financial situation facing WHO and the need to prioritize activities, he said that the provision of emergency health assistance in the occupied Palestinian territory must strengthened not reduced.

The Observer of PALESTINE said that he welcomed the report and that the Gaza Strip had been turned into a graveyard; Palestinians could not even seek safety among the rubble of their destroyed homes. The people of the Gaza Strip had been stripped of basic human rights, including access to health. He recalled the adoption of resolution EBSS7.R1 (2023), which demonstrated

[8] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Palestinians' desire to collaborate with WHO to develop recommendations that would alleviate the suffering endured by the people of the Gaza Strip, maintain the health sector and ensure unhindered humanitarian access. However, that resolution had not been fully implemented, and the international community had repeatedly failed to protect the people of the Gaza Strip. The decades of oppression and occupation must come to an end. It was disappointing that a United Nations vote had been required to speak out against the killing of civilians and attacks on healthcare facilities, and to facilitate the entry of humanitarian aid and medical teams into the Gaza Strip. Besieging an entire population and targeting civilians and health workers and facilities were war crimes, and the current living and health conditions were inhumane, particularly for women and girls. Health for all should not be a meaningless slogan. He called on WHO to focus on how to rebuild the health sector and Palestinian health facilities, and restore health conditions in the occupied Palestinian territory, including east Jerusalem. He expressed sincere condolences to the families of health and humanitarian workers killed by Israel in the occupied Palestinian territory.

The representative of the PLURINATIONAL STATE OF BOLIVIA[9] said that the unprecedented humanitarian crisis was a result of the indiscriminate attacks carried out by the occupying power against the Palestinian people. The ceasefire was long overdue, given the violation of human rights and dignities. She condemned the attacks against civilian and medical targets, which violated international humanitarian law. Those attacks had led to the collapse of the health system in the Gaza Strip, which had long suffered under the illegal occupation. Reconstruction would be costly and would take decades. She commended the work of WHO to alleviate the critical health situation in the occupied Palestinian territory, and called for adequate resources to be mobilized for that work to continue. She further called for unhindered access for humanitarian assistance and essential services. To that end, she requested that her Government be added to the list of sponsors of the draft resolution.

The representative of TÜRKIYE[9] expressed his Government's full support for the draft resolution and asked that it be added to the list of sponsors. He welcomed the report and recognized the unprecedented health crisis, loss of life and number of Palestinians displaced in the Gaza Strip; the health system had been devastated and health workers and facilities had been targeted. The Israeli Government's decision to ban UNRWA from operating in the occupied Palestinian territory constituted a violation of international law, and would disrupt the delivery of humanitarian aid, reconstruction efforts and the provision of emergency health services. UNRWA was irreplaceable, and he called for the international community to support its work. Recognizing the recent ceasefire agreement, he called for a permanent ceasefire and rejected any attempt to forcibly displace Palestinians from the Gaza Strip. His Government would continue to support all efforts towards the two-State solution.

The representative of FRANCE[9] said that WHO's activity in the Gaza Strip was rendered necessary by the unprecedented health and humanitarian crisis. Health infrastructure had been severely damaged and the death toll, catastrophic levels of hunger and lack of potable water were deplorable. He welcomed the entry into force of the ceasefire agreement and the release of hostages, and called on all parties to implement the ceasefire in full. He called for all entry points into the Gaza Strip to be opened, and for the work of WHO and other humanitarian and international actors to be facilitated by Israel, in keeping with international law and the orders of the International Court of Justice. Reconstruction in the Gaza Strip should begin without delay, including the restoration of health services, in which WHO should play its part. His Government remained committed to the diplomatic and financial support of WHO's response, and had

[9] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

announced an additional contribution for the population of the Gaza Strip in 2025. The ceasefire should initiate an irreversible process leading to the two-State solution.

The representative of INDONESIA[10] said that the humanitarian crisis and disrupted health systems were straining the already fragile infrastructure in the occupied Palestinian territory. He noted the number of attacks against health workers and facilities. The international community should speak out against violations of international human rights and international humanitarian law by the occupying power. The destruction of the health system had increased preventable mortality, and mental health challenges had been exacerbated by prolonged violence and displacement. The situation was rooted in the denial of Palestinians' right to self-determination. He welcomed the ceasefire agreement, and called for its full implementation, including the restoration of UNRWA's activities. He looked forward to a permanent ceasefire that would allow for the negotiation of the two-State solution and ensure the right to health of the Palestinian people. WHO should continue its vital work and its reporting on health conditions in the occupied Palestinian territory. He asked that his Government be added to the list of sponsors of the draft resolution.

The representative of TUNISIA[10] expressed appreciation for the report and for WHO's work on health conditions in the occupied Palestinian territory, despite the challenges it was facing. The humanitarian situation in the Gaza Strip was catastrophic, and the scale of destruction had been unprecedented. His Government reaffirmed the right of the Palestinian people to self-determination and the establishment of a Palestinian State. He called for the ceasefire to be respected and for unhindered access to humanitarian and medical aid in line with priorities established by the Palestinian people. That included the restoration of the Palestinian health system, the immediate launch of reconstruction efforts and the lifting of the blockade on the Gaza Strip.

The representative of ALGERIA[10] expressed concern regarding the unprecedented humanitarian and health crisis in the Gaza Strip, especially among women, children and the elderly. She expressed appreciation for the report and for WHO's efforts to respond to the crisis by maintaining access to health services and coordinating humanitarian efforts on the ground. She welcomed the long-awaited ceasefire agreement that would bring an end to the genocidal war by Israel. The ceasefire must lead to permanent peace and the removal of all restrictions on humanitarian aid for the Palestinian people. The only legitimate solution to the situation was self-determination for the Palestinian people and the establishment of a Palestinian State.

The representative of the RUSSIAN FEDERATION[10] noted with satisfaction the positive steps towards resolving the Israeli–Palestinian conflict and expressed the hope that the ceasefire would be honoured by all parties. She noted the catastrophic humanitarian situation in the Gaza Strip and the scale of the destruction, including of homes and hospitals. Rebuilding the healthcare system would require many years and significant cost. She welcomed the increase in humanitarian aid entering the Gaza Strip following the ceasefire agreement, which must continue unhindered. A permanent solution to the crisis could only be found if the Palestinian people were free to establish a legitimate Palestinian State under the two-State solution. Nonetheless, Israel's security concerns should also be addressed. The Russian Federation would continue to provide humanitarian aid to the people of the Gaza Strip.

[10] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of SAUDI ARABIA[11] noted that Israeli attacks were ongoing in the Gaza Strip, leading to devastating security and humanitarian consequences and the destruction of healthcare infrastructure. She urged all parties to abide by their obligations under international humanitarian law and ensure the protection of health and humanitarian workers. She reaffirmed her Government's commitment to supporting the establishment of an independent Palestinian State, in order to attain a just, lasting and comprehensive solution in the region.

The representative of MALAYSIA[11] commended the dedication of healthcare workers on the ground and the efforts made to prepare the report, and expressed concern regarding the information presented in the report about the current situation. Her Government strongly opposed any proposal that could lead to the forced displacement of Palestinians that would constitute ethnic cleansing and a violation of international law. Any attempt to disregard Palestinians' right to self-determination was unacceptable, and would only prolong the conflict. She urged all parties to ensure unhindered humanitarian access, establish humanitarian protected zones around healthcare facilities and provide humanitarian aid packages to rebuild the healthcare system. She called for the implementation of a permanent ceasefire in order to start rebuilding efforts. Inaction would only exacerbate the humanitarian situation. She requested that her Government be added to the list of sponsors of the draft resolution and expressed support for the Palestinians' right to establish an independent State.

The representative of EGYPT[11] expressed support for the statements made by the representatives of Lebanon, Yemen and the Democratic People's Republic of Korea. He said that peace could only be achieved through the two-State solution and that the occupying power should meet its obligations under international humanitarian law. His Government would not accept any proposed displacement of Palestinians out of their land, and urged the occupying power to comply with the terms of the ceasefire agreement to achieve permanent peace. He urged the Board not to accept groundless allegations against health workers; staff members of the Organization who had lost their lives were not terrorists. Calls for WHO to remain apolitical should not be accompanied by the rejection of factual reporting. He highlighted the exceptional work at all levels of the Organization during the conflict and condemned indiscriminate attacks on health facilities. He called for the full implementation of resolution EBSS7.R1.

The representative of HUNGARY[11] welcomed the ceasefire and hostage release agreement and said that it was a priority to ensure that the agreement was implemented in full. The lives taken in the terrorist attacks of 7 October 2023 must not be forgotten; the international community should ensure that Hamas and other terrorist organizations could no longer gain power and militarize the Gaza Strip through coordinated attacks and the misuse of civilian infrastructure, including health facilities. She welcomed the increase in aid entering the Gaza Strip since the ceasefire, which must reach those in need and not be diverted by Hamas or others. She commended WHO's efforts in the region.

The representative of BANGLADESH[11] expressed concern regarding the grave health and humanitarian crisis in the occupied Palestinian territory, including east Jerusalem, and condemned the attacks on health infrastructure in the Gaza Strip. He welcomed WHO's continued support for the people in Palestine in the light of the challenges facing the health system. Donors should fill the funding gap for the humanitarian and emergency health response. He called for unhindered access to the Gaza Strip for humanitarian aid and medical personnel, exit permits for medical evacuations, supply and replenishment of medicines and medical equipment, protection of health

[11] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

and humanitarian workers, and an end to the illegal occupation. The provisional measures issued by the International Court of Justice should be implemented immediately and in full. He reaffirmed his Government's support for the Palestinians' right to self-determination and the establishment of a Palestinian State under the two-State solution. He requested that his Government be added to the list of sponsors of the draft resolution.

The representative of MEXICO[12] acknowledged the report and WHO's work to meet the immediate needs of civilians and the health sector in the occupied Palestinian territory and reiterated his Government's support for the two-State solution. He condemned attacks against the civilian population and civilian infrastructure, including health workers and facilities, and the taking of hostages, which constituted violations of international humanitarian law. He expressed concern regarding the unacceptable effects of such actions on the health and humanitarian situation in the Gaza Strip. The international community must defend the right to health for all, and he urged Member States to work towards sustainable solutions in that regard.

The representative of IRELAND[12] welcomed the ceasefire in the Gaza Strip, which should be fully implemented to ensure the release of all hostages and a permanent end to hostilities. He commended the role of WHO staff in the humanitarian response and in the delivery of life-saving assistance. The destruction of health facilities had led to the complete collapse of the health system in Gaza. That had a devastating impact on civilians, particularly women and children. He supported WHO's efforts to scale up its operations, including for medical evacuations and the delivery of medical resources, and to support early recovery efforts. He urged all parties to comply with international humanitarian law, including the protection of health facilities, patients and medical staff. His Government would continue to seek lasting peace on the basis of the two-State solution.

The representative of JAPAN[12] welcomed the ceasefire and hostage release agreement. He took note of the 2025 Health Emergency Appeal. His Government had recently pledged US$ 100 million in emergency aid for the Palestinian people, including in the Gaza Strip, through WHO and other international organizations.

The representative of the UNITED REPUBLIC OF TANZANIA[12] expressed concern regarding the health conditions in the occupied Palestinian territory, including east Jerusalem. He noted the reported shortages of essential medicines, equipment and personnel, and called for the unhindered delivery of medical supplies and humanitarian assistance. It was vital to protect healthcare workers and infrastructure, in accordance with international humanitarian law. He expressed support for the work of WHO and others in the multilateral system. He welcomed the ceasefire agreement and expressed support for the two-State solution as a means to peace.

The representative of SOUTH AFRICA[12] welcomed the report and expressed appreciation to health workers providing services on the ground in the Gaza Strip. She expressed concern regarding the humanitarian crisis, which was exacerbated by the collapse of the healthcare system. Israel's aim to erase the Palestinian people was reflected in its decision to ban UNRWA, which was an irreplaceable lifeline for millions of people. In that connection, she recalled the memorial filed by the Government of South Africa with the International Court of Justice in October 2024 in its case against Israel under the Convention on the Prevention and Punishment of the Crime of Genocide and the 2024 Report of the Special Committee to Investigate Israeli Practices Affecting the Human Rights of the Palestinian People and Other Arabs of the Occupied

[12] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Territories. She welcomed the ceasefire agreement, which was the basis for a just peace and the first step towards ending the humanitarian crisis. To that end, the provisional measures issued by the International Court of Justice should be implemented. She expressed support for the draft resolution.

The representative of GHANA[13] welcomed the report. He welcomed the ceasefire agreement and called for its full implementation as a step towards lasting peace in the region. He expressed appreciation to WHO's emergency medical teams and urged Member States to mobilize support to ensure access to humanitarian aid for all people in the Gaza Strip.

The representative of MÉDECINS SANS FRONTIÈRES INTERNATIONAL, speaking at the invitation of the CHAIR, said that most hospitals in the Gaza Strip were not fully functional and more than 1000 health workers had been killed. In the West Bank, patients were being denied access to life-saving care. He urged all parties to respect and protect health workers and facilities in Palestine and in all conflict settings. WHO should take steps to ensure accountability for attacks against healthcare.

The representative of the INTERNATIONAL ASSOCIATION FOR HOSPICE AND PALLIATIVE CARE, INC., speaking at the invitation of the CHAIR, highlighted the long-term health impacts of the situation in the Gaza Strip. She requested the Board to support UNRWA's mission to coordinate and deliver essential health services and begin to rebuild the health system in the Gaza Strip, strengthen demands for the protection of health workers and facilities, and recommend that humanitarian kits should include all essential medicines, including opioid analgesics for pain management.

The REGIONAL DIRECTOR FOR THE EASTERN MEDITERRANEAN outlined the suffering and destruction in the Gaza Strip. Very few health facilities remained intact, yet health workers were maintaining health services with minimal resources. During the ceasefire, the priority was to restore health facilities and services, deliver medical supplies and respond to outbreaks. Medical evacuations would continue, and she welcomed the support of partners in that regard. Mental health support was at the heart of WHO's response.

WHO would also continue to coordinate efforts in the region, for example through the Eastern Mediterranean Region's Regional Health Alliance. However, a successful response required systematic and sustained access to the population in the Gaza Strip, an end to restrictions on the entry of medical supplies and the protection of civilians and healthcare workers, including those conducting medical evacuations. WHO also required a significant increase in funding to meet immediate health needs and to begin restoring the health system. She called on all parties to honour their commitments, implement the ceasefire and work towards a political solution to the protracted crisis.

The DEPUTY EXECUTIVE DIRECTOR (WHO Health Emergencies Programme) reiterated that the humanitarian and health needs in the Gaza Strip were unprecedented. He said that 85% of the population was displaced and the health system was on the brink of collapse. Funding would need to be scaled up in order for WHO and its partners to meet the health needs in the region and begin to restore the health system.

[13] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The DIRECTOR (Health Emergency Interventions) said that the ceasefire in the Gaza Strip and the hostage and prisoner/detainee release deal were important steps towards relieving the suffering due to the conflict. In the Gaza Strip, 18 of 35 hospitals were partially functioning, and 57 of 142 primary healthcare centres and 11 field hospitals remained operational. Between 12 000 and 14 000 critically ill patients, including 2500 children, required immediate medical evacuation. Since the Rafah border crossing had reopened, WHO and its partners had facilitated the evacuation of 104 patients and 172 companions to Egypt. Since the ceasefire, 62 trucks had entered the Gaza Strip carrying vital medical supplies, with a further 22 expected. WHO had delivered fuel, tents and equipment to establish trauma stabilization points. WHO intended to expand Al Shifa hospital and support the restoration of the Indonesian hospital. In the West Bank, the situation remained dire and frequent military incursions obstructed access to healthcare. WHO was strengthening emergency preparedness in 11 hospitals.

He recalled the Director-General's statement that UNRWA was irreplaceable. It had been the main health provider in the Gaza Strip and the West Bank for 70 years. It provided vital physical and mental health services, and had supported the two rounds of the vaccination programme for poliomyelitis; more emergency vaccination campaigns were needed to ensure child survival. The loss of that healthcare would be devastating and lead to disease outbreaks, malnutrition and untreated mental health and psychosocial disorders.

More than 1325 attacks on healthcare had been reported since 7 October 2023, causing death and injury to patients and healthcare workers, despite assurances that healthcare was not a target.

WHO and its partners could only continue their work if urgent funding needs were met. The Secretariat would provide an updated technical report for the Seventy-eighth World Health Assembly.

The DIRECTOR-GENERAL, responding to the representative of Argentina, said that the report included the number of fatalities and injuries that had occurred in Israel, and the number of unreleased hostages. Since the report had been published, the ceasefire had led to the release of hostages. He emphasized the balanced nature of the report.

He welcomed the ceasefire, and expressed the hope that it would be maintained. Peace was the best medicine. He urged Israel to reconsider the banning of UNRWA from operating in the occupied Palestinian territory, including east Jerusalem. UNRWA was irreplaceable. He called for more border crossings to reopen in order to expedite medical evacuations.

The Board noted the report contained in document EB156/20.

The CHAIR invited the Board to adopt the draft resolution on health conditions in the occupied Palestinian territory, including east Jerusalem.

The representative of ISRAEL said that he did not support the draft resolution.

The meeting rose at 17:35.

Tenth meeting

Thursday, 6 February 2025, at 18:10

Chair: Dr J.X. Walcott (Barbados)

Pillar 2: One billion more people better protected from health emergencies (continued)

1. Health conditions in the occupied Palestinian territory, including east Jerusalem: Item 17 of the agenda (document EB156/20) (continued)

The CHAIR recalled that the Board had before it a draft resolution on health conditions in the occupied Palestinian territory, including east Jerusalem.

The representative of ISRAEL said that, although he had agreed to note the report, he did not support the draft resolution.

The CHAIR suggested that the Board might wish to adopt the draft resolution without a vote and place on record that the Government of Israel dissociated itself from the resolution.

The representative of ISRAEL objected to proceeding with the draft resolution.

The CHAIR invited the Board to proceed to a vote on the draft resolution.

The representative of ISRAEL objected since no vote had been requested.

The LEGAL COUNSEL explained that voting was the default mechanism for making decisions under the Rules of Procedure of the Executive Board, although a decision could be taken by consensus in the absence of any objections. As an objection had been made, the usual procedure was to vote by show of hands, or by roll-call if a Board member so requested.

The representative of ISRAEL asked which rule allowed a vote to be held without a specific request from a Board member.

The LEGAL COUNSEL said that, according to Rule 49 of the Rules of Procedure, decisions on important questions required a two-thirds majority, while other decisions required a majority of the members present and voting. The Rules of Procedure did not contain specific provisions regarding consensus, the use of which had developed over the years as a way of proceeding without a vote when a decision clearly had full support. Thus, it was not necessary to call for a vote, as that would take place automatically whenever a member blocked consensus, as in the current case.

The representative of ISRAEL said that a vote must be requested. As no one had requested a vote, the report should simply be noted and discussion of the draft resolution closed.

The CHAIR invited the Board to consider whether it wished to take any further action on the draft resolution.

The representative of QATAR requested clarification.

The CHAIR said that the Board, having noted the report contained in document EB156/20, now needed to decide how to proceed with the draft resolution, given that the representative of Israel did not wish it to be adopted or further discussed or voted on, even if his dissociation was placed on record.

The representative of ISRAEL stressed that he did not wish to dissociate his Government from the draft resolution, but rather proposed that the report be noted and the discussion be closed without making a decision on the draft resolution.

The LEGAL COUNSEL said that the report had already been noted and the Board was now considering the draft resolution. If the Board agreed to the proposal by the representative of Israel, the draft resolution would not be adopted.

The representative of QATAR said that the Board should comply with its Rules of Procedure and usual practice.

The CHAIR invited the Board to proceed to a vote on the draft resolution.

The representative of ISRAEL said that the Board must first respond to his proposal to close the discussion.

The representative of SOMALIA requested a vote.

The LEGAL COUNSEL said that, as a vote on the draft resolution had been requested, the Board must normally vote by show of hands under Rule 51 of the Rules of Procedure, unless a member requested a vote by roll-call. In the absence of such a request, he explained the procedure for the vote by show of hands.

The representative of SOMALIA said that, after consultation with the Member States of the Eastern Mediterranean Region, he wished to withdraw his request for a vote, preferring adoption by consensus.

The representative of ISRAEL said a decision should first be made on his outstanding motion.

The CHAIR said that he had proceeded to a vote in accordance with the Legal Counsel's guidance. As the representative of Somalia had withdrawn the request for a vote, he invited the Board to return to consideration of the draft resolution.

The representative of ISRAEL said that he was ready to note the report and close the discussion.

The CHAIR said that the report had already been noted, and invited the Board once again to adopt the draft resolution by consensus.

The representative of QATAR reiterated that the normal rules and procedures must be followed.

The CHAIR invited the Board to proceed to a vote on the draft resolution.

The representative of ISRAEL objected, stating that, in his understanding of the Rules of Procedure, a vote must be requested.

The representative of BRAZIL said that the role of the Executive Board was to take decisions according to the Rules of Procedure. It would be preferable to adopt the draft resolution by consensus. However, given the importance of avoiding discrimination in healthcare, he would formally request a vote if necessary.

The representative of SOMALIA said that the draft resolution should be adopted by consensus, as had been done during the Seventh special session of the Executive Board.

The CHAIR explained that the draft resolution could not be adopted by consensus without the support of all Board members.

The representative of ISRAEL said that the Board should not vote on the draft resolution until it had addressed his motion.

The LEGAL COUNSEL confirmed that the report contained in document EB156/20 had already been noted. The Board must now consider how to proceed with the draft resolution. The proposal by the representative of Israel to take no further action could be treated as a no-action motion, on which the Board must vote before any vote on the draft resolution could be held. Or, as the Chair had suggested, the Board could move directly to a vote on the draft resolution, which was the default process in the absence of consensus. Both approaches were acceptable.

The representative of ISRAEL said that, in that case, the Board should first decide on the no-action motion.

The LEGAL COUNSEL clarified that the no-action motion would effectively constitute a motion to adjourn the debate under Rule 40 of the Rules of Procedure, which established that, in addition to the proposer of the motion, one speaker was permitted to speak in favour and one against, after which the motion must be immediately put to the vote. If the motion was passed, the item would be closed without adopting the draft resolution; if not, the Board would consider the draft resolution, which could be adopted by consensus or, if necessary, by vote.

The representatives of LEBANON and QATAR objected to the adjournment.

The CHAIR invited any speakers in favour of adjournment, other than the representative of Israel, to take the floor.

The representative of SOMALIA said that, as only one member was calling for adjournment, the decision should be taken by consensus.

The CHAIR invited the Board to vote on the motion proposed by the representative of Israel.

The representative of ISRAEL asked why he could not speak in favour of adjournment.

The LEGAL COUNSEL restated that, according to Rule 40, in addition to the proposer of the motion – in this case, the representative of Israel – one other speaker could speak in favour and one against. If no other member wished to speak in favour, the Board should proceed to a vote on the motion, which would be taken by show of hands, unless a member requested a roll-call vote.

The representative of BRAZIL asked why the Board needed to vote, as there was clearly no support for adjournment. The extensive discussion of the issue was wasting valuable time and resources.

The LEGAL COUNSEL clarified that a member was entitled to a vote on their motion to adjourn, which was a procedural matter similar to a point of order. The motion had been discussed and could now be put to the vote.

The representative of BRAZIL said that it should have been made clearer that support from the proposer alone was sufficient to trigger the vote.

The LEGAL COUNSEL said that the possibility, under Rule 40, of hearing from one member in favour of the motion and one against was simply to avoid a protracted debate. He explained the procedure for the vote on the motion to adjourn, which would be taken by show of hands.

The CHAIR announced the results of the vote, saying that 34 Board members had the right to vote but 1 was absent. Five Board members had abstained, and of the 28 Board members present and voting, 1 had voted in favour and 27 against.

The motion to adjourn the debate was therefore rejected by 27 votes to 1, with 5 abstentions.

The CHAIR invited the Board to adopt the draft resolution by consensus.

The representative of ISRAEL expressed his objection.

The LEGAL COUNSEL said that the Board would therefore vote on the draft resolution by show of hands, in accordance with Rule 51 of the Rules of Procedure, unless a member requested a recorded vote by roll-call. Responding to a question from the representative of Israel, he explained that the vote was being taken not on the basis of the request made by the representative of Brazil, but as an automatic consequence of the representative of Israel objecting to adoption by consensus.

The representative of ISRAEL said that, in his understanding, a vote should be requested.

The LEGAL COUNSEL stressed that a vote did not need to be requested, as it was the default decision-making mechanism under the Rules of Procedure. The Board would proceed to a vote whenever a member blocked adoption by consensus.

The representative of ISRAEL disagreed with that interpretation of the Rules of Procedure.

The representative of YEMEN asked whether the Rules of Procedure covered cases in which only one member went against consensus.

The LEGAL COUNSEL said that the Rules of Procedure did not cover decision-making by consensus. The practice for both the Executive Board and the Health Assembly was to proceed without a vote if no voting members objected. As one voting member had objected, the decision would be taken by vote in accordance with the Rules of Procedure. In practice, that meant that one Board member could force a decision to be put to the vote.

The representative of QATAR asked whether, under the Rules of Procedure, objection could be regarded as dissociation.

The LEGAL COUNSEL said that the established practice for both the Executive Board and the Health Assembly was to allow dissociation from a text so that it could be adopted without a vote. The representative of Israel had declined that course of action, thereby necessitating a vote.

The representative of QATAR asked whether the Rules of Procedure provided a definition of objection. As far as she understood, the available options were dissociation, consensus or a vote.

The LEGAL COUNSEL said that, although voting was the default decision-making procedure, it was established practice to allow decisions to be taken by consensus, without a vote. In such cases, the Chair proposed a motion to the Board, and if a voting member objected, it was taken as a lack of consensus. The Board would then proceed to a vote, as in the Rules of Procedure. Dissociation was another longstanding practice, whereby a member recorded their reservations regarding a text as dissociation, avoiding a vote. However, a member had objected both to adopting the draft resolution by consensus, and to recording their dissociation so as to allow the adoption to proceed. Therefore, according to the Rules of Procedure, the Board must automatically move to a vote.

The representative of EGYPT[1] said that, as the Legal Counsel had made very clear, the Board was complying with its Rules of Procedure. Despite claiming to stand against the politicization of WHO, the Board member objecting to the draft resolution had wasted the Organization's time and resources by repeatedly disputing the legal procedures. No other Member State would have been afforded such courtesy and leeway in the same situation. Permitting a Member State to obstruct WHO's work in that fashion would set a fatal precedent.

The LEGAL COUNSEL explained the procedure for the vote on the draft resolution, which would be taken by a show of hands.

The CHAIR announced the results of the vote, saying that 34 Board members had the right to vote but 1 was absent. Five Board members had abstained, and of the 28 Board members present and voting, 26 had voted in favour and 2 against.

The resolution was therefore adopted by 26 votes to 2, with 5 abstentions.[2]

2. **Universal Health and Preparedness Review:** Item 18 of the agenda (document EB156/21)

The representative of the REPUBLIC OF KOREA said that the Secretariat should facilitate wider participation in the Universal Health and Preparedness Review through clear, concise messaging about its benefits, and by highlighting complementarity with existing mechanisms, such as the joint external evaluation. In addition, countries that had participated in the pilot phase should share their experiences through peer-to-peer exchange. Integration into existing global health frameworks and regional initiatives would be crucial to improve consistency and avoid duplication of efforts. In particular, the Review outcomes should be aligned with the key indicators of the Fourteenth General Programme of Work, 2025–2028, and the Sustainable Development Goals. Integrating the Review into regional initiatives and capacity-building programmes would support needs-based implementation by Member States. Joint initiatives with civil society, academia and the private sector could help to bridge financial and technical gaps and enhance

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[2] Resolution EB156.R3.

multisectoral engagement, while collaboration with regional organizations would provide localized support for implementing recommendations.

The representative of TOGO, speaking on behalf of the Member States of the African Region, welcomed the support provided by the Secretariat to enable Member States to undertake the Review. Close collaboration with partners, in particular the Africa Centres for Disease Control and Prevention, had also enabled Member States in the Region to apply to the Pandemic Fund for resources to support the process. However, further Secretariat support and dedicated funding was required, with strong involvement from the private sector and civil society. The lack of notable improvements in health system preparedness following the Review should not discourage Member States from investing in the process.

The representative of CAMEROON said that the national review process had notably strengthened high-level engagement on health security, improved focus on governance, health systems strengthening and financing, and supported the harmonization of efforts to improve health resilience. She encouraged Member States to support the initiative and consider participating in the process.

The representative of MOROCCO, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that conflict and a lack of resources posed serious threats to health systems in his Region. The Review represented a unique opportunity to expand universal health coverage, promote transparency and advance the health security agenda at the global, regional and national levels. The successful pilot project in Iraq provided valuable lessons on implementing the Review in fragile and conflict-affected settings. The Secretariat should strength advocacy efforts and provide context-appropriate technical support to Member States to encourage wider participation, especially by resource-limited and conflict-affected countries. It should also align the process with the International Health Regulations Monitoring and Evaluation Framework and strengthen partnerships with global health initiatives to ensure coherence and complementarity.

The representative of NORWAY said that the pilot phase should be continued before any final decision was made on the Review. It was especially important to understand how the Review would relate to other evaluation instruments, such as the joint external evaluations and the State Party Self-Assessment Annual Reporting Tool, in order to assess its added value.

The representative of BRAZIL welcomed the acknowledgement that a multisectoral, whole-of-society approach was vital to increasing social participation in health governance. Her Government supported further development of the Review, based on evidence and in close consultation with Member States. However, it was concerned about the proliferation of monitoring, assessment and capacity-planning instruments, including those within the International Health Regulations Monitoring and Evaluation Framework and those currently under discussion by the Intergovernmental Negotiating Body to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response. Given the need to avoid the duplication of work, efforts must be made to harmonize and align monitoring and assessment mechanisms to ensure coherence and efficiency.

The representative of THAILAND stressed that monitoring and evaluation exercises must be followed by the development and implementation of an action plan. The Review contained concepts not covered by the joint external evaluation or the State Party Self-Assessment Annual Reporting Tool; Member States should therefore have the option of deciding whether to undertake a full Review or to integrate key elements of it into those existing mechanisms, according to their context and capacities. The outcomes should be shared and reviewed at the

regional level to promote greater collaboration on pandemic preparedness, prevention and response.

The representative of CHINA said that, given the current financial context, WHO must prioritize actions to make the most of limited resources. Noting that the Review was meant to complement, not replace, the joint external evaluation and other similar assessments, she expressed concern that the process might place an additional burden on the Secretariat and Member States. It was preferable to have fewer monitoring and evaluation mechanisms without any overlap. Following the pilot phase, the Secretariat should provide feedback on the function of the Review and its relationship with other mechanisms and consult with Member States on its continued use. In particular, the Review should remain voluntary and must not be incorporated into any global health frameworks or regional initiatives until Member States had reached a consensus on the matter.

The representative of SWITZERLAND recognized the importance of assessing health emergency preparedness at the national level to identify gaps in coverage and enable the strategic deployment of resources. A pandemic agreement must incorporate a robust monitoring and evaluation mechanism. Given the financial constraints on WHO, such a mechanism must be as cost-effective as possible and allow a holistic evaluation based on existing instruments.

The representative of BULGARIA stressed the importance of highlighting that the Review complemented other assessments, adding value to health security strengthening by promoting a whole-of-society approach to emergency preparedness. Duplicate reporting and unnecessary burdens on administrative staff should be avoided. The Secretariat should provide further details on how Member States participating in the pilot phase had been supported to identify key challenges and funding priorities, achieve a return on investment in health security preparedness and allocate domestic and international resources to priority areas. Coordination in public health emergency management should be improved, taking into account specific national features, human resource capabilities and funding mechanisms. To that end, the Review must be integrated into existing mechanisms to improve its impact. Cooperation and partnership networks must also be strengthened at the national, subregional and regional levels to improve emergency preparedness. In that regard, the Secretariat could raise awareness among Member States of the importance of preparedness for health threat detection.

The representative of BRUNEI DARUSSALAM said that the Secretariat should facilitate tailored national or regional workshops to help Member States to understand the Review process and the practical challenges involved. Resource mobilization and technical assistance were crucial to overcome the significant financial or technical barriers to participation faced by many countries, and in particular developing countries. In addition, the Review should be aligned with the existing joint external evaluation to avoid duplication. Identifying areas of convergence and integrating key components of the two processes would lead to a more streamlined and cohesive evaluation framework, enabling Member States to focus on implementation without being overburdened by multiple assessments. The Review had the potential to drive meaningful progress in health emergency preparedness; capacity-building, equitable resources and streamlined processes would enhance the effectiveness and inclusivity of the initiative.

The representative of GUATEMALA[3] said that it was vital to address the inequalities hampering progress towards universal health coverage. The Review should lead to the

[3] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

development of tailored interventions to ensure that people in situations of vulnerability could access comprehensive, high-quality healthcare. His Government welcomed the lessons learned from the pilot phase and reaffirmed its commitment to upholding the International Health Regulations (2005). Highlighting the importance of stronger international cooperation to ensure timely emergency responses, he thanked the Republic of China (Taiwan)[4] for the support provided to improve health services in his country.

The representative of PANAMA[5] called for greater high-level commitment to a context-specific, strategic, multisectoral approach to health emergency preparedness, with appropriate monitoring. It was important to highlight Member States' confidence in the Review process. Failures to update national health emergency plans continued to hold back improvements to health security measures. Appropriate financing and greater solidarity would help to strengthen global health security and governance. However, it was also vital to increase the efficiency and effectiveness of the Review, optimize existing initiatives and increase participation among Member States.

The representative of PORTUGAL[5] said that, as a participant in the pilot phase, her Government recognized the Review as a crucial mechanism for making preparedness a strategic and political national priority. The process had been instrumental in identifying challenges, strengthening resilience and facilitating preparations for the joint external evaluation and other regional assessments, and promoting stakeholder engagement in the initiative. Her Government welcomed WHO's leadership in advancing global health security and called for sustained international collaboration to ensure that preparedness efforts were coordinated, adequately financed and effectively implemented.

The representative of FRANCE[5] said that the Review was a key mechanism in promoting health security and solidarity among Member States. Work should continue to establish a model suited to the capacities of participating States. A multisectoral approach was needed to promote and harmonize health emergency preparedness activities. In the current budgetary context, the Secretariat should continue streamlining the Review, ensuring close alignment with the joint external evaluation and existing regional evaluation processes. His Government supported the joint efforts of the Secretariat and Member States to make the Review an agile and effective mechanism for multisectoral collaboration on health emergencies in all countries.

The representative of the RUSSIAN FEDERATION[5] agreed that multisectoral reviews were challenging, notably due to time constraints. She emphasized the need to maintain the voluntary nature of the Review, in line with decision WHA77(10) (2024); it should not be a pretext for interfering in the internal affairs of Member States or be presented as a condition for receiving capacity-building support for health security.

The representative of GERMANY[5] said that a high-level instrument like the Review could boost implementation of the results of technical evaluations and action plans. The report had shown that the Review could be an effective complementary tool to help Member States to improve national preparedness capacities, adding an important optional layer to existing evaluation tools. Current budgetary challenges called for enhanced financial scrutiny, with priority

[4] World Health Organization terminology refers to "Taiwan, China".

[5] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

given to ensuring the continuity of essential programmes and actions. In that context, the Review should continue to be offered to Member States in a cost-effective manner.

The representative of INDONESIA[6] recognized that the Review could play a valuable role in enhancing global health security and strengthening national health systems. However, it should remain voluntary to avoid additional financial burdens on Member States. It was essential to prevent any duplication of existing mandatory or voluntary assessment frameworks, such as the joint external evaluation or the State Party Self-Assessment Annual Reporting Tool. A clear distinction between mechanisms would enhance their effectiveness and support a more coordinated, efficient approach to health security. Moreover, the collaborative nature of the Review should be maintained, including through engagement with all relevant stakeholders.

The representative of COLOMBIA[6] said that the Secretariat should continue to develop strategies to enhance awareness and understanding of the Review process and promote broader participation, particularly at the community level, which required ongoing capacity-building and effective communication channels due to their dynamic nature. The Review could be integrated effectively into other global health initiatives by optimizing information systems in the different regions, thereby facilitating the timely identification of the strategies implemented and the evaluation of their impact on local health systems and enhancing efficiency and coherence.

The representative of the UNITED REPUBLIC OF TANZANIA[6] said that the Review conducted in her country had highlighted the need for strong government commitment and high-level disaster management structures as part of a One Health approach, and an effective health information system. Her Government had integrated community health workers into the health system to ensure the skilled workforce vital for effective detection, reporting and response during public health emergencies. A costed national health security plan, disaster management funds and strategic resource mobilization mechanisms were also key to enhancing emergency preparedness and response.

The representative of SINGAPORE[6] welcomed the development of the Review, noting its potential to galvanize high-level political commitment and strengthen the capacity of Member States to manage health emergencies effectively. However, given the resources required, the process must not duplicate other evaluation work. The Review would be particularly valuable in enhancing collaboration where stronger political engagement was needed to advance pandemic preparedness, while the joint external evaluation could continue to serve as the framework for assessing technical capabilities and promoting comprehensive, multisectoral dialogue between government agencies. To optimize resource allocation and maximize the impact of the Review, the Secretariat should consider developing tailored national implementation strategies, prioritizing those Member States that would benefit the most.

The representative of BANGLADESH[6] expressed concern at the proliferation of monitoring and assessment instruments, noting that the Review would serve the same purpose as monitoring and assessment frameworks for the International Health Regulations (2005) and the pandemic agreement. Monitoring and assessment were vital to improve health systems, but duplication and excessive administrative and financial overheads for both Member States and the Secretariat must be avoided. A new reporting avenue was not feasible given the likely staff cuts across WHO. Monitoring and assessment should therefore be carried out within the framework of the International Health Regulations (2005), as that would maximize Member State inclusion. In

[6] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

addition, the Review had had mixed results due to a lack of support measures; that should be taken into account when deciding on its future application.

The representative of EGYPT[7] emphasized the voluntary nature of the Review process.

The representative of the EUROPEAN SOCIETY FOR MEDICAL ONCOLOGY, speaking at the invitation of the CHAIR, urged Member States to include cancer prevention and control measures in their preparedness plans to ensure continuity of care during emergencies. In particular, they should strengthen the resilience of the secondary and tertiary care levels and develop digital and telemedicine capabilities to enable continued care during physical access restrictions.

The representative of THE WORLD MEDICAL ASSOCIATION, INC., speaking at the invitation of the CHAIR, emphasized the importance of multisectoral collaboration, equity and transparency in pandemic preparedness and response activities. It was equally important to engage with healthcare professionals to ensure inclusive and realistic strategies. The Review offered a valuable platform to strengthen global health systems and foster resilience; priority should be given to countries facing the most challenges in implementing the core capacities required by the International Health Regulations (2005).

The representative of the WORLD ORGANIZATION OF FAMILY DOCTORS, speaking at the invitation of the CHAIR, said that family doctors remained underrepresented in national and global health crisis planning. She urged WHO to formally integrate family doctors into decision-making bodies for emergency preparedness and response, so as to strengthen health system resilience, improve outcomes and build trust in public health interventions.

The DEPUTY EXECUTIVE DIRECTOR (WHO Health Emergencies Programme) thanked speakers for their comments. Responding to concerns regarding the voluntary nature of the Review, he stressed that the process could not take place without the full and willing participation of the Member State concerned.

The DIRECTOR (Health Security Preparedness), emphasizing the voluntary, Member State-led nature of the Review, said that many Member States were interested in participating in the process. As speakers had highlighted, the Review had boosted high-level engagement on preparedness and response in health emergencies, facilitated multisectoral collaboration and rigorous technical discussions, and improved capacities to advocate for domestic resources. The process was being updated to reflect the lessons learned, with a focus on addressing gaps, promoting best practices and avoiding the duplication of work. Some Member States participating in the pilot phase had performed the Review either alongside the joint external evaluation or shortly afterwards; the findings from those experiences would be shared and used to inform future models. The Review put and maintained preparedness high on the political agenda in a way that the joint external evaluation generally had not. Many lessons learned from previous health emergencies were central to robust preparedness. The Review process demonstrated to Member States that the impact of health emergencies extended far beyond the health sector, meaning that the response required close multisectoral collaboration, including with civil society organizations and communities. It had also empowered ministries to elevate critical health issues to the highest levels of government and build on investments put in place during recent emergencies. The process had furthermore enabled regional and global dialogue on capacity-building, innovation and investment, providing a transformative platform for global collaboration and national action.

[7] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The Secretariat was committed to following up on Member State guidance as it advanced towards the global review phase for the next set of participants.

The Board noted the report.

3. Poliomyelitis: Item 19 of the agenda (document EB156/22)

The representative of the REPUBLIC OF KOREA said that the underreporting of unvaccinated children was often influenced by vaccine hesitancy and insufficient awareness. It was therefore vital to enhance immunization campaigns. While recognizing the significant contribution of oral polio vaccines in interrupting transmission, her Government called for their use to be carefully phased out to mitigate the risks associated with vaccine-derived polioviruses. The collective global commitment to eradicating poliomyelitis, and the recent extension of the Polio Eradication Strategy 2022–2026 to 2029 were commendable. Highlighting national efforts on vaccination and containment, she stressed the need for effective resource allocation and comprehensive poliovirus containment systems.

The representative of QATAR, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that conflict, displacement and weak health systems in her Region hampered poliomyelitis vaccination efforts. She welcomed the momentum in addressing the re-emergence of wild poliovirus type 1 and outbreaks of variant poliovirus type 2, outlining regional efforts to improve vaccination rates in countries facing particular access difficulties. Her Region remained committed to protecting children from poliomyelitis, including through the Regional Health Alliance.

The representative of CANADA said that more should be done to strengthen integration and find efficiencies, notably through closer collaboration with routine immunization programmes, the humanitarian sector and other health services. Member States where poliovirus was circulating should allow the Global Polio Eradication Initiative to act as necessary to ensure that all children had access to vaccination, including by supporting best practices, such as house-to-house campaigns. Use of inactivated poliovirus vaccine or hexavalent vaccine should be prioritized, alongside tools like fractional-dose inactivated poliovirus vaccine and a birth dose of oral polio vaccine. It was imperative to strengthen country capacity and provide technical support to ensure national ownership of processes. A localized, context-based, gender-responsive approach was needed to engage communities and address gender-related barriers to immunization with the objective of vaccinating all children. Member States should consider pledging or renewing funding to the Initiative to finally eradicate the disease.

The representative of NORWAY called for poliomyelitis prevention, surveillance and response to be integrated into national health systems and regional and global preparedness and response systems. Better integration into immunization and primary healthcare services would contribute to a more sustainable response, ensuring that zero-dose children received vaccines now and in the future. Successful implementation of the polio transition agenda would play an important role in that work. During humanitarian crises, it was particularly important to facilitate effective collaboration among all stakeholders, including civil society. An integrated approach provided the strongest case for receiving both domestic and international financial support, focusing on funding for health systems strengthening and primary healthcare, rather than individual diseases.

The representative of LESOTHO, speaking on behalf of the Member States of the African Region, expressed appreciation for the healthcare workers and communities striving to combat poliomyelitis amid daunting challenges. The successful response to wild poliovirus type 1 importation in her Region had been due to strong government leadership, cutting-edge surveillance and the contribution of workers in the field. However, declining immunity had led to further outbreaks of circulating variant poliovirus, underscoring the need for sustained action. She commended the efforts made in that regard and called for commitment from global stakeholders to close gaps and safeguard future generations from the scourge of poliomyelitis.

The representative of SENEGAL said that country action plans should integrate high-impact public health activities as part of a holistic approach to ensure the efficient use of resources. To that end, plans to reinvigorate routine immunization efforts to reach all zero-dose children must ensure equitable service provision and should be based on alternative financing from global health security partners, WHO and UNICEF country office emergency funds for vaccine response, and sustainable government resources. Workforce strengthening for effective coordination of surveillance and response activities would also help to overcome the challenges related to circulating vaccine-derived poliovirus, environmental surveillance and poliovirus surveillance in patients with primary immunodeficiency disorders.

The representative of BRAZIL said that the recent global resurgence of poliovirus cases was a stark reminder of the pressing need to eradicate the disease. Describing national activities to address the issue, she stressed that achieving eradication hinged on united efforts to effectively implement the Polio Eradication Strategy, in particular through sustainable funding and public–private sector collaboration. Member States should strengthen their commitments to eradication and redirect their focus towards neglected diseases. It was also crucial to combat misinformation and rebuild vaccine confidence by engaging local leaders, religious figures, community health workers and wider civil society. Such work must be continuously improved through investment in science and innovation.

The representative of AUSTRALIA welcomed the progress made towards stopping transmission of circulating variant poliovirus, especially the improvements in the supply of novel oral polio vaccine type 2. However, the wide geographical distribution of wild poliovirus type 1 cases was a cause of concern, and efforts to interrupt transmission must be intensified in line with the recommendations of the Independent Monitoring Board of the Global Polio Eradication Initiative. Given the important role played by women health workers in reaching zero-dose and under-immunized children, it was critical to continue implementing the Initiative's Gender Equality Strategy. The safety of all frontline poliomyelitis workers should remain a high priority. The weakness of routine immunization systems persisted as a key underlying cause of variant poliovirus outbreaks and must be addressed with UNICEF and Gavi, the Vaccine Alliance, as part of broader integration work.

The representative of MALDIVES emphasized the need for context-specific strategies to improve vaccination coverage, using detailed microplanning and robust population data to identify underserved communities. Building trust through community engagement was paramount to address vaccine hesitancy and misinformation. To maximize accessibility, poliomyelitis vaccination should be integrated into other essential health services, such as routine immunization and maternal health programmes, while mobile vaccination teams were indispensable to reach populations with limited access to healthcare facilities. Expanding environmental surveillance, including through the use of digital monitoring tools, would facilitate the timely follow up of any missed children. Securing the necessary financial resources for the Polio Eradication Strategy

required strong advocacy with both traditional and non-traditional donors. Member States should also establish dedicated immunization budgets, explore innovative financing mechanisms, optimize programme cost and favour multiyear funding commitments. At the national level, maintaining high routine immunization coverage should be prioritized. Regionally, the focus must be on improving cross-border coordination, adhering to containment strategies and leveraging technical expertise. At the global level, robust governance frameworks were essential, as were adequate vaccine stockpiles to respond to outbreaks.

The representative of SOMALIA drew attention to his Government's ongoing commitment to high immunization coverage and effective disease surveillance, despite the funding limitations and the complex humanitarian context. Addressing those challenges required sustained political commitment, increased financial and technical support, and innovative approaches. Enhanced cross-border collaboration and community involvement were also vital; the global effort to eradicate poliomyelitis was a shared responsibility.

The representative of THAILAND said that targeted microplanning, focusing on hard-to-reach areas, mobile populations and underserved communities, was vital to reach zero-dose children. Integrating poliomyelitis vaccination into maternal and child health services would maximize reach, and community health volunteers could play a key role in fostering trust, identifying missed children and conducting house-to-house campaigns. Digital tools should also be used to improve real-time monitoring and accountability. In terms of financial resources, Member States should prioritize domestic investment and donor engagement. Public–private partnerships and platforms such as the Global Polio Eradication Initiative could help to bridge funding gaps; in that regard it was important to emphasize the economic and social benefits of eradication. At the national level, poliomyelitis functions should be integrated into routine immunization programmes and improvements should be made to acute flaccid paralysis monitoring. Regionally, cross-border collaboration would be crucial to reach mobile populations, particularly in conflict settings, while at the global level, the post-certification strategy should be revised to incorporate emerging technologies.

The representative of SLOVAKIA said that persistent barriers such as humanitarian insecurity, service sustainability, access constraints and vaccine hesitancy must be addressed to achieve full eradication. Noting that the recent extension of the Polio Eradication Strategy showed the complexity of the task and the need for sustained commitment, he asked how the current global health landscape would affect implementation, what strategies the Science Division proposed to accelerate progress, and in which areas there was scope for cooperation with Member States and other organizations. It would also be useful to know how implementation could be optimized for greater efficiency; and how resource sharing, regional cooperation and technology, including artificial intelligence, could improve outcomes. Furthermore, he asked what additional operations or financial mechanisms were needed to ensure full vaccination coverage for children and sustain progress beyond certification. The Secretariat should conduct evaluations and expenditure reviews to improve the efficiency of initiatives.

The representative of CHINA, detailing efforts to enhance the national immunization programme and improve poliovirus surveillance, said that WHO should continue to play a leading technical role in work towards polio eradication. Increased financial and technical support should be provided to countries where poliovirus remained endemic and those where importation was a risk. Improved regional and global cooperation and effective measures in high-risk areas would reduce transmission and accelerate global eradication. Her Government would continue to support those efforts, including by sharing technical expertise and promoting access to vaccines.

The representative of PARAGUAY[8] said that it was the responsibility of Member States to improve vaccination through focused campaigns, strengthen epidemiological surveillance and promote integration to optimize resources. Mass vaccination campaigns must cover hard-to-reach communities, with community leader involvement and continuous monitoring of areas of low coverage. Capacity-building among health workers and the use of technology would allow accurate, equitable monitoring and would require sustainable financial resources. It was vital to assess needs, draw up efficient financing plans and mobilize both government and international funds.

The representative of COLOMBIA,[8] highlighting national strengths and challenges in the implementation of vaccination programmes, said that the integration of poliomyelitis functions into other health campaigns would optimize resources and improve coverage. Public–private partnerships could also provide financial and logistical support. It was essential to improve healthcare infrastructure in rural areas, strengthen the cold chain and improve epidemiological surveillance, including environmental and wastewater monitoring. At the regional level, vaccination strategies should be coordinated with neighbouring countries to prevent poliovirus reintroduction and ensure consistent campaigns across borders. Participating in initiatives led by WHO/PAHO, among others, would be key to aligning eradication strategies with international best practices and guaranteeing sufficient attention to border areas. Globally, continued engagement in the Global Polio Eradication Initiative and collaboration with international donors were crucial. Health systems must be strengthened to maintain the polio-free status of a country in the post-certification phase.

The representative of SPAIN,[8] highlighting his Government's national and international efforts to tackle poliovirus, said that the Global Polio Eradication Initiative's Gender Equality Strategy was crucial, as the empowerment of women was key in eradicating the disease. Commending the efforts to maintain immunization programmes in challenging contexts, including through the Big Catch-Up, he called on all Member States and WHO partners to ensure that the announced intent of the United States of America to withdraw from the Organization did not affect the global fight against poliomyelitis at a time when eradication was within reach.

The representative of PERU[8] said that poliomyelitis vaccination for all children, especially those in vulnerable or hard-to-reach communities, should be a global priority. Effective mechanisms such as immunization registers were needed to reach unvaccinated children. It was vital to identify the direct and indirect costs of the Polio Eradication Strategy and strengthen political commitment to secure sufficient funding. Governments should prioritize the cause within national public health budgets. Coordination and improved surveillance were needed at all levels. Moreover, it was important to strengthen laboratories and emergency preparedness at the national level, cross-border monitoring at the regional level, and research and resource mobilization at the global level.

The representative of MONACO[8] expressed support for the initiatives to integrate immunization services into wider public health campaigns, reduce the number of zero-dose children and promote gender equality in vaccination campaigns. The work under way to mitigate the risk of resurgence of the disease, notably the approval of a second supplier of novel oral polio vaccine type 2, was also welcome. However, intensified collective efforts, additional financing and

[8] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

firm political commitment were needed to guarantee the success and sustainability of eradication and transition strategies, including the extended Polio Eradication Strategy.

The representative of INDONESIA,[9] highlighting the national progress made in eradication, stressed that sustainable financing remained a priority. To that end, her Government was exploring diverse funding sources, including the private sector and philanthropic organizations. It remained committed to global health equity, as reflected in its support for vaccination campaigns worldwide and international cooperation more generally.

The representative of PAKISTAN[9] expressed deep concern at the significant increase in poliomyelitis cases in 2024. Despite the challenges arising from flooding in her country and the associated population displacement, the Government had continued to run large-scale immunization campaigns. It remained committed to protecting health workers and dispelling misinformation and disinformation regarding the campaigns. Thanking global partners for their support, she expressed the hope that strengthened collaboration and increased resource allocation would make it possible to interrupt poliovirus transmission in 2025.

The representative of PANAMA[9] recognized the need for high levels of vaccination coverage and heightened surveillance to mitigate the risk of importation of wild poliovirus type 1. Countries in which poliovirus was endemic must continue to improve the effectiveness of their campaigns as recommended in the report. More generally, all national surveillance systems must be strengthened to ensure the timely detection of, and response to, circulating variant poliovirus. The Global Polio Eradication Initiative's integration workplan and Polio Transition Monitoring and Evaluation Framework would be valuable mechanisms for addressing gaps and inequalities.

The representative of the RUSSIAN FEDERATION[9] said that reduced surveillance indicated waning commitment to polio eradication in a number of countries, and anti-vaccination sentiment was also on the rise. Long-term financial and organizational planning required strengthening at the national, regional and global levels. Given the limited progress in implementing the containment programme, the 2026 target for full containment certification of all facilities retaining wild and vaccine-derived polioviruses was unrealistic and should therefore be extended by three years. Attention must also be paid to guaranteeing an adequate supply of inactivated poliovirus vaccine, which would require appropriate financial and organizational strategies given its higher cost.

The Observer of PALESTINE, drawing attention to the challenges of addressing the spread of poliomyelitis in the occupied Palestinian territory, particularly the Gaza Strip, said that access to poliomyelitis vaccination must be guaranteed to all children in all settings, in peacetime and during war. Although a successful vaccination campaign had been carried out in very difficult circumstances, Member States, international organizations and non-State actors must work together to ensure that vaccination teams on the ground could continue their work in safety.

Rights of reply

The representative of the RUSSIAN FEDERATION,[9] speaking in exercise of the right of reply, rejected the unfounded accusations regarding the special military operation in Ukraine. WHO had graded the humanitarian situation in the country as a health emergency as early as February 2014. The special military operation by her country was a response to military escalation by the armed forces of Ukraine and intensified attacks in the Donetsk and Luhansk People's Republics, including on health infrastructure. The operation was based on the right to self-defence under Article 51 of

[9] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

the Charter of the United Nations, and the United Nations Security Council had been duly informed of that. She strongly condemned attempts to use the Executive Board as a platform for fallacious political attacks. The time would be better spent discussing preparedness and response to the high number of ongoing health emergencies identified by WHO worldwide.

The representative of UKRAINE, speaking in exercise of the right of reply, said that the statement by the representative of the Russian Federation was a cynical attempt to mislead the Executive Board. The Russian army continued to shell Ukrainian hospitals and other critical infrastructure and to deny the rights of millions of Ukrainians, including the right to health. The Russian Federation's intentions had been exposed in February 2022, when it had launched its unprovoked aggression against her country, inflicting the serious, ongoing health emergency.

The representative of ARGENTINA,[10] speaking in exercise of the right of reply, said that his Government had carefully analysed the report on health conditions in the occupied Palestinian territory, including east Jerusalem, contained in document EB156/20. The report had not specified that Hamas had carried out the terrorist attack on 7 October 2023, was responsible for the more than 1,500 Israeli fatalities and was still holding hostages, including Argentine citizens. The paltry three lines covering the attack demonstrated that the report was shockingly biased.

The meeting rose at 21:10.

[10] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Eleventh meeting

Friday, 7 February 2025, at 10:20

Chair: Dr J.X. WALCOTT (Barbados)

Pillar 2: One billion more people better protected from health emergencies (continued)

1. Poliomyelitis: Item 19 of the agenda (document EB156/22) (continued)

The representative of ISRAEL, responding to comments made at the previous meeting, clarified that poliovirus had been detected by the Israeli Ministry of Health. The information had been shared with the WHO Regional Office for the Eastern Mediterranean and the Ministry of Health of the Palestinian Authority. Her Government had also played an important role in coordinating the vaccination campaign.

The representative of TOGO described national efforts to maintain Togo's polio-free status, and highlighted the importance of quality campaigns, and the use of innovative technology and measures to identify and reach all unvaccinated or under-vaccinated children. Strengthened health surveillance for acute flaccid paralysis and enhanced cross-border activities, including microplanning and the mapping of specific populations were also required. She also stressed the need to implement coordinated, joint campaigns in border areas, and to mobilize national resources to complement international financial and policy commitments to respond to outbreaks.

The representative of YEMEN outlined measures at the national level to eradicate poliomyelitis with international support. Although no new cases had been recorded in government-controlled areas since 2022, poliovirus transmission in areas outside the government's control undermined eradication efforts. Diplomatic efforts were needed to convince parties in such areas to conduct immunization campaigns. Sustained commitment from the international community was needed to support the countries most at risk since poliomyelitis eradication was a collective responsibility.

The representative of COSTA RICA expressed support for integrated strategic action to reach zero-dose children and eradicate poliomyelitis. His country had been polio-free since 1973; national strategies to maintain the country's status focused on surveillance, the assessment and follow-up of all suspected cases, training for the public and private sector, coordinated interministerial action and an interinstitutional approach.

The representative of ETHIOPIA said that his country had been polio-free since 2017 and was working to improve vaccination access, coverage and quality. Nevertheless, challenges remained with respect to reaching all zero-dose children, addressing subnational disparities in vaccine access and tackling vaccine-derived poliovirus strains. Efforts were needed to focus on digital technologies to map and identify zero-dose children, integrate polio vaccination into other health

interventions, strengthen routine immunization, surveillance and monitoring, and ensure sustainable funding.

The representative of BANGLADESH[1] said that his country had been certified as polio-free in 2014, along with the rest of the South-East Asia Region. Despite resource constraints, his Government conducted vaccination campaigns, including for the Rohingya community sheltering in Bangladesh. He thanked the Secretariat, UNICEF and other partners for their support in that regard. It was imperative to ensure the continuation of WHO's poliomyelitis eradication efforts in resource-constrained countries and among vulnerable populations. Unfortunately, it seemed likely that vaccination programmes would be discontinued in some vulnerable countries owing to the impact of recent political events on the WHO programme budget. To achieve the ambitious target of a polio-free world, it was vital to ensure collective action and requisite funding, especially in vulnerable countries, including through flexible donor funding.

The representative of NIGERIA[1] provided an overview of national poliovirus surveillance, identification and control measures, including synchronized cross-border vaccination campaigns and additional outreach efforts, as well as steps to measure and improve performance and coordination. Challenges included campaign and data quality, compliance, security issues and vaccine fatigue. He expressed thanks for the work of the Secretariat, Gavi, the Vaccine Alliance, and other partners and encouraged support for the Global Polio Eradication Initiative, to stop transmission of circulating vaccine-derived poliovirus variants and wild poliovirus.

The representative of the UNITED REPUBLIC OF TANZANIA[1] said that poliovirus importation remained a threat. Her Government continued to maintain robust surveillance systems and to conduct immunization campaigns aligned with WHO guidelines to maintain its polio-free status, increase immunity levels and prevent cross-border transmission. WHO and stakeholders should sustain support for polio eradication activities during the transition to domestic funding. She highlighted the importance of enhanced microplanning, community engagement and measures to reach high-risk populations. Efforts were also needed to strengthen health systems to ensure vaccine availability, address vaccine hesitancy and integrate services, and to develop data-driven approaches through the use of digital tools for real-time monitoring and to address coverage gaps. Advocacy was essential to secure government and private sector support.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND[1] reaffirmed her Government's commitment to poliomyelitis eradication and urged the Global Polio Eradication Initiative to consider the recommendations of the Independent Monitoring Board. The integration of eradication measures into primary healthcare and collaboration were crucial. A focused approach was essential to ensure that all remaining zero-dose children were vaccinated. The Global Polio Eradication Initiative should also strengthen primary care, working alongside global health initiatives such as Gavi, the Vaccine Alliance, to coordinate delivery with nutrition, water, sanitation and hygiene activities and humanitarian interventions, and to introduce birth-dose vaccine strategies. Significant investment and coordinated action were needed to permanently interrupt poliovirus transmission. In addition to enhancing reach, greater integration would bring efficiencies and help to identify new funding sources, which would be crucial to fully implement the polio eradication strategy. Her Government also encouraged efforts to review the accountability and quality improvement mechanisms of the Global Polio Eradication Initiative.

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of MOZAMBIQUE[2] said that, following outbreaks in 2021, her Government had carried out several immunization campaigns, including to reach displaced persons and those living in conflict zones. Mozambique had been declared free of wild poliovirus type 1 in May 2024. Her Government was grateful to the Secretariat and WHO regional and country offices, and to the Global Polio Eradication Initiative, for their support, and recognized that the coordination of its interventions with those of neighbouring countries had contributed to the success of vaccination campaigns. The availability of vaccines and other medical supplies was crucial to reach zero-dose children in remote communities. Thus, funding for WHO work, including the Global Polio Eradication Initiative, was vital for poliomyelitis eradication. In the current challenging period, WHO should seek to identify innovative funding sources and mechanisms.

The representative of URUGUAY[2] outlined measures to maintain her country's polio-free status. Uruguay had high rates of immunization coverage and had strengthened its epidemiological surveillance system, in line with her Government's strategy to guarantee health for all. Immunization was a shared responsibility to ensure a disease-free world.

The representative of the ISLAMIC REPUBLIC OF IRAN[2] said that his Government was committed to the Global Polio Eradication Strategy 2022–2026 and described the action being taken to ensure high vaccination coverage. Cross-border migration from areas where poliomyelitis was endemic posed a significant challenge. He called for continued support from the Secretariat and for continued collaboration on global eradication efforts.

The representative of BURUNDI[2] stressed the importance of combating poliomyelitis, and provided an overview of national activities to that end as part of the polio transition plan. To achieve a polio-free world, it was vital to strengthen routine immunization and enhance environmental and other surveillance systems.

The Observer of GAVI, THE VACCINE ALLIANCE, said that, although cases of wild poliovirus had dropped by 99% since the establishment of the Global Polio Eradication Initiative, conflicts, fragile contexts and humanitarian crises had facilitated a resurgence of the virus, including in previously poliomyelitis-free countries. It was vital to prioritize the scaling-up of routine immunization and reaching all unvaccinated and under-vaccinated children worldwide. Member States should adopt an integrated approach to that end, especially in humanitarian and complex emergency settings, and accelerate polio transition efforts by integrating polio-funded assets into existing national health systems.

The representative of ROTARY INTERNATIONAL, speaking at the invitation of the CHAIR, urged all Member States to implement high quality immunization campaigns, improve routine immunization coverage, conduct robust surveillance, and identify solutions to reach every child. Progress continued to be hampered by political instability, insecurity and competing priorities, and was exacerbated by limited funding. While those issues were a distraction, they should not prevent the achievement of the goal of a polio-free world. He stressed the need to remain united and committed to ending poliomyelitis.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIR, highlighted challenges in eradicating poliomyelitis. He noted the importance of vaccination and called on all stakeholders to prioritize targeted strategies to address vaccine hesitancy, provide training to healthcare professionals and

[2] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

reach under-vaccinated populations, adopt transparent and consistent policies and provide funding to support immunization programmes.

The REGIONAL DIRECTOR FOR THE EASTERN MEDITERRANEAN noted that the Eastern Mediterranean was the last remaining WHO Region with circulating endemic wild poliovirus. At the start of 2024, poliovirus eradication programmes in Afghanistan and Pakistan had appeared close to fulfilling their goal. However, a resurgence of cases had occurred, with outbreaks in Somalia, Sudan, Yemen and the Gaza Strip. In that regard, she stressed the need to strengthen the capacity of frontline health workers. The response strategy was straightforward: to vaccinate every child and ensure surveillance to stop the spread of disease. The challenges in Afghanistan and Pakistan, which included geopolitical, environmental, infrastructure and security problems, were not insurmountable. In 2024, more than half a million children in the Gaza Strip had been vaccinated thanks to WHO-led, multi-actor and multilevel coordination efforts and the support of communities and health workers; that achievement could be replicated elsewhere. The Member States of the Eastern Mediterranean Region led the way in terms of coordination and cooperation. Together with the Director-General, she was working to address political challenges, in coordination with the Global Polio Eradication Initiative partners. The disengagement of the United States Centers for Disease Control and Prevention and the United States Agency for International Development had already had an impact in terms of strategic, technical and functional support. The Global Polio Eradication Initiative, which had been extended until 2029, was facing a funding shortfall in the order of US$ 2.4 billion and she was grateful to the Government of Saudi Arabia for its timely pledge of US$ 500 million for eradication efforts. While the Member States of the Eastern Mediterranean Region were playing their part, the steadfast support of the broader international community was needed to eradicate poliomyelitis and ensure that all children were vaccinated.

The CHEF DE CABINET welcomed the supportive comments and suggestions from Member States. The previous year had been particularly challenging, especially in countries where poliovirus was endemic. The Global Polio Eradication Initiative, which had been expected to complete its work in 2025, had suffered setbacks, such as the resurgence of wild poliovirus and the circulation of variant type 2 poliovirus, including in several European countries, and the tragic loss of the WHO Director for Polio Eradication. Global efforts had stalled. Nevertheless, all the necessary medical and technical resources to eradicate poliomyelitis were available; all that remained to be done was to reach and vaccinate the last remaining unvaccinated or under-vaccinated children. That work required the sustained stewardship of governments and ownership by communities. While the extension of the Global Polio Eradication Strategy until 2029 was welcome, poliomyelitis would only be eradicated once the last remaining children had been vaccinated. That goal could be achieved within the next two years, with the support and cooperation of all partners, based on a multisectoral approach and leveraging technology. She welcomed Member States' support and ongoing efforts to combat poliomyelitis, stressing the need to achieve the ultimate goal of eradicating the disease. The Secretariat would follow-up bilaterally with the Member States concerned on the strategic, technical and operational issues raised.

The Board noted the report.

Pillar 1: One billion more people benefiting from universal health coverage (continued)

2. Communicable diseases: Item 9 of the agenda (document EB156/9) (continued)

- **Global road map on defeating meningitis by 2030** (document EB156/10) (continued) (continued from the seventh meeting, section 2)

The CHAIR recalled that the Board had before it the reports contained in documents EB156/9 and EB156/10, as well as two draft decisions, on accelerating the eradication of dracunculiasis (Guinea-worm disease) and on skin diseases as a global public health priority.

The representative of TOGO commended the Secretariat's efforts to combat meningitis, including its strategic leadership and collaboration with partners, and support for national measures to assess meningitis risk factors, with a view to achieving indicator targets. She also welcomed the support provided by the WHO Regional Office for Africa to priority countries in her Region. She called for the mobilization of resources and collaboration with partners and donors to support the implementation of national strategic plans on meningitis. She drew attention to the considerable burden that skin diseases represented for global health and called for further action to address challenges limiting access to dermatological care.

The representative of YEMEN said that vector-borne diseases, including dengue, West Nile virus and malaria, posed a major challenge for the national healthcare sector, and the situation was exacerbated by the ongoing conflict in his country. Factors such as climate change, displacement and the emergence of new disease vectors, and a lack of public awareness, had led to a rise in dengue-related deaths. He called for additional technical support for epidemiological surveillance and control programmes, intensified community awareness campaigns, strengthened coordination between the government and international organizations, and improved water, sanitation and hygiene infrastructure. He also stressed the importance of strengthening international coordination and assistance.

The representative of MALDIVES said that her country had a high level of immunization coverage and planned, with the support of Gavi, the Vaccine Alliance, to introduce the pneumococcal conjugate vaccine into the routine immunization schedule in 2025. There was mandatory vaccination for travellers to high-risk areas, as well as mandatory notification of meningitis cases. Challenges included access to reliable and affordable diagnostic tools, the high cost of key vaccines and the need to strengthen surveillance and workforce capacity. The Secretariat should provide support in key areas, including by fostering partnerships for rapid diagnostic tools to improve early detection and treatment, and advocating for equitable access to vaccines and sustainable financing. Enhanced surveillance was also needed to track the impact of interventions, along with strengthened awareness-raising campaigns on meningitis prevention, symptoms and the importance of vaccination.

The representative of ETHIOPIA noted that meningitis remained a major public health challenge in his country and in other areas of the African meningitis belt. Although significant progress had been made, certain barriers persisted, and innovative strategies were needed to meet the road map targets. He urged the Secretariat to strengthen support for Member States, including by facilitating equitable vaccine distribution, developing surveillance tools, incorporating meningitis interventions into primary healthcare, and increasing funding through innovative financing mechanisms. He welcomed the two draft decisions under consideration and called on partners and stakeholders to undertake joint efforts to achieve a dracunculiasis-free world by 2030.

The representative of CHINA said that the Secretariat should take into account the specific circumstances of each country, including socioeconomic development levels, when implementing strategies and guiding Member States' targeted responses to communicable diseases. His Government attached great importance to the prevention and control of communicable diseases, particularly mpox, including in Taiwan,[3] which was a province of China, and he outlined measures being taken in that regard. The global road map on defeating meningitis by 2030 provided a framework for control and guidance. He encouraged the Secretariat to continue to play a leading technical role and foster exchange and cooperation. His Government was ready to share products, including meningitis vaccines, and provide technical support to other Member States. He urged Member States to stop politicizing technical issues and refrain from making statements that undermined his country's sovereignty.

The representative of CHAD[4] said that significant progress had been made on dracunculiasis and eradication was within reach, and he praised the efforts made to that end. Eradication efforts would benefit from stronger collaboration with WHO's Health Emergencies Programme and every new case of dracunculiasis should trigger an outbreak response. He expressed the hoped that the proposed draft decision would help to accelerate progress towards the complete and permanent eradication of dracunculiasis.

The representative of JAPAN[4] said that community support was essential for managing skin diseases, including mpox, and underlined the continued importance of strengthening capacity to analyse and utilize collected data. He welcomed the Secretariat's efforts to combat meningitis through various initiatives, including facilitating the integration of prevention, diagnosis, and treatment in primary healthcare. Vaccines were crucial and he trusted that the results of the evaluation of Men5CV vaccination campaigns in the Niger and Nigeria and of the risk assessment for including Men5CV in routine immunization would be shared with Member States once available. To address global health challenges and tackle infectious diseases, it was critical for all countries and regions to share information and knowledge in an unrestricted, transparent and timely manner, including regions, such as Taiwan,[3] that had taken effective measures against coronavirus disease (COVID-19).

The representative of CÔTE D'IVOIRE[4] said that skin diseases were a neglected group of diseases that affected millions of people globally. They caused physical suffering and stigma, impacted mental health and economic productivity, and exacerbated existing inequalities. He urged the Board to adopt the proposed draft decision on skin diseases as a global public health priority. The draft resolution it contained was intended to serve as a catalyst, and to place skin diseases on the public health agenda. It recognized the burden of skin diseases for individuals, communities and health systems and called for action to promote equitable access to affordable treatment and essential medicines, capacity-building for healthcare staff and integration of interventions into primary healthcare, and early screening, awareness-raising and investment in research and innovation.

The representative of FRANCE[4] expressed gratitude to the Secretariat for its work to combat communicable diseases, and highlighted the importance of the One Health approach in achieving that goal. In collaboration with WHO, her Government had hosted the first high-level meeting on defeating meningitis, in Paris, in 2024. She expressed concern regarding the significant budgetary constraints on programmes to combat communicable diseases which, coupled with a significant

[3] World Health Organization terminology refers to "Taiwan, China".

[4] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

decline in access to, and promotion of, sexual and reproductive health and rights, were giving rise to unprecedented threats for key and vulnerable populations. The Secretariat was requested to clarify, to the extent possible, the strategy envisaged to achieve the collectively set objectives. She called for a community-based and people-centred approach and for action to combat the stigmatization of key populations and to improve access to screening, diagnosis, treatment and health innovations for all. The Secretariat should coordinate with stakeholders to ensure the optimal use of resources for effective and sustainable action.

The representative of NIGERIA[5] said that his Government was committed to defeating meningitis by 2030 and provided an overview of national efforts in that regard. The identification of different serogroups of the bacterial pathogen was troubling and made treatment interventions cumbersome. His country, along with the Niger, had been the first to use the Men5CV vaccine and he thanked the Secretariat, Gavi and other partners for their support.

The representative of COLOMBIA[5] said that his Government wished to be added to the list of sponsors of the draft decision on skin diseases as a global public health priority.

The representative of PANAMA[5] stressed the importance of robust, resilient and effective health and surveillance systems, action focused on environmental and community risks, and the promotion and development of technical and political capacity. Vaccination schemes were a cost-effective part of an integrated approach to eliminating communicable diseases. It was vital to ensure timely access to affordable vaccines and serological and molecular diagnostic tests and treatment, without any cultural, social and economic or financial barriers. Noting the importance of WHO/PAHO's Regional Revolving Funds, she expressed concern about WHO's financial situation; a comprehensive approach to communicable diseases relied on technical collaboration at all three levels of the Organization.

The representative of PARAGUAY[5] welcomed the progress made on combating meningitis and stressed the importance of research to support policy-making. It was also important to identify opportunities and challenges, including with respect to unequal access to vaccines and the availability of rapid diagnostic tests. She encouraged WHO to provide incentives to prevent and control meningitis. It was crucial to raise awareness, promote access to vaccines and foster best practices for diagnosis, treatment and prevention, and patient rehabilitation.

The representative of the RUSSIAN FEDERATION[5] stressed the need for a comprehensive approach to counter the spread of communicable diseases. Efforts to that end were hampered by unreliable statistics and inadequate treatment, and there was an urgent need for strengthened diagnostics. The report on communicable diseases should be supplemented with information on how to improve differential diagnosis, including through bilateral and multilateral efforts to ensure the availability of modern mobile technology, especially in remote regions. He noted the importance of ensuring that affected countries had access to countermeasures for mpox, and of promoting local production of vaccines, particularly in Africa, through partnerships with stakeholders and new technologies. Evidence-based approaches were needed to determine the infection burden associated with meningitis. Action was also required to raise awareness among the public and healthcare workers, and to promote immunization.

The representative of MEXICO,[5] said that it was important to build alliances among countries in the Region of the Americas to share good practices, epidemiological data and successful

[5] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

strategies to control meningitis and foster regional collaboration. There was a need to support the local development of new vaccines and their equitable distribution. He recommended an approach that integrated prevention and control into primary healthcare and universal health coverage frameworks. He welcomed the Secretariat's support of national and regional efforts to combat meningitis and build the capacity of healthcare staff. Additional financing strategies were needed for the implementation of the global road map and action that took into account Member States' cultural and economic contexts, in order to avoid gaps and ensure an inclusive approach. Community awareness-raising strategies were needed to highlight the importance of immunization and early intervention. His Government supported the road map, and remained committed to defeating meningitis.

The representative of URUGUAY[6] said that the global road map on defeating meningitis by 2030 aligned with national health policies that focused on vaccination, epidemiological surveillance and equitable access to healthcare. She outlined the action being taken by her Government to combat meningitis.

The representative of the PHILIPPINES[6] said that his Government continued to prioritize communicable diseases, and provided an overview of measures and strategies, including to combat zoonotic diseases and skin-related neglected tropical diseases, based on a collaborative, intersectoral and inter-agency approach, with a focus on diagnostics and surveillance. His Government was committed to the global road map on defeating meningitis by 2030 and underscored the need for enhanced surveillance, partnerships and evidence-based responses.

The Observer of GAVI, THE VACCINE ALLIANCE said that vaccination programmes were key to defeating meningitis, and he outlined support provided by Gavi in that regard. He called on Member States to introduce the meningitis A vaccine into routine immunization, conduct prevention campaigns and consider switching to multivalent vaccines, particularly in countries at risk of meningitis.

The representative of THE CARTER CENTER, INC., speaking at the invitation of the CHAIR, encouraged Member States to adopt the draft decision on accelerating the eradication of dracunculiasis. That disease could be the first to be eradicated without the use of vaccines or therapeutics. Achieving the complete eradication of dracunculiasis would also be a way of showing due recognition for the frontline health workers whose efforts had reduced dracunculiasis cases by more than 99% since 1986.

The representative of THE INTERNATIONAL LEAGUE OF DERMATOLOGICAL SOCIETIES, speaking at the invitation of the CHAIR and also on behalf of the Anesvad Foundation, called for the adoption of the draft decision on skin diseases as a global public health priority, which acknowledged the immense burden of skin diseases on individuals, communities and health systems worldwide. Member States and partners should increase domestic and international investment in affordable treatments, build a skilled workforce, and prioritize prevention, early detection, research and innovation.

The representative of BANGLADESH[6] said that it was important to ensure affordable access to vaccines, therapeutics and diagnostics to address unmet needs relating to the prevention and management of skin diseases, which had the potential to escalate to the level of public health emergencies of international concern. Local production of vaccines, therapeutics and diagnostics

[6] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

should be increased, including by facilitating access to technology and know-how. He hoped that Member States would work together to create the required enablers in negotiating the draft pandemic agreement.

The representative of the WORLD FEDERATION OF NEUROLOGY, speaking at the invitation of the CHAIR, said that meningitis was a devastating, yet preventable, disease that continued to claim hundreds of thousands of lives each year. It had an impact on the neurological health of survivors, often resulting in long-term disabilities. Welcoming the efforts of WHO and other stakeholders in recognizing meningitis as a key priority, especially the launch of the global road map to defeat meningitis by 2030, he stressed the need to continue to promote universal access to vaccines, ensure the availability of rapid diagnostics and strengthen health systems to deliver effective care.

The representative of the DRUGS FOR NEGLECTED DISEASES INITIATIVE, speaking at the invitation of the CHAIR, expressed support for the draft decision on skin diseases as a global public health priority. Skin-related neglected tropical diseases had a significant impact on communities in low- and middle-income countries. Detection and diagnosis remained limited, and many treatments were outdated. Member States should support the development of health tools through collaborative research and development with public, private and non-profit organizations and train health workers to enhance detection and screening.

The ASSISTANT DIRECTOR-GENERAL (Universal Health Coverage/Communicable and Noncommunicable Diseases) said that, on the issue of skin diseases, integration measures were key to ensuring efficient use of limited resources, and the Secretariat, Member States and partners should support efforts to that end, building on existing strategies and action plans where possible. The WHO Academy and other technical training platforms could provide support for capacity-building for frontline health workers, thus helping to improve surveillance and data. As the skin disease spectrum also covered noncommunicable diseases, it was important to coordinate efforts with other health areas. Given the cross-cutting nature of the work, mobilization of existing staff and of new financial resources was necessary. The Secretariat had developed technical products, including implementation toolkits, training and guidelines covering all strategic areas, to defeat meningitis by 2030. He thanked the Government of France for its support on meningitis eradication. The Secretariat would continue to support Member States in strengthening health and social systems to meet the specific needs of people affected by meningitis. The Secretariat would also continue to work with Member States to strengthen cross-border collaboration on dracunculiasis, including joint surveillance, coordination and information exchange, especially in regions with mobile populations. The Secretariat was ready to work with Member States on multi-disease elimination strategies to achieve the road map goal to eradicate neglected tropical diseases such as dracunculiasis by 2030.

The DEPUTY EXECUTIVE DIRECTOR (WHO Health Emergencies Programme) welcomed the comments and suggestions from Board members. Regarding meningitis, the Secretariat was working to integrate new opportunities relating to outbreak detection, diagnostics and response, as well as vaccines and immunization campaigns into surveillance and response strategies, and to minimize outbreak occurrence and ensure early detection and response. The situation with regard to mpox was rapidly evolving, and new diagnostic options were being developed. Efforts to tackle leptospirosis relied on surveillance, and the Secretariat was helping Member States to develop such tools, in cooperation with One Health partners.

The ASSISTANT DIRECTOR-GENERAL (Universal Health Coverage/Life Course) reaffirmed the Secretariat’s commitment to eliminating the scourge of meningitis and stressed that it was working in an integrated manner; the global road map to defeat meningitis by 2030 was a

cross-cutting initiative that touched on prevention, diagnostics, treatment, vaccination and rehabilitation. Member States from all WHO regions, not only those most affected by meningitis, had spoken on the issue. Important events in 2024 relating to meningitis eradication had included the high-level meeting hosted by the Government of France, the roll-out of a new vaccine in the Niger and Nigeria and measures to identify high-incidence countries to accelerate access to the Men5CV vaccine through Gavi. More Member States were focusing on the implementation of the road map through the development of national plans. The Secretariat would provide support to Member States relating to rapid diagnostics, equitable access to vaccines and the integration agenda. Policy guidance on the new vaccine had been published in January 2024 and was being used to guide its roll-out.

The CHAIR took it that the Board wished to note the reports contained in documents EB156/9 and EB156/10.

The Board noted the reports.

The CHAIR took it that the Board wished to suspend consideration of the draft decisions on skin diseases as a public health priority and on accelerating the eradication of dracunculiasis (Guinea-worm disease) pending the outcome of the broader discussion on the costing implications of resolutions and decisions recommended by the 156th session of the Executive Board for adoption by the Seventy-eighth World Health Assembly.

It was so agreed.

(For the adoption of decisions, see the summary record of the eighteenth meeting, section 4.)

3. Substandard and falsified medical products: Item 10 of the agenda (documents EB156/11, EB156/11 Add.1 and EB156/12)

The CHAIR invited the Board to consider the reports contained in documents EB156/11 and EB156/12, in particular the guiding questions set out in paragraph 5 of document EB156/12. He drew attention to the draft decision, which contained a draft decision to be submitted to the Seventy-eighth World Health Assembly, contained in document EB156/11. The financial and administrative implications of the draft decision were contained in document EB156/11 Add.1.

The representative of LEBANON, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that substandard and falsified medical products posed a threat to public health in the Region owing to multiple challenges, including a lack of timely, equitable and unhindered access to standard medical products. The COVID-19 pandemic and protracted conflicts in the Region had contributed to the proliferation of substandard and falsified products in all main therapeutic categories. Recent examples had included contaminated paediatric syrups. In December 2024, a meeting had been held for the focal points for the WHO Global Surveillance and Monitoring System for substandard and falsified medical products in the Region with a view to strengthening national capacities to manage incidents, encouraging reporting and establishing a network for collaboration and information sharing. Current challenges for the Member State mechanism related to participation, funding and operational agility, and structural reforms might be needed to improve its functionality. Better resource allocation and more inclusive participation could improve its efficiency and equity. A combination of strategies was needed to increase Member State participation, including raising awareness and sharing case studies on the positive

impact of participation on health outcomes. There was also a need to enhance collaboration and communication among regulators, customs and enforcement authorities. She also highlighted the need to establish networking opportunities, build capacity, strengthen regulatory authorities, identify focal points, offer incentives for engagement, secure resources and foster political commitment.

The representative of ETHIOPIA, speaking on behalf of Member States of the African Region, noted that his Region had a high burden of substandard and falsified medical products and highlighted initiatives in the Region to promote local manufacturing, including the work of the African Medicines Agency. It was important to support the WHO Global Surveillance and Monitoring System, build capacity and identify digital solutions to improve post-market surveillance. Challenges identified in the evaluation report with a particular impact on his Region included inadequate risk awareness, insufficient Member State participation and persistent financing difficulties hindering the full implementation of activities. There was a need to ensure functional regional and international networks to foster cross-border and cross-regional collaboration. He supported the recommendations outlined in the evaluation report, including proposals to strengthen regulations and implement traceability systems to protect regional supply chains and the development of national action plans to strengthen stakeholder engagement. To improve Member State participation, he expressed support for option B under recommendation 1. He urged the Secretariat and partners to explore modalities for sustainable technical and financial support to strengthen the effectiveness of the Member State mechanism, and to enhance the support provided to Member States.

The representative of TOGO welcomed the independent evaluation and the measures proposed. Noting the recurring challenge of ensuring funding for the Member State mechanism, she expressed support for recommendations aimed at strengthening its effectiveness, particularly those to enhance Member State participation, ensure sustainable financing and introduce other improvements. Her Government, which had developed a national plan to combat substandard and falsified medical products, called on Member States to prioritize strengthening regulation to better combat the circulation of substandard and falsified medical products, and to establish systems to improve supply chains at the national and regional levels.

The representative of MOROCCO expressed appreciation for the Secretariat's commitment to strengthening the Member State mechanism on substandard and falsified medical products and welcomed the recommendations to improve its functioning. The documents under consideration reflected the urgent need for coordinated international action to safeguard patient safety and strengthen confidence in national healthcare systems. He expressed support for the evaluation report recommendations to strengthen international cooperation, coordination of regulatory mechanisms and resource mobilization. His Government supported option B under recommendation 1, and was in favour of establishing a structured framework with indicators and systematic evaluations to ensure transparency and commitment by Member States, raising awareness among Member States, establishing strategic partnerships with external stakeholders and facilitating access. His Government, which had introduced measures to strengthen the national regulatory framework, training and surveillance, reaffirmed its commitment to working with the Secretariat to implement the recommendations and ensure the mechanism's relevance, effectiveness and sustainability.

The representative of CHINA said that his Government had introduced a wide range of regulations and measures to control production and distribution, and combat substandard and falsified medical products. Professional technical exchanges and technical demonstrations should

be organized for Member States to encourage their participation in the work of the Member State mechanism.

The representative of THAILAND said that, in order to enhance Member States' participation in the work of the Member State mechanism, it was essential to strengthen the capacity of national focal points; simplify the WHO Global Surveillance and Monitoring System database; encourage the reporting of events to the global surveillance and monitoring platform; and enhance the use of surveillance findings as the basis for legal measures. Given the diverse contexts of incidents and country-specific factors, mutual support among Member States in a region could accelerate implementation and contribute to achieving the goals of the mechanism. Her Government supported the WHO pharmaceutical starting materials certification scheme to address the root cause of substandard and falsified medical products. The capacity of national regulatory authorities to assess the quality and standard of medical products should be strengthened.

The representative of SENEGAL acknowledged the importance of global access to safe, effective, high-quality and affordable medical products, particularly in developing countries where technological and regulatory issues posed major challenges. He welcomed the legislative and regulatory measures introduced in many countries to strengthen the pharmaceutical regulatory system, and described actions taken in his country. He supported measures relating to risk-based post-market surveillance and the electronic tool to facilitate implementation. He also stressed the need for funding to combat falsified and substandard medical products, and called for improved awareness and adoption by Member States of technologies for tracing and detecting substandard and falsified medical products, and for the implementation of national traceability systems.

The representative of MALDIVES noted that the report on substandard and falsified medical products underscored the persistent threat posed by such products to global health, and rightly highlighted the need for greater Member State engagement and enhanced information sharing. She described her Government's prompt identification and reporting of contaminated cough syrups, which had triggered a rapid response, including an international investigation and product recalls. That experience underscored the value of the WHO-led initiative to combat substandard and falsified medical products. It had also highlighted the critical importance of robust national regulatory authorities, proactive market surveillance and international collaboration to safeguard vulnerable populations, particularly children. She stressed the need for sustainable investment and a multifaceted approach. Many countries, especially small island developing States, faced technical and resource constraints relating to monitoring and reporting. Targeted training programmes, regional workshops and knowledge-sharing platforms facilitated by WHO could empower national regulatory systems. Tackling underreporting through simplified and digitalized reporting mechanisms and incentives for information sharing could encourage Member State participation. She highlighted the importance of regional collaboration, particularly for countries that relied on imports, and of multisectoral engagement. She urged Member States to implement the recommendations in the report.

The representative of CHILE said that priority activities in her country aligned with the WHO strategy on substandard and falsified medical products. The WHO Global Surveillance and Monitoring System database received far more submissions from legal persons and private entities than from national health authorities; online channels should be made available to simplify the sharing of information by manufacturers or businesses. Training should be provided at the national level for all entities responsible for the detection of substandard and falsified products to facilitate preventive action and response. Her Government would be pleased to

review a draft decision for consideration by the Health Assembly, with guidelines to follow-up on the independent evaluation of the Member State mechanism.

The representative of BRUNEI DARUSSALAM said that substandard and falsified health products remained a serious global health challenge. The Member State mechanism played a vital role as a collaborative platform for enhancing regulatory capacity, strengthening surveillance and fostering cooperation. To encourage Member State participation, it was essential to provide capacity-building and technical support, particularly for Member States with limited regulatory capacity that faced challenges in detecting and responding to substandard and falsified medical products. It was also important to enhance information sharing and implement rapid alert systems, and he encouraged simplifying reporting mechanisms, adopting digital surveillance tools and strengthening regional cooperation through information-sharing platforms. Political commitment and multisectoral engagement were also needed to ensure stringent enforcement of regulatory frameworks and collective action against substandard and falsified medical products. His Government remained committed to working with the Secretariat and Member States towards a safer medical supply chain.

The representative of BARBADOS underscored the importance of detecting and preventing substandard and falsified products. He provided an overview of measures at the national level in that regard, including the areas of focus of the National Regulatory Authority.

The representative of COSTA RICA said that his Government had implemented a range of measures to protect consumers and ensure safe and effective medical products. Major challenges for the Member State mechanism included poor Member State engagement, lack of expert knowledge, including in working groups, and limited Member State financing. There were also concerns relating to the mechanism's capacity and the effectiveness of its communications, which could lead to a loss of public confidence and trust. The active participation of Member States and cooperation were essential to ensure the implementation of effective strategies to combat substandard and falsified medical products.

The representative of SLOVAKIA asked the Secretariat to share information on methods for measuring the impact of, and progress on, strengthening the Member State mechanism, to better understand gaps with respect to approaches, tools and legal guidelines on the independent evaluation and implementation of the recommendations at the national and regional levels. He also asked the Director-General to report back to Member States on progress relating to the WHO list of essential medicines, including their selection and use.

The representative of the FEDERATED STATES OF MICRONESIA acknowledged the critical role of the Member State mechanism in combating substandard and falsified medical products. The recommendations of the evaluation should be implemented on a context-specific basis. He highlighted some of the challenges for small island developing States in detecting and responding to substandard and falsified products and called for increased technical support and capacity-building tailored to the needs of resource-limited countries. Regional cooperation mechanisms, including partnerships with larger regulatory authorities and WHO-led networks, should be enhanced. Greater access to surveillance data, best practices and early warning systems would also be useful, as would multisectoral, multidisciplinary and inter-agency collaboration to bridge regulatory and capacity gaps.

The representative of LESOTHO said that robust legal and regulatory frameworks were needed to prevent the proliferation of substandard and falsified medical products, which posed a severe threat to public health and hindered progress towards universal health coverage and the

Sustainable Development Goals. She described the key instruments and regulatory mechanisms introduced in her country to address the problem and stressed the need for improved enforcement and regional cooperation. The global community should strengthen the support provided to low- and middle-income countries in the fight against substandard and falsified products, and the Secretariat and WHO partners should build capacity, provide technical support and mobilize resources for effective enforcement. Pharmaceutical companies should uphold stringent quality standards and ensure that medicines supplied to developing countries met safety and efficacy requirements. She also urged the Board to avoid politicizing health matters and called on Member States to refrain from infringing others' national sovereignty. United Nations General Assembly resolution 2758 (XXVI) (1971) provided a legal basis for WHO in addressing the question of Taiwan[2] under the one-China principle, which her Government fully supported.

The representative of SOMALIA said that it was crucial to prevent and detect substandard and falsified medical products, especially for low- and middle-income countries. He provided an overview of measures taken to that end in his country, including to strengthen regulatory capacity and collaboration with the private sector. He called for further strengthening of the WHO Global Surveillance and Monitoring System, and support to develop national regulatory capacity for reporting and investigation. Clear guidance on reportable incidents would also be useful.

The representative of GERMANY[7] said that her Government participated in the work of the Member State mechanism. Turning to the recommendations in the evaluation report, she highlighted the importance of recommendation 1 for the future of the Member State mechanism and was in favour of exploring option B. Recommendation 3 was also essential.

The representative of COLOMBIA[7] encouraged the Secretariat to increase the mechanism's technical and operational capacity and impact, and to maximize its benefits by establishing specific objectives and clear goals. Her Government participated in the work of the mechanism, including by leading a working group on strategies to tackle the online distribution of substandard and falsified medical products. It was also implementing measures to strengthen surveillance and control of medicines.

The representative of PARAGUAY[7] said that her Government was involved in the Member State mechanism. Greater Member State participation in working groups and measures to strengthen legislative frameworks and regulatory capacity would enable a more effective response to the risks associated with substandard and falsified medical products. Advanced technologies should be used to detect such products and communication strategies should be developed to raise public awareness of associated risks. The recommendation in the report on enhancing WHO technical support for the Member State mechanism was important and would ensure that the most vulnerable groups received the protection they deserved. She expressed her Government's support for the draft decision.

The representative of OMAN[7] noted that substandard and falsified medical products were difficult to detect and put millions of people at risk, particularly in low- and middle-income countries. He outlined efforts at the national level to combat substandard and falsified medical products, and described challenges in identifying products that were made to resemble the genuine article. He called on Member States to share information on technology and approaches for detection.

[7] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of NAMIBIA[8] recognized the relevance of the Member State mechanism in supporting regional initiatives to combat the circulation of substandard and falsified medical products, particularly those aimed at enhancing local manufacturing capabilities, including the work of the African Medicines Agency. He described progress at the national level, including pre- and post-market surveillance and the nomination of focal points, but noted that collaboration among regional focal points remained insufficient. To improve participation in the Member State mechanism, regional collaboration platforms should be established to facilitate communication, information sharing and the coordination of efforts. Persistent funding challenges continued to hamper the effective implementation of essential activities, and WHO and partners should explore sustainable financial and technical support modalities. He supported the recommendations outlined in the evaluation report, and endorsed option B under recommendation 1.

The representative of BANGLADESH[8] sought further information on differentiated engagement strategies to which recommendation 5 referred and clarification regarding the placement of "in line with the Framework of Engagement with Non-State Actors" in brackets. He recommended avoiding conflicts of interest with non-State actors and upholding the spirit of the Framework of Engagement with Non-State Actors in any interactions with such entities.

The representative of SAUDI ARABIA[8] said that her Government was committed to high quality standards for medical products, its regulatory authority having achieved maturity level 4, and attached great importance to the safety and local production of medicines. She provided an overview of national measures, including surveillance, cross-border initiatives and efforts to guarantee safe access to products, strengthen health systems and ensure affordable access to medicines in her Region.

The representative of INDONESIA[8] said that her Government supported and participated in the Member State mechanism. Continued efforts were needed to facilitate training and capacity-building for Member States, address cross-border issues, online and informal markets, and leverage technologies to screen and detect substandard and falsified products. There was also a need to optimize the WHO Global Surveillance and Monitoring System portal, including by expanding its scope, integrating reports on in vitro diagnostics and leveraging WHO epidemic intelligence for real-time monitoring. She was in favour of strengthening the visibility and health communication of the Member States mechanism, exploring sustainable financing models to support Member States' participation and increasing the involvement of technical experts. Any review of the format of the Member State mechanism should be considered carefully, taking into account practical implementation, benefits and challenges.

The representative of ITALY[8] said that, while her country played an active role in the Member State mechanism, the participation of Member States at the technical level was sometimes limited by the strategic level. The Secretariat should encourage and support the establishment of working groups and enhance its role in existing groups, for example in the European Region. Her Government would be pleased to work with the Secretariat to enhance WHO collaboration in that regard, strengthen the operational connection with WHO regions, and exchange good practices in combating pharmaceutical crime.

The representative of the RUSSIAN FEDERATION[8] said that her Government recognized the need to revise the format of the Member State mechanism and supported option B under

[8] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

recommendation 1. Regular seminars and meetings to exchange best practices were useful and information about such events should be provided in a timely manner.

The representative of the INTERNATIONAL PHARMACEUTICAL FEDERATION, speaking at the invitation of the CHAIR, welcomed the Member State mechanism's efforts to tackle substandard and falsified medical products and facilitate stakeholder collaboration. Well-trained pharmacists could swiftly detect such products in supply chains, report them to the authorities, and educate and advise affected patients. In collaboration with WHO, her organization had developed a competency framework and comprehensive course for pharmacy students that had been expanded from African universities to educational and regulatory institutions around the world.

The representative of the UNION FOR INTERNATIONAL CANCER CONTROL, speaking at the invitation of the CHAIR, noted the high proportion of substandard or falsified medical products, including cancer medicines and antibiotics, in low- and middle-income countries. To ensure improved implementation of the mechanism, Member States should increase funding for implementation, enhance technical expertise and reporting processes, improve participation, establish robust accountability pathways for continuous monitoring and evaluation, and strengthen engagement with stakeholders.

The representative of the INTERNATIONAL PHARMACEUTICAL STUDENTS' FEDERATION, speaking at the invitation of the CHAIR, urged the Secretariat and Member States to effectively incorporate pharmacy professionals at all levels in action plans on substandard and falsified medical products, including strategic planning, supply chain management and community education. Investment should be made in training on prevention, identification and reporting of substandard and falsified medical products.

The representative of the WORLD HEART FEDERATION, speaking at the invitation of the CHAIR, welcomed the independent evaluation of the Member State mechanism. His organization stood ready to work with Member States, the Secretariat and all relevant stakeholders to ensure universal access to safe, effective and high-quality medical products.

The representative of the UNITED STATES PHARMACOPEIAL CONVENTION, speaking at the invitation of the CHAIR, said that the work of the Member State mechanism was more critical than ever. His organization supported the recommendations of the independent evaluation, particularly the call to enhance engagement with non-State actors and looked forward to more opportunities to collaborate in support of the mechanism's vital efforts.

The ASSISTANT DIRECTOR-GENERAL (Access to Medicines and Health Products) thanked representatives for their support and efforts on the critical issue. More than US$ 30 billion was estimated to be wasted annually on substandard and falsified medical products in low- and middle-income countries, with a negative impact on public health. The Member State mechanism provided a unique platform for global efforts to combat the proliferation of substandard and falsified medical products. The findings of the independent evaluation had highlighted key achievements, including the development of tools for frameworks to prevent, detect and respond more effectively to incidents involving substandard and falsified medical products, and recommended ways to improve the mechanism, assess its impact on public health and identify areas for action to strengthen the mechanism's structure, effectiveness and sustainability. The three main opportunities identified were: enhancing regional engagement, including through multilateral support for capacity-building and systems at the regional level, such as the African Medicines Agency; enhancing stakeholder collaboration by expanding partnerships, including with non-State actors; and operational agility, including through the active monitoring and timely

sharing of information via the digital platform and rapid coordination at the regional and global levels. The Secretariat had identified practical steps to address the recommendations made and some of those initiatives were already under way. A steering committee meeting was planned within the coming months to discuss the recommendations in depth, including recommendation 1. She took note of the preference for option B under that recommendation expressed by some Member States. There were also plans to hold a technical meeting later in 2025, and the Secretariat would share further information with Member States in due time. The Secretariat continued to work with Member States and broader partners. Active engagement by more Member States was indispensable to shape the future of the Member State mechanism, ensuring that it served the needs of all WHO regions.

The DIRECTOR (WHO Evaluation Office) said that he had welcomed the opportunity to conduct the independent evaluation to review the operation and impact of the Member State mechanism on substandard and falsified medical products. He acknowledged the work of the steering committee, the members of the mechanism and the Secretariat throughout the evaluation and noted that the report and supporting documents were available on the WHO website. The evaluation had been key to consider the mechanism's relevance, effectiveness and means to improve going forward. The WHO Evaluation Office would continue to support the Chair of the Member State mechanism, the Assistant Director-General for Access to Medicines and Health Products and the Secretariat in facilitating the next steps, as well as the steering committee's work to take forward the recommendations, including by developing a theory of change and a forward-looking plan.

The CHAIR took it that the Board was ready to note the reports contained in documents EB156/11 and EB156/12.

The Board noted the reports.

The CHAIR took it that the Board wished to suspend consideration of the draft decision, contained in document EB156/11, pending the outcome of the broader discussion on the costing implications of resolutions and decisions recommended by the 156th session of the Executive Board for adoption by the Seventy-eighth World Health Assembly.

It was so agreed.

(For the adoption of a decision, see the summary record of the eighteenth meeting, section 5.)

4. Standardization of medical devices nomenclature: Item 11 of the agenda (document EB156/13)

The CHAIR invited the Board to consider the report contained in document EB156/13 and to provide guidance on the questions set out in paragraph 32 of the document.

The representative of CANADA, speaking also on behalf of Australia, Brazil and the United Kingdom of Great Britain and Northern Ireland, welcomed the Secretariat's efforts to assist Member States in accessing accurate, relevant and up-to-date medical device nomenclature. Since regulators relied on accurate and comprehensive data for post-market surveillance, it was critical for the Secretariat to ensure that nomenclature coding was up to date in WHO publications and databases. She commended the Secretariat for reaching an agreement with the Global Medical Device Nomenclature Agency to publish codes, terms and definitions in WHO databases, including the Priority Medical Devices Information System and stressed that the Global Medical Device

Nomenclature database could be accessed and searched by any member of the public, as registration was free of charge. Given the communication of updates to registered users in real-time, the Global Medical Device Nomenclature remained a reliable, trusted, and comprehensive nomenclature consistent with WHO principles. She acknowledged that the process of mapping and copying information from the Global Medical Device Nomenclature and the European Medical Device Nomenclature and the Priority Medical Devices Information System was technically complex and required significant resources. She recommended that the Secretariat continue to focus resources on ensuring accurate and timely updates to the coding information that WHO published in partnership with the original data custodians.

The representative of POLAND, speaking on behalf of the European Union and its Member States, said that the candidate countries North Macedonia, Montenegro, Serbia, Ukraine, the Republic of Moldova, Bosnia and Herzegovina and Georgia, the European Free Trade Association country Norway, member of the European Economic Area, as well as Armenia, aligned themselves with her statement. Welcoming the Secretariat's work, particularly with regard to the uptake of the European Medical Device Nomenclature and other nomenclature systems in its publications and platforms, she reaffirmed the European Union's commitment to advancing global harmonization of medical device nomenclature and fostering regulatory convergence to improve patient safety, enhance healthcare systems and support global regulatory reliance on European Union medical device certificates. The European Medical Device Nomenclature was a publicly accessible system developed using a transparent and collaborative approach following a global public consultation process that had included invaluable contributions from WHO. It was available free of charge to all stakeholders. In parallel to the European Medical Device Nomenclature system, the European Database on Medical Devices was also under development, designed to enhance transparency, traceability and regulatory oversight in the medical device sector. From 2026 onwards, use of that new database would gradually become mandatory. Noting that the European Medical Device Nomenclature system met the criteria to be classified as a global public good, she reaffirmed the European Union's commitment to supporting Member States and providing access to that system.

The representative of ETHIOPIA, speaking on behalf of the Member States of the African Region, acknowledged the progress made in implementing decision WHA75(25) (2022) on the standardization of medical devices nomenclature, including the integration of the Global Medical Device Nomenclature system into WHO platforms and the development of the Medical Devices Information System as a comprehensive clearing house for medical device information. He welcomed the establishment of the African Medical Devices Forum to support regional initiatives to enhance access to quality health products and local manufacturing. Challenges to progress included a lack of standardized nomenclature across African countries, inadequate regulatory frameworks, resource and infrastructure constraints, limited technical expertise, weak governance in oversight structures and limited access to advanced equipment. The Secretariat should focus on capacity-building for regulatory authorities, support the development of national medical device lists using standardized nomenclature, ensure that regional needs and contexts were taken into account when updating the Medical Devices Information System, provide technical support to implement traceability systems and strengthen the link between the Medical Devices Information System and national procurement systems. A sustainable funding mechanism should be established to support Member States in implementing those systems and building the necessary technical capacity.

The representative of CHINA welcomed the Secretariat's efforts to standardize medical device nomenclature; a globally harmonized system would improve accessibility and ensure the use of safer, higher quality and more affordable products. Mapping systems and integrating that

data into WHO's information system was time-consuming. The Global Medical Device Nomenclature and the European Medical Device Nomenclature were only used in certain Member States, and countries yet to adopt those systems lacked any effective means of linking national products to relevant WHO lists. While advocating compatibility with mainstream systems, he noted that to enhance global access to devices it was important to consider the needs of countries that used their own systems or had yet to implement a standardized system. A standardized system and high-quality data were essential. Strengthening training for Member States and industry would encourage broader use of the WHO system and enhance data quality through public feedback. Unique device identifiers served as identity cards for medical devices, enabling rapid and accurate identification, thus improving traceability and facilitating the integration and sharing of regulatory data. At present, WHO primarily used unique device identifiers for mapping systems. Expanding their scope of application and reserving dedicated unique device identifier fields in WHO information systems would enhance accuracy and product accessibility. His Government had implemented its own unique identifier system in 2019 and stood ready to strengthen its cooperation with other Member States.

The meeting rose at 13:00.

Twelfth meeting

Friday, 7 February 2025, at 14:35

Chair: Dr J.X. Walcott (Barbados)

Pillar 1: One billion more people benefiting from universal health coverage (continued)

1. **Standardization of medical devices nomenclature:** Item 11 of the agenda (document EB156/13) (continued)

The representative of THAILAND, sharing information on achievements in harmonizing medical device regulation in her country, called for sustainable maintenance and timely updating of the Priority Medical Devices Information System, which would give Member States' access to reliable information, thus benefiting regulators, manufacturers, purchasers and other stakeholders. Intensified stakeholder engagement and national implementation efforts were needed to promote rapid adoption of the standardized nomenclature, including among regulators, industry representatives and healthcare providers. Strengthening national implementation and alignment with international standards would help to foster collaboration and improve the overall efficiency of regulatory frameworks.

The representative of the REPUBLIC OF MOLDOVA, describing progress in her country, recognized the critical role of standardized medical devices nomenclature in enhancing patient safety, healthcare delivery and health system resilience. Welcoming the WHO initiative to provide free access to the Global Medical Device Nomenclature to actors in the medical devices field, she commended the integration of the European Medical Devices Nomenclature and Global Medical Device Nomenclature into the Priority Medical Devices Information System as a significant step towards a harmonized, accessible and reliable worldwide system. It was important to ensure that all Member States – including low- and middle-income countries – could access the Information System and to enhance interoperability between the Information System and other WHO platforms, such as the Universal Health Coverage Compendium and the WHO Model List of Essential In Vitro Diagnostics, and with national systems. Attention should be focused on providing capacity-building and technical support through training sessions and knowledge-sharing platforms to facilitate the sharing of best practices; aligning medical device selection criteria with emerging health challenges; and ensuring open access and sustainability.

The representative of TOGO welcomed the progress reported in harmonizing medical device nomenclatures for greater regulatory compliance and patient safety throughout the world. Her Government called on the Secretariat and Member States to create national nomenclature committees to ensure that the nomenclature system was effectively integrated into national health systems. Creating alignment with existing systems and implementing capacity-building initiatives was also important.

The representative of SOMALIA, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the initiative to standardize medical devices nomenclature was particularly important to his Region with its very diverse healthcare settings. WHO lists of priority medical devices for a wide range of conditions were valuable tools to ensure equitable access to those devices.

His Region welcomed the ground-breaking integration of standardized nomenclature systems such as the European Medical Device Nomenclature and the Global Medical Device Nomenclature into the Priority Medical Devices Information System thus supporting Member States with procurement, regulation and service delivery. However, nomenclature systems should also be integrated across other WHO platforms, such as the Universal Health Coverage Compendium and the International Statistical Classification of Diseases and Related Health Problems to ensure interoperability. Those systems must be updated regularly to reflect evolving health needs and technological advancements. The Secretariat should support Member States in developing national priority medical device lists and essential laboratory diagnostic lists, and in building the capacities of national healthcare workers, regulators and procurement officers in using the Information System and the standardized medical devices nomenclature. Moreover, the Secretariat should promote integration between the Information System and global databases to ensure seamless data sharing and cross-referencing.

The representative of MOROCCO welcomed the Secretariat and the Board's focus on standardizing medical devices nomenclature, which was of crucial strategic importance for greater transparency, effectiveness and equity in access to health technology. He described initiatives under way in his country that reflected his Government's sympathy with WHO's vision. Collaboration between the Secretariat, countries and regions was key to sharing best practices, harmonizing systems and strengthening medical device supply chains.

The representative of COLOMBIA,[1] stressing the need to consolidate the position of the Global Medical Device Nomenclature as an international standard by integrating it into platforms such as the Priority Medical Devices Information System, called on the Secretariat to promote continual updates to databases and harmonize them with national systems. It was vital to introduce uniform regulation that facilitated tracking, emergency response and transparency in managing health technology, thus ensuring equitable access to priority medical devices in all regions. Sharing information on efforts in his country, he reaffirmed his Government's support for WHO as a guarantor of world peace and health, and called for all Member States to remain committed to maintaining it.

The representative of JAPAN[1] acknowledged the challenges of standardization, given that medical devices and technology developed rapidly and information on them was constantly being updated. His Government highly valued the Secretariat's crucial role in fostering an environment where Member States had access to those devices, requesting that the Priority Medical Devices Information System be linked to the Global Medical Device Nomenclature.

The representative of the RUSSIAN FEDERATION[1] welcomed the principles expressed in the report, such as open access for all stakeholders, arrangements for managing the nomenclature and two-way communication with all interested countries, and transparency in methods and procedures for updates. Nonetheless, despite the fact that WHO recognized four nomenclature systems, the Priority Medical Devices Information System linked only to two, the European Medical Device Nomenclature and the Global Medical Device Nomenclature. The requirements of

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

those two systems concerning stability, transparency and ease of management were insufficient when faced with requirements for the precise identification of medical devices and responsiveness to the dynamic medical devices market, and a way must be found to balance those requirements. Her Government therefore proposed creating a mechanism within the Priority Medical Devices Information System to provide a link between the internationally standardized nomenclature and non-standard national nomenclatures. Thus, the new system would take account of national healthcare systems, facilitate the integration of national nomenclatures into the international system, and increase transparency and the effectiveness of sharing medical device data between countries.

The representative of PANAMA[2] said that standardized medical devices nomenclature was a key step for strengthening regulation and ensuring patient safety. Not only would it improve traceability but also post-marketing surveillance systems and the procurement of devices globally. Having a list of priority medical devices alongside the WHO Model List of Essential Medicines was important to guide the procurement and distribution of essential medical devices in care settings, particularly those with limited resources. It would also contribute to standardizing and regulating the use of those devices, building the capacities of staff members and integrating national regulation. Greater attention should be paid to enhancing interoperability with national databases, which involved ensuring compatibility with management systems to avoid redundancy and errors in registration; providing training and technical support; and conducting impact assessments through analysing the standardized nomenclature's effectiveness in improving the regulation and management of medical devices.

The representative of MEXICO[2] welcomed the integration of the International Statistical Classification of Diseases and Related Health Problems into the Priority Medical Devices Information System as key for strengthening interoperability and promoting more efficient and person-centred systems. Standardized medical devices nomenclature would allow the devices to be used safely and effectively, expanding universal health coverage and ensuring equitable access to technologies. Although the Information System was an opportunity to strengthen medical resources and device registers, it was important to guarantee interoperability by considering the connection between equipment and strategic resources, medicines and the services portfolio, ensuring the timely provision of treatment, particularly in rural areas. Diseases must also be contextualized within their regional epidemiological profiles, allowing monitoring and preventive planning. The alignment of interoperability with a healthcare model was crucial for integrating medical device databases into community health settings, promoting timely identification of risks and effective management of chronic diseases. Those technological and regulatory advancements must translate into real healthcare improvements for populations.

The representative of the INTERNATIONAL FEDERATION FOR MEDICAL AND BIOLOGICAL ENGINEERING, speaking at the invitation of the CHAIR, said that the Secretariat must provide the necessary resources to increase the 2500 priority device entries available in its systems, compared to the more than 7000 offered by the European Medical Device Nomenclature and the 20 000 offered by the Global Medical Device Nomenclature. It was to be hoped that multilingual access would become available in accordance with WHO policy.

The ASSISTANT DIRECTOR-GENERAL (Access to Medicines and Health Products), responding to comments, thanked Member States for their continual support for standardizing medical devices nomenclature, which was vital for promoting digitalized healthcare. In accordance with

[2] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

decision WHA75(25) (2022), the Secretariat had launched the Priority Medical Devices Information System including both the European Medical Device Nomenclature and Global Medical Device Nomenclature, and would launch the second version of the Information System over the coming days. The Secretariat would continuously update and maintain the Information System and expand the priority medical devices list with related names and additional technical information. Responding to the representative of China, she acknowledged that the unique device identification system was a different and more accurate naming system but broad harmonization was challenging. The Secretariat wished to continue to discuss with Member States how to harness different naming systems for greater interoperability through knowledge group consultations, and would liaise with other programmes such as regulatory and supply chain databases for health products to expand references across systems. She looked forward to working together with Member States, nongovernmental organizations and other partners towards harmonizing nomenclature and increasing access to essential and priority medical devices.

The CHAIR took it that the Board wished to note the report contained in document EB156/13.

The Board noted the report.

2. Health and care workforce: Item 12 of the agenda

- **WHO Global Code of Practice on the International Recruitment of Health Personnel** (documents EB156/14 and EB156/14 Add.1)
- **Global strategy on human resources for health: workforce 2030** (document EB156/15)

The CHAIR invited the Board to consider a draft decision, which contained a draft decision to be submitted to the Seventy-eighth World Health Assembly, contained in document EB156/14. The draft decision concerned the interim report of the Expert Advisory Group on the WHO Global Code of Practice on the International Recruitment of Health Personnel and its financial and administrative implications were contained in document EB156/14 Add.1.

A further draft decision, which contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly, on accelerating action on the global health and care workforce by 2030, was proposed by Armenia, Bangladesh, Brazil, China, Croatia, Germany, Jamaica, Morocco, Nigeria, Norway, the Philippines, Romania, South Africa, Thailand and Ukraine, read:

> The Executive Board, having considered the report by the Director-General,[3]
>
> Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following resolution:
>
> > The Seventy-eighth World Health Assembly,
> > (PP1) Having considered the report by the Director-General;
> > (PP2) Reaffirming that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition and recognizing that access

[3] Document EB156/15.

to health and care services is an important component of this fundamental right, which is a cornerstone of human dignity and well-being;

(PP3) Recalling the commitments made under the Sustainable Development Goals, particularly Goal 3, which aims to ensure healthy lives and promote well-being for all at all ages, and recognizing the integral role of and contribution by an adequate, well-distributed and competent health workforce in both achieving these objectives and advancing progress on the employment, economic growth, education and gender-equality agendas and targets;

(PP4) Acknowledging the critical importance of a robust and well-supported health and care workforce, as underscored by the Director-General's comprehensive report on the implementation of the Global Strategy on Human Resources for Health: Workforce 2030, and the Working for Health Action Plan 2022–2030, and recognizing that investing in health worker initial education and lifelong learning, employment, fair remuneration, and supportive working conditions represents a fundamental driver to advance the primary healthcare approach and for accelerating progress towards universal health coverage and health security, while ensuring the sustainability of health systems;

(PP5) Recognizing that the world is making progress in increasing the total number of health and care workers, which now exceeds 70 million worldwide, yet acknowledging that many countries continue to experience national shortages, uneven distribution, high turnover rates and migration, necessitating fair and shared responsibility, global collaboration and urgent action to ensure an adequate, sufficient, competent, protected and motivated health and care workforce in every country, while taking into account the specific needs of those countries facing challenges caused by armed conflicts and the migration of healthcare workers;

(PP6) Noting with concern the revised WHO shortage estimate of more than 11 million health workers by 2030,[4] in particular in low- and middle-income countries;

(PP7) Recognizing also that enhancing health systems resilience, particularly in the face of the impact of the coronavirus disease (COVID-19) pandemic, other infectious disease outbreaks, and ongoing humanitarian crises and conflicts in some areas, climate change, emergencies, disasters resulting from natural hazards and emerging epidemiological risks requires adaptive and responsive health systems, including mental health, and workforce strategies, including investments in education, training, support, retention strategies, occupational safety standards, workforce surge capacity during a public health event, equitable distribution and adequate workforce competency to perform uninterrupted essential public health functions;

(PP8) Recalling the need to further advance equity for women in the health and care sector and emphasizing the critical role that women, who represent 67%[5] of health workers, play in the health and care sector;

(PP9) Recalling the commitments established in previous Health Assembly resolutions[6] aimed at strengthening health and care workforce capacity development, protecting safe, healthy, supportive, and dignified working conditions especially for women and early career workers at all levels, optimizing distribution, deployment, and utilization of health workforce, sustaining investments in human resources for health

[4] World Health Organization (2024). National Health Workforce Accounts (NHWA).

[5] WHO (2024). NHWA.

[6] Resolutions WHA63.16 (2010), WHA69.19 (2016), WHA70.6 (2017), WHA72.3 (2019), WHA74.14 (2021), WHA74.15 (2021) and WHA75.17 (2022); and decision WHA73(30) (2020).

to deliver effective and quality healthcare services and contribute towards the promotion of global health security.

(PP10) Reaffirming the significance of the WHO Global Code of Practice on the International Recruitment of Health Personnel and welcoming its review by the Director-General's Expert Advisory Group to further enhance its relevance and effectiveness, and strengthen its implementation, including through mechanisms that deliver mutual benefits, while mitigating the negative effects of health workforce migration on the health systems of source countries advance efforts to both maximize the positive effects of health workforce migration and address challenges faced by the health systems of less resourced countries;

(PP11) Emphasizing the essential role of international and regional cooperation, partnerships and technical support in strengthening national[7] or subnational health workforce capacities, particularly in developing settings, to ensure that all countries have resilient health systems to respond effectively to both routine health challenges and public health emergencies and appreciative of WHO and its Academy, UN specialized agencies, academic, scientific and civil society partners for their investments in education, training and lifelong learning;

(PP12) Acknowledging that the rapid advancements in medical science and technology, digital health, and the evolving landscape of artificial intelligence, biotechnologies, the pharmaceutical industry and medical practices require continuous skill development and adaptation within the health workforce, and sustained support to equip them with the competencies necessary to leverage these innovations responsibly to improve service delivery and enhance outcomes for patients, families and communities,

(OP)1. URGES Member States, taking consideration of national context and priorities:

(1) to accelerate implementation of the Global Strategy on Human Resources for Health: Workforce 2030 and Working for Health Action Plan 2022–2030, including through subnational, national, regional and international cooperation, to increase investments as appropriate – including through greater mobilization, prioritization, and more efficient use of domestic resources – in pre-service education, continuous in-service training, supportive supervision, employment and retention efforts for a skilled workforce, particularly for women and early career workers, aligned with the current and future population, health system, and health and care labour market needs with a special focus on the primary healthcare workforce in remote or otherwise vulnerable health settings in order to accelerate progress towards universal health coverage;

(2) to address sustainably the shortages in education, training and employment capacity thereby substantially increasing the number of qualified health and care personnel while maintaining high educational standards, in line with the objectives contemplated in the Declaration of Astana[8] aiming to achieve the highest possible qualification rates, in countries requiring a substantial scale up or that are facing a rapid ageing of their health workforce;

(3) to promote for all health and care workers decent work, promote formal recognition, fair and equal remuneration based on qualification and roles

[7] Policy and actions at the "country" or "national" level should be understood as relevant in each country in accordance with subnational and national responsibilities.

[8] Global Conference on Primary Health Care: Astana, Kazakhstan, 25 and 26 October 2018, https://www.who.int/publications/i/item/WHO-HIS-SDS-2018.61.

undertaken, enabling and supportive work environments, and equal access to education, training, employment and career progression opportunities, through equity-focused approaches that address disparities such as the gender pay gap and any barriers faced by women, persons with disabilities, foreign workers, community-based workers and others at risk, promoting their full and meaningful participation and representation including in senior leadership and decision-making roles, in line with the ILO Declaration on Fundamental Principles and Rights at Work;

(4) to prioritize the safety and protection of all health and care workers from abuse, attacks, discrimination including any form of sexual exploitation or abuse, harassment and violence, and specific support for health workers in emergencies and conflict settings, and implement measures to prevent and respond to burnout and promote mental health and well-being through workplace policies, institutional support mechanisms and community-based initiatives, in line with the Global Health and Care Worker Compact;

(5) to prioritize investments in education, training, employment and retention, including capacity to manage and provide supportive supervision to reduce migration pressures in countries with high out-migration or critical shortage and foster ethical cooperation on international recruitment and migration of health personnel, in alignment with the provisions of the WHO Global Code of Practice on International Recruitment of Health Personnel, including by encouraging equitable bilateral agreements, mutually beneficial partnerships, engaging and acknowledging the significant role of the private sector, and where applicable reinvesting agencies fees into education, training, responsible engagement with the private sector and strengthening circular migration programmes, as appropriate that facilitate skills transfer and benefit health systems of both source and destination countries and creating the conditions for the return of health workers to their countries of origin through special reintegration programs and professional development opportunities;

(6) to strengthen stewardship, leadership and management capacities to enable effective oversight of health and care workforce agendas, including strategic workforce planning informed by strong information systems, national health workforce accounts, where appropriate, and health labour market analyses, to deliver essential services and public health functions, to enhance workforce performance and optimal utilization of available workers, and build capacity for health, prevention, emergency preparedness and response;

(7) to harness safe and effective digital health and artificial intelligence opportunities, while supporting policy measures and incentives that improve access, affordability and inclusivity for these technologies, particularly in developing settings and underserved or rural areas;

(OP)2. INVITES partners and stakeholders to contribute to accelerating the agenda in support of health and care workers, with a specific call to:

(1) development partners, global health initiatives, international financial institutions and United Nations agencies to increase support and technical assistance, aligned with national priorities and mechanisms, for health workforce development, management, regulation, employment and research, and to provide this support in accordance with the Lusaka Agenda and aid effectiveness principles, with a focus on countries facing critical shortages identified by WHO through the WHO Health Workforce Support and Safeguards List and to support

countries affected by conflicts and humanitarian crises to promote the stability of health systems;

(2) education and training institutions, especially health science and medical education institutions, and health and care service providers to adopt competency-based education approaches, promote tracking of health worker skills and competencies across institutions, and include in education and lifelong learning programs, including in collaboration with the WHO Academy and other collaboration platforms, digital health competencies, artificial intelligence and other medical innovations of proven safety and effectiveness, to ensure that health workers are prepared to meet the demands of modern health systems.

(3) professional councils and regulatory agencies to optimize workforce competencies and management, in line with the WHO guidance on health practitioner regulation;

(OP)3. REQUESTS the Director-General:

(1) to prioritize resources in line with the Fourteenth General Programme of Work, 2025−2028 to those actions and workstreams dedicated to support policy development and implementation, normative and technical cooperation activities that support the health and care workforce priorities outlined in the Global Strategy on Human Resources for Health: Workforce 2030, the Working for Health Action Plan 2022−2030 and related Health Assembly resolutions, including by fostering relevant collaboration through regional and global initiatives, such as the joint WHO-ILO-OECD Working for Health partnership, and actions with development partners and other relevant stakeholders in line with the Framework of Engagement with Non-State Actors as applicable;

(2) to accelerate support to Member States, upon request, on the implementation and monitoring of the Global Strategy on Human Resources for Health: Workforce 2030, to promote investments in education, training, employment and retention of the health and care workforce, [accelerate progress towards meeting target 3.c of the Sustainable Development Goals], and strengthen capacities to prevent, prepare for and respond to public health emergencies, including workforce surge capacity during public health events, with a special focus on countries and regions facing the most critical health and care workforce challenges, providing technical and methodological support for rebuilding and strengthening the health workforce in countries impacted by conflicts and the loss of professional staff.

(3) to facilitate Member States' access to data, knowledge, expertise, guidance and good practices on health and care workforce leadership, management and regulation, education, training and adoption of digital health technology, employment, deployment and retention, gender equality, and international mobility and migration, including the use and implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel as well as through peer-to-peer and South-South cooperation;

(4) to support Member States in strengthening national information systems and the implementation of WHO National Health Workforce Accounts to enable national and international monitoring and analysis to inform policy, and health labour market analyses to inform acceleration plans and investments for education, training and employment;

(5) to support countries, in collaboration with associations, institutions and schools of public health, to implement technical guidance and tools to

strengthen workforce capacity to deliver essential public health functions, including health emergency prevention, preparedness and response, and the implementation of the International Health Regulations, building on existing initiatives to strengthen availability, accessibility, acceptability, and quality of a skilled, trained and multidisciplinary global health emergency workforce while ensuring a safe and healthy working environment;

(6) to report on the implementation of this resolution within the existing reporting cycle for the Global Strategy on Human Resources for Health: Workforce 2030 and the WHO Global Code of Practice on the International Recruitment of Health Personnel, with the next reports due to the Eighty-first World Health Assembly in 2028.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[9]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:
1.1.5. Countries enabled to strengthen their health and care workforce

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:
Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:
Not applicable.

4. Estimated time frame (in years or months) to implement the decision:
Six years (2025–2030).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:
US$ 125.47 million.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:
US$ 2.18 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:
Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:
US$ 48.16 million.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:
US$ 75.13 million.

[9] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic “bridge” between results structures can be provided as needed.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions

– **Financial resources available to fund the decision in the current biennium:**
US$ 0.61 million.

– **Remaining financing gap in the current biennium:**
US$ 1.57 million.

– **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Resource mobilization efforts are under way.

Table. Breakdown of estimated resource requirements (in US$ millions)[a]

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	0.14	0.12	0.05	0.13	0.10	0.11	0.33	0.98
	Activities	0.15	0.15	0.15	0.15	0.15	0.15	0.30	1.20
	Total	0.29	0.27	0.20	0.28	0.25	0.26	0.63	2.18
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	12.85	1.31	1.41	2.19	2.93	0.47	11.29	32.47
	Activities	5.63	1.62	1.15	1.99	1.78	2.40	1.12	15.69
	Total	18.48	2.93	2.57	4.18	4.71	2.87	12.42	48.16
B.4. Future bienniums cost of resources to be planned	Staff	20.04	2.05	2.20	3.42	4.58	0.73	17.62	50.65
	Activities	8.78	2.53	1.80	3.10	2.77	3.75	1.75	24.48
	Total	28.82	4.58	4.01	6.52	7.35	4.48	19.37	75.13
B.1. Total planned costs required to implement the decision									125.47

[a] The row and column totals may not always add up, owing to rounding.

The representative of the PHILIPPINES, speaking in his capacity as Co-Chair of the Expert Advisory Group, said that the Group's discussions had shown the Code's increasing relevance. Its responsiveness to present and future challenges could be strengthened by enhancing health worker mobility data, providing clear guidance for bilateral negotiations and advocating for sustained investment. Collective action was essential for the ethical management of health workforce migration, especially in the light of health security risks and requirements for universal health coverage. He thanked the Director-General for advancing the Group's recommendation to hold regional consultations on the Code; Member States should remain constructively engaged in that process.

Addressing persistent shortages and disparities in health workforce distribution was a global health imperative. Further robust health workforce accounts were needed to guide health labour market analysis considering evolving contexts such as climate change, conflicts and digital technology advancements. The Expert Advisory Group encouraged Member States to prioritize investing in education, retention and improved working conditions, protection and mental health, while the Secretariat should support continued technical guidance and coordinated action within

and across regions. He thanked the other sponsors of the draft decision, encouraging support and collaboration from Member States towards an equitable and sustainable global health workforce.

The representative of the REPUBLIC OF KOREA shared information on initiatives by his Government, including providing support for the continuous professional development of health professionals, mitigating regional disparities, improving working conditions and promoting gender equality in that sector. Based on those experiences, he urged the Secretariat to expand platforms for policy exchange and cooperation among Member States, to allow for sharing of best practices in health workforce management, and to strengthen technical support for data-driven policy-making by enhancing the collection and use of refined data through national health workforce accounts.

The representative of POLAND, speaking on behalf of the European Union and its Member States, said that the candidate countries North Macedonia, Montenegro, Serbia, Albania, Ukraine, the Republic of Moldova, Bosnia and Herzegovina and Georgia, as well as Armenia, aligned themselves with her statement. Global priority should be given to enhancing access to, and investment in, healthcare education, infrastructure for tertiary education and scholarships; expanding student numbers; promoting lifelong learning; and strengthening partnerships with academic institutions, including the WHO Academy. It was important to enhance working conditions for the health and care workforce through competitive salaries and benefits, including initiatives to close the gender pay gap and for flexible work schedules. Policies should include equity and gender perspectives to address disparities, ensuring the meaningful participation and representation of women in senior leadership and decision-making roles. For staff retention, workforce planning tools could be adopted to predict shortages and plan resource allocation. Retention was paramount for safeguarding healthcare systems' resilience and ensuring accessible, affordable high-quality health services in accordance with the Sustainable Development Goals.

The Secretariat should promote intersectoral engagement and increased collaboration across education, labour, finance and health ministries in order to enable holistic workforce planning and facilitate investment decisions, assisting Member States in prioritizing their health workforce investments in national budgets. Aligning workforce strategies with universal health coverage and the Sustainable Development Goals to promote innovative financing mechanisms should also be supported, with a focus on healthcare. The Secretariat should continue to support national and regional capacity-building by training policy-makers and developing regional training centres, networks and the WHO Academy to facilitate local solutions and knowledge sharing. Health workforce shortages also increased the need for innovation in many professions' education curricula by rethinking skill mixes and task shifting. She underlined the need for the Secretariat to advocate for global and regional cooperation and promote global benchmarks and accountability to monitor and report on progress towards workforce-related targets under initiatives such as the Global Strategy on Human Resources for Health: Workforce 2030. The Secretariat would thus empower Member States to make informed, evidence-based decisions, enhancing the health and care workforce and so ensuring a sustainable and equitable global health system. It should share any data on or analysis of the number of staff assigned to human resources for health projects and programmes as well as information on the funding required.

The representative of the COMOROS, speaking on behalf of the Member States of the African Region, welcomed the Secretariat's consultative approach. There were undeniable challenges in the reported deficit of health workers, with 51% of the 11.1 million shortfall projected for 2030 to be in his Region, resulting in universal access issues. To remedy that deficit, he proposed building training capacities and boosting the numbers and expertise of educational centres. He welcomed the establishment of the WHO Academy and called for other such initiatives

to be put in place. African languages beyond Hausa and Amharic, such as Swahili and Lingala, should be integrated into those initiatives and made accessible, and decentralized training should be made available for his Region. Information systems on human resources for health should be strengthened, and guidance should be created for developing a mechanism for North-South and South-South cooperation. The Secretariat should encourage Member States to create administrative and legal mechanisms to enhance the status and career plans of health workers, and to invest heavily in equitable recruitment. Policies should be updated to attract more qualified health workers in rural and remote areas, and create decent work opportunities for women and young people. Noting the unique challenges faced by small developing island States in the African region, such as remoteness and a lack of resources, he called for a special human resources for health capacity-building programme to be established for island States.

The representative of SWITZERLAND welcomed the increased national reporting rate and the rise in the number of designated national authorities, noting the need to sustain the health workforce against population ageing, as concluded in the Global Strategy. To optimize retention of the health and care workforce, the Swiss Government had noted several factors for consideration, such as the extent to which someone was identified with a job, workload, work-life balance, and compensation for inconveniences. It was currently implementing a federal initiative for care, which, as well as being a considerable investment in training to increase the number of carers qualifying in her country, focused on improving working conditions and professional development opportunities.

The representative of BRAZIL, noting the stark disparities in access to healthcare between countries as highlighted by the report, said that such inequities also existed within the health workforce itself: the gender pay gap persisted, and those of African descent and migrants could face multiple barriers to fair pay and favourable working conditions. It was an urgent priority to protect the well-being of health and care workers who faced immense burdens and risks, as demonstrated during the coronavirus disease (COVID-19) pandemic. Their rights, working conditions and mental health must be safeguarded, for which, crucially, key provisions had been included in the text of the pandemic agreement currently being negotiated. She expressed concern at the slow progress towards addressing the global shortage of health workers and the impact of that shortage, in particular on developing countries. Her Government was therefore pleased to sponsor the draft decision on accelerating action on the global health and care workforce by 2030.

The representative of BULGARIA expressed support for the goals on optimizing the development of human resources for health, particularly plans to introduce evidence-based policies, align education, employment and investment, and build institutional capacity and partnerships. Member States were encouraged to share successful policies, including any efforts to develop education programmes and training tailored to public health needs, new technology and artificial intelligence; measures taken in the areas of planning and equitable distribution of human resources for health; staff retention policies in remote and rural areas, including financial incentives; efforts to provide professional support and create working conditions promoting equitable access to care; and international collaboration and staff mobility policies, such as those supporting cross-border training programmes and telemedicine. The Secretariat could support Member States by developing capacity-building courses on health, labour market analysis, policy-making and investment decisions; improving data management; providing technical support, including for data collection, analysis and use through global platforms such as national health accounts; developing training materials in blended learning models on workforce planning, management, investment and monitoring; organizing workshops to share practices that

successfully promoted international cooperation; and supporting investment in sustainable health workplaces, including long-term planning and mobilization of internal and external resources.

The representative of QATAR, speaking on behalf of the Group of Friends of the WHO Academy, said that the Academy was a unique, world-class tool for strengthening the capacities of health workers on a global scale and a powerful instrument for promoting global health equity, given its focus on providing prioritized training opportunities for health workers from low- and middle-income countries. The Academy was also a vital resource for WHO itself as it played an integral role in human resources development, working closely with departments at all three levels of the Organization to align with WHO's broader human resources strategy. The Group of Friends of the WHO Academy had been created to support the Academy, including by promoting it and facilitating partnerships with academic and research initiatives. At present, the Group comprised around 30 Member States and would hopefully grow into an ever-broader coalition.

The representative of the REPUBLIC OF MOLDOVA expressed concern at the increasing migration of health professionals, exacerbating workforce shortages and impacting the sustainability of national health systems. The fifth round of national reporting reaffirmed the urgent need to address health workforce disparities, particularly in countries with limited capacity to replace departing health workers. In small source countries where scarce budgetary resources had been invested in health workforce education, the loss of certain specialists abroad could be fatal. Additionally, it could hinder Governments' ability to face local and cross-border health challenges. In that respect, she underlined the importance of promoting equitable partnerships, capacity-building investments, sustainable workforce planning and migration of medical staff based on ethical principles, and the need for stronger international cooperation, financial and technical support, and innovative strategies to improve retention and working conditions in source countries. Commending the Secretariat's efforts to enhance data collection and reporting through national health workforce accounts, she noted that evidence-based decision-making and targeted interventions were crucial. All Member States must actively engage in that process and contribute to refining the Code's implementation based on emerging global health challenges. Regarding the Expert Advisory Group's ongoing review, she called for an updated framework that reflected contemporary workforce realities – including lessons from the coronavirus disease (COVID-19) pandemic – and the permanent, growing demand for care workers. Reaffirming its commitment to the Code's ethical principles, her Government would sponsor the draft decision on accelerating action on the global health and care workforce by 2030.

The representative of THAILAND said that the training of health professionals must respond to populations' emerging needs, in line with demographic and epidemiological changes. He called for the Secretariat to support Member States in implementing the Global Strategy. Member States should accelerate the implementation of transformative health professional education and support implementation of resolutions on gender equality, retention of health workers – especially in rural areas – workplace safety, strengthening of community health worker engagement and adherence to standards of primary healthcare. Implementation of the global health and care worker compact should be accelerated to protect those workers and their rights. Decent work free from all forms of discrimination should be ensured, thus providing a safe and enabling professional environment. He supported the adoption of the draft decision on accelerating action on the global health and care workforce by 2030.

The representative of TOGO welcomed the progress detailed in the Director-General's report on the health and care workforce, including on skills-based education and training, gender equality and staff retention. She described corresponding policies in her country, such as the

human resources development strategy 2024–2027 and sectoral strategy for retention of health workers in remote areas. She called on the Secretariat to prioritize sustained investment in training, employment and retention of health workers; strengthen databases and policies relating to the health workforce; advocate for the integration and professionalization of community health workers; and encourage the use of digital technology and artificial intelligence to modernize health worker training.

The representative of UKRAINE said that ongoing challenges such as conflicts and humanitarian crises highlighted the urgent need for sustainable investment in health workers' education, employment and retention. In the context of the Russian Federation's aggression against Ukraine, which had created unprecedented challenges for her country's healthcare system, particularly in terms of human resources, her Government was developing strategies to train and retain health professionals, including raising salaries and improving working conditions. High-quality health worker training should be ensured through cooperation between medical universities and clinics, allowing students to gain practical experience. Global challenges required the introduction of modern technology such as telemedicine. Her Government was actively engaged in developing international medical partnerships to facilitate the exchange of experience and resources and advised other governments to join that initiative.

The representative of SENEGAL, describing initiatives in his country like the national human resources for development plan for 2020–2028, called for improved management of human resources using performance-based measures and for initiatives to combat stress in the workplace to boost health and care worker resilience. Such initiatives could be linked to leadership strengthening programmes. The Secretariat should publish data showing that investment in human resources promoted economic development with a view to placing staff at the heart of health policy. His Government supported the draft decision on accelerating action on the global health and care workforce by 2030.

The representative of LEBANON, speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed appreciation for the ongoing efforts by the Secretariat and its partners to address health workforce shortages and related challenges. Significant issues remained, however, including in her Region, which was predicted to have a shortage of 2.1 million health workers – about 20% of the global projected deficit – by 2030. Improved monitoring of the Code had yielded better information, but the situation was deteriorating as ever more health workers were displaced by conflict. Member States in her Region had joined a call to accelerate implementation of commitments in that critical area. She noted the flagship initiative in her Region to increase investment in the health workforce and the establishment of a regional health workforce collaborative. She called for global efforts to be accelerated, welcoming the extension of the global strategic directions for nursing and midwifery 2021–2025 until 2030.

The representative of ETHIOPIA, noting that her Government was a member of the Friends of the WHO Academy, expressed support for the draft decision on the Expert Advisory Group's interim report. Initiatives such as her Government's human resources for health compact had shown that government ownership was critical for optimizing education, employment and retention of the health and care workforce, with policies, legal enablers and sustainable investment and prioritization as key factors. Timely and reliable data for innovative real-time monitoring and evaluation was especially important at present. She called for collaboration on addressing workforce migration through the Code and strengthening of regional initiatives by enhancing South–South cooperation. The Secretariat would need continued support to implement the global health and care worker compact with enhanced support for implementing national

human resources for health investment plans. Country strengthening and training, human resources for health information systems, national health workforce accounts and labour market analysis were critical and should be maintained. Her Government wished to be added to the list of sponsors for the draft decision on accelerating action on the global health and care workforce by 2030.

The representative of CHINA said that human resources development, deployment and promotion had met with success in his country. His Government had proactively adapted to emerging issues in chronic disease, rehabilitation, care and mental health due to ageing and low birth rates, by prioritizing professionals in elderly care, mental and psychosocial health and rehabilitation in recent years. For medical school admissions, training, salary and motivation, his Government had increased support to attract more professionals, focusing on the primary healthcare workforce, through targeted rural training, urban–rural partnerships, regular circuit medical services, integrated talent management and subsidies for rural and remote areas. Regarding the Secretariat's development of a curriculum covering health labour market analysis and accompanying technical support activities, he asked the Secretariat to share the framework and elements of that analysis online and offline, and provide more national case studies on applying the training course and recognizing experience in human resources, development, deployment and retention. His Government wished to enhance exchanges and experience sharing on human resources for health.

The representative of CANADA supported the findings of the interim report by the Expert Advisory Group, welcoming the improvements in data availability and inter-agency data exchange. While work remained to be done, improved data collection and reporting were critical to inform discussion and ensure a strong evidence base for human resources planning. She expressed support for the Global Strategy and future discussion with fellow Member States on policies to promote shared goals. Her Government greatly valued work with all health partners to strengthen data on human resources for health; international progress in that area would inform and assist efforts in her country.

The representative of BARBADOS said that the Code was of particular importance for small island developing States such as his own, whose limited capacity for domestic training impeded their ability to maintain sufficient qualified health workers and mitigate the effects of their migration. Migration hampered the achievement of universal health coverage in small island developing States and aggressive recruitment – especially in nursing – exacerbated gaps in health service delivery. His Government fervently advocated for the Code's implementation at the national level but called for special consideration for small island developing States that could not compete with the recruiting practices of more developed nations. Regional discussions were a helpful platform to build support for implementing and strengthening the Code; address challenges in monitoring and understanding migration; and consider the unique issues facing small island developing States. The Code should not reduce the availability of personnel, and migration should be managed according to the specific needs of health workers and the requirements of individual countries. The initiatives described in the reports could be a foundation for bilateral engagement and lead to a mandatory framework code. He called for collaborative efforts for a future where ethical recruitment practices and sustainable health workforce strategies were the norm, ensuring access to high-quality healthcare for all.

The representative of MOROCCO, speaking also on behalf of Germany, the Philippines, Nigeria and Thailand, supported the draft decision on accelerating action on the global health and care workforce by 2030 and called for its implementation to be aligned with the Secretariat's

strategic priorities and the resources available. He commended, in particular, the comprehensive attention paid to: investing in education and training to create a workforce equipped to meet the evolving demands of modern health systems, especially in underserved and remote areas; improving working conditions and retention, including equitable pay, safe workplaces, and protection against violence and harassment; and addressing the issue of health worker migration in accordance with the Code, to ensure that workforce mobility was fair, ethical and also benefited source countries. Member States and stakeholders were encouraged to increase domestic and international investment in staff training, employment and retention; develop innovative strategies to address regional disparities, especially in precarious, conflict-affected and humanitarian settings; and strengthen national monitoring and analysis of staff data. Welcoming the Secretariat's continued leadership in advancing the Global Strategy, he called on Member States to adopt the draft resolution contained in the draft decision contained in document EB156/14 during the Seventy-eighth World Health Assembly.

The representative of SLOVAKIA, describing steps taken in his country to combat the pressing challenge of global health workforce shortages, such as hospital network optimization and integration of telemedicine, called on the Secretariat to optimize planning through enhanced data collection and workforce registries; provide guidance on competency-based education and digital health integration retention policies, trauma incidence management, and prevention of health worker burnout; strengthen global and regional knowledge exchange, including through the WHO Academy; and support policy dialogue and innovative education on health, education and finance for health workers. In that context, the draft decision on accelerating action on the global health and care workforce by 2030 was welcome. Reflection was needed of whether governing bodies meetings were being used effectively to support health workers and to strengthen WHO's role as an essential organization guiding unified, science-, data- and evidence-based action in that area.

The representative of the DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA said that scaling up the quality of health professionals' education and addressing the shortages in the health and care workforce were crucial for implementing the Global Strategy and pivotal for cross-regional balance, focused on primary healthcare and women's empowerment. Sharing information on initiatives in her country, such as health worker education reform, she called on the Secretariat to promote global and regional platforms for sharing experience and best practices; develop more technical guidelines for health workers; and further facilitate fellowship programmes for health workers and training through the WHO Academy, while maintaining cross-national and inter-regional balance and equity. It was also important to update and expand the criteria to transparently select consultants for technical aid and address challenges in a timely manner by strengthening monitoring and assessment of consultancy activities with a focus on country-level impact.

The representative of NORWAY, welcoming the Secretariat's efforts on the health and care workforce agenda and the positive results achieved, noted that a comprehensive approach was needed to successfully optimize health and care workforce training, employment and retention. The focus in her country was on retention, development and continued recruitment through a strategic approach to working conditions, task sharing and continuous professional development. Her Government acknowledged the importance of the Secretariat's review of programme budget priorities, given WHO's financial constraints, and condemned the extremely worrying trend of attacks on health facilities and their workers which must be protected as safe havens for civilians.

The representative of BRUNEI DARUSSALAM recognized the significance of both reports for sustainable health workforce policies at all levels. Efforts to improve workforce planning for evolving healthcare needs in his country included enhancing competency-based education, strategic partnerships with the private sector, identification of retention strategies and alignment of workforce policies with national health priorities. Small countries, such as his own, faced the ongoing challenge of maintaining an adequately sized, resilient, well-trained and equitably distributed workforce. Enhanced workforce governance was crucial for supporting Member States' workforce strategies, particularly in regions facing demographic shifts, evolving disease burdens and technological advancement. Greater long-term workforce sustainability was needed in training and in health labour market policies to promote optimum employment, fair wages and career development. He called for stronger international cooperation and technical support for small Member States to overcome regulatory barriers, optimize workforce mobility and improve workforce data sharing.

The representative of LEBANON, speaking in her national capacity, called for global education programmes and investment in retention through capacity-building and on-the-job training to reduce national and regional health workforce disparities. She welcomed the increased investment in the health workforce in her Region, the competency-based education initiative under way at the WHO Academy, and the Secretariat's involvement in revising the International Standard Classification of Occupations, for which her Government proposed revising the recommended skills mix. However, guidance should be issued indicating where technological advancements such as telemedicine could be beneficial and where they risked worsening unemployment and furthering disparities. The status of community health workers must be improved and her Government looked forward to receiving WHO guidance to that effect with evidence-based recommendations. Furthermore, palliative care was crucial for the future of health. She welcomed the expansion of health labour market analysis to cover more countries and help them to develop national health workforce investment plans. The Secretariat should advocate for national health workforce accounts as an additional tool for leveraging data availability and supporting retention policies and investment planning. Her Government supported the draft decision on the Expert Advisory Group's interim report and wished to sponsor the draft decision on accelerating action on the global health and care workforce by 2030.

The representative of the FEDERATED STATES OF MICRONESIA said that, while it was encouraging that the global health workforce shortage had decreased between 2020 and 2023, for many Member States, such as low- and middle-income countries and small island developing States, the shortage remained a challenge. His Government joined calls for increased training opportunities and partnerships, including competency-based training and professional and technical training for all workers, and for appropriate remuneration packages. Given his country's geographical isolation, he expressed support for online training.

The representative of SOMALIA said that, despite the considerable challenges of prolonged conflict, political instability and economic difficulties, his Government had made notable strides in strengthening its human resources for health by convening a national health workforce summit, retraining midwives, recruiting health professionals, operationalizing health professional regulatory bodies, and developing policies to address workforce distribution and enhance training quality. He expressed support for the draft decision on accelerating action on the global health and care workforce by 2030.

The representative of MOROCCO, speaking in her national capacity, recalled that health workers were the backbone of healthcare and accelerated action was needed to address their

expectations in a way that was viable for the health system. Her Government had introduced structural reforms that promoted a comprehensive capacity-building approach to health worker development, attraction and retention. Managing human resources for health could not be separated from equity, social justice and international solidarity. She welcomed the guidance set out in document EB156/14, calling for stronger international collaboration on ethical recruitment and brain drain prevention, particularly in countries with limited resources, and for the creation of opportunities for exchange and training. The report on the Global Strategy should serve as a reference for action. She underscored the need for more investment in workforce training and planning, placing particular emphasis on recognition of qualifications and improvements in working conditions. Greater support was needed for countries with limited resources to optimize their training, recruitment and retention strategies for health workers. Adopting a harmonized global framework to regulate health worker migration would allow worker mobility to be balanced with health system resilience.

The representative of MALDIVES said that, while health workers' rights to seek opportunities abroad should be respected, ethical recruitment practices were essential to prevent workforce shortages, especially in lower-income countries and small island developing States. To address those shortages, her Government had implemented strategies such as enhanced training, retention incentives and improved working conditions. However, sustainable solutions required global solidarity: the Secretariat and Member States must support national health workforce plans through financial and technical cooperation. Improved data collection and reporting on health workforce migration patterns were crucial. In addition to the global health and care worker compact, which she welcomed, the Secretariat should facilitate bilateral and multilateral agreements that prioritized health workforce sustainability and included capacity-building, training partnerships and technology transfers to redress the fragility of global health workforce distribution. Health systems must be made more resilient by integrating climate and emergency preparedness and digital health innovations. Reaffirming her Government's commitment to the Code and urging Member States to uphold its principles, she requested that the Secretariat strengthen mechanisms for monitoring compliance, providing technical support and enhancing global dialogue on ethical recruitment.

The representative of COSTA RICA described his Government's national human resources for health plan to address the lack of specialist doctors and nurses through training, employment and workforce regulation. The Government was making use of new technology to collect data and report on standardized indicators in accordance with WHO recommendations.

The representative of TÜRKIYE[10] said that, while the report on the Global Strategy provided an important framework for the future of the health workforce, there was a need for more detailed planning and strategy recommendations for areas such as health workforce inequalities, training needs, crisis preparedness, gender equality and digital health. Gaps in those areas could be a significant obstacle to the Global Strategy's effectiveness. The specific needs, resources and social structures of local and regional health systems should also be taken into account, with an approach based on global solidarity. The report was an important step forward in strategic planning for the health workforce.

The representative of URUGUAY,[10] welcoming the Global Strategy as a key tool for ensuring universal health coverage, said that her Government had developed a national nursing plan and had strengthened the health ministry's role in planning medical residencies to meet challenges in

[10] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

the training and distribution of medical specialists. Policies must be continually promoted for equitable distribution of health staff. Advances had been made in telemedicine, which had broadened access to medical care and optimized resources, and her Government had strengthened its monitoring and reporting mechanisms, using national health workforce accounts.

The representative of GERMANY[11] repeated the European Union's call for information on the number of Secretariat staff working on health and care workforce topics and the funds available. Successful policies in her country to support the health and care workforce included legally implementing the Support and Safeguards List, creating a quality label for fair healthcare recruitment and establishing mutually beneficial skills partnerships. In addition, her Government was setting a target to increase nurse training numbers by 10%; compiling a catalogue of competencies that medical students should acquire; ensuring that general nurse training comprised theoretical and practical elements and that initial training was free and nursing trainees were paid; and implementing a monitoring and forecasting model.

The representative of COLOMBIA[11] said that his Government had been drafting a public policy for human resources for health since 2023 to promote decent working conditions and personal and professional development. The policy was intended to improve and promote fundamental health education for the population in various regions, and to ensure decent working conditions in accordance with international agreements regulating international migration of human resources for health and care. His Government wished to sponsor the draft decision on accelerating action on the global health and care workforce by 2030, and reiterated its support for WHO as a guarantor of health and global peace.

The representative of ROMANIA[11] expressed support for the findings and recommendations of the comprehensive report contained in document EB156/14, welcoming Member States' increasing engagement in reporting on the matter. In particular, her Government considered that bilateral agreements should ensure mutual benefits and stronger data sharing on migration and return trends. The spirit of the report's recommendations ensured that international mobility did not compromise access to healthcare in source countries. Her Government had addressed its significant outflows in health and care professionals since joining the European Union through salary increases, expanded medical education, investment in infrastructure, and strategic workforce policies to slow migration and increase retention.

The representative of FRANCE[11] said that, to better manage the health and care workforce, his Government recommended ambitious national policies for training health professionals. It had adopted an action plan to strengthen continuous professional development through better geographically distributed training and diversified teaching methods. There was also a need for employment support and retention measures – financial incentives in underserved areas had helped to maintain high-quality health coverage throughout the country. Initiatives to improve working conditions and recognition for care staff were also needed, while responding to the growing needs of aged and disabled populations. Progress in that direction depended on increasing international cooperation. To implement the Global Strategy successfully, the Secretariat should support sharing of best practices and data collection in relation to the health workforce; encourage political dialogue between health ministries and local actors for a coordinated approach to staff management; and use the WHO Academy to support

[11] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

competency-building for low- and middle-income countries, encouraging all Member States and partners to make full use of it.

The representative of NAMIBIA[12] urged immediate and sustainable action to address the disparities in the reported health workforce shortage, which was particularly concentrated in the African and Eastern Mediterranean regions despite progress in workforce development. Implementing a robust strategic plan on national human resources for health – as his Government had done – that focused on increasing the number of health professional posts and developing scarce priority skills was essential for optimizing the education, employment and retention of the health and care workforce. His Government had prioritized competency-based education and equitable workforce distribution to ensure alignment with health system needs. Investment in continuous professional development and competitive remuneration were also crucial to enhancing workforce retention.

The representative of the NCD ALLIANCE, speaking at the invitation of the CHAIR, said that she was speaking also on behalf of The Royal Commonwealth Society for the Blind – Sightsavers, the International Society of Nephrology, The International Society of Paediatric Oncology, the International Society on Thrombosis and Haemostasis, Inc., HelpAge International, the International Diabetes Federation, the Multiple Sclerosis International Federation, PATH, the Global Self-Care Federation, The Fred Hollows Foundation, CBM Christoffel-Blindenmission-Christian Blind Mission e.V., the International Association for Dental Research, The Worldwide Hospice Palliative Care Alliance, Alzheimer's Disease International and the World Hepatitis Alliance.

Expressing deep concern at the projected global shortfall of health workers, she applauded the commitment of the Secretariat and Member States to accelerate action on workforce shortages, encouraging Member States to support the draft decision to that effect. However, WHO's road map to strengthen national health and care capacity for essential public health functions had been a missed opportunity to better equip the health workforce – especially at the primary healthcare level – and to respond to the growing burden of noncommunicable diseases. Member States must prioritize health workforce issues as critical to reaching targets for universal health coverage, child mortality and noncommunicable diseases. Health workers and people with lived experience of those diseases should be included in shaping health policy at all levels. Member States should also conduct health labour market analysis to identify their policy and fiscal needs for workforce supply and demand; invest in training health workers, particularly in areas critical for preventing and controlling noncommunicable diseases, to deliver age- and disability-inclusive and gender-responsive services; and invest in digital, data and artificial intelligence technology. The WHO Academy could optimize access to workforce competencies, including on noncommunicable diseases and particularly for health workers in low- and middle-income countries. She highlighted the importance of collaborative care models using multidisciplinary teams, from community health workers to specialists.

The representative of the DOMINICAN REPUBLIC[12] said that her Government wished to join the list of sponsors of the draft decision on accelerating action on the global health and care workforce by 2030.

The representative of SPAIN[12] described the national human resources for health strategy that was under development in her country, in accordance with the European regional action framework for behavioural and cultural insights for health, 2022–2027. It was aimed at optimizing specialized and continuous training, and the employment and retention of health workers. Pay

[12] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

and working conditions must be improved with better working hours and bonuses to attract health workers to rural or underserved areas. Health workers must be offered psychological support against burnout, especially from crisis situations, to prevent psychological damage by identifying its structural factors. Technological innovation was also key, including the use of digital clinical history, telemedicine, and training in artificial intelligence and big data. The Secretariat could support Member States by advising on resource mobilization and sustainable financing to optimize investments; implementing monitoring and evaluation mechanisms for the impact of such investments; strengthening information systems on human resources for health; identifying and helping to eliminate working conditions that risked psychologically damaging health workers; training in strategic planning and management of health staff; and encouraging the sharing of best practices and promoting technical cooperation to align strategies and strengthen governance in health workforce planning.

The representative of SAUDI ARABIA[13] said that her Government's commitment to a sustainable health system and a skilled, comprehensive health workforce was reflected in national initiatives such as Vision 2030 and the Saudi Commission for Health Specialities, with expertise and solutions being developed across all health specialities. Recognizing the lack of balance in and international regulation of health workforce supply, demand, migration and skills, her Government called on Member States and stakeholders to join discussions towards a comprehensive road map for action. Collaboration with the Secretariat would be welcome in areas such as training and accreditation, standardization and quality assurance.

The representative of JAPAN,[13] recognizing that equitable access to and delivery of health services required the appropriate deployment of health and care workers, said that his Government had been developing career paths for health and care professionals, including certified care workers. It was also supporting the development and deployment of health staff internationally through technical cooperation programmes.

The representative of the RUSSIAN FEDERATION,[13] noting that the Expert Advisory Group's recommendations primarily emphasized strengthening Member States' accountability and increasing funding of the monitoring component, called on the Secretariat to increase awareness among the international community of the Code's principles and goals, and best practices in its implementation. Her Government was taking measures to implement the Code and supporting neighbouring countries to boost the capacities of health workers. Member States should fully comply with the Code and develop their own health workforce potential for greater health emergency preparedness and response, among other things. The Secretariat could contribute considerably to that goal by sharing best practices at the country level. Her Government supported the draft decision on the interim report of the Expert Advisory Group, which called for a further round of consultations.

The representative of BANGLADESH[13] urged destination countries to reinvest the benefits of health workforce mobility in the education sector of source countries, whose initial investment made that mobility possible. Since health workforce migration could not be seen in isolation, data on recruitment of overseas health workers by the private and public sectors should be reported to the Secretariat to identify health workforce movement. As the Expert Advisory Group recommended, it was necessary to ensure equal opportunities for professional education and career progression and set out objective criteria for the recruitment, promotion and remuneration of the migrant health workforce. The Secretariat could respond to the lack of health workforce

[13] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

data through a Code-specific public awareness campaign to avoid the undesirable impacts of health workforce migration.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of the CHAIR, said that he was also speaking on behalf of FDI World Dental Federation, the International Pharmaceutical Federation, the Association Médicale Mondiale and the International Association For Hospice And Palliative Care, Inc.

He expressed concern at the continuing, unsustainable depletion by high-income countries of the health workforce from low-income countries, which threatened access to essential health services in under-resourced regions and undermined fragile in-country capacity-building initiatives and shared global commitments to health equity. The announcement made by the Director-General in 2023 to convene a meeting with the high-income countries driving international health workforce recruitment was commendable, but the meeting was yet to take place; the convening of that meeting should be made a priority. He expressed concern at the Global Strategy's implementation rate, which was slowing, and at the increase in the projected health workforce shortage for 2030, which reflected a continuing shortfall in investment. Working conditions were deteriorating as governments cut health budgets or privatized services – which additionally meant a loss of labour and pension rights. Health professionals, subject to increased and more severe violence, were suffering moral distress as a result of underfunded health services. Member States must prioritize quality of care and the right to decent, safe working conditions. The Secretariat's troubling conflation of health professionals – who were licensed, regulated and highly trained – with health service providers such as care workers and community health workers – with lower levels of regulation, training and accountability – directly impacted the safety and quality of care. The Secretariat and Member States should consistently highlight that difference and reflect it in health workforce planning and service delivery.

The representative of INDIA,[14] recognizing the critical role of a robust and equitably distributed healthcare workforce in achieving universal health coverage, described the policies implemented by his Government to optimize education, employment and retention of the health workforce. They included regulatory and education reforms and the use of digital technology, all while shifting from a siloed, medical-only model to a multidisciplinary, inclusive care framework to bolster health service delivery at all levels.

The representative of PARAGUAY,[14] highlighting the importance of investment in the health workforce, described policies in her country such as the national human resources for health policy 2020–2030 and national training plan 2022–2030 to build capacities and ensure high-quality health services. Welcoming reported increases in health workforce data availability, she said that measures such as pay scaling, reduced workloads and establishment of an oversight body for human resources for health had improved working conditions in her country.

The representative of NIGERIA[14] said that, in implementing the Global Strategy and faced with considerable skilled workforce migration, his Government had made progress in strengthening its healthcare system through increased training of health and care workers. It had also launched a workforce migration policy and was engaged in discussions with destination countries on collaboration for mutual national benefit.

The representative of GHANA,[14] noting the predicted shortage of essential health and care workers in his country and reaffirming that their welfare should be ensured by all States, called for

[14] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

adherence to the Code. He commended the Secretariat for the health market analysis, the Working for Health 2022–2030 Action Plan and its Multi-Partner Trust Fund, and continuous advocacy for long-term, sustainable investments in the health and care workforce. He joined the representative of Namibia's call to implement a robust strategic plan on national human resources for health.

The representative of INDONESIA[15] said that her Government had integrated the Code's principles into national law, with support from the WHO Country Office. The Secretariat should continue such support within national contexts. She shared information on national policies to enhance retention of health and care workers, such as special allowances and security measures for health workers in remote border areas, and investment in education and residency programmes.

The Observer of GAVI, THE VACCINE ALLIANCE, called on Member States to invest in the health workforce, especially at the primary care level; leverage digital technologies to enhance training and service delivery; ensure that community health workers – who notably helped to identify and reach unvaccinated children and were often the first contact with the health system – had decent remuneration and working conditions; and address inequities faced by women, including the gender pay gap.

The representative of the EUROPEAN SOCIETY FOR MEDICAL ONCOLOGY, speaking at the invitation of the CHAIR, urged Member States to build a sustainable cancer workforce and optimize its well-being, manage workplace psychosocial risks and reduce burnout in oncologists.

The representative of the INTERNATIONAL FEDERATION FOR MEDICAL AND BIOLOGICAL ENGINEERING, speaking at the invitation of the CHAIR, regretted that the Global Strategy did not mention biomedical staff, who were essential for the functioning of healthcare systems. The WHO medical devices team must be strengthened, including to facilitate data exchange.

The representative of the WORLD ORGANIZATION OF FAMILY DOCTORS, speaking at the invitation of the CHAIR, urged the prioritization of family doctors within primary healthcare in order to address medical deserts, reduce health inequities and achieve universal health coverage.

The representative of the INTERNATIONAL SOCIETY OF PHYSICAL AND REHABILITATION MEDICINE, speaking at the invitation of the CHAIR, called for Member States to increase investment in rehabilitation education and training to allow for more equitable access to rehabilitation, enabling people to function at their highest capacity.

The representative of PUBLIC SERVICES INTERNATIONAL, speaking at the invitation of the CHAIR, called on Member States to uphold decent work for all health and care workers; support transparent and rights-based bilateral agreements and strict regulation of private recruitment agencies; be cautious of circular migration, which perpetuated exploitation and discrimination; prohibit recruitment or agency fees; and ensure the meaningful participation of trade unions and civil society, including in consultations on the Expert Advisory Group's interim report.

[15] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of MEDICUS MUNDI INTERNATIONAL – NETWORK HEALTH FOR ALL, speaking at the invitation of the CHAIR, said that the rights of healthcare staff and their trade union representatives must be strengthened to provide input on the running of the working environment and on the development of health policy frameworks and bilateral agreements, thus improving social dialogue.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIR, urged Member States to ensure that young health professionals could meaningfully contribute to the development of resilient and equitable health systems through inclusive decision-making, targeted investments in education and training, and the creation of structured opportunities for youth engagement at all levels of policy and practice.

The representative of the MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION, speaking at the invitation of the CHAIR, stressed the urgency of full-scale implementation of the Code, especially during emergencies and with regard to ethical recruitment of healthcare professionals from countries on the Support and Safeguard List. Member States, donor and business communities must ensure long-term financial investments in human resources for health and secure sustainable and equitable employment opportunities for women and young professionals.

The ASSISTANT DIRECTOR-GENERAL (Universal Health Coverage/Life Course) thanked Member States for their valuable guidance and information on national policies, especially in primary healthcare and retention in underserved areas. He noted the urgency with which the projected shortfall of 11 million health workers by 2030 should be addressed. The figure was particularly alarming because it reflected the decreased rate of improvement in the workforce. Thanking the Governments of Canada and the Philippines for leading the Expert Advisory Group, he recalled that another year of consultation on the Code remained, and the regional consultations would be essential as it was the first review of the Code with proposals on its language. On the Global Strategy, he welcomed the number of Member States discussing and submitting data on national health workforce accounts, though more data was still needed. He appreciated the comments on the WHO Academy and the work of the Friends of the WHO Academy in emphasizing its value and role beyond human resources development in the lifelong learning and training agenda.

Member States' advocacy for safe and decent work conditions was vital given the increasing violence against health workers, and he noted their requests for sharing of best practices, technical support on evidence-based policy and measures to address gender gaps. Responding to the representative of Germany, he said that there were 40 WHO staff members working on workforce and around 30 at full-time equivalence with a budget of US$ 36 million allocated annually to the agenda, which likely could not cover the agenda. He thanked the Governments of Morocco, the Philippines and the other sponsors for their draft decision, most of the cost of which was for the staff mentioned previously. That decision would help the Secretariat to respond to the requests made to help countries and regions with national health workforce accounts, labour market associations and evidence-based policy. He clarified that the figures for biological engineering workers were available on the Secretariat website, even if they were absent from the report.

The EXECUTIVE DIRECTOR (WHO Academy), thanking Member States and the Group of Friends of the WHO Academy for their support for the Academy's growing role, stressed that continuing education for health workers was key both for improving the quality of care and to increase the retention of health workers. The Academy's work was fully aligned with the global

work of the Organization as a whole – its priorities were linked to the priorities of the Fourteenth General Programme of Work, 2025–2028, and its internal steering committee included representatives of various divisions and the Regional Offices. Multilingualism was at the heart of the Academy's work; it would develop its materials in a number of languages beyond the six official languages of the United Nations, including a growing number of African languages. A specific team was working on localization, both to account for linguistic factors and to contextualize material for Member States' specific settings. Regarding small island developing States, he confirmed that their challenges and needs were accounted for in the Academy's work, including through consultations with regional offices, including those for the Western Pacific and African regions. Furthermore, he confirmed that the function of capacity-building and development for WHO staff had now been transferred to the Academy.

The CHAIR took it that the Board wished to note the reports contained in documents EB156/14 and EB156/15.

The Board noted the reports.

He took it that the Board wished to suspend consideration of the two draft decisions pending the outcome of the broader discussion on the costing implications of resolutions and decisions recommended by the 156th session of the Executive Board for adoption by the Seventy-eighth World Health Assembly.

It was so agreed.

(For the adoption of a decision, see the summary record of the eighteenth meeting, section 6.)

3. Draft global traditional medicine strategy (2025–2034): Item 13 of the agenda (documents EB156/16 and EB156/16 Add.1)

The CHAIR drew attention to the draft decision, which contained a draft decision to be submitted to the Seventy-eighth World Health Assembly, contained in document EB156/16. Its financial and administrative implications were contained in document EB156/16 Add.1.

The representative of SOMALIA, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that countries in his Region had long practised traditional medicine – mainly herbal treatments – with over 90% acknowledging its use among their populations. The WHO traditional medicine strategy for 2014–2023 had supported countries in building the knowledge base for developing national policies and regulations, however there were fewer such policies and programmes in his Region than in any other and many countries in the Region lacked proper regulation of traditional medicine practitioners, services or products. He recommended that the World Health Assembly should adopt the draft WHO traditional medicine strategy: (2025–2034) which incorporated broader approaches to the topic while stressing the importance of better regulation for the safety and quality of traditional medicine practitioners and products. Regular updates on its implementation should be provided in 2030 and 2034, as proposed in the draft decision.

The representative of AUSTRALIA welcomed the draft strategy's vision of universal access to safe, effective and people-centred traditional complementary and integrated medicine, respecting indigenous and ancestral medicine for health and well-being. His Government supported the draft

strategy's central focus on guaranteeing patient safety and ensuring that treatments were underpinned by research, data and regulation.

The representative of ZIMBABWE, speaking on behalf of the Member States of the African Region, welcomed the draft strategy, to which they had contributed through regional consultations. His Region acknowledged the significant contribution traditional medicine could make to healthcare systems worldwide and had developed a plan of action within the African Union in that area. Nonetheless, traditional medicine in the Region was still confronted by issues such as mistrust among stakeholders; scarcity of research and data in national health systems; inadequate financing; weak regulatory mechanisms; deficient education and training; lack of recognition of traditional health practitioners and limited safety monitoring capacity. He called on Member States, international partners and stakeholders to support implementation of the draft strategy and the regional plan of action, requesting the Board's assistance in mobilizing resources to support the development of traditional medicine.

The representative of the DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA welcomed the draft strategy and its four strategic objectives, highlighting the third objective on integrating safe and effective traditional medicine into health systems, especially at the primary healthcare level. She recommended that the Secretariat should continue to provide technical support to Member States by setting out standards and technical guidance on research, regulation and integration of traditional medicine into national health systems, considering the diversity of traditional medicine worldwide. Her Government agreed that traditional medicine should actively contribute to promoting health.

The representative of CHINA, welcoming the draft strategy and its four strategic objectives and appreciating the active participation of Member States in its development, called for stronger legal regulation, including on the need for prior informed consent and benefit-sharing agreements before the facilitation of access to traditional knowledge. She called for the draft strategy to promote international cooperation on traditional medicine research, in particular by encouraging Member States to register clinical trials on the WHO International Clinical Trials Registry Platform with a view to enhancing the scientific evidence for traditional medicine. Equally, the strategy should combine traditional medicine with modern medical education and facilitate exchanges on traditional medicine through international conferences to promote sustainable development of the global health system.

The representative of POLAND, speaking on behalf of the European Union and its Member States, said that the candidate countries North Macedonia, Montenegro, Serbia, Albania, the Republic of Moldova, Bosnia and Herzegovina and Georgia, as well as Armenia, aligned themselves with his statement. Acknowledging the importance of protecting traditional medicine in its diversity, he called for clarity on the subject matter to avoid promoting ineffective or harmful practices under a vague umbrella term or undermining WHO's unique status as a science- and evidence-based organization. There was a difference between safeguarding traditional medicine and integrating it into medical systems. Without delegitimizing those practices, Member States should therefore implement the draft strategy based on their specific regional and cultural factors and legal frameworks.

In the light of resource limitations, he highlighted the importance of focusing on high-impact global health outcomes and common standards to avoid duplicative work and allow comparisons between studies and practices. Any such standards should adhere to the principles of safety, effectiveness and scientific and ethical rigour, including the preservation of endangered species. He requested further guidance on including traditional, complementary and integrative medicine

in cross-sector policies such as the One Health Joint Plan of Action (2022–2026): Working together for the health of humans, animals, plants and the environment. While including traditional knowledge to guide One Health decision-making remained essential, it should not undermine the One Health approach's scientific purpose or cause confusion regarding its aim and operationalization. Since there could be significant economic interests involved in traditional, complementary and integrative medicine, he called for due diligence when engaging with the industry and practitioners in line with the Framework of Engagement with Non-State Actors. Noting the significant developments – many of them improvements – in the draft strategy's text since the last Member State consultation, the European Union and its Member States would have appreciated a more transparent and predictable process and were not at present ready to adopt the draft decision. He requested further consultation with Member States prior to its consideration by the Health Assembly.

The representative of the REPUBLIC OF KOREA, sharing information on initiatives in his country, welcomed the draft strategy, calling for international cooperation to establish a system for verifying the safety and effectiveness of traditional medicine in order to achieve universal health coverage.

The representative of TOGO, welcoming the vision, objectives and guiding principles of the strategy, called for the Secretariat and Member States to encourage collaboration between traditional medicine practitioners and conventional health workers to improve primary health coverage; develop and implement robust regulations ensuring the safety and quality of traditional medicines; and integrate traditional medicine into health systems, officially recognizing traditional medicine practitioners as health workers. There was a need to encourage evidence-based traditional medicine research and development, improve access to traditional medicines, strengthen local industries and promote entrepreneurship, innovation and local production. Scaling up resource mobilization and partnerships to develop traditional medicine was also key.

The meeting rose at 17:40.

Thirteenth meeting

Friday, 7 February 2025, at 18:10

Chair: Ms B. Schedler Fischer (Switzerland)

Pillar 1: One billion more people benefiting from universal health coverage (continued)

1. Draft global traditional medicine strategy (2025–2034): Item 13 of the agenda (documents EB156/16 and EB156/16 Add.1) (continued)

The CHAIR recalled that the Board had before it a draft decision, which was contained in document EB156/16.

The representative of BRAZIL said that the integration of traditional, complementary and integrative medicine into national health systems would serve, among other things, the recognition of medicines and cultural rights of Indigenous Peoples. It would also prove useful in the prevention and treatment of diseases. The integration of socially embedded knowledge with science and innovation would make health services more accessible and support sustainable development.

The representative of THAILAND commended the vision, guiding principles and strategic directions of the draft WHO traditional medicine strategy: 2025–2034 and the Secretariat's continued engagement with Member States. The registration of clinical trials should not be limited to those contained in the International Traditional Medicine Clinical Trial Registry; other international registries recognized by WHO should be included when building an evidence base, while ensuring data interoperability across registries. Successful implementation of the strategy would hinge on robust monitoring and evaluation mechanisms, with measurable indicators to track progress and adapt to emerging trends, and the mid-term review in 2023 was useful in that regard. An additional briefing session for Member States on the draft strategy prior to the Seventy-eighth World Health Assembly could be useful.

The representative of NORWAY said that the term "evidence-based" failed to distinguish between the rigorous regulatory processes for approval and use of medical products, and the preparation for the use of traditional and complementary medicine. Blurring that distinction could work against WHO's normative functions and regulatory capacities in developing evidence-based technical guidance. Established guidelines and best practices, not "innovative approaches", must be used to build the evidence base for integrating traditional medicine into health systems. Further internal consultations were needed to align the draft with established practice. As it stood, her Government would not be in a position to implement most of the recommendations contained in the strategy, as they were incompatible with the underlying principles of the country's health system.

The representative of CHILE said that she was pleased that the draft strategy recognized health as a human right and took into account the diverse realities encompassed by traditional, complementary and integrative medicines around the world. The use of high quality, effective traditional medicines and practices would improve health outcomes. The document was in alignment with domestic plans and priorities.

The representative of ETHIOPIA said that, notwithstanding the benefits of traditional medicine, it was important to acknowledge the challenges posed by unregistered practitioners, the absence of a traditional medicine curriculum, and the marketing of products that failed to comply with regulatory requirements. Further research and clinical trials were needed to provide scientific validation of the quality and safety of traditional medicine. Efforts were also needed to enhance training, build an evidence base and expand local production capacities.

The representative of FEDERATED STATES OF MICRONESIA said that the use of traditional medicine in his country was currently based on custom and Indigenous knowledge. The technical support provided by WHO to develop domestic strategies for the integration of traditional medicine into the health system would advance universal health coverage.

The representative of LESOTHO welcomed WHO's sustained commitment to the promotion of traditional medicine. As an affordable, culturally accepted option, traditional medicine could help to remove barriers to healthcare in rural and underserved communities. Efforts to promote the safety, effectiveness and quality of traditional medical products through regulation, research and collaboration with traditional practitioners were commendable. Evidence-based use in line with overarching health goals and capacity-building were crucial. To safeguard the rights of Indigenous knowledge-holders, transfer of knowledge must occur through appropriate intellectual property and benefit-sharing mechanisms.

The representative of COLOMBIA[1] said that, while she supported the overall objectives of the draft strategy, reference should be made to the need to train health workers in intercultural approaches, preserve cultural practices through intercultural dialogue around knowledge transfer, and involve Indigenous knowledge-holders in decisions on how such knowledge should be documented and registered.

The representative of SRI LANKA[1] welcomed the tireless efforts by WHO and others to promote the integration of traditional, complementary and integrative medicine into mainstream health systems. In doing so, issues around effective resource management, protection of traditional knowledge of Indigenous and local communities, cultivation of medicinal plants for commercial use, and manufacturing of traditional medicine products should be taken into account. Regulatory frameworks and monitoring systems would be needed to ensure the quality and safety of traditional medicines.

The representative of MEXICO[1] said that legal safeguards were needed to protect the social and cultural rights of Indigenous Peoples when using and marketing their traditional medicines, with due respect for their knowledge and decisions. It was important to enhance the visibility of traditional Indigenous medicine and develop it further, including by training new generations of Indigenous practitioners. The strategy must affirm Indigenous Peoples' autonomy and ownership of their traditional medicine as a model in its own right, and must not be subsumed or subordinated to the conventional medical model. Guidance and policies should be developed to

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

create links between traditional and mainstream systems and services. Health workers must be trained to deliver intercultural, integrated services.

The representative of SINGAPORE[2] supported the strategic directions and objectives of the draft strategy, the focus on evidence-based integration, and the proposed establishment of regulatory mechanisms. Without such safeguards, the integration of traditional medicine into health systems could conflict with mainstream medical practices, increasing costs and compromising healthcare. The use of traditional medicine should be limited to a select number of diseases and adapted to the unique context, health system and cultural landscape of each country. Patient safety, efficacy and cost-effectiveness were paramount.

The representative of the KINGDOM OF THE NETHERLANDS[2] said that the safe and effective use of traditional medicine required a One Health approach. The implications for human, animal and environmental health, and environmental sustainability and biodiversity must also be considered. Member States must engage in safe manufacturing and trading practices, minimize the risk of infectious zoonotic diseases associated with the production of, and trade in, animal-derived traditional medical products, and combat illegal trade.

The representative of BELGIUM[2] said that, while she was not opposed to a strategy on traditional medicine, the current draft provided insufficient guarantees of safety, effectiveness and scientific rigor. The traditional and the biomedical models must be held to the same standards. Particular attention must be paid to the protection of endangered species. Given WHO's important role in countering misinformation and disproven practices, further consultations were needed on the content of the draft, and its financial implications, prior to its submission to the Health Assembly.

The representative of ECUADOR[2] said that, in her country, the integration of traditional medical practices was part of broader efforts to provide culturally sensitive healthcare. Close cooperation with Indigenous and traditional knowledge-holders and due respect for their worldviews and collective rights were paramount, and designated mechanisms could support those processes.

The representative of PARAGUAY[2] said that the integration of traditional, complementary medicine was key to achieving universal health coverage and promoting a people-centred, integrated approach. The draft strategy aligned well with her country's own approach to Indigenous health. An intercultural approach based on equity and respect for Indigenous worldviews, and close engagement with Indigenous Peoples and communities were essential. If sufficiently resourced, the implementation of the global strategy could help to pave the way to universal, inclusive and culturally sensitive healthcare.

The representative of INDIA[2] said that the WHO Global Centre for Traditional Medicine, in Gujarat, would provide crucial support for Member States to develop national traditional medicine policies and action plans. The Centre would focus on ensuring the quality, safety, efficacy, accessibility and rational use of traditional medicine, develop standards and tools to that end, collect data and assess impact. In order to harness traditional medicine for the overarching goal of universal health coverage, it must be of good quality, affordable and administered by trained staff. Member States should be free to enter clinical trials in any clinical trial registry linked with the primary registries in the WHO network, a list of which could be annexed to the strategy.

[2] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of OMAN[3] emphasized the importance of registration standards, good manufacturing practices, accurate laboratory analyses to ensure that traditional medicines were free of steroids, pesticides and heavy metals, and compliance with the International Pharmacopeia. Alcohol content must also be considered. Looking ahead, further scientific research, unification of international standards and regulations for traditional medicines, training, and building of domestic capacities to implement traditional medicine programmes would be crucial. The Secretariat should facilitate strong global and regional cooperation for the detection of fake products, and sharing of data and best practices. It should also develop guidelines and deliver technical support for national implementation.

The representative of the PLURINATIONAL STATE OF BOLIVIA[3] said that the draft strategy was in line with domestic efforts to promote culturally sensitive medical care. The integration of traditional medicine into the health system must go hand in hand with legal recognition of the rights of Indigenous knowledge-holders, including the right to own and use their traditional medicines. The establishment of a database on traditional medicines and practices must be subject to extensive prior consultations with Indigenous knowledge-holders. All programmes and plans derived from the strategy must include an intercultural perspective, foster inclusive, culturally appropriate healthcare in line with country-specific priorities, and be respectful of traditional practitioners.

The representative of MALAYSIA[3] welcomed the recognition of the need for fair and equitable sharing of the benefits arising from the use of traditional medical knowledge. Any access to traditional knowledge must be subject to prior and informed consent; existing access and benefit-sharing frameworks could be harnessed to that end. It was important to raise awareness among the scientific community of the ethical implications of collecting, sharing and developing traditional medicines. Data sovereignty, responsible information exchange in digital libraries and knowledge bases, and prior and informed consent to the publication of traditional knowledge were paramount. The draft strategy should be further refined prior to submission to the Health Assembly.

The representative of NAMIBIA[3] welcomed the emphasis on collaboration with traditional medical practitioners, knowledge-sharing, patient autonomy and safety. A reference should nevertheless be added to the draft strategy to encourage the use of countries' existing access and benefit-sharing regimes. Where there were none, they should be developed in close consultation with the competent regulatory authorities. Methods of documentation and registration of traditional medical knowledge and practices must ensure that the custodians of that knowledge could benefit. Like others, he saw a need for further refinement of the draft strategy.

The representative of ESWATINI[3] expressed appreciation for the emphasis on evidence-based research, quality assurance and adequate frameworks to ensure the safety and effectiveness of traditional medicine. Collaboration between traditional and modern medical practitioners was crucial to enable holistic healthcare delivery. Indigenous knowledge must be protected, its benefits shared equitably and local communities empowered. The integration of traditional medicine into individual health plans could improve outcomes and ensure culturally sensitive care. International partners should support countries in capacity-building, knowledge transfer and research, and countries' experiences in managing inclusive health systems could be shared.

[3] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of the UNITED REPUBLIC OF TANZANIA[4] said that the establishment of an evidence base must be a core strategic goal. Adequate resources, institutional partnerships and the leveraging of technology for the development and management of comprehensive databases were crucial. The use of traditional medicine must be properly regulated, safe and mindful of the sustainable management of resources. In addition, traditional practitioners should be trained in modern patient care and referral systems. Cross-sectoral cooperation with international organizations, regional bodies, and stakeholders to share best practices was critical.

The representative of INDONESIA[4] said that the draft strategy aligned well with her country's own regulatory framework for integrating traditional medicine into the health system. Comprehensive mapping, cross-sectoral collaboration and a robust evidence base were prerequisites for the development of safe and effective traditional medical products. By developing phytopharmaceuticals and including them in national health insurance policies, countries could strengthen the resilience of their health systems and move towards pharmaceutical self-reliance. The Secretariat must support Member States in tailoring the global strategy to domestic circumstances.

The representative of BANGLADESH[4] praised the Secretariat's support of his country's efforts to strengthen domestic regulations, advance in the integration of traditional medicine into the health system, develop a list of essential traditional medicines for inclusion in the national drug policy, and publish a pharmacopoeia of ayurvedic and homeopathic medicine and corresponding treatment guidelines. When discussing efficacy and safety, it was important to remember that the relevance of traditional medicines for recovery from illness predated the current dominance of allopathic medicine and had not disappeared. The WHO Global Centre for Traditional Medicine could herald a paradigm shift in the perception of traditional medicine and enable its full-scale commercialization. Countries required additional support to harness traditional medicine for achieving universal health coverage.

The representative of PERU[4] said that the draft strategy could only be implemented effectively if the knowledge and culture of Indigenous Peoples were respected and their cultural, social and territorial characteristics were recognized. She welcomed the specific actions designed to enhance collaboration between Member States' research and development institutions. The focus on political commitment, the support for a holistic approach to healthcare, and the call for cross-sectoral and intergovernmental cooperation were also commendable.

The Observer of PALESTINE, describing Palestine's rich heritage in using wild plant-based traditional medicine, said that WHO should sustain its efforts to promote traditional medicine and experiences from different cultures and Indigenous Peoples to complement modern medical models. The WHO Group of Friends of Traditional Medicine was an important platform for knowledge exchange.

The representative of the ISLAMIC REPUBLIC OF IRAN[4] said that he welcomed the Secretariat's commitment to support Member States in optimizing the safe and effective use of traditional, complementary and integrative medicine. Traditional medicine represented an important and often underestimated part of healthcare around the world. Executive Board sessions should serve as a forum for exchange on technical issues, not for discussion of the

[4] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Taiwan[5] question. There was only one China, the Government of which was the sole legal Government representing the whole of China.

The representative of the GLOBAL SELF-CARE FEDERATION, speaking at the invitation of the CHAIR, said that traditional and complementary medicines enhanced equity, access and self-care. Self-care should be placed at the heart of the draft strategy in order to empower people. The draft strategy's focus on safety and efficacy was commendable, as a well-regulated approach could help to transform healthcare delivery. Her organization looked forward to collaborating with WHO to maximize the draft strategy's global health impact.

The representative of the UNION FOR INTERNATIONAL CANCER CONTROL, speaking at the invitation of the CHAIR, welcomed the recognition of traditional, complementary and integrative medicine to enable accessible, culturally sensitive, patient-centred healthcare. Member States must establish and strengthen effective regulatory systems to ensure the safety, efficacy and quality of traditional practices and products, whose use should be aligned with cancer treatment guidance. Harmonized training programmes and comprehensive guidance for health workers, meaningful engagement of the noncommunicable disease community, and collaboration between traditional practitioners and biomedical communities were crucial.

The representative of KNOWLEDGE ECOLOGY INTERNATIONAL, INC., speaking at the invitation of the CHAIR, said that the draft strategy provided an opportunity to reorient healthcare towards a whole-person approach, and harness existing resources in times of uncertainty. Many evidence-based traditional and complementary approaches were already being integrated across the care continuum, but more research was needed. Indigenous medical knowledge played a key role in improving human and planetary health and well-being. Innovative intellectual property management models were needed to safeguard and harness Indigenous knowledge, balancing protection concerns with healthcare imperatives.

The representative of the WORLD FEDERATION OF ACUPUNCTURE-MOXIBUSTION SOCIETIES, speaking at the invitation of the CHAIR, said that a rich evidence base confirmed the efficacy of traditional, complementary and integrative medicine. Recent research demonstrated the quality, safety and efficacy of acupuncture in treating a wide range of mental health disorders. As the new evidence was being incorporated into international standards and protocols, incentives were needed to drive investment in further research. Traditional, complementary and integrative medicine must be integrated into primary healthcare to maximize its contribution to universal health coverage.

The representative of the UNITED STATES PHARMACOPEIAL CONVENTION, speaking at the invitation of the CHAIR, said that, although traditional, complementary and integrative medicine played an important role in health systems worldwide, there was little global consensus on its scope, definitions or terminology. As ingredients for such medicines increasingly moved through complex international supply chains, transparent, science-based quality standards were paramount. WHO should explore ways to expand engagement with non-State actors to boost global collaboration and regulatory alignment.

The ASSISTANT DIRECTOR-GENERAL (Universal Health Coverage/Life Course) said that the Secretariat had noted the importance Member States attached to the safety, quality and effectiveness of traditional, complementary and integrative medicine. It had also noted the emphasis placed on the need for regulatory processes and rigorous scientific research, and the

[5] World Health Organization terminology refers to "Taiwan, China".

requests for implementation in line with national and regional circumstances. Noting the comments on consultation, it was important to point out that the draft strategy had been developed in close consultation with all WHO units concerned. Still, the call for further consultation would be taken on board. The Secretariat had also taken note of the suggestions for improvements to the draft strategy and looked forward to engaging with Member States prior to the forthcoming session of the Health Assembly.

The CHAIR took it that the Board wished to note the report contained in document EB156/16.

The Board noted the report.

The CHAIR took it that the Board wished to postpone the adoption of the draft decision on the global traditional medicine strategy: 2025–2034 pending the outcome of the broader discussion on the costing implications of resolutions and decisions recommended by the 156th session of the Executive Board for adoption by the Seventy-eighth World Health Assembly.

It was so agreed.

(For the continuation of the discussion and adoption of a decision, see the summary record of the eighteenth meeting, section 7.)

2. Global Strategy for Women's, Children's and Adolescents' Health: Item 14 of the agenda (document EB156/17)

The CHAIR drew attention to the report contained in document EB156/17. She also invited the Board to consider two draft decisions. The first draft decision, which contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly, on incorporation of the World Prematurity Day into the WHO calendar, to strengthen approaches to prevent preterm births and treat and care for preterm infants, was proposed by Brazil, Eswatini, Lesotho, Namibia, South Africa, the United Republic of Tanzania, Zambia and Zimbabwe. The draft decision read:

> The Executive Board, having considered the report by the Director-General,[6]
>
> Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following resolution:
>
> > The Seventy-eighth World Health Assembly,
> >
> > (PP1) Having considered the report on the Global Strategy for Womens', Children's and Adolescents' Health;
> >
> > (PP2) Reaffirming the commitment made in the 2030 Agenda for Sustainable Development, including to end preventable deaths of newborn and children under 5 years of age;
> >
> > (PP3) Recalling the resolution WHA69.2 (2016) on committing to the implementation of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030);[7]

[6] Document EB156/17.

[7] https://data.unicef.org/wp-content/uploads/2017/02/EWEC_globalstrategyreport_200915_FINAL_WEB.pdf.

(PP4) Noting with concern that infants who are born preterm or small for gestational age or who are born sick or who become sick are at significant risk of post neonatal mortality, long-term development impairment, life-long disability, stunting and noncommunicable diseases. And also noting that globally 2.3 million infants died in the first 28 days of life in 2022. Approximately 80% of these have low birth weight, and two thirds are born preterm. In addition, each year, an estimated 1 million small and sick newborns survive with a long-term disability, including cerebral palsy and cognitive delays;[8]

(PP5) Recognizing that we are still far from our goal of reducing neonatal mortality rate to at least as low as 12 per 1000 live births, by 2030 in all countries and that countries need to strengthen newborn care to meet the SDG 3.2.2 target for newborn survival;[9]

(PP6) Acknowledging that resolution WHA77.5 (2024) called for Member States to accelerate progress towards reducing maternal, newborn and child mortality, by promoting access to affordable quality and respectful antenatal, intrapartum and postnatal care, especially for adolescent mothers who face higher risk of eclampsia, puerperal sepsis, endometriosis and babies of adolescent mothers who face higher risks of low birth weight, preterm birth and severe neonatal conditions by scaling up affordable quality essential newborn care services for every newborn and investing in special care units for small and sick newborns at the district level;[10]

(PP7) Noting that preterm birth is defined as a birth that happens before 37 completed weeks of pregnancy,[11] also that an estimated 13.4 million babies were born preterm and the preterm birth rate varied from 4 to 16% across countries in 2020, that preterm birth complications are the leading cause of death among children under 5 years of age, and that three quarters of these deaths could be prevented with current, cost-effective interventions;

(PP8) Acknowledging that while preterm births are a global concern the majority of preterm births occur in southern Asia and sub-Saharan Africa, and there is a dramatic difference in the survival of preterm infants depending on where they are born. For example, more than 90% of extremely preterm infants less than 28 weeks born in low-income countries die within the first few days of life, yet less than 10% of extremely preterm infants die in high-income settings; [9]

(PP9) Recognising WHO's global position paper and its implementation strategy establishing Kangaroo Mother Care (KMC) as a transformative innovation in healthcare and noting that KMC can be provided by all care givers;

(PP10) Taking note of the WHO's 2022 recommendations for care of the preterm or low-birth weight infant which promote preventive and promotive care for complications and the role of family or care giver involvement and support networks;

(PP11) Appreciating the role that World Prematurity Day on 17 November has to raise awareness of the global challenges and burden of preterm birth. The day was initiated by the European Foundation for the Care of Newborn Infants (EFCNI) and partnering European parent organizations in 2008. The international co-founders

[8] Survive and thrive: transforming care for every small and sick newborn. Geneva: World Health Organization; 2019. Licence: CC BY-NC-SA 3.0 IGO.

[9] Survive and thrive: transforming care for every small and sick newborn. Geneva: World Health Organization; 2019. Licence: CC BY-NC-SA 3.0 IGO.

[10] apps.who.int/gb/ebwha/pdf_files/WHA77/A77_R5-en.pdf.

[11] https://icdcdn.who.int/icd11referenceguide/en/html/index.html#period-of-gestation.

LittleBigSouls (Africa), March of Dimes (USA), and National Premmie Foundation (Australia) joined the celebrations and made World Prematurity Day an intercontinental movement. Meanwhile, countless individuals and organizations from more than 100 countries join forces with activities and special events and commit to action to help to address preterm birth and improve the situation of preterm infant and their families;

(PP12) Acknowledging that not all WHO Member States commemorate World Prematurity Day and that in the countries that do so, it is not a national event, but individuals or nongovernmental organizations lead it,

(OP)1. URGES Member States in line with their national context and priorities:[12]

(1) to commemorate World Prematurity Day in an appropriate manner to create awareness, promote health education, evidence-based and cost-effective clinical guidance and policies, advocacy, and resource mobilization for preterm birth prevention and care of preterm infants;

(2) to collaborate with relevant local, national and international stakeholders on the World Prematurity Day events, to promote perinatal and newborn care including scale-up of newborn care interventions, clinical and public health guidance, research, and dissemination of the findings, as appropriate;

(3) to implement the WHO's 2022 guidelines which promote preventive and promotive care for complications and the role of family or caregiver involvement and support networks;

(4) to strengthen preventive and curative strategies by facilitating universal access to sexual and reproductive healthcare services including for family planning, evidence-based, relevant and timely information and education, and the integration of reproductive health into national strategies and programmes including primary healthcare services with particular emphasis on addressing risk factors of preterm birth;

(5) to plan, implement, and monitor lifesaving interventions and technologies such as, but not limited to, essential newborn care interventions, zero separation, breastfeeding, care for the small and sick newborn, safe use of oxygen, including use of continuous positive airway pressure (CPAP) machines and availability of quality assured medicines, including antibiotics and caffeine citrate and surfactant and screening for retinopathy of prematurity as appropriate for each level of care, whether at the primary level including the community, secondary hospital care level or tertiary care level as defined by each national health system;

(6) to consider establishing comprehensive follow-up packages for the small and sick newborns, including hearing and visual screening, and neurodevelopmental assessment across all the levels of the system;

(7) to consider integration of preterm infant care into a basic package of health services under universal health coverage with relevant funding arrangements so as to reduce the financial burden associated with preterm infant care;

(8) to recognize Kangaroo Mother Care (KMC) method as a cost-effective, efficient and safe strategy for the care of preterm and low birth weight infants and to implement and resource KMC, provided by the caregiver within health facilities or at home, as an essential standard of care that should be offered to all

[12] And, where applicable, regional economic integration organizations.

preterm infants, together with early initiation and exclusive breastfeeding and other evidence-based, cost-effective, life-saving interventions;

(9) to provide healthcare workers with comprehensive training on developmental care for preterm infants, including the health benefits of breastfeeding, and ensure the implementation of the International Code of Marketing of Breast-milk Substitutes to safeguard and promote optimal feeding practices in neonatal care units;

(10) to implement community-based support programmes and interventions that offer evidence-based guidance and emotional, psychological, financial, material and administrative support for families of preterm infants, helping them to navigate the unique challenges associated with preterm birth;

(11) to consider establishing or reviewing national and local laws, regulations, and standards on leave for parents and caregivers, and related benefits that support taking care of a preterm infant;

(OP)2. REQUESTS the Director General:

(1) to incorporate World Prematurity Day into the WHO calendar to commemorate World Prematurity Day in an appropriate manner to raise national and global awareness, promote health education, evidence-based and cost-effective clinical guidances and policies, research and resource mobilization for prevention of preterm birth and care of preterm infants;

(2) to support Member States in strengthening national information systems that contribute to tracking the progress of global and national preterm birth rates and associated mortality and morbidity to help to address funding gaps and develop evidence-based policies, programs and strategies;

(3) to support countries in developing and aligning their national health action plans, including implementation costing, to achieve their preterm-birth-related morbidity and mortality-reduction targets;

(4) to collaborate with relevant stakeholders in line with FENSA, as applicable, including through the Every Woman Every Newborn Everywhere (EWENE) initiative to strengthen technical assistance and programmatic support for preventing preterm births and providing care for preterm infants, helping countries to scale up high-impact interventions and strengthen their health systems, including healthcare workers and community-level care;

(5) to promote standard definitions and advance sufficiently detailed metrics for measuring preterm birth outcomes, alongside other Reproductive, Maternal, Newborn, and Child Health (RMNCH) outcomes;

(6) to report back to the Health Assembly on this resolution as part of the biennial substantive reporting on the Global Strategy for Women's Children's and Adolescents' Health with a special focus on the effectiveness of renewed efforts to accelerate achievement of SDG 3.2.2.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[13]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:
1.1.3. Countries enabled to strengthen their health systems to address population-specific health needs and barriers to equity across the life course

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:
Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:
Not applicable.

4. Estimated time frame (in years or months) to implement the decision:
Six years (2025–2030 in line with the Sustainable Development Goals, potentially longer depending on post-2030 goals and targets).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:
Zero.

The work requested to implement the decision was already costed in respect of the implementation of resolution WHA77.5 (2024) (see Extracts from document WHA77/2024/REC/1 for consideration by the Executive Board at its 156th session, Annex 4). Further, many country offices in high newborn mortality burden countries are already implementing World Prematurity Day together with WHO, the relevant health ministries and partners.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:
Not applicable.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:
Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:
Not applicable.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:
Not applicable.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions

– **Financial resources available to fund the decision in the current biennium:**
Not applicable.

– **Remaining financing gap in the current biennium:**
Not applicable.

– **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Not applicable.

[13] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic "bridge" between results structures can be provided as needed.

The second draft decision, which contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly, on regulating the digital marketing of breast-milk substitutes, was proposed by Armenia, Bangladesh, Brazil, Burkina Faso, Chile, Colombia, the Dominican Republic, El Salvador, Guatemala, Iraq, Lesotho, Mexico, Norway, Panama, Paraguay, Peru, Slovakia, Spain, Sri Lanka, Uruguay and Vanuatu. The draft decision read:

> The Executive Board, having considered the report by the Director-General,[14]
>
> Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following resolution:
>
> > The Seventy-eighth World Health Assembly,
> >
> > (PP1) Having considered the report by the Director-General;
> >
> > (PP2) Recalling all previous resolutions on infant and young child nutrition, appropriate feeding practices and related questions, in particular resolutions WHA31.47 (1978), WHA33.32 (1980), WHA34.22 (1981), WHA35.26 (1982), WHA37.30 (1984), WHA39.28 (1986), WHA41.11 (1988), WHA43.3 (1990), WHA45.34 (1992), WHA46.7 (1993), WHA47.5 (1994), WHA49.15 (1996), WHA54.2 (2001), WHA55.25 (2002), WHA58.32 (2005), WHA59.21 (2006), WHA61.20 (2008), WHA63.23 (2010); WHA65.6 (2012); WHA69.9 (2016), WHA71.9 (2018), and relevant decisions including decisions WHA73(26) (2020) and WHA75(21) (2022);
> >
> > (PP3) Recognizing that the marketing of breast-milk substitutes and feeding bottles and teats and the inappropriate promotion of foods for infants and young children,[15] continue to significantly undermine progress in optimal infant and young child feeding;
> >
> > (PP4) Mindful of the United Nations Convention on the Rights of the Child, under which 196 States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and that State Parties shall take appropriate measures to ensure that all segments of society, in particular parents and children are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, and the advantages of breastfeeding as emphasized under Article 24 of the Convention;
> >
> > (PP5) Emphasizing that protecting, promoting and supporting breastfeeding as well as ensuring the protection of children's and women's rights from harmful effects and interference of marketing by breast-milk substitute manufacturers and distributors are both relevant for the implementation of States Parties' commitments under the United Nations Convention on the Rights of the Child;
> >
> > (PP6) Noting the conclusions of recent evidence on the marketing of breast milk substitutes, including recognizing that digital technologies have created powerful new marketing tools for the promotion of breast milk substitutes, and the needs to strengthen the implementation of the International Code of Marketing of Breast-milk Substitutes;

[14] Document EB156/35.

[15] Foods for infants and young children are defined as commercially produced food or beverage products that are specifically marketed as suitable for feeding children from the age of 6 months to 36 months, accordingly with the Guidance on ending the inappropriate promotion of foods for infants and young children.

(PP7) Recognizing that digital marketing, including influencer marketing, has become the dominant form of marketing in many countries;[16] that when not effectively regulated, it leads to harmful impact on public health; and that parents and caregivers in every country of the world are exposed to direct and indirect promotions of breast-milk substitutes;

(PP8) Expressing deep concern over inappropriate digital marketing strategies used by manufacturers and distributors of breast-milk substitutes, feeding bottles and teats, and food for infants and young children to target pregnant women, parents and caregivers, as well as health professionals, including with personalized content;

(PP9) Noting the importance of ensuring that information on infant and young child feeding available to health professionals and consumers is unbiased, objective, evidence-based, free of conflicts of interest and in accordance with WHO recommendations;

(PP10) Expressing also further concern over challenges that digital marketing, including influencer marketing, presents for the development, monitoring and enforcement of national regulatory measures aimed at restricting promotion and advertising of breast-milk substitutes and ending the inappropriate promotion of foods for infants and young children, including cross-border digital marketing strategies and practices;

(PP11) Aware that effective application of the International Code of Marketing of Breast-milk Substitutes[17] to digital environments requires the development of national regulatory mechanisms, coordination across a broader set of government bodies within Member States, as appropriate, and between Member States, as appropriate, and the establishment of specific legal duties on the range of entities involved in digital marketing, including influencer marketing, along with effective, proportionate deterrent sanctions and disincentives for non- compliance with any established mandatory regulatory measures;

(PP12) Reiterating the need for good governance practices that include safeguards against possible conflicts of interest when developing and implementing regulatory measures to regulate the digital marketing of breastmilk substitutes, the need for mandatory regulatory measures as voluntary measures have proven ineffective or insufficient for the implementation of the International Code of Marketing of Breast-milk Substitutes,[18] and the importance of ensuring that effective monitoring and enforcement systems are developed to function in a transparent, and independent manner that is free from commercial influence;

(PP13) Underscoring the need for technical support for Member States on regulatory measures aimed at restricting digital promotion and advertising of breast-milk substitutes, feeding bottles and teats and ending the inappropriate digital promotion of foods for infants and young children, so as to ensure that such practices are adequately addressed by the existing and new national regulations designed to implement the International Code of Marketing of Breast-milk Substitutes, as well as the Guidance on Ending Inappropriate Promotion of Foods for Infants and Young

[16] See Scope and impact of digital marketing strategies for promoting breastmilk substitutes. Geneva: World Health Organization; 2022.

[17] International Code of Marketing of Breast-Milk Substitutes.

[18] See WHO guideline on Policies to protect children from the harmful impact of food marketing.

Children[19] and the Guidance on regulatory measures aimed at restricting digital marketing of breast-milk substitutes,[20]

(OP)1. CALLS ON Member States,[21] in accordance with national context and priorities:

(1) to enhance their efforts to develop and strengthen robust regulatory measures to regulate the marketing of breast-milk substitutes and foods for infants and young children, including in digital environments, taking into full consideration the recommendations contained in the Guidance on regulatory measures aimed at restricting digital marketing of breast-milk substitutes;[22]

(2) to build and strengthen their monitoring systems and technologies to identify and report on marketing of breast-milk substitutes and foods for infants and young children and strive to ensure that such systems are sufficiently equipped to detect inappropriate marketing practices in digital environments;

(3) to identify, empower, coordinate and strengthen all appropriate government agencies responsible for domestic implementation and monitoring of the International Code of Marketing of Breast-milk Substitutes, the Guidance on Ending Inappropriate Promotion of Foods for Infants and Young Children and the Guidance on regulatory measures aimed at restricting digital marketing of breast-milk substitutes;

(4) to engage all appropriate government agencies responsible for regulating advertising, marketing content, and communication technologies to ensure effective regulation across all areas and to carry out the necessary inspection, monitoring, and control processes;

(5) to safeguard against conflicts of interest in the development, implementation, monitoring and evaluation of regulatory measures to enact and implement the International Code of Marketing of Breast-milk Substitutes, the Guidance on Ending Inappropriate Promotion of Foods for Infants and Young Children and the Guidance on regulatory measures aimed at restricting digital marketing of breast-milk substitutes;

(OP)2. CALLS ON civil society to support the development and implementation of robust regulatory measures to regulate the digital marketing of breast-milk substitutes and foods for infants and young children;

(OP)3. REQUESTS the Director-General:

(1) to provide technical support to Member States, upon request, in implementing the recommendations of the Guidance on regulatory measures aimed at restricting digital marketing of breast-milk substitutes, as well as in monitoring and evaluating their application, including through the implementation of new or existing monitoring tools;

(2) to compile national experiences, challenges faced and lessons learned related to implementing the recommendations of the Guidance on regulatory measures aimed at restricting digital marketing of breast-milk substitutes through, including

[19] Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children.

[20] Guidance on regulatory measures aimed at restricting digital marketing of breast-milk substitutes.

[21] And, where applicable, regional economic integration organizations.

[22] While taking into account international obligations, as applicable.

but not limited to, regional consultations, in order to summarize new or existing evidence on their effectiveness and consider changes, if required;

(3) to report back to the Health Assembly on the implementation of this resolution, as part of the report on progress in implementing the comprehensive implementation plan on maternal, infant and young child nutrition in 2028.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[23]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:

3.1.2. Countries enabled to strengthen equitable access to safe, healthy and sustainably produced foods through a One Health approach

3.2.1. Countries enabled to address risk factors through multisectoral actions

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:

Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:

Not applicable.

4. Estimated time frame (in years or months) to implement the decision:

Twelve months (May 2025–May 2026).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:

US$ 0.66 million.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:

US$ 0.32 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:

Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:

US$ 0.34 million.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:

Not applicable.

[23] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic “bridge” between results structures can be provided as needed.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions

– **Financial resources available to fund the decision in the current biennium:**
US$ 0.34 million.

– **Remaining financing gap in the current biennium:**
Not applicable.

– **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Not applicable.

Table. Breakdown of estimated resource requirements (in US$ millions)

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.02
	Activities	0.00	0.00	0.00	0.00	0.05	0.05	0.20	0.30
	Total	0.00	0.00	0.00	0.00	0.05	0.05	0.22	0.32
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.03	0.03
	Activities	0.00	0.00	0.00	0.00	0.05	0.05	0.21	0.31
	Total	0.00	0.00	0.00	0.00	0.05	0.05	0.24	0.34
B.4. Future bienniums cost of resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.1. Total planned costs required to implement the decision									0.66

The representative of BRAZIL said that, in order to accelerate progress in reducing maternal, neonatal and child mortality, intersectoral policies were needed that promoted human rights, tackled the social determinants of health, and ensured universal access to healthcare, especially for vulnerable populations. Although the health benefits of exclusive breastfeeding were well known, the International Code of Marketing of Breast-milk Substitutes had yet to be fully implemented despite its adoption 40 years earlier. New challenges were arising from digital marketing of such products, which exposed caregivers and health professionals to direct and indirect promotion of breast-milk substitutes, further increasing public health risks. The draft decision sought to address those challenges through effective regulation.

The representative of LEBANON said that the gaps in data on mass population movements might distort statistics on maternal and child mortality and make progress less visible. In her country, the decrease in the number of hospital births among refugee populations and the failure to register live births had led to a false increase in child and maternal mortality rates. Data governance strategies must be adjusted to take account of the growing number of people on the move worldwide, and civil registration and vital statistics systems must be adapted to allow for the registration of community births and deaths and ensure accurate figures.

The representative of THAILAND said that poor reproductive, maternal, neonatal and child health outcomes, especially in low-income countries, were partly owing to a lack of public investment in health systems. Where donor priorities did not align with countries' priorities, universal health coverage could only be achieved through public investment in the health and social sectors. Alignment of health-related development assistance with national priorities was as crucial as good governance and support from international partners. He supported the draft decision on regulating the digital marketing of breast-milk substitutes.

The representative of ETHIOPIA, speaking on behalf of the Member States of the African Region, said that countries in sub-Saharan Africa, in particular, required additional support to expand maternal, newborn, child and adolescent health services to reduce maternal, newborn and child mortality. While the Secretariat's work on guidelines and monitoring was commendable, more high-impact interventions were needed to address inequalities among countries, advance the Every Woman, Every Newborn, Everywhere initiative, and support local capacity-building and ownership of programmes. Close cooperation among Member States and with other United Nations agencies and humanitarian actors was crucial, especially in regions where maternal and child mortality and morbidity rates were disproportionately high. His Region supported the draft decision on the World Prematurity Day and the draft decision on the regulation of digital marketing of breast-milk substitutes.

The representative of POLAND, speaking on behalf of the European Union and its Member States, said that the candidate countries North Macedonia, Montenegro, Serbia, Albania, Ukraine, the Republic of Moldova, Bosnia and Herzegovina and Georgia, as well as Armenia aligned themselves with the statement. As progress towards better health outcomes for women, children and adolescents was stagnating and mortality and morbidity rates remained unacceptably high. Member States must remain committed to advancing collectively towards the relevant targets of the Sustainable Development Goals. Promoting healthy lifestyles and overcoming all forms of malnutrition was important in that regard. While WHO was doing its best to provide guidance, tools and country support for better health outcomes, health emergencies, crises, poverty, conflict and climate hazards placed a growing number of people at risk of disease, injury and death. Pregnant women and newborns were among the most vulnerable during crisis situations and expanding equitable access to healthcare services must be a priority.

Access to education for women, children and adolescents and training for health workers were crucial. In times of widespread misinformation, WHO must collect data and produce evidence-based guidance on sexual and reproductive health. Full and effective implementation of the Beijing Declaration and Platform for Action, the International Conference on Population and Development and the outcomes of the respective review conferences must remain high on the agenda. The right of every individual to decide freely on matters related to their sexuality and sexual and reproductive health must be respected at all times. WHO should advocate for the transformation of social norms that prevented women and girls from enjoying their rights and hampered access to high-quality, safe and effective healthcare. The costs and workloads associated with adding additional "Health Days" to the WHO calendar should be discussed in depth.

The representative of SOMALIA, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that he was grateful for WHO's leadership in the implementation of the Every Woman, Every Newborn, Everywhere initiative and the Child Survival Action initiative, among other things. Greater investment was also needed in early childhood development and adolescent well-being. Collaboration was crucial in addressing the challenges related to conflict, fragile health systems and socioeconomic disparities. Resolution WHA77.5 (2024) on accelerating

progress towards reducing maternal, newborn and child mortality was expected to lend additional momentum to efforts that area of work. Given that premature birth remained a leading cause of neonatal mortality, his Region supported the inclusion of the World Prematurity Day in the WHO calendar. It also supported the adoption of the draft decision on regulating the digital marketing of breast-milk substitutes.

The representative of SLOVAKIA said that a multisectoral approach was needed to promote exclusive breastfeeding for at least the first six months of life. Member States should endeavour to exceed the target of 50% exclusive breastfeeding by 2025. The establishment of multidisciplinary health hubs in underserved communities could help to address inequalities through various initiatives, such as holistic childhood development support. Existing initiatives could be expanded to include comprehensive metrics on breastfeeding, maternal mental health and overall well-being to generate a greater understanding of early childhood health outcomes. Global and regional knowledge-exchange platforms could facilitate the effective adaptation of global strategies to local and regional contexts. Health data systems and paediatric disease registries should be harmonized to improve data quality, inform domestic policy-making, and enable cross-country comparisons. Paediatric cancer care interventions must be a priority.

The representative of the REPUBLIC OF KOREA said that the Secretariat should issue guidance on effective prenatal interventions to address low birthweight and prematurity. The Every Woman, Every Newborn, Everywhere initiative could be expanded to include data on tried-and-tested interventions. Comprehensive health promotion across the life-course was important to advance towards the targets of the Sustainable Development Goals relating to women, child and adolescent health.

The representative of YEMEN, describing the consequences of the prolonged conflict in his country, said that the unprecedented humanitarian crisis had a disproportionate effect on women and children. There was extremely limited access to healthcare and the situation was compounded by cuts in humanitarian assistance. Despite those challenges, efforts continued to reduce child, neonatal and maternal mortality, and expand prenatal, birth and postnatal care services. His country was in dire need of international support to help children to survive and thrive.

The representative of CANADA said that better access to comprehensive sexual and reproductive healthcare, particularly in conflict areas and in low- and middle-income countries, was crucial to save lives and improve health outcomes for women, children and adolescents. Unsafe abortions were a leading yet preventable cause of maternal mortality and morbidity. Restricting access did not curb abortions, but rather increased the number of unsafe abortions and endangered women's lives. Health inequalities could only be addressed through leadership and enhanced cooperation between Member States and stakeholders at all levels. WHO must build on existing guidance and generate good quality data on sexual and reproductive health and rights, in close cooperation with the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction and other partners, to combat misinformation and disinformation.

The representative of BULGARIA said that access to maternal and child health services for vulnerable groups should be expanded, including through their more equitable geographic distribution. It was also important to mediate between users with access problems and health providers, step up social services, and build capacities to report and analyse inequalities. The Secretariat should support Member States in implementing tools and guidelines in line with country-specific circumstances, building capacities and improving information systems to monitor and report progress.

The representative of NORWAY said that the current pushback against women's sexual and reproductive health and rights was likely to exacerbate existing inequalities in access to services. Member States must continue to draw on evidence-based knowledge to inform political leadership at all levels. Comprehensive sexual and reproductive health services and rights for all, strong health systems, and universal coverage were critical.

The representative of MOROCCO said that adolescent health outcomes must be improved through better access to sexual and reproductive health interventions, especially in rural areas and for persons with disabilities. Interministerial action plans could facilitate a coherent and effective approach to adolescent health, and help to combat early marriage, unwanted pregnancies, sexually transmitted diseases and harmful traditional practices. Monitoring and follow-up must be improved through age-specific health indictors, and vulnerabilities associated with disability, geographic location and socioeconomic status must be taken into account. Awareness-raising and better sexual and reproductive health education at school and at home were crucial. Access to healthcare could be facilitated by integrating adolescent health services into primary healthcare and using telemedicine.

The representative of SENEGAL said that innovative high-impact strategies were needed to address challenges to maternal and child health. Family planning should be integrated into maternal, neonatal and child health and nutrition programmes and comprehensive early childhood care packages should be developed. High-quality, people-centred reproductive, maternal, neonatal and infant healthcare services, evidence-based strategies and policies, and better monitoring of maternal and perinatal deaths and the response were needed. Countries required technical support and additional funding to implement innovative approaches for better reproductive, maternal and child health.

The representative of AUSTRALIA said that the Sustainable Development Goals relating to maternal, child and adolescent health were moving out of reach, as women continued to experience unequal access to safe and affordable sexual and reproductive health services. Sexually transmitted infections among young people were on the rise and high out-of-pocket payments prevented people from accessing much needed care. Urgent action must be taken to accelerate progress and remove inequalities.

The representative of CHINA said that he wished to be added to the list of sponsors of the draft decision on World Prematurity Day. Reducing maternal, newborn and under-5 mortality must remain a strategic priority for WHO. Developing countries must be supported in establishing comprehensive, accessible and high-quality health services, special care units for critically ill pregnant women and newborns, and prenatal screening facilities. In order to tackle infant mortality associated with prematurity, health workers must be trained in maternity and paediatric care and hospital and follow-up care must be improved. It was crucial to share best practices in that regard.

The representative of CHILE said that public health tools were needed to facilitate the implementation of community-based programmes based on a life-course approach. Primary care must be expanded, and child and adolescent obesity must be addressed urgently, including by curbing advertising for unhealthy foods. Member States should share their experiences, knowledge and best practices to drive the maternal, child and adolescent health agenda towards and beyond 2030.

The representative of UKRAINE said that high maternal and child mortality rates, limited access to care, and uneven distribution of resources were particularly acute in low- and

middle-income countries and in areas of armed conflict, natural disasters and humanitarian crises. Those challenges could only be addressed through expanded programmes for women and child health, and better sexual and reproductive health education. International cooperation was crucial, and her Government appreciated the support provided by the Secretariat and other Member States.

The representative of MALDIVES said that women, children and adolescents in small island States were disproportionately affected by unequal access to essential health services. Gaps in coverage, quality and equity could only be closed through holistic approaches. Women must be empowered to participate in decision-making on their health, and women's education must be strengthened. Better health infrastructure in dispersed island communities would require, among other things, expanded primary care, a focus on prevention, training and capacity-building for health workers, and secure supply chains for essential medicines. More comprehensive health insurance schemes and lower out-of-pocket payments were crucial to reach marginalized communities. All those measures required political will, financial commitment and partnerships. The Secretariat should issue guidance on best practices and effective interventions, support capacity-building for health providers, policy-makers and community leaders, and help countries to mobilize financial resources.

The representative of CAMEROON said that adequate nutrition gave children a healthy start in life and a sound basis for development. Community-based nutrition strategies, nutrition education and monitoring of food quality were thus crucial. Malnutrition in mothers, children and young people must be tackled through cross-sectoral policies, in cooperation with local communities and international partners.

The representative of LESOTHO said that there was an urgent need to raise awareness of the disproportionately high rates of preterm mortality in low-income countries. The incorporation of the World Prematurity Day into the WHO calendar would be an important tool in that regard.

The representative of the FEDERATED STATES OF MICRONESIA said that there was a crucial need for greater investment in high-impact programmes for women, children and adolescents and better training for midwives, nurses and paediatricians. Public health programmes must be expanded to remove access barriers and reduce maternal and infant deaths. She wished to be added to the list of sponsors of the draft decision on World Prematurity Day.

The representative of FINLAND[24] said that investment in sexual, reproductive, maternal and child health services was key to reducing maternal, infant and child mortality. More must be done to ensure universal access to comprehensive sexual and reproductive health services, including adolescent-friendly health services, address harmful traditional practices, and build young people's agency around bodily autonomy and safe, healthy and future-proof choices.

The representative of SINGAPORE[24] said that strengthening primary healthcare to ensure equitable access to essential services, especially for underserved populations, was of paramount importance. Investment in maternal and newborn health must be stepped up, in particular to build skills around antenatal, birth and postpartum care. Addressing adolescent mental health problems and reducing stigma was also critical. Community-based interventions and comprehensive sexual and reproductive health education were needed to close the equity gap. WHO should advocate for universal access to reproductive, maternal, and adolescent health

[24] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

services and mobilize resources for countries most in need. Technical support, the sharing of best practices and guidance tailored to local contexts could be facilitated through the regional offices. At the country level, tools for monitoring inequalities should be used to help Member States to develop data-driven, evidence-based interventions.

The representative of MEXICO[25] said that providing guidance and information to the population was insufficient to fight malnutrition. Decisive action was needed to ensure the availability of healthy foods and promote exclusive breastfeeding. Aggressive digital marketing of breast-milk substitutes undermined child health and must be regulated to place the best interests of the child above commercial concerns.

The representative of PARAGUAY[25] said that the problems highlighted in the report could only be addressed through people-centred health policies that focused on universal access to sexual and reproductive health services. Monitoring was crucial to measure progress and identify gaps and areas where countries needed specific support. Aside from the much-needed technical support provided by the Secretariat, countries must prioritize high-impact interventions to meet the most pressing needs and sustain them over time.

The representative of SPAIN[25] said that her Government attached utmost importance to the right of all women to decide freely about their health, regardless of their place of residence, socioeconomic status, belief, sexual orientation or gender identity. Adequate regulatory frameworks were needed to protect women from sexual violence and allow them to exercise their sexual and reproductive rights. WHO played a key role in promoting and protecting those rights, which were key to the well-being of women and children around the world. In order to reduce child mortality, the social determinants of health and the double burden of malnutrition needed to be addressed. National policies were as important as WHO-led evidence-based, sustainable, equitable interventions and regulation. The health impact of violence against children, in particular gender-based violence, must also be addressed.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND[25] said that multisectoral approaches were needed to reduce maternal and newborn mortality. Health systems played a critical role in ending preventable maternal and infant deaths. Primary care packages should include comprehensive sexual and reproductive health and rights interventions and maternal, infant, child and adolescent health services, with a particular focus on underserved population groups.

The representative of KENYA,[25] speaking also on behalf of Armenia, Benin, Brazil, Colombia, Costa Rica, Moldova, Sierra Leone, Finland, Thailand and Spain, said that the alarming global prevalence of violence against children and its consequences required urgent attention. The first Global Ministerial Conference on Ending Violence Against Children, held in November 2024 in Bogotá, Colombia, had catalysed unprecedented political commitment to protect children. Drawing attention to, among other things, the prevalence, ramifications and costs of corporal punishment, participants had called for the adoption of prevention strategies. Building awareness around the public health impact of corporal punishment was crucial.

The representative of OMAN[25] said that establishing and strengthening surveillance and response systems for maternal and perinatal deaths was critical, and the Secretariat must support countries in establishing such mechanisms at the national and local levels. Training on obstetric

[25] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

emergencies must be strengthened, along with newborn screening, including for metabolic diseases, to help to reduce child mortality and morbidity.

The representative of SRI LANKA[26] said that strong legislation was needed to control unethical marketing of food and beverages and to regulate labelling and advertising, especially for products intended for mothers, infants and children. The emerging challenge of digital marketing of infant formula and products for young children could be tackled by expanding the scope of the International Code of Marketing of Breast-milk Substitutes, among other things.

The representative of FRANCE[26] said that efforts to reduce maternal and child mortality must focus, above all, on ensuring access to health services and combating all forms of malnutrition. she highlighted the Muskoka Initiative on Maternal, Newborn and Child Health as a key tool. Training health workers to deliver sexual and reproductive health interventions was also important. WHO should step up efforts to promote access to education for women and girls, including comprehensive sex education, and transform social norms that compromised the health and well-being of women and girls. The right to abortion should be upheld.

The representative of the UNITED REPUBLIC OF TANZANIA[26] said the incorporation of the World Prematurity Day into the WHO calendar could raise awareness and strengthen approaches aimed at reducing preterm birth complications and associated mortality in low-income countries.

The representative of PANAMA[26] said that the global strategy and its adaptation to local contexts could help to meet national, regional and global targets for women's, children's and adolescents' health. To address gaps in sexual, reproductive, maternal, infant, child and adolescent healthcare, primary care must be strengthened and access to services in rural and remote areas broadened. Training and equitable distribution of health services, with a focus on underserved communities, were vital. It was also important to ensure the sustainability of mental, sexual and reproductive health programmes for adolescents, address the social determinants of health and deliver nutrition education. To accelerate progress, the Secretariat must help Member States to secure sustainable financing of priority health programmes, provide standardized technical tools, facilitate transfer of knowledge and best practices, and support the development of national plans.

The representative of the DOMINICAN REPUBLIC[26] said that she wished to sponsor the draft decision on the World Prematurity Day.

The representative of the RUSSIAN FEDERATION[26] said that, to facilitate progress towards the achievement of Sustainable Development Goal targets, national strategies and international cooperation programmes must focus on training health workers. Midwives, obstetricians, gynaecologists, neonatologists and resuscitators must be trained to deliver high-quality maternal and intensive care for children. He wished to sponsor the draft decision on the World Prematurity Day and the draft decision on regulating the digital marketing of breast-milk substitutes.

The representative of COLOMBIA[26] said that equitable distribution of basic health facilities and comprehensive family care plans were crucial to guarantee the right to health. Targeted interventions, such as neonatal screening, were needed to bring down maternal and child mortality rates. Recalling the outcome of the first Global Ministerial Conference on Ending

[26] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Violence Against Children, she urged Member States to do more to address violence against children and add their voices to the Bogotá Call to Action.

The representative of ECUADOR[27] said that comprehensive sexual and reproductive health policies must be developed to deliver contraceptives, respond to gender-based violence, promote adolescent-friendly health services, and expand maternal and neonatal care facilities. Countries could address unequal access to sexual and reproductive health services by investing in information systems, building scientific evidence and delivering comprehensive sexual education. Like others, her country relied on support from WHO to provide training in essential midwifery and other sexual and reproductive health interventions. International cooperation was crucial to advance the health agenda.

The representative of GERMANY[27] said that universal access to sexual and reproductive health services and rights was central to improving the well-being of women, children and adolescents. Comprehensive services, including contraception, safe abortion, maternal care and sexuality education, were essential to address persistent inequalities. A world where everyone could exercise their sexual and reproductive rights freely was a healthier, more equitable world, and WHO played an important role in upholding those values. The addition of new days to the WHO calendar might not be the most effective way to tackle prematurity-related deaths.

The representative of BANGLADESH[27] said that adolescent-responsive health services and programmes to tackle child undernutrition and obesity could improve health outcomes for women, children and young people. Barriers to healthcare associated with high out-of-pocket payments must be removed, Member States must maintain their commitment to provide sustainable financing for the achievement of the relevant Sustainable Development Goals, and donors must provide flexible funding. Breast-milk substitutes must not be promoted as the nutrition of choice for infants.

The representative of SOUTH AFRICA[27] said that the Secretariat should support Member States in implementing high-impact initiatives to reduce maternal, newborn and child mortality, especially where rates were disproportionately elevated. Advertising was an inappropriate way of providing information about infant nutrition. Given the wide range of actors engaging in digital marketing of infant food products, legislation must contain implementation mechanisms to hold them accountable. A strong resolution from the Health Assembly could provide momentum to Member States' efforts to regulate the marketing of breast-milk substitutes and her Government wished to join the sponsors of the respective draft decision.

The representative of JAPAN[27] said that a future global strategy beyond 2030 should take account of contemporary disease burdens and fertility trends, among other things. His Government delivered bilateral assistance in areas such as health workforce development, technical cooperation and hospital construction and participated in global financing initiatives. Increased investment was needed to improve the quantity and quality of healthcare services around the world.

The representative of UNFPA said that investment in sexual, reproductive and maternal health must be stepped up in line with national priorities. Health systems should be strengthened to include high-quality midwifery services. At the community level, women and girls must be empowered and supported in making informed decisions about their bodies, including their bodily

[27] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

autonomy. At the global level, the leadership of WHO and other United Nations agencies in the implementation of the Every Woman, Every Newborn, Everywhere initiative was crucial – it was similar in approach to the Start with Her: UNFPA Strategy for Reproductive, Maternal and Newborn Health and Well-Being 2025–2030.

The Observer of GAVI, THE VACCINE ALLIANCE, expressed grave concern over the rise in the number of unvaccinated children, who often came from severely deprived households and could only be reached if efforts were stepped up. The malaria vaccine roll-out in 17 countries provided a historic opportunity to combat that leading cause of child mortality. WHO Member States must intensify efforts to halve the number of zero-dose children by 2030, implement malaria vaccination programmes in endemic countries, and expand human papillomavirus vaccination for adolescent girls.

The representative of THE SAVE THE CHILDREN FUND, speaking at the invitation of the CHAIR, said that aggressive digital marketing of breast-milk substitutes undermined breastfeeding and misled parents. Strong, enforceable regulations were needed to protect parents and infants from exploitative tactics. Member States should unite behind the draft decision on regulating digital marketing of breast-milk substitutes to ensure that infant feeding decisions were based on science, not corporate profit.

The representative of the DRUGS FOR NEGLECTED DISEASES INITIATIVE, speaking at the invitation of the CHAIR, said that shortages in child-specific drug formulations and knowledge gaps around the impact of medicines on pregnant or lactating women caused delays in accessing treatment. Member States must support and implement strategies to include women and children early in the drug development process. They should also support the implementation of the WHO-led Global Accelerator for Paediatric Formulations Network mission to develop and make available safe, effective, high-quality, and affordable paediatric formulations.

The representative of the NCD ALLIANCE, speaking at the invitation of the CHAIR, said that Member States must urgently address the wider determinants of health inequalities, working across sectors. Since voluntary measures had proven ineffective or insufficient to advance the prevention of noncommunicable diseases, Member States' support for mandatory regulation of digital marketing of breast-milk substitutes was crucial. Parents and caregivers must be protected from the inappropriate promotion of infant and child nutrition in digital environments.

The representative of MMV MEDICINES FOR MALARIA VENTURE, speaking at the invitation of the CHAIR, said that malaria affected children and pregnant and lactating women more than others. More needed to be done to close gaps in therapeutic options for pregnant and breastfeeding women. As novel tools and approaches were being developed, continued investment and leadership must help to fill gaps in quality medicines for women and children.

The representative of the WORLD HEART FEDERATION, speaking at the invitation of the CHAIR, said that cardiovascular disease remained one of the leading causes of maternal mortality worldwide. Detection and multidisciplinary care across the life course, with key intervention points before, during and after pregnancy, were essential. The inclusion of standardized, comprehensive cardiovascular disease care in primary healthcare packages was crucial. Gaps in availability and access to cardiovascular care during pregnancy must be addressed.

The representative of the MEDICINES PATENT POOL FOUNDATION, speaking at the invitation of the CHAIR and also on behalf of the Drugs for Neglected Diseases initiative, Medicines for Malaria Venture, the International AIDS Society and the Global Accelerator for Paediatric

Formulations Network, said that improved access to quality-assured, affordable medicines was crucial to reduce maternal and child mortality. Member States, industry and donors must support the development of innovative health tools and essential medicines roll-out, including for pregnant and breastfeeding women, to close critical gaps and ensure equitable access to essential medicines.

The representative of the INTERNATIONAL ASSOCIATION FOR HOSPICE AND PALLIATIVE CARE, INC., speaking at the invitation of the CHAIR, said that a global report on children's health must acknowledge the number of children killed, injured and seriously affected mentally and physically by war. Young caregivers, especially girls, who often cared for dependent older relatives, must be supported. Rising female cancer rates in low- and middle-income countries were often associated with palliative care needs. The Board should adopt a more holistic approach to women's, children's and adolescents' health by considering social and political determinants and access to palliative care.

The representative of the INTERNATIONAL BABY FOOD ACTION NETWORK, speaking at the invitation of the CHAIR, said that digital marketing of breast-milk substitutes had long-term consequences for child health and survival. National laws informed by the International Code of Marketing of Breast-milk Substitutes often failed to keep pace with new marketing strategies. Additional resources were not especially required to monitor digital violations of the Code, however, and the related draft decision should serve as guidance for governments. She encouraged the adoption of that draft decision.

The representative of the INTERNATIONAL LACTATION CONSULTANT ASSOCIATION, speaking at the invitation of the CHAIR, said that digital marketing of breast-milk substitutes and associated products was pervasive, often not recognized as such, and had a negative effect on breastfeeding rates and health outcomes. A WHO decision to regulate such marketing would be key in protecting families from harmful corporate influences, reducing the burden on health systems and improving public health.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIR, said that inequities in maternal, child and adolescent health outcomes must be addressed through inclusive, context-transforming policies focusing on vulnerable populations. National and global political agendas must prioritize maternal, neonatal and child health. Only strong, resilient health systems and well-trained health workers could provide effective responses to emerging needs.

The representative of PUBLIC SERVICES INTERNATIONAL, speaking at the invitation of the CHAIR, said that women must be given full ownership and decision-making authority over their bodies, and public health services must support and uphold their sexual and reproductive rights. Gender-based violence must be addressed within and beyond health services, with public health services leading by example in protecting their staff and providing decent work conditions. Care must be recognized as a human right.

Rights of reply

The representative of the RUSSIAN FEDERATION,[28] speaking in exercise of the right of reply, regretted that some representatives made unprofessional statements that jeopardized the constructive and substantive dialogue on technical issues. The special military operation of the

[28] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Russian Federation had been launched in retaliation against the military escalation by the Armed Forces of Ukraine against the people and civilian objects in the Donetsk People's Republic and the Luhansk People's Republic. The attempts to use the Board as a podium for political debate were to be condemned in the strongest terms.

The representative of UKRAINE, speaking in exercise of the right of reply, objected to the repeated attempts by the Russian Federation to use Board meetings as a forum to legitimize its crimes against international law and the territorial integrity of Ukraine, and to reiterate its false propaganda. The regions of Donetsk and Luhansk and the Republic of Crimea were integral parts of Ukraine within its internationally recognized borders.

The representative of POLAND, speaking in exercise of the right of reply and on behalf of the European Union and its Member States, objected to the misleading narrative and accusations levelled by the Russian Federation, which had once again used the Board as a forum to mispresent the facts. The Russian Federation's war of aggression against Ukraine constituted a flagrant violation of the Charter of the United Nations and must be resolutely condemned. The European Union fully supported the independence, sovereignty and territorial integrity of Ukraine within its internationally recognized borders and its inherent right to self-defence. The Russian Federation's brutal war had brought immense suffering and destruction upon Ukraine and must stop immediately. The attacks on civilians and civilian infrastructure by the Russian Federation could not be justified under any circumstances.

The meeting rose at 21:10.

Fourteenth meeting

Saturday, 8 February 2025, at 10:05

Chair: Dr J.X. Walcott (Barbados)

Pillar 1: One billion more people benefiting from universal health coverage (continued)

1. Global Strategy for Women's, Children's and Adolescents' Health: Item 14 of the agenda (document EB156/17) (continued)

The CHAIR recalled that the Board had two draft decisions before it, one on the incorporation of the World Prematurity Day into the WHO calendar, and the other on regulating the digital marketing of breast-milk substitutes.

The ASSISTANT DIRECTOR-GENERAL (Universal Health Coverage/Life Course) noted that the request for an update on the Global Strategy for Women's, Children's and Adolescents' Health, given that the adoption of resolution WHA77.5 (2024) was so recent, indicated how important it was to make progress in that area. Over the previous five years, a woman or baby had died every seven seconds due to complications arising in pregnancy, childbirth or the first weeks of life. He therefore appreciated the Board's focus on data to monitor progress and identify subnational areas that required further work. Data comprised one of the four pillars of the Every Woman, Every Newborn, Everywhere initiative co-led by WHO with UNICEF and UNFPA. Key guidance, such as on antenatal care, had become living guidelines that were updated in real time. The maternal and newborn transition framework would help Member States to accelerate progress and transition through the stages of the framework. The Board had emphasized the importance of health systems strengthening and primary healthcare and, in that regard, one of the Secretariat's key metrics for progress was a decrease in maternal mortality. The Secretariat appreciated the emphasis on addressing adolescent pregnancies and sexual health; sexual and reproductive health in general was essential to advancing universal health coverage. There was a particular need for support in fragile, conflict-affected and vulnerable settings, where 50% of maternal deaths occurred. The integration of World Prematurity Day into the WHO calendar would incur no additional costs since it was already marked nationally and internationally on 17 November – the related draft decision would simply integrate it officially into the calendar of health days.

The ASSISTANT DIRECTOR-GENERAL (Universal Health Coverage/Healthier Populations) said that the global increase in breastfeeding was a public health achievement that demonstrated how collaboration could improve health. Work to address unequal breastfeeding rates across countries and regions would continue. Harmful digital marketing strategies that targeted women were jeopardizing that increase, however. Less than 20% of countries prohibited the promotion of breast-milk substitutes on digital platforms. Evidence clearly showed that countries that had implemented the International Code of Marketing of Breast-milk Substitutes through legal measures had significantly higher breastfeeding rates. She was pleased to note that the first

Global Ministerial Conference on Ending Violence Against Children had spurred interest in that area. The Secretariat would draft a report on that topic in the coming months.

The CHAIR invited the Board to note the report contained in document EB156/17.

The Board noted the report.

The CHAIR took it that the Board wished to postpone the adoption of the draft decisions pending the outcome of the broader discussion on the costing implications of resolutions and decisions recommended by the 156th session of the Executive Board for adoption by the Seventy-eighth World Health Assembly.

It was so agreed.

(For the adoption of decisions, see the summary record of the eighteenth meeting, section 8.)

Pillar 3: One billion more people enjoying better health and well-being

2. The impact of chemicals, waste and pollution on human health: Item 20 of the agenda (document EB156/23)

The CHAIR invited the Board to consider the report contained in document EB156/23 and to provide guidance on the questions contained in paragraph 27 of that document. He also invited the Board to consider two draft decisions. The first draft decision, which contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly, on galvanizing global support for a lead-free future, was proposed by Bangladesh, Chile, Ghana, Indonesia, Ireland, Malawi, Nepal, the Philippines and Vanuatu, and read:

> The Executive Board, having considered the report by the Director-General,[1]
>
> Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following resolution:
>
> > The Seventy-eighth World Health Assembly,
> > (PP1) Having considered the report by the Director-General;
> > (PP2) Recalling the 2002 World Summit on Sustainable Development[2] commitments to phase out lead in lead-based paints and in other sources of human exposure; to work to prevent children's exposure to lead in particular; and to strengthen monitoring, surveillance, and treatment efforts;[3]
> > (PP3) Recognizing that preventing and mitigating the health impacts caused by all sources of lead exposure aligns with WHO's Fourteenth General Programme of Work, 2025–2028[4] (GPW 14), which emphasizes addressing health determinants and the root

[1] Document EB156/23.

[2] Report of the World Summit on Sustainable Development, Johannesburg, SA, Aug. 26 to Sept. 4, 2002. A/CONF.199/20, Para 57.

[3] See the Plan of Implementation of the World Summit on Sustainable Development, Section VI, para. 57.

[4] See WHO draft fourteenth general programme of work, 2025–2028.

causes of ill health, including climate change and environmental degradation;

(PP4) Recognizing also the WHO Chemicals Roadmap[5,6] approved at the Seventieth World Health Assembly to help to achieve the 2020 ("and beyond") goals of the Strategic Approach to International Chemicals Management (SAICM), to enhance the global health sector's leadership role in the health-related components of exposure to harmful chemicals, including lead, and its important supporting role in multisectoral cooperation in the sound management of chemicals, which includes lead as one of the WHO 10 chemicals of major public health concern;[5]

(PP5) Welcoming that the 2023 Global Framework on Chemicals – for a Planet Free of Harm from Chemicals and Waste[7] recognizes the health sector's critical role and unique expertise to contribute to the sound management of chemicals and waste and to the promotion of health and well-being[8] and recalling also World Health Assembly resolution WHA76.17 (2023) on the impacts of Chemicals Waste and Pollution on Human Health, which highlighted the critical importance of WHO and health sector work in global chemicals management, particularly in relation to lead and support of the negotiations towards the GFC;

(PP6) Recognizing the need to update the WHO Chemicals Roadmap to enhance the engagement of the health sector in relation to the 2023 Global Framework on Chemicals, in particular the importance of health protection strategies focusing on specific chemicals of concern, including lead, and addressing the needs of individuals at risk of exposure, including those in vulnerable situations, and noting that the Director-General is drafting a related report to address the needed updates;

(PP7) Recalling the growing political commitment to address exposure to lead including the G20 Call to Action on Strengthening Drinking Water, Sanitation, and Hygiene Services, which highlights the role of international technical cooperation to combat water pollution, including from lead;

(PP8) Recognizing ongoing collaboration such as the new global public-private Partnership for a Lead-free Future (launched on the sidelines of the 79th UN General Assembly, in September 2024) dedicated to tackling lead exposure in low- and middle-income countries (LMICs) and to ending childhood lead poisoning by 2040;

(PP9) Recognizing also that lead is a heavy metal with no known safe blood lead levels and that some studies have estimated that lead accounted for nearly half of the two million lives lost due to chemical exposure in 2019[9] with an estimated 1.5 million annual lead-associated deaths as of 2021 (primarily due to cardiovascular effects);[10]

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[5] See the Chemicals Roadmap: To enhance health sector engagement in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond. WHO 2017.

[6] In May 2016, WHA Resolution 69.4 requested the WHO Secretariat to prepare "a road map" to enhance health sector engagement at the national, regional, and international levels in the SAICM 2020 goals and beyond.

[7] Adopted as the successor to SAICM, in Bonn, Germany, during the fifth session of the International Conference on Chemicals Management, 28 and 29 September 2023, The Global Framework on Chemicals.

[8] See The Global Framework on Chemicals, Para 45, P9.

[9] See WHO fact sheets, Lead poisoning, 27 September 2024. See also: The Institute for Health Metrics and Evaluation: Global Health Metrics, Lead Exposure – Level 3 Risk – Global Burden of Disease in 2021, and the WHO Public Health Impacts of Chemicals: Knowns and Unknowns, 2016: "The Overview states that: "The 2021 data addendum estimates that 2 million lives and 53 million disability-adjusted life-years were lost in 2019 due to exposures to selected chemicals."

[10] See the Institute for Health Metrics and Evaluation, 2021 Global Burden of Disease Study. See also: resolution WHA76.17.

(PP10) Expressing concern that young children are particularly vulnerable to the health effects from exposure to lead, with an estimated one in every three children globally with blood lead levels of significant concern leading to high risk for poor developmental outcomes, learning and behavioral difficulties, lower educational attainment, lower incomes, and ultimately premature mortality[11] and noting that 99% of these children live in LMICs;[12,13]

(PP11) Noting that chronic exposure of adults to even low levels of lead has deleterious health effects and is associated with increased risk of cardiovascular disease,[14] and that pregnant women exposed to lead are at greater risk of pregnancy complications, miscarriages, fetal development disorders, lower child birth weight, preterm births, and stillbirths;[15] and also noting that older people exposed to low levels of lead may have increased risk of high blood pressure, cognitive impairments, and psychiatric symptoms, as well as dementia;[16]

(PP12) Noting the global initiative launched by a consortium of governments, manufacturers and civil society partners at the United Nations (UN) 2023 Water Conference to achieve lead-free drinking water[17] and acknowledging the ongoing efforts of WHO to address the serious health impacts of lead through outreach and engagement, as well as the significant progress made through the UNEP Partnership for Clean Fuels and Vehicles, which eradicated all automotive leaded petrol from world markets,[18] and through the WHO/UNEP Global Alliance to Eliminate Lead Paint,[19] with over 100 partners seeking to prevent children's exposure to lead paint (and minimize occupational exposure);

(PP13) Concerned that neglecting the adverse health impacts of lead exposure could undermine the efforts of WHO and Member States to improve health and well-being and reduce health inequalities and inequities globally;

(PP14) Underscoring the importance of paying particular attention to those disproportionately impacted by lead exposure, especially children and women of reproductive age, people in low-income communities, and people living in developing countries;

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[11] See UNICEF and Pure Earth (2020). For the negative effects on development and health outcomes come from a variety of sources: Poorer cognitive development and IQ loss: Crump et al. (2013), Lanphear et al. (2005); Learning difficulties: Donzelli et al., 2019, Goodlad et al. (2013); Lower educational attainment: Crawfurd et al. 2023; Behavioral difficulties: Marcus et al. (2010); Lead and cardiovascular disease risk: Ava Navas-Acien et al. (2006) and Lamas et al. (2023).

[12] See Opportunities for the G7 to address the global crisis of lead poisoning in the 21st century a Rapid Stocktaking Report 2023.

[13] See UNEP Global Chemical Outlook II, Page 159, April 29, 2019.

[14] See Journal of the American Heart Association, Contaminant Metals as Cardiovascular Risk Factors: A Scientific Statement from the American Heart Association, June 12, 2023.

[15] See preeclampsia [Zhong et al. (2022) and Poropat et al. (2018)], preterm birth [Khanam et al. (2021), Habibian et al. (2022), and Wu et al. (2022)], low birth weight [Wang et al. (2020) and Vigeh et al. (2022], stillbirths [Kaur et al. (2021)].

[16] See page 60, UNEP Global Chemical Outlook II, April 29, 2019.

[17] https://www.globalleadfreewater.org/#about.

[18] See UNEP Lead Campaign and also Inside the 20-year campaign to rid the world of leaded fuel.

[19] See Global Alliance to Eliminate Lead Paint webpage. As of January 2024, 94 countries (48% of all countries) have legally binding controls to limit the production, import, sale and use of lead paints.

(PP15) Acknowledging that multisectoral cooperation, as recognized in the WHO Chemicals Roadmap, can drive progress on chemical safety and relies on evidence-based health interventions to reduce the lifelong health impacts of lead exposure, especially on children;

(PP16) Emphasizing that this resolution presents a timely, additional opportunity for the global health community to leverage its convening power to advocate for improving health outcomes by increasing action and commitment from the sectors continuing the use of lead in construction materials, including in paint, pipes, and pipe fittings, but also in toys, spices, cosmetics, and other consumer goods, and from industrial sources that contribute to lead contamination including the unsafe production, disposal, and recycling of lead acid batteries,

(OP)1. URGES Member States,[20] in accordance with national context and priorities:

(1) to commit to a shared vision for a world free of lead exposure and prioritize efforts to address this pressing global health challenge;

(2) to strengthen the implementation of relevant WHO Guidelines including the WHO Guidelines for the Clinical Management of Exposure to Lead, WHO Drinking Water Quality, the WHO Chemicals Roadmap, and the WHO/UNICEF online training course on children's environmental health;

(3) to engage proactively at the national, sub-regional, regional, and international levels to develop and strengthen holistic, multisectoral cooperation for action, including to exchange scientific data and good practices; to promote research and risk assessment; to prevent and mitigate lead exposure by all sources to reduce the related health impacts, and to adapt and strengthen health systems to tackle these health problems;

(4) to strengthen and maintain systems for monitoring progress in the reduction of lead exposures, including blood lead level testing, especially in children, and the screening of high-risk individuals;

(5) to actively engage in the development of a WHO Global Action Plan on Lead Mitigation (requested in this resolution under OP2.1) to strengthen the global health response to lead exposure and progressively reduce the impact of lead on human health;

(6) to develop and strengthen health sector capacities to prevent, detect and mitigate lead exposure in children, including strengthened awareness, advocacy, and training to healthcare workers, particularly those engaged in maternal and child health programmes, and increasing the availability of diagnostics, enhancing laboratory capacities for detection of lead levels and the availability of recommended antidotes on the WHO Model List of Essential Medicines;

(7) to provide, as appropriate, increased financial or in-kind scientific and logistic support to the WHO Secretariat to allow for strengthened national, sub-regional, regional, and global efforts on lead mitigation and adaptation and strengthening of health systems to address health problems related to lead exposure;

(OP)2. REQUESTS the Director-General:

(1) to develop, in consultation with Member States, relevant United Nations specialized agencies, and other relevant stakeholders in line with FENSA, as applicable, a Global Action Plan on Lead Mitigation, which should include

[20] And, where applicable, regional economic integration organizations.

consideration of measures to adapt health systems to address health problems related to lead exposure, to strengthen the global health sector's response to lead exposure in keeping with the interlinking "action areas" set forth in the WHO Chemicals Roadmap;

(2) to strengthen and enhance WHO's role in efforts to reduce lead exposure at the national, sub-regional, regional and global levels including through the development of normative evidence-based guidance, provision of targeted technical support, strengthening existing networks of poisons centres and WHO Collaborating Centres, and communication campaigns such as the WHO International Lead Poisoning Prevention Week;

(3) to support capacity strengthening at all levels to produce timely, credible, and appropriately disaggregated data to explore all sources of lead exposure, including waste, and its effects, for adequate analysis and measurement of progress achieved by Member States towards the relevant Sustainable Development Goals;

(4) to encourage scientific and interdisciplinary research that informs innovative solutions to prevent health impacts from lead exposure and related pollution;

(5) to support Member States in strengthening health sector leadership and coordination with international efforts in lead mitigation; and

(6) to submit the Global Action Plan on Lead Mitigation to the Eighteenth World Health Assembly in 2027 through the Executive Board at its 160th session, and then to submit a progress report to the Health Assembly in 2029 and 2031.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[21]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:
3.3.1. Countries enabled to address environmental determinants of health, including climate change

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:
Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:
Not applicable.

4. Estimated time frame (in years or months) to implement the decision:
Six years (2025–2030).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:
US$ 5.62 million.

[21] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic "bridge" between results structures can be provided as needed.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:
US$ 0.54 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:
Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:
US$ 1.97 million.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:
US$ 3.11 million.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions

- **Financial resources available to fund the decision in the current biennium:**
  Zero.
- **Remaining financing gap in the current biennium:**
  US$ 0.54 million.
- **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
  The Unit is undertaking concrete efforts with specific Member States that advocate for this topic and with new initiatives, such as the Partnership for a Lead-Free Future.

Table. Breakdown of estimated resource requirements (in US$ millions)[a]

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	0.07	0.06	0.05	0.06	0.05	0.06	0.09	0.44
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.10	0.10
	Total	0.07	0.06	0.05	0.06	0.05	0.06	0.19	0.54
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	0.15	0.11	0.11	0.13	0.11	0.12	0.43	1.16
	Activities	0.07	0.07	0.07	0.07	0.07	0.07	0.40	0.81
	Total	0.22	0.18	0.18	0.20	0.18	0.19	0.83	1.97
B.4. Future bienniums cost of resources to be planned	Staff	0.23	0.18	0.17	0.21	0.18	0.19	0.28	1.43
	Activities	0.22	0.22	0.22	0.22	0.22	0.22	0.38	1.67
	Total	0.45	0.39	0.38	0.42	0.39	0.40	0.67	3.11
B.1. Total planned costs required to implement the decision									5.62

[a] The row and column totals may not always add up, owing to rounding.

The second draft decision, which contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly, on the [effects of [nuclear weapons and] nuclear war on health and [health] services, was proposed by Fiji, Guatemala, Iraq, Kazakhstan, the Marshall Islands, the Federated States of Micronesia, Peru, Samoa and Vanuatu, and read:

> The Executive Board, having considered the report by the Director-General,[22]
>
> Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following resolution:
>
> > The Seventy-eighth World Health Assembly,
> >
> > (PP1) Having considered the report by the Director-General;
> >
> > (PP2) Reaffirming the principle enshrined in the Constitution of the World Health Organization that the health of all peoples is fundamental to the attainment of peace and security;
> >
> > (PP3) Noting United Nations General Assembly resolutions 34/58 (1979), 38/188 J (1983) and 40/10 (1985), and also resolutions WHA34.38 (1981), WHA36.28 (1983) and WHA77.9 (2024) stressing the close interrelationship between health and the preservation and promotion of peace;
> >
> > (PP4) Noting the 1983 report, *Effects of Nuclear War on Health and Health Services,*[23] prepared by the International Committee of Experts in Medical Sciences established by the Director-General in conformity with resolution WHA34.38 (1981), the second 1987 report on the same topic prepared by the WHO Management Group on follow-up of resolution WHA36.28 (1983),[24] and the 1993 report Health and Environmental Effects of Nuclear Weapons noted by the Health Assembly in resolution WHA46.40 (1993);
> >
> > (PP5) [Recalling the Final Document of the Tenth Special Session of the General Assembly and the ultimate goal of complete elimination of nuclear weapons;]
> >
> > (PP6) [Noting that the United Nations Secretary-General's A New Agenda for Peace identifies the irreversible and verifiable elimination of nuclear weapons as a high priority for international peace and security;]
> >
> > (PP7) Noting that, at the United Nations Summit of the Future (New York, 2024), Member States expressed concern about the growing risks of a nuclear war, which could pose an existential threat to humanity, and deep concern over the state of nuclear disarmament; recommitted to the goal of the total elimination of nuclear weapons; and committed to strengthening the disarmament and non-proliferation architecture, working to prevent any erosion of existing international norms and taking all possible steps to prevent nuclear war;
> >
> > (PP8) Noting United Nations General Assembly resolution 79/238 (2024) on nuclear war effects and scientific research, in which the General Assembly requested the United Nations Secretary-General to convene an independent Scientific Panel on the Effects of Nuclear War to examine such effects, and called upon the United Nations

[22] Document EB156/23.

[23] World Health Assembly, 36 (A36/INF.DOC./18) (1983). Effects of nuclear war on health and health services. World Health Organization.

[24] World Health Assembly, 40 (A40/11) (1987). Effects of nuclear war on health and health services: report of the WHO Management Group on follow-up of resolution WHA36.28. World Health Organization.

system and relevant agencies, including WHO, to support the work of the Panel, by contributing expertise, commissioned studies, data and papers,

(OP)1. ENCOURAGES Member States, in accordance with their national contexts and legal frameworks, to support the work of the Director-General;

(OP)2. REQUESTS the Director-General:

(1) [to update the World Health Organization reports "Effects of nuclear war on health and health services" (1983 and 1987) and the report "Health and environmental effects of nuclear weapons" (1993) and in this regard, collect and analyse existing related studies;]

(2) [to cooperate, where appropriate, with relevant stakeholders in line with the Framework of Engagement with Non-State Actors, as applicable, and other United Nations bodies and international organizations, in accordance with their respective mandates; and]

(3) to report on progress in the implementation of this resolution to the Eightieth World Health Assembly in 2027.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[25]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:
3.3.1. Countries enabled to address environmental determinants, including climate change

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:
Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:
Not applicable.

4. Estimated time frame (in years or months) to implement the decision:
Five years (2025–2029).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:
US$ 0.54 million.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:
US$ 0.15 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:
Not applicable.

[25] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic "bridge" between results structures can be provided as needed.

3. **Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:**
US$ 0.32 million.

4. **Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:**
US$ 0.07 million.

5. **Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions**
   - **Financial resources available to fund the decision in the current biennium:**
     US$ 0.05 million.
   - **Remaining financing gap in the current biennium:**
     US$ 0.10 million.
   - **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
     Not applicable.

Table. Breakdown of estimated resource requirements (in US$ millions)[a]

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.05	0.05
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.10	0.10
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.15	0.15
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.11	0.11
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.21	0.21
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.32	0.32
B.4. Future bienniums cost of resources to be planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.06	0.06
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.02
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.07	0.07
B.1. Total planned costs required to implement the decision									0.54

[a] The row and column totals may not always add up, owing to rounding.

The representative of LEBANON, speaking on behalf of the Member States of the Eastern Mediterranean Region, outlined how chemicals, waste and pollution, including lead exposure, had impacted her Region. Implementation of evidence-based interventions remained challenging, including for countries experiencing states of emergency. The capacity of the health sector to monitor and manage the health impacts of exposure to specific chemicals needed to be strengthened. The Road map to enhance health sector engagement in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond (WHO Chemicals road map) should be updated, in line with the Global Framework on Chemicals – For a Planet Free of Harm from Chemicals and Waste, to boost access to poison centres and their links with health

ministries; generate and ensure access to biomonitoring and health surveillance data; and strengthen synergies with environmental, health and labour policies, including on climate change, emergencies, biodiversity, human rights, universal health coverage and primary healthcare. The Secretariat should support national dialogues between the health and environmental sectors, and provide technical tools to ensure that health remained central to national implementation of the Global Framework on Chemicals.

The representative of CANADA said that, since the Global Framework on Chemicals reflected the important and unique role of WHO in that area of work, the report should include a clear mandate for WHO to implement the Framework's health-related targets. She agreed with the proposed areas for updates to the WHO Chemicals road map and the proposed next steps for WHO engagement in international chemicals management. She supported the actions called for in resolution WHA76.17, particularly implementing a One Health approach and integrating WHO work with other public health priorities, such as primary healthcare and universal health coverage. Such actions would align with the WHO Chemicals road map, the Fourteenth General Programme of Work, 2025–2028, and the WHO global strategy on health, environment and climate change.

The representative of CAMEROON, speaking on behalf of the Member States of the African Region, said that she was pleased to note the adoption of the Global Framework on Chemicals, particularly since it supported work towards the Sustainable Development Goals. She called on WHO to continue efforts to secure increased financing to address all aspects of chemical safety; provide capacity-building and technical support, particularly through the transfer of technology and skills; strengthen multisectoral collaboration based on cross-border health security mechanisms; prioritize health sector goals; and consider the effects of climate change in follow-up and monitoring.

The representative of CHINA highlighted that pollution, especially chemical pollution, was among the three most significant challenges that the world faced and required urgent global collaboration. The participation of the health sector was key to implementing the Global Framework on Chemicals, especially to the identification of hazardous chemicals and the assessment of human exposure. Her Government would participate in WHO's work in that area, including updating the WHO Chemicals road map, enhancing communication and cooperation with other countries, and sharing its experience of managing chemicals, waste and pollution.

The representative of MOROCCO noted that the impact of chemicals, waste and pollution on health was a global issue that required an urgent and coordinated response. The report highlighted the scale of the threat and the need for stronger policy on prevention, monitoring and risk management. Efforts at the national level must be supported through global, collective action. WHO should intensify efforts to improve the regulation of hazardous chemicals and the management of toxic waste. The Secretariat should strengthen mechanisms to monitor and evaluate the effects of chemical substances on human health. It should develop guidelines and recommendations to manage industrial and medical waste more safely, support low-income countries in implementing clean technologies and environmental practices, promote scientific research on the health impacts of pollutants to guide public policy and increase synergies with other United Nations specialized agencies.

The representative of NORWAY said that she supported the Secretariat's efforts to develop a proposal for an independent intergovernmental science-policy panel and called for clarification of WHO's role concerning the panel's secretariat. The Partnership for the Assessment of Risks from Chemicals provided an example of health surveillance and biomonitoring, and WHO should facilitate and leverage international research cooperation in that field. Acknowledging the impact

of lead exposure, particularly for low- and middle-income countries, she welcomed the draft decision on galvanizing global support for a lead-free future, emphasized the importance of strengthening health systems and fostering cross-sectoral collaboration, and noted the pending discussion on handling resolutions and decisions in the light of budgetary constraints.

The representative of THAILAND expressed support for the Global Framework on Chemicals; the Board was unable to endorse it but should acknowledge it and urge Member States to work towards its objectives and targets. Member States should ensure proper risk management during the transportation of chemicals and in the event of accidental chemical release. To strengthen the WHO Chemicals road map, the Secretariat should engage regional stakeholders in revision and planning processes in order to better understand the impact of national contexts and capacities on implementation. WHO technical support and guidance for developing countries and regional stakeholders could accelerate implementation of the road map.

The representative of SLOVAKIA said that, regarding the implementation of the Global Framework on Chemicals, it was important to strengthen national health systems – particularly in the areas of surveillance, biomonitoring and poison control centres – and ensure that the updated WHO Chemicals road map was aligned with a One Health approach, universal health coverage and noncommunicable disease prevention. Science-based decision-making was crucial. He supported WHO's work on the science-policy panel, which would ensure that public health priorities remained central to global discussions on chemicals and waste.

Under the Global Framework on Chemicals, resources must reach frontline health services, and high-impact interventions should be prioritized. The Secretariat should establish stronger partnerships with UNEP and the WMO to integrate climate and health strategies, and lower WHO expenditure. It should also assist Member States in strengthening national policies on hazardous substances and pollution, and developing clear biomonitoring guidelines. More detailed recommendations on laboratory standards for biomonitoring and a voluntary register of accredited laboratories would boost the effectiveness of global and regional monitoring. He called for a transparent, cost-effective and country-driven approach to reducing chemical waste and pollution.

The representative of COSTA RICA emphasized the role of international organizations in the sharing of experiences, capacity-building and regional initiatives on the management of chemicals and waste. Distributive justice and economic growth should be addressed as elements in informal employment that prompted migration and the disproportionate and careless use of chemical substances in protected, marginalized and border areas. International efforts should focus on creating alternatives to those substances, sharing experiences and designing national and international governance mechanisms.

The representative of BRUNEI DARUSSALAM said that, although the Global Framework on Chemicals represented progress, it was particularly difficult for small developing nations to implement it, and many countries struggled to monitor, regulate and respond to chemical exposures. Regional cooperation, which WHO could facilitate, was needed to strengthen regional networks, facilitate the sharing of expertise and improve access to real-time toxicological data. Greater cooperation with the environmental, trade and development sectors was necessary to ensure better regulation of hazardous substances and promote safer alternatives. Increased technical support and capacity-building were also needed as many professionals lacked specialized training in handling chemical hazards. Although the WHO Global Chemicals and Health Network had facilitated knowledge-sharing, the development of training programmes, accessible guidance and the integration of chemical risk management into primary healthcare would be key to

progress. Access to the Global Framework on Chemicals Fund must be equitable and practical, especially for smaller nations that may not have the resources to navigate complex application processes. Aligning chemical safety programmes with existing climate and environmental health initiatives could create new avenues for support. The discussion on strengthening WHO's role in global chemical safety was welcome. He supported refining the WHO chemical road map to ensure that all Member States could meaningfully benefit from it.

The representative of YEMEN emphasized that conflict, together with fragile legislative and regulatory systems, enabled the smuggling of hazardous substances into his country. WHO should put pressure on countries to take responsibility for smuggling and control and regulate exports of hazardous substances to fragile countries under the Global Framework on Chemicals.

The representative of the FEDERATED STATES OF MICRONESIA noted that inadequate progress had been made on minimizing the health and environmental effects of chemicals, which was a particular concern for low- and middle-income countries and small island developing States. The Secretariat should prioritize the latter in the update to the WHO Chemicals road map. He supported establishing and strengthening poison centres, and WHO's watchdog role in protecting health from chemicals, lead and other harmful substances. WHO should partner with UNEP and other United Nations specialized agencies to step up its work on chemical waste.

The draft decision on the [effects of [nuclear weapons and] nuclear war on [health] and health services was aimed at enabling updates to WHO reports that had been published 30 years earlier. Although some areas required further discussion, he noted the intention to present a final draft of the text at the Seventy-eighth World Health Assembly.

The representative of the DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA expressed his support for the Global Framework on Chemicals. The destructive and humanitarian consequences of nuclear weapons on human health and the environment were obvious, sufficient research had already been conducted in that area and he was therefore opposed to the related draft decision. WHO should concentrate instead on addressing emerging and pressing global health challenges, to provide all people with the highest possible level of health. The draft decision deviated from WHO's mandate and would require additional human and financial resources.

The representative of PERU,[26] speaking also on behalf of Bangladesh, Chile, Ecuador, Ghana, Indonesia, Ireland, Malawi, Nepal, the Philippines and Vanuatu, recognized the challenges that WHO faced to streamline priorities. Lead exposure caused a significant burden of disease, affecting millions of people, and was among the ten chemicals of major public concern requiring action to protect health workers, children and women of reproductive age. She urged WHO to continue working to eliminate lead exposure and poisoning, including through the development of a global action plan, technical guidance, and training and advocacy materials for decision-makers. The draft decision on galvanizing support for a lead-free future would help to foster a shared vision for a world free of lead exposure and prioritize efforts to address that pressing global health challenge.

The representative of the DOMINICAN REPUBLIC,[26] noting the report, said that her Government wished to be added to the list of sponsors of the draft resolution on galvanizing support for a lead-free future.

[26] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of OMAN[27] outlined his Government's work to reduce the impact of chemicals, waste and pollution on human health. He expressed the hope that the Secretariat would help to develop capacities in chemical safety, toxin control and health risk assessments, and provide support to implement pollution monitoring systems and track health and environmental indicators.

The representative of KAZAKHSTAN[27] expressed her firm belief that WHO must have access to the latest research to assess and address the impacts of nuclear substances. The financial implications of implementing the draft decision on the [effects of [nuclear weapons and] nuclear war on health and [health] services were a modest and necessary investment in global health security. It was crucial to update WHO reports to ensure that policy-makers had access to the best available data to inform their decisions and protect lives.

The representative of MONACO[27] welcomed the report and the actions contained therein to combat environmental and health hazards. The adoption of the Global Framework on Chemicals had marked significant progress in that regard. She supported the implementation of dialogue mechanisms between WHO and health and environment ministries to strengthen cooperation, share best practices, raise awareness and improve regional coordination. She called for greater cooperation to implement solutions to manage chemicals, waste and pollution.

The representative of BELARUS[27] said that it was more important than ever to consider the issue of highly infectious medical waste, which was a by-product of the activities of certain types of laboratories and research centres and could lead to the emergence of new pandemics. His Government would welcome a WHO assessment of Bio City, a biotechnology park in Lithuania that was due to open in 2025, to provide information about the park's biosecurity and waste disposal measures.

The representative of COLOMBIA[27] highlighted the urgent need to implement the Global Framework on Chemicals through a comprehensive and flexible approach, taking into account the life cycle of substances such as pesticides and the differentiated management of substances such as endocrine disruptors in medicines with environmental impacts. Joint programmes were needed with the participation of the Secretariat at the global and regional level, health ministries and multisectoral partners to ensure the effective use of scientific, technological and financial resources. The science-policy panel was a significant step forward for decision-making. He urged WHO and PAHO to establish strategies to strengthen monitoring – including biomonitoring – and poison centres, and to optimize technical and financial resources.

The representative of GERMANY[27] noted that draft decisions were subject to a prioritization process to ensure that their implementation was aligned with WHO's strategic priorities and available resources. She supported the endorsement of the Global Framework on Chemicals. Collaboration with existing United Nations structures, such as the Sustainable Development Cooperation Framework, and intergovernmental organizations would raise awareness of health considerations. Substandard recycling of lead acid batteries and the consumption of contaminated drinking water contributed to childhood lead exposure and posed significant global health risks. It was also important to consider the cost of lead exposure in terms of lost economic potential.

The representative of VANUATU[27] highlighted the complementarity between the draft decision on the [effects of [nuclear weapons and] nuclear war on health and [health] services, and

[27] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

the study on the effects of nuclear war that had been commissioned by the United Nations General Assembly. United Nations General Assembly resolution 79/238 (2024) invited WHO to support that work; WHO must therefore update its scientific information by considering the research and studies that had been carried out since the publication of both of its reports on the health implications of nuclear war.

The Observer of PALESTINE said that the war against Palestine had led to the collapse of solid waste management in the Gaza Strip, compounding the public health crisis. Missiles, ammunitions and weapons remained on the ground and required specialized clearing. Bombing had seriously polluted the environment, and contaminated soil needed to be secured. The suffering of Palestinians in the occupied Palestinian territory, the Gaza Strip and the West Bank, including east Jerusalem was compounded by the deterioration in environmental conditions. The environmental community should support humanitarian agencies in addressing those issues in the occupied Palestinian territory.

The representative of MALAYSIA[28] supported work to update the WHO Chemicals road map following the adoption of the Global Framework on Chemicals, in particular to help the health sector to take a leading role in sound chemicals management, strengthen poison centres, implement health surveillance and biomonitoring systems, and curate monitoring data. WHO should continue to provide technical support and training programmes, and to share chemicals, waste and pollution risk reduction strategies. In the light of current financial constraints, a WHO global action plan on lead mitigation could be integrated into the WHO Chemicals road map, which would help to achieve targets 3.9, 6.3 and 12.9 of the Sustainable Development Goals. She called for inclusivity in the procedures to prepare draft decisions and resolutions.

The representative of the PHILIPPINES[28] expressed his support for deepening partnerships and engagement between the Secretariat and Member States to implement the Global Framework on Chemicals. His Government intended to operationalize that Framework through intersectoral collaboration.

The representative of ZAMBIA[28] welcomed the WHO Chemicals road map and the Global Framework on Chemicals Fund. Toxic chemical pollution remained a significant environmental risk factor for disease and premature death, and redoubled efforts were needed to safely handle and dispose of waste and hazardous substances. She called for a robust, harmonized, sustainable and human-centred approach to chemicals and waste management, and pollution control. Interventions should be harmonized across all levels and based on a multisectoral approach, and relevant investments should be increased. Biomonitoring should be improved and increased. It was necessary to promote low-carbon and environmentally sustainable health supply chains and technologies, and address the many dangerous substances that remained unclassified. Regarding paragraph 13 of the report, she requested clarification of WHO's role as custodian of several indicators relating to the targets of the Global Framework on Chemicals.

The representative of ETHIOPIA outlined the challenges to implementing comprehensive chemical management systems at the national level, including the limitations imposed by high costs and the lack of skilled human resources and medical supplies. He supported the endorsement of the Global Framework on Chemicals and the establishment of robust coordination mechanisms between WHO and national health ministries. Low- and middle-income countries needed tailored implementation guidelines. Prioritizing the establishment of poison centres,

[28] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

regional biomonitoring networks and standardized surveillance protocols would strengthen health surveillance, and he called for increased technical and financial support to implement those measures effectively.

The representative of LESOTHO commended WHO's leadership in addressing the impact of chemicals, waste and pollution on human health, which disproportionately affected developing countries. She outlined the significant challenges that chemical exposure, inadequate waste management and environmental pollution posed in her country. She called on the Secretariat and international partners to enhance technical support and capacity-building to strengthen regulatory frameworks, improve enforcement mechanisms and build institutional capacity. Access was needed to sustainable technologies for industrial waste disposal, and air and water purification.

The representative of PANAMA[29] said that the impact of chemicals, waste and pollution on human health should be tackled through evidence-based interventions. Despite progress, a lack of awareness, particularly among decision-makers, caused resources to be allocated elsewhere. Social and environmental factors, and the production of dioxins, furan, lead and mercury, hindered the achievement of the targets of the Global Framework on Chemicals. It was necessary to implement monitoring and biomonitoring systems; increase health worker training and public awareness; develop integrated, intersectoral and sustainable health, environmental and education strategies; manage funding and resources to implement programmes and policies effectively; and audit, monitor and check emissions in different areas. The Secretariat must show leadership through the WHO Chemicals road map, support the International Conference on Chemicals Management, and take ownership of the Global Framework on Chemicals. She supported the draft decision on galvanizing global support for a lead-free future.

The representative of GHANA[29] said that the statistics on lead exposure and its impacts on human health were alarming. It represented a complex global challenge that was inextricably linked to social injustice, and significantly undermined health, education, economic growth and environmental protection. Member States should work with partners to identify and improve access to safer alternatives to lead, in keeping with Sustainable Development Goals 3, 9 and 12. The draft resolution on galvanizing global support for a lead-free future would support further work in that regard. Member States could work with WHO to prioritize the elimination of lead exposure and poisoning, including through global action, technical guidance and advocacy materials.

The representative of the RUSSIAN FEDERATION[29] said that she was not in favour of discussing the draft decision on the [effects of [nuclear weapons and] nuclear war on health and [health] services. Such a discussion was aimed at broadening WHO's mandate to cover issues such as weapons control, disarmament and non-proliferation. Further research on the consequences of using nuclear weapons would not alter the international discourse; there were sufficient data already and the destructive nature of nuclear explosions for humans and the environment was obvious. Such draft decisions diverted WHO resources from other areas. It also duplicated the work of the United Nations Scientific Committee on the Effects of Atomic Radiation and undermined the expert dialogue of the United Nations Disarmament and International Security Committee and the review process of the Non-Proliferation Treaty.

The representative of INDONESIA[29] said that safe and effective chemicals management required an integrated approach. She supported the Global Framework on Chemicals, particularly

[29] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

its focus on waste management, pollution control and the integration of climate change into health policies. Health systems were essential to responding to chemical-related emergencies, hence the need to train health workers in that area and in risk assessment. WHO was critical to facilitating technical and financial assistance to strengthen national capacity in that area.

The representative of PARAGUAY,[30] outlining the work carried out and challenges encountered in her country, said that international cooperation, supported through the Global Framework on Chemicals Fund, was essential to accessing tools to strengthen epidemiological surveillance. It was also vital to strengthen poison centres and epidemiological surveillance systems for chemical-related morbidity and mortality. A One Health approach was needed, integrating primary healthcare, environmental health and universal health coverage. She supported the draft decision on galvanizing support for a lead-free future.

The representative of SAMOA,[30] welcoming WHO cooperation to tackle plastic pollution in and around the Samoan islands, expressed her support for the draft decision on the [effects of [nuclear weapons and] nuclear war on health and [health] services, which was aligned with the Fourteenth General Programme of Work, 2025–2028. The Secretariat had shared that it could absorb the cost of implementing the decision, estimated at US$ 500 000. It remained relevant to all Member States to update WHO studies, since nuclear weapons did not discriminate. WHO should leverage the authority that its Constitution bestowed upon it to provide the most recent science and research, and ensure full understanding of the negative consequences of nuclear weapons, in order to support the call for peace and protect health.

The representative of the MARSHALL ISLANDS,[30] aligning himself with the statement delivered by the representative of the Federated States of Micronesia, said that the text of the draft resolution on the [effects of [nuclear weapons and] nuclear war on health and [health] services was not final, and he remained committed to holding discussions in good faith and reaching compromises. The text spoke to the lived experiences of his country and others with nuclear legacies, and he called on Member States to give due consideration to the views of those proposing the draft decision. Work would continue to finalize the text during the intersessional period.

The representative of UNEP recognized the importance of the health sector in soundly managing chemicals and waste, and preventing pollution. UNEP had mandated the establishment of the science-policy panel to provide advice and improve national responses to global pollution challenges. Those responses required multisectoral collaboration, including between the health and environment sectors. It would be crucial to leverage WHO's technical expertise and networks to engage with the global health community. Two intergovernmental meetings would be held in June 2025 to finalize proposals for the panel.

The representative of IAEA said that her agency was addressing the impact of chemical and plastic pollution, including in marine environments, and supporting Member States in developing resilient food safety systems. IAEA was working with WHO to review the evidence on using nuclear techniques to ensure food safety and would explore future opportunities for collaboration with FAO and WHO at a technical meeting in July 2025.

The representative of the WORLD HEART FEDERATION, speaking at the invitation of the CHAIR, said that cardiovascular disease was the leading cause of death globally, with air pollution representing one of the deadliest risk factors and accounting for over a third of

[30] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

cardiovascular-related deaths. She called on Member States to reduce levels of air, water and ground pollution, participate in the second WHO Global Conference on Air Pollution and Health, and produce an actionable political declaration at the Fourth High-level Meeting of the United Nations General Assembly on the prevention and control of non-communicable diseases.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS welcomed the WHO Chemicals road map, particularly its focus on the critical advocacy role of civil society and the health sector. She urged WHO to strengthen that road map by prioritizing equity in air pollution mitigation strategies in order to protect at-risk groups, and to foster multisectoral collaboration by engaging governments, industries and communities to implement effective solutions. She called on stakeholders to act decisively and collaboratively as clean air was a fundamental human right.

The representative of the INTERNATIONAL BABY FOOD ACTION NETWORK said that prenatal and postnatal exposure to toxic chemicals could harm children's health. In most cases, breastfeeding continued to provide benefits, despite the risk of contamination, and helped babies to build their immune systems. Infant feeding products and packaging contained plastics and endocrine disruptors that impacted babies' immune, reproductive and endocrine systems. WHO must continue to work on the global plastics treaty and ensure that parents received sound information that was free of commercial influence.

The ASSISTANT DIRECTOR-GENERAL (Universal Health Coverage/Healthier Populations), noting the comments by Member States, said that the triple planetary crisis of climate change, pollution and biodiversity loss significantly impacted human health. The significant yet preventable burden of disease related to chemicals, waste and pollution called for a greater sense of urgency. She noted requests for Member States to participate in updating the WHO Chemicals road map and expressed appreciation for efforts to strengthen the role of the health sector in addressing chemical- and waste-related harm. The Secretariat was developing guidance to support Member States on poison centres and national biomonitoring and surveillance. The Secretariat would continue to work with Member States, including by providing technical support and checking progress. Through wise financial decisions and collaboration, WHO would maintain its scientific work and technical excellence, provide tailored support to Member States and advance partnerships to minimize the negative impacts of chemical waste and pollution on human health.

The CHAIR took it that that the Board wished to note the report contained in document EB156/23.

The Board noted the report.

The CHAIR took it that the Board wished to suspend consideration of the two draft decisions pending the outcome of the broader discussion on the costing implications of resolutions and decisions recommended by the 156th session of the Executive Board for adoption by the Seventy-eighth World Health Assembly.

It was so agreed.

(For the adoption of a decision, see the summary record of the eighteenth meeting, section 10.)

3. Updated road map for an enhanced global response to the adverse health effects of air pollution: Item 21 of the agenda (documents EB156/24 and EB156/24 Add.1)

The CHAIR drew attention to the report contained in document EB156/24 and to the draft decision contained therein, which contained a draft decision to be submitted to the Seventy-eighth World Health Assembly, the financial and administrative implications of which were contained in document EB156/24 Add. 1.

The representative of MOROCCO, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the first road map for an enhanced global response to the adverse health impacts of air pollution had been insufficient, and further progress was urgently required. Air pollution was a particular issue in his Region and a major environmental health hazard. Reducing air pollution would not only improve public health, but also mitigate the effects of climate change. He strongly recommended adopting the draft updated road map, which acknowledged countries' different baselines and contexts, and was pleased to note the key interventions for the health sector. The health sector must reduce emissions, in line with resolution WHA77.14 (2024), and call for action to reduce air pollution in other sectors. He requested that the Director-General report on progress in implementation of the draft updated road map to the Eighty-third World Health Assembly in 2030.

The representative of ZIMBABWE, speaking on behalf of the Member States of the African Region, welcomed the draft updated road map and expressed appreciation for WHO's efforts to promote an enhanced global response to the adverse effects of air pollution. Outlining the measures currently being implemented across his Region, he called on the Board to assist countries in mobilizing resources to implement activities that would enhance the global response to the adverse health effects of air pollution; assist his Region in improving data collection and research capabilities; and strengthen institutional capacity to manage air quality at the national and local levels, and integrate that work into national development policies.

The representative of NORWAY acknowledged the detrimental effect of air pollution on human, animal and planetary health. She welcomed the focus in the draft updated road map on protecting vulnerable groups and ensuring equity; WHO could play a key role in that regard. There was a clear need for cooperation with United Nations specialized agencies, the World Bank, governments and civil society. Her Government would continue to support WHO work on climate, and she encouraged WHO to focus on the interlinkages between climate, the environment and air quality across sectors and stakeholders.

The representative of TOGO welcomed the draft updated road map and supported its overall target to achieve a 50% reduction in the population-attributable fraction of mortality from anthropogenic sources of air pollution by 2040, relative to 2015 baseline values. Achieving that global target would require tailored strategies in the African Region. She called on WHO to mobilize and prioritize resources for air quality management, improve data collection and research by installing surveillance systems in African cities, raise awareness, strengthen institutional capacities to manage air quality, and promote regional cooperation to combat cross-border air pollution and include air quality management in national development policies.

The representative of THAILAND said that, although the draft updated road map was comprehensive, its success would depend on national implementation capacity and multisectoral collaboration. Depending on national context, efforts should focus on containing pollution at source through regulation and financial incentives, and transitioning to green energy sources. Most Governments had invested in monitoring pollution; real-time data should be made publicly

available to encourage action. Addressing air pollution and its health impacts required national, regional and global cooperation, and the Secretariat should provide technical support, guidance and expertise to Member States in that regard. He supported the draft decision.

The representative of CANADA underscored the importance of international cooperation. She asked which air pollution sources and types of pollutants were taken into consideration in the draft updated road map, and whether and how it would take into account demographic changes such as population growth and aging populations.

The representative of CHINA said that the draft updated road map should take into consideration the differences between countries in socioeconomic development, air pollution levels and control capacity, and the health impacts of air pollution. The targets, workplans and evaluation indicators for the overall target of the draft updated road map should be clarified, as should the responsibilities of United Nations specialized agencies and health-related organizations to promote it. The draft updated road map should reflect the importance of air quality monitoring, health risk assessment and public awareness. Her Government had implemented measures to tackle air pollution and stood ready to share its experience.

The representative of SLOVAKIA supported the draft updated road map and recommended the development, in consultation with Member States, of specific, measurable, achievable, relevant and time-bound indicators to track progress. It was unclear how the draft road map would be coordinated with existing initiatives and he therefore called for the creation of an intergovernmental task force to tackle alignment. Regarding the proposed budget, he suggested the adoption of an equity-based funding model that prioritized regions with limited monitoring infrastructure. The Programme, Budget and Administration Committee of the Executive Board should provide annual expenditure reports, including financial breakdowns by region and type of activity. He asked how the Secretariat would ensure that Member States retained flexibility in integrating the draft updated road map into their national policies while maintaining a harmonized global approach, and what mechanism the Secretariat would establish to prevent overlap with existing international air pollution initiatives. He requested greater clarity on regional funding allocations and the criteria for distributing financial resources.

The representative of CAMEROON supported the overall target of the updated road map. Air pollution presented a major challenge and health threat, leading to complex impacts that health systems were not always equipped to handle. An increase in transmissible disease epidemics, obstacles to healthcare, and extreme weather events had led to premature deaths, malnutrition and the spread of waterborne and vector-borne diseases. He outlined national measures to tackle air pollution, and noted the report.

The representative of COLOMBIA[31] welcomed the draft decision and invited Member States to attend the upcoming WHO Second Global Conference on Air Pollution and Health to be held in Cartagena, Colombia. The updated road map should include the commitments that had been made at the First Global Conference, and highlight the need to reduce the use of short-lived substances and raise public awareness of the risks of air pollution. It was also important to strengthen air quality monitoring systems and epidemiological surveillance to track the effects of air pollution.

The representative of SPAIN[31] expressed support for the updated road map; as a global problem, air pollution was a global challenge that particularly affected the most vulnerable and

[31] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

which required a coordinated and ambitious response. The burden of noncommunicable diseases was directly linked to the triple planetary crisis. He welcomed the strengthening in the updated road map of the leadership of the health sector in the response to air pollution. International cooperation and funding mechanisms should be strengthened to guarantee clean air for all. The overall target of the updated road map was ambitious but necessary, and would require the promotion of clean energy sources, zero-emission technology and health. He was committed to ensuring that health remained central to climate action. He was pleased to note the upcoming Second Global Conference on Air Pollution and Health.

The meeting rose at 12:00.

Fifteenth meeting

Saturday, 8 February 2025, at 14:35

Chair: Dr J.X. Walcott (Barbados)

Pillar 3: One billion more people enjoying better health and well-being (continued)

1. Updated road map for an enhanced global response to the adverse health effects of air pollution: Item 21 of the agenda (documents EB156/24 and EB156/24 Add.1) (continued)

The CHAIR recalled that the Board had before it the draft decision contained in document EB156/24.

The representative of OMAN[1] expressed his Government's commitment to the updated road map for an enhanced global response to the adverse health effects of air pollution. The Secretariat should support the development of national competencies in environmental health through specialized training programmes with a particular focus on addressing air pollution. Technical support should be provided to measure the health impact of air pollution, optimize the calculation of air quality indicators and link health data with environmental monitoring data.

The representative of the PHILIPPINES,[1] welcoming the updated road map, said that his Government continued to support interventions that addressed the health risks associated with air pollution, including tobacco smoke. Inaction had severe consequences on health, especially on the onset of noncommunicable diseases and on children's health. The road map had the potential to prompt further action in numerous related areas, including climate change and primary healthcare.

The representative of the RUSSIAN FEDERATION[1] said that, in the light of budgetary constraints, WHO should stick to its mandate and not interfere in the activities of other organizations. The updated road map required further development and consultation with Member States. Indicators for calculating health risks should be developed, and then updated every three to five years, in order to take a uniform approach to assessing the impact of air pollution on health. A clear set of data should be collected, such as hospitalization and mortality rates.

The representative of the EUROPEAN SOCIETY FOR MEDICAL ONCOLOGY, speaking at the invitation of the CHAIR, welcomed the updated road map and supported the increased emphasis on tackling air pollution in the Fourteenth General Programme of Work, 2025–2028. Noting the link between ambient air pollution and lung and breast cancer, she encouraged Member States to

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

harmonize their national standards with WHO guidelines. Urgent action was needed to control air pollution, with particular attention to low- and middle-income countries.

The representative of the NCD ALLIANCE, speaking at the invitation of the CHAIR, noted that air quality interventions were urgently required to reduce premature mortality from noncommunicable diseases in line with target 3.4 of the Sustainable Development Goals. She welcomed the updated road map and its overall objective to build further momentum for action on clean air and urged Member States to adopt it. Member States should integrate air quality goals and interventions into national noncommunicable disease and climate plans; prioritize actions to reduce fossil fuel use; seek health co-benefits from activities to reduce air pollution; and monitor impacts on vulnerable populations.

The representative of the UNION FOR INTERNATIONAL CANCER CONTROL, speaking at the invitation of the CHAIR, welcomed the updated road map, applauding the proposed target to reduce mortality from anthropogenic air pollution by 50% by 2040. In advance of the Seventy-eighth World Health Assembly, the Secretariat should ensure that people with cancer were recognized in the road map as a vulnerable group; provide guidance on the delivery of global best buys for air pollution; and provide clarity on the role of stakeholders, including civil society groups, in the road map's implementation.

The representative of STICHTING HEALTH ACTION INTERNATIONAL, speaking at the invitation of the CHAIR, said that it was essential for WHO to drive coordinated action and leadership on air pollution. While WHO's global air quality guidelines provided clear parameters to reduce the burden of respiratory, cardiovascular and neurological diseases associated with pollution, their implementation remained insufficient. She urged Member States to adopt the air quality limits proposed by WHO, strengthen epidemiological and air pollution data collection, and ensure sustainable financing for the implementation of evidence-based policies.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIR, welcomed the updated road map and its focus on the critical role of civil society and the health sector in environmental advocacy. Air pollution should be considered a public health crisis. Member States should prioritize equity in mitigation strategies to protect at-risk groups; strengthen air quality monitoring in regions with limited resources; scale up investments in clean energy and sustainable transport systems; address root causes of air pollution; and foster multisectoral collaboration between governments, industries and communities.

The ASSISTANT DIRECTOR-GENERAL (Universal Health Coverage/Healthier Populations) recognized that air pollution had a huge impact on health, including on the onset of noncommunicable diseases. The Secretariat was developing an innovative, integrated approach to achieving the voluntary target to address the health impacts of air pollution by 2030. She took note of requests to implement more ambitious actions on air pollution, energy access, climate mitigation and health, stating that the voluntary target aimed to do just that. The request to develop a smart indicator had also been noted. Those requests were in line with the Fourteenth General Programme of Work, 2025–2028, and would help WHO to fulfil its mandate to monitor progress towards Sustainable Development Goals 7 (Ensure access to affordable, reliable, sustainable and modern energy for all), 11 (Make cities and human settlements inclusive, safe, resilient and sustainable) and 13 (Take urgent action to combat climate change and its impacts).

The Secretariat was working to strengthen health sector leadership and promote collaboration with other sectors to enhance implementation of the road map. It was working within the United Nations system, including with United Nations country teams, to support

Member States in achieving national and regional targets. She agreed that implementation would be most effective if tailored to national and regional contexts. Requests for an equity-based funding model for transparent resource distribution across all WHO regions in the implementation of the road map would be taken into account.

She said that fine particulate matter was used to monitor the health impact of air pollution, including through air quality indicators, and was regularly reported on by the Secretariat. The Scientific Advisory Group and Global Air Pollution and Health Technical Advisory Group would provide guidance concerning the integration of demographic change in modelling. The Secretariat would continue to avoid duplicating the work of other agencies.

The Board noted the report.

The CHAIR took it that the Board wished to suspend consideration of the draft decision contained in document EB156/24 pending the outcome of the broader discussion on the costing implications of resolutions and decisions recommended by the 156th session of the Executive Board for adoption by the Seventy-eighth World Health Assembly.

It was so agreed.

(For the adoption of a decision, see the summary record of the eighteenth meeting, section 11.)

2. Climate change and health: Item 22 of the agenda (documents EB156/25 and EB156/25 Add.1)

The CHAIR drew attention to a draft decision, which contained a draft decision to be submitted to the Seventy-eighth World Health Assembly and was contained in document EB156/25. The financial and administrative implications of which were contained in document EB156/25 Add.1.

The representative of BRAZIL said that WHO must adopt a bold and inclusive approach to the draft global action plan on climate change and health. Goals aimed at addressing structural and social inequalities should be included, and he emphasized the importance of empowering vulnerable communities through meaningful participation in decision-making processes and increased access to financial and technical resources. Equity should be a guiding principle and a measurable outcome in the implementation of the draft global action plan.

It was vital to integrate health into national, regional and global climate policies, including under the United Nations Framework Convention on Climate Change. Strengthening health systems' resilience to climate impacts and reducing greenhouse gas emissions within the health sector must remain priorities. Traditional knowledge should be integrated with scientific research to strengthen the evidence base on climate change and health.

The representative of SOMALIA, recognizing that climate change was a global health crisis in addition to an environmental issue, welcomed the draft global action plan and supported its adoption. He urged the international community to prioritize climate-resilient health systems and strengthen global cooperation to address the health impacts of climate change. He called for financial and technical support to build climate-resilient infrastructure and strengthen disease surveillance. Strengthening collaboration between the health and environment sectors would facilitate the development of integrated policies that addressed the root cause of climate change while safeguarding public health. Low-income countries must have equitable access to resources,

technologies, capacity-building initiatives, early warning systems and preparedness measures to mitigate the health impacts of climate-related disasters. He urged Member States to honour their commitments under the Paris Agreement under the United Nations Framework Convention on Climate Change and prioritize climate action plans.

The representative of AUSTRALIA, appreciating the benefits of clear, demonstrable actions that addressed the impacts of climate change related to health and well-being, welcomed the consultative process to develop the draft global action plan. Its adoption would enable WHO to strengthen its ongoing work to curtail the catastrophic impacts of climate change on human health, and support Member States in identifying relevant national action.

The representative of BRUNEI DARUSSALAM applauded WHO's leadership in integrating health considerations into climate change agendas and fully supported the draft global action plan. He expressed appreciation for the inclusive and consultative development process and encouraged the Secretariat to continue fostering collaboration with all stakeholders during the implementation phase to ensure that diverse regional and local needs were addressed effectively, particularly in nations with limited resources. Digital health could enhance the efficiency and reach of health services, minimize environmental impact, and facilitate real-time data collection and analysis. The mental health impact of climate change warranted further attention. Mental health support, including psychosocial care for affected communities, should be integrated into climate adaptation strategies. Regional collaboration should be strengthened to share expertise, data and best practices in climate change and health adaptation. Investing in early warning systems and disease surveillance would be critical in managing climate-related health risks. Sustainable financing mechanisms needed to be explored so that climate adaptation did not come at the expense of other pressing health priorities.

The representative of POLAND, speaking on behalf of the European Union and its Member States, said that the candidate countries Türkiye, North Macedonia, Montenegro, Serbia, Albania, Ukraine, the Republic of Moldova and Georgia, as well as Armenia, aligned themselves with her statement. There was a need for urgent and coordinated global action on climate change. She commended WHO for its leadership on climate change and health and was grateful for the progress made under resolution WHA77.14 (2024). It was encouraging that the draft global action plan was aligned with the WHO global strategy on health, environment and climate change and the Fourteenth General Programme of Work, 2025–2028. To maximize health benefits in climate adaptation efforts, it was vital to create a robust and relevant evidence base that explored the connection between climate change and health; adopt a Health in All Policies approach at the national and subnational levels; and promote health-centred cross-sectoral cooperation that acknowledged the links between human, animal and environmental health. She acknowledged the importance of multilateral instruments focusing on climate change and health. She called on all Member States to join WHO's Alliance for Transformative Action on Climate and Health. The Secretariat should share the outcomes of its work to develop clear norms, standards, policy guidance and capacity-building guidelines on reducing health sector emissions, as outlined in the Fourteenth General Programme of Work, 2025–2028. She called for ambitious common targets and strong engagement and commitment from all sectors. All stakeholders must work to curb emissions and reduce waste in the health sector, including in supply chains. In the current financial context, where prioritization was vital, she asked how many WHO staff members were working on climate change and health and how much funding was available.

The representative of MALDIVES welcomed the comprehensive draft global action plan and the consultative nature of its development. She recognized the urgent need for coordinated global action to address the health impacts of climate change. Building climate-resilient health facilities

required sustainable and innovative financing that was integrated into national health budgets; equitable country-specific approaches; and a health workforce equipped to tackle climate-related health challenges, including disaster preparedness, climate adaptation strategies and new and emerging diseases linked to climate shifts. National commitments under the draft global action plan should be fully aligned with the Paris Agreement, ensuring health was mainstreamed into all climate policies. The Secretariat must work with partners to enhance synergy and avoid duplication of efforts. She urged the Secretariat to ensure the full and accountable implementation of the draft global action plan; work with Member States to mobilize sustainable financing and technical support; and provide regular updates to track the impact and effectiveness of interventions.

The representative of COSTA RICA supported the draft global action plan but drew attention to several areas that required further development. Specific support, including the allocation of sufficient resources, should be provided for developing countries, vulnerable groups and communities with limited resources, to enable the development of implementation strategies. The planned monitoring and evaluation framework was welcome but should include specific indicators to measure progress on climate change and health in practical terms. He noted the need to mobilize resources; however, the draft global action plan should clarify how to overcome barriers to financing, particularly in countries with fragile economies. Welcoming the focus on multisectoral collaboration, he asked how work would be divided up among the environment, agriculture and health sectors, in line with the One Health approach.

The representative of THAILAND noted the draft global action plan and the consultative nature of its development. The draft plan would play a critical role in harmonizing efforts across multiple sectors. Its success depended on effective implementation at the country level; national targets and indicators should be set to monitor progress. To that end, the Secretariat should provide technical support to build climate-resilient health systems and help to mobilize resources. He supported the adoption of the draft decision.

The representative of QATAR, speaking on behalf of the Member States of the Eastern Mediterranean Region, commended the efforts of the Secretariat in advancing initiatives related to climate change and health. However, he expressed reservation at the absence of references in the draft global action plan to the foundational principles of the Paris Agreement and other relevant climate change commitments, particularly the principle of common but differentiated responsibilities and respective capabilities.

The representative of the REPUBLIC OF MOLDOVA commended the draft global action plan, which took a comprehensive and results-based approach to addressing the health impacts of climate change. Effective implementation of the draft plan required a multisectoral effort that engaged all relevant public authorities, as well as local administrations to strengthen community resilience. To that end, she encouraged the Secretariat to develop guidelines for national authorities on developing and implementing adaptation measures. She acknowledged the crucial role of the health workforce in promoting sustainable behaviour and health consequences. Her Government supported further consultation on the draft global action plan.

The representative of BARBADOS acknowledged WHO's leadership in addressing the profound impact of climate change on health. He highlighted the vulnerability of small island developing States. He endorsed PAHO's Smart Hospitals initiative which aimed to make healthcare facilities greener and more resilient to natural disasters. Noting the problems experienced by his Government in accessing internationally available financial and technical support mechanisms for

climate change, he expressed support for the consultative process undertaken to develop the draft global action plan.

The representative of BULGARIA supported the development of the draft global action plan and agreed with the need to take action on climate change. A Health in All Policies approach to climate adaptation would promote effective cross-sectoral cooperation and the coordination of government departments. The success of climate adaptation interventions depended on the degree of awareness of the problem, the existence of effective response strategies and the availability of resources, information and initiatives for implementation.

The representative of CANADA welcomed efforts to foster complementarity, avoid duplication of work, and ensure flexibility to account for diverse health system structures. There were opportunities to enhance the impact of the draft global action plan by encouraging a stronger public health approach, placing greater emphasis on mental health impacts, incorporating Indigenous knowledge, and considering a distinct evaluation pillar.

The representative of SLOVAKIA supported the draft global action plan but emphasized the need for clear priorities, cost-effective implementation and strong accountability measures. To avoid duplication and improve efficiency, climate action must be integrated within existing WHO programmes. Financial resources should be directed toward scalable solutions such as cross-training health workers and repurposing disease surveillance systems for climate-sensitive illnesses. Strengthening national and regional health systems would be key to reducing reliance on centralized technical support. His Government remained concerned about the lack of clarity on specific allocations for high-risk and vulnerable regions and the remaining funding gap. The Secretariat should explore multiyear financial models and strategic partnerships and redeploy existing staff members from environmental health and emergency response programmes. He urged the Secretariat to adopt a more sustainable and results-based approach that included measurable outcomes of mutual benefit to other sectors, such as reducing respiratory diseases through clean energy investment, building stronger collaboration between United Nations organizations to integrate climate data, and developing green healthcare infrastructure. The Secretariat should clarify how it would ensure that climate health financing reached frontline providers in vulnerable regions and what safeguards were in place to prevent overlap with other United Nations organizations. He asked whether the Secretariat could adopt a phased approach at the headquarters and regional levels, prioritizing contextualized high-impact, low-cost interventions before complex initiatives.

The representative of the REPUBLIC OF KOREA said that health should be integrated into national and global climate agendas, including through monitoring the impacts of climate change, assessing the effectiveness of evidence-based policies and interventions, and building resilient health systems through robust capacity-building initiatives at the national level. Collaboration among Member States, civil society and the broader United Nations system was essential for addressing challenges through sustainable and comprehensive strategic approaches. Health-oriented approaches should be embedded in all policies, connections between climate change and health should be strengthened, and financing secured. There was an urgent need to intensify global action on climate change and health and to provide technical and financial support. Her Government strongly supported adopting the draft global action plan. However, progress reports on its implementation should focus on generating practical evidence on climate vulnerability and health equity at the local, national and global levels. The international community should prioritize minimizing the health impacts of climate change through the establishment of measurable targets, including on greenhouse gas emissions, global and regional

temperature trends, mortality from heat-related illnesses and damage caused by climate-related disasters.

The representative of NORWAY, speaking on behalf of the Nordic and Baltic countries, recognized that the climate crisis was also a health crisis. The draft global action plan must be adopted at the Seventy-eighth World Health Assembly and Member States and the Secretariat alike should prioritize its implementation. The impact of climate change and health should be addressed from a One Health perspective. Moreover, health systems needed to be strong and resilient; local communities and health and care workers could contribute to health systems strengthening. Climate mitigation and adaptation in the health sector must include measures to reduce the carbon footprint of the sector itself, which accounted for 5% of global greenhouse emissions. The draft global action plan would be key in promoting climate change as a core priority in national health policies. The cost of inaction on climate change and health was much greater than that of investing in change.

The representative of CHINA commended the draft global action plan and fully supported the three action areas outlined in the report. However, the draft plan failed to adequately reflect the principles of equity and common but differentiated responsibilities and respective capabilities. The Secretariat should convene consultations to promote further discussion, ensuring the meaningful participation of all Member States.

The representative of ETHIOPIA, speaking on behalf of the Member States of the African Region, said that Africa bore a disproportionate climate change burden, despite contributing minimally to global emissions. Yet, the health systems in many African countries lacked adequate resources and capacity to respond effectively to mounting climate-related challenges. He recognized efforts to incorporate health into broader climate change strategies and to increase awareness of climate change and health in the African Region, prioritizing adaptation and building resilience. He welcomed the draft global action plan, but called for it to be further strengthened ahead of its adoption at the Seventy-eighth World Health Assembly. Above all, the principle of common but differentiated responsibilities and respective capabilities must be included. There was a need for more substantial and accessible funding mechanisms to support climate-health integration, especially in Africa and in developing countries. More specific attention should be paid to vulnerable populations disproportionately affected by the impacts of climate change. A stronger focus should also be placed on building climate-resilient health systems, infrastructure and workforces.

The representative of SENEGAL called on all relevant stakeholders to pay specific attention to the impact of climate change on health, particularly in the most vulnerable population groups. The draft global action plan would support Member States in creating sustainable and resilient health systems and in implementing the necessary strategies and plans for climate change and health. He encouraged WHO to increase investment in climate adaptation initiatives and health systems strengthening. Member States should implement the draft global action plan to build sustainable health systems resilient to climate change.

The representative of TOGO supported the draft global action plan, including its three action areas, and expressed appreciation for the consultative process used in its development. Its results-based approach that was tailored to country needs and capacities was particularly welcome. He urged the Secretariat, with the support of its partners and in line with other relevant mechanisms, to develop indicators for measuring progress towards the goals of the draft plan. More should be done to support Member States to implement the draft plan, including mobilizing resources.

The representative of YEMEN outlined the many immediate impacts of climate change on health. Close cooperation was needed between government agencies and humanitarian and health organizations to monitor the real-world effects of climate change, develop rapid response plans, and facilitate the sharing of experiences of addressing public health challenges resulting from environmental disasters.

The representative of the FEDERATED STATES OF MICRONESIA urged the Secretariat to prioritize the unique challenges faced by small island developing States in relation to climate change and health, which included geographic remoteness, fragile infrastructure, limited human resources and constrained financial capacity. WHO must enhance its leadership role and coordinate a global response that prioritized the needs of small island developing States, for instance, by building financial capacity and health systems resilience. He supported the draft decision.

The representative of CHILE strongly supported the draft global action plan, which reflected collective commitment to protecting health and health systems from the impacts of climate change. Clear goals, indicators and deadlines would ensure that the draft plan, like other similar WHO instruments, could be implemented easily and that progress was measurable.

The representative of TÜRKIYE[2] said that the draft global action plan required further improvement, including by providing for long-term assessments of the impacts of the climate change on health, addressing social inequalities and strengthening crisis management strategies. It was important to involve sectors other than health in efforts to address climate change, and to promote international cooperation. Social and mental health should be addressed within the framework of the draft global action plan.

The representative of PERU[2] supported the draft global action plan, which was a significant step forward in integrating health into global and national climate programmes. The draft plan was key to protecting the health of individuals and communities affected by climate change and would serve as a basis for the development of related measures and actions. The draft plan must be implemented in line with Article 8 of the Paris Agreement, with specific action to avoid health losses and damages associated with climate change, for instance, by meeting the needs of populations most vulnerable to climate-related health problems. WHO should participate permanently and actively in global climate change events in order to ensure that health remained a priority.

The representative of PANAMA,[2] appreciating the consultations held to develop the draft global action plan, said that international cooperation on climate change and health was essential. The only way to slow down the impact of climate change on health and prevent the spread of climate-related diseases was through holistic, comprehensive, collective and sustainable interventions based on the Health in All Policies approach. Implementing climate adaptation measures would contribute to addressing the determinants of health. It was encouraging that the draft plan sought to strengthen collaboration with local communities, taking into account their vulnerabilities, knowledge and traditional practices. Successful implementation of local and regional strategies required financial efficiency, use of technology and innovation, and multisectoral collaboration, including with national actors. Food and water security and reduction of emissions must be addressed in a health-conscious and environmentally friendly way. It was necessary to build technical and research capacity on climate change and health.

[2] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of SPAIN[2] called on the health sector to play a part in reducing global emissions and becoming more sustainable. Given that climate change and health were inextricably linked, climate action was needed to take account of related health impacts in order to guarantee equity and prevent deaths. She supported the draft decision.

The representative of THE SAVE THE CHILDREN FUND, speaking at the invitation of the CHAIR and on behalf of Women in Global Health, Inc., The Royal Commonwealth Society for the Blind – Sightsavers, the International Planned Parenthood Federation, World Vision International, Women Deliver, Inc., Amref Health Africa, the International Pharmaceutical Students' Federation, the Global Health Council and the International Association for Suicide Prevention, welcomed the draft global action plan. She noted that the disproportionate impact of climate change on vulnerable and marginalized groups had been acknowledged. She commended the draft plan's emphasis on investing in mitigation and adaptation measures, and calls for multisectoral action that would help to tackle root causes and boost resilience. The focus on strengthening early warning systems and emergency preparedness with robust, disaggregated data was also welcomed.

To implement the draft global action plan effectively, Member States should develop integrated, equitable, gender-responsive, age- and disability-inclusive national climate change and health plans, policies and strategies. They were encouraged to secure resources to transform health systems, support frontline communities, and strengthen the health workforce. Establishing cross-sectoral coordination with all relevant stakeholders was also important. Progress must be tracked through a monitoring framework that engaged stakeholders and protected policy-making from commercial interests. There was a need to collect and use disaggregated data to address the differentiated impacts of climate change on vulnerable groups. Member States should also engage civil society, communities and vulnerable population groups in decision-making and locally led solutions.

The representative of NAMIBIA[3] noted the need for comprehensive strategies and the integration of health into climate policies. Building a climate-resilient health system required climate adaptation measures that focused on strengthening health infrastructure, disease surveillance and essential health services delivery and workforce development. He expressed concern that the principle of common but differentiated responsibilities and respective capabilities had been omitted from the draft global action plan. Operationalizing that principle was crucial to ensuring equitable responsibility and action, particularly for developing countries. Furthermore, while the draft plan acknowledged disease outbreaks and pandemics as climate-related health impacts, it did not sufficiently address equitable and affordable access to diagnostic tools and countermeasures. He urged WHO to advocate for stronger international financial commitments in line with the principle of common but differentiated responsibilities and respective capabilities to aid developing countries in building climate-resilient health systems. The draft global action plan should be further strengthened before adoption.

The representative of BELGIUM[3] said that WHO's leadership and evidence-based guidance was essential for the implementation of policies and plans on climate change and health. The draft global action plan was an opportunity for the Secretariat to lead Member States towards bolder commitments and tangible actions with clear mandates for all stakeholders. A health and climate in all policies approach was fundamental to addressing the health impact of the combined environmental crisis of climate change, biodiversity loss and pollution in a comprehensive and coherent manner. Public policies should benefit climate change and health, rather than harming the health and well-being of people and planet. Multilateral cooperation was critical.

[3] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of ITALY[4] welcomed the draft global action plan, particularly the promotion of climate change adaptation efforts to address health risks and mitigation efforts that maximized health benefits. Her Government supported an approach to climate change mitigation focused on health co-benefits, such as active mobility, nature-based solutions and sustainable urban planning to reduce heat and air pollution. The draft plan's focus on integrating the health and climate agendas at the national level was also welcomed.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND[4] reaffirmed that reducing climate-related vulnerabilities, building resilience among populations and strengthening health systems to cope with increased burdens was critical to WHO's mandate. As the impacts of climate change on health were expected to worsen over time, failure to prioritize that area of work would result in poorer health outcomes globally. He welcomed the draft global action plan and endorsed a One Health approach to climate services, early warning and health surveillance. The draft plan could be strengthened by including tangible actions for the Secretariat and Member States, with clear targets and objectives to deliver on the commitments set out in resolution WHA77.14. An accompanying explanation of the assumptions and risks between targets, objectives and actions would also be welcome. The Secretariat should clarify how the draft plan complemented other international frameworks and set out specific expectations for other health actors.

The representative of THE WORLD MEDICAL ASSOCIATION, INC., speaking at the invitation of the CHAIR and on behalf of FDI World Dental Federation, International Pharmaceutical Federation, International Council of Nurses, the World Confederation for Physical Therapy, the International Federation of Biomedical Laboratory Science, the World Federation of Societies of Anaesthesiologists and the Council for International Organizations of Medical Sciences, commended the timely and inclusive development of the draft global action plan, which highlighted the urgent need for transformative action. He welcomed the strong focus on integrated climate change and health policy across sectors that placed human well-being at the centre of climate action. To strengthen the draft plan, he suggested including health professionals and civil society in the development, implementation and evaluation of climate health strategies; prioritizing guidance on building resilient healthcare systems, particularly in small island developing States and low- and middle-income countries; sharing evidence-based guidance and good practices to reduce carbon footprints and emission rates in the health sector; encouraging a whole-of-society approach to climate change and health through multisectoral cooperation; promoting public and health sector awareness of the links between climate change and health; strengthening research and development on climate-sensitive health threats and equitable health service provision; and establishing an ambitious monitoring framework for the draft global action plan with clear targets, timelines and indicators. Urgent climate mitigation efforts were critical to reducing the health burden of climate-related infections and noncommunicable diseases.

The representative of JAPAN[4] called on WHO to maximize efficiency and effectiveness and avoid duplication of efforts when implementing initiatives on climate change and health such as those undertaken by the Alliance for Transformative Action on Climate and Health or as part of the Research Agenda for Action on Climate and Health. His Government was ready to share its experience in climate disaster risk management.

The representative of FINLAND[4] said that cross-border and multisectoral collaboration was necessary to understand and address climate challenges and safeguard health. WHO should

[4] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

ensure that resilience, epidemic preparedness, public health and health equity, especially for the most vulnerable, were shared priorities. Investment in health protection and health promotion, particularly at the community level, benefited people and planet. It was important to promote sustainable diets and curb the environmental impact of the healthcare sector to reduce global emissions. All efforts should promote the overarching goal of maintaining and enhancing planetary health.

The representative of SAUDI ARABIA[5] recognized the importance of addressing the effects of climate change and strengthening the adaptability of the health sector. However, she stressed that WHO's activities must remain within its core public health mandate. The draft global action plan must be fully consistent with the principles and provisions of the United Nations Framework Convention on Climate Change and the Paris Agreement, without duplicating the efforts resulting from those instruments. She highlighted the importance of the principles of equity and common but differentiated responsibilities. While her Government appreciated the efforts made to develop the draft global action plan, it did not support its adoption in its current form. Additional consultations with Member States were needed to ensure that it better reflected diverse national priorities and circumstances, and avoided unnecessary duplication.

The representative of COLOMBIA[5] said that climate change was a growing threat to health but also an opportunity to strengthen the resilience of health systems and promote sustainable and inclusive development. The draft global action plan would address the effects of climate change on human health while also providing guidelines for the implementation of mitigation and adaptation strategies within health systems. However, his Government wished to propose a number of amendments. The proposed Member State actions under Objective B in the action area on leadership, coordination and advocacy should include the reduction of single-use plastics. Under Objective A in the action area on evidence and monitoring, the collaboration proposed for Member States should include the scientific community and academic institutions for empirical data to be translated into practical policies and innovation. The final action proposed for the Secretariat in the same section should emphasize the need for technical support that strengthened monitoring and early warning systems.

The representative of the INTERNATIONAL FEDERATION OF PHARMACEUTICAL MANUFACTURERS AND ASSOCIATIONS, speaking at the invitation of the CHAIR and on behalf of the Global Diagnostic Imaging Healthcare IT and Radiation Therapy Trade Association, the Global Self-Care Federation and the International Hospital Federation, commended WHO's focus on climate change and health and the development of a draft global action plan with clear actions for the Secretariat, Member States and stakeholders. Recognizing the link between health and climate change would ensure that climate challenges were mitigated, addressed and appropriately financed while safeguarding access to health products and care. The healthcare industry had a key role to play in collaborative initiatives and public health innovation. He encouraged the Secretariat to coordinate with expert groups and to leverage existing data, mechanisms and metrics. Pharmaceutical, biotechnology and other healthcare companies had previously invested in research and development for sustainable products, manufacturing and supply chains and had set ambitious targets. His organization was ready to support the Alliance for Transformative Action on Climate and Health and Member States to reduce the environmental impact of health systems while balancing the needs of patients and healthcare providers. Climate change did not exist in a vacuum; multisectoral action would ensure aligned and implementable policies. The Secretariat

[5] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

should coordinate that alignment across global efforts while maintaining health outcomes as a clear guiding objective.

The representative of OMAN[6] said that the Secretariat should build national competencies in climate change and health through specialized training programmes on the health challenges associated with climate change. Technical support was also needed to implement assessments of vulnerability and adaptation in healthcare facilities to ensure that responses were evidence-based.

The representative of SAMOA,[6] noting that small island developing States were at the forefront of the climate crisis, acknowledged the efforts of WHO in developing the draft global action plan. Accessible financing was essential to building climate resilience and health and care workforce capacity. She welcomed opportunities that accelerated climate action.

The representative of the PHILLIPINES[6] said that there was an urgent need for climate action to be prioritized and scaled up to safeguard people and planet. He expressed support for the actions proposed in the draft global action plan. Supporting the Secretariat's leadership in that regard, his Government requested technical support and capacity building activities in the area of data and evidence generation for policies and interventions. Climate financing was also necessary, particularly co-financing for climate change and health, including for adaptation and mitigation measures.

The representative of PARAGUAY[6] expressed support for the adoption of the draft global action plan. All Member States must take effective measures to protect their people from the effects of climate change on health.

The representative of the RUSSIAN FEDERATION[6] expressed concern regarding the gradual expansion of WHO's work to include climate-related issues, which risked diluting the mandate of the Organization and interfering in the activities of other competent international bodies, and which was an inefficient use of WHO's limited resources. Climate change was already considered in many areas of WHO's work. Thus, the draft global action plan must avoid going beyond the mandate of WHO. It was important to set out criteria for assessing indicators and results, and to use geographically disaggregated data, including quantitative and qualitative analysis, in the development and implementation of measures on climate change and health. The draft global action plan should include measures to detect and monitor antimicrobial resistance of microorganisms in the environment, specifically in air particles.

The representative of the WORLD HEART FEDERATION, speaking at the invitation of the CHAIR, speaking on behalf of the Global Alliance for Tobacco Control, HelpAge International, the International Alliance of Patients' Organizations, the International Diabetes Federation, the International Society of Nephrology, the NCD Alliance, the Union for International Cancer Control, World Cancer Research Fund International and the World Stroke Organization, welcomed the draft global action plan. She commended its call for intersectoral and multisectoral cooperation among national authorities on health and climate change; its focus on health co-benefit assessment for mitigation and adaptation; the recommendations to strengthen the evidence base underpinning health and climate policy; the mechanism to mainstream climate change and health actions across WHO; closer collaboration with the United Nations and other international partners to integrate health policies into climate change processes; and recognition of the need for health ministries to develop and implement climate mitigation and adaptation policies and programmes. However,

[6] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

she expressed concern regarding critical gaps in the draft global action plan. The scope of the proposed actions should be refined to support implementation, including through progress indicators. Greater emphasis should be placed on making the case for investment and communicating the return on investment in climate change and health. There was a need to strengthen guidance on risk forecasting, and to recommend interventions to reduce the use of fossil fuels. Measures to build more resilient health systems should be included, alongside plans to engage civil society in the development, implementation and evaluation of national climate change and health strategies. A monitoring mechanism to track progress should be established. Guidance for stakeholders should be developed, including on safeguarding against commercial and other vested interests.

The representative of ECUADOR,[7] recognizing the serious impact of the climate crisis on health and that less than 1% of financing for climate change was spent on health, supported the draft global action plan. She expressed appreciation for the consultative approach used in the development of the draft plan, which offered coordinated activities to strengthen national capacity, tackle diseases sensitive to climate change and facilitate access to financing. Its success would require international cooperation, effective integration of health in climate policies, generation of scientific evidence, and resource mobilization. The Secretariat should support Member States to develop a sustainable and equitable response to climate change and health.

The representative of MALAYSIA[7] recognized that achieving meaningful progress required Member States, the Secretariat and other stakeholders to take transformative action that advanced climate-resilient health systems and promoted equitable health outcomes for all. She took note of the draft global action plan but proposed that further improvements should be made prior to its adoption. The principle of common but differentiated responsibilities and respective capabilities should be integrated into the draft plan, rather than promoting a one-size-fits-all approach, which could place additional demands on developing countries' health systems. While the draft emphasized mitigation efforts to reduce emissions from healthcare facilities, it did not sufficiently address the adaptation efforts needed by developing countries, which should be a priority. Moreover, the Secretariat should address the damage suffered by health systems in developing countries in natural disasters. It was disappointing that the draft plan did not refer to equitable access to medicines and treatments for diseases emerging or re-emerging as a result of climate change. The draft plan should also address barriers to its implementation faced by developing countries. Consideration of socioeconomic and environmental determinants should inform its implementation. Further consultations would be beneficial to develop a more comprehensive and equity-driven draft plan, and to avoid duplication of work.

The representative of BANGLADESH[7] expressed concern regarding the draft global action plan. The draft plan omitted any reference to the principle of common but differentiated responsibilities and respective capabilities and therefore side-stepped the legal regimes of the United Nations Framework Convention on Climate Change and the Paris Agreement. The principle of equity was also absent. The mitigation-centric approach risked diverting the limited resources available for the health sector, thus leading to a potential increase in out-of-pocket expenditure and health inequity. The draft plan should include enablers to facilitate access to affordable health products for diseases emerging or re-emerging as a result of climate change; details on how to build climate-resilient health systems; sources of sustainable financing; and access to technology and knowledge for adaptation and mitigation measures related to health. He called for additional consultations to improve the draft plan, and encouraged Member States to submit suggestions in

[7] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

writing. It would be unfair and unacceptable to adopt a plan that omitted the historical responsibility of those that had significantly contributed to climate change.

The Observer of GAVI, THE VACCINE ALLIANCE, welcomed the draft global action plan and called for increased investment in health promotion and prevention. Preventive and primary healthcare measures were crucial first steps in addressing climate-related health risks, strengthening health systems and protecting vulnerable communities most affected by the climate crisis, particularly in low-income countries. Member States should invest in immunization for climate-sensitive diseases as part of climate adaptation, integrate preventive health measures into national adaptation plans and climate assessments, and prioritize the development of immunization-related progress indicators.

The representative of STICHTING HEALTH ACTION INTERNATIONAL, speaking at the invitation of the CHAIR, noted that the draft global action plan recognized the need to ensure that resources meant for primary healthcare were not diverted. While she supported the concept of leading by example, it was regrettable that the draft plan stopped short of calling for an end to the dependence on fossil fuels. Given that the effects of climate change were not felt equally, more specific actions were needed to protect vulnerable populations that were already enduring the brunt of the climate breakdown.

The representative of the MMV MEDICINES FOR MALARIA VENTURE, speaking at the invitation of the CHAIR, welcomed the draft global action plan. Development of and equitable access to innovative tools, including medicines that were simple to administer, stable and long-acting, were crucial for community resilience and protection of vulnerable populations in the context of climate change. She recommended that the draft global action plan should include indicators on climate-sensitive infectious diseases and on the development and availability of health tools that responded to the needs of affected populations.

The representative of the DRUGS FOR NEGLECTED DISEASES INITIATIVE, speaking at the invitation of the CHAIR, supported the inclusion of Member States' commitment to research and development related to the detection, prevention, testing and treatment of climate-sensitive diseases in the draft global action plan. Inadequate investment in research and development for climate-sensitive diseases, including neglected tropical diseases, threatened climate change adaptation. Equitable access to medicines, diagnostic tools and vaccines was vital for adaptation and health systems strengthening, and required concerted action and investment. Member States should promote research on climate change and neglected tropical diseases, and support the development of indicators on climate-sensitive diseases.

The representative of PUBLIC SERVICES INTERNATIONAL, speaking at the invitation of the CHAIR, called on Member States to fully commit to addressing the climate crisis as a global public health emergency through public sector and multilateral initiatives. While he welcomed the draft global action plan, the principle of common but differentiated responsibilities and respective capabilities and the principle of a just transition should also be included. The draft plan should address the environmental determinants arising from the climate crisis, with particular regard to marginalized communities, and the links between racial, gender and social inequalities and the climate. Member States should call for the elimination of cuts in public health funding to strengthen the health workforce, and thus public health systems, in the context of climate change.

The representative of the INTERNATIONAL LACTATION CONSULTANT ASSOCIATION, speaking at the invitation of the CHAIR, expressed appreciation for the draft global action plan. Breastfeeding was a key health strategy with positive outcomes for climate change. Supporting breastfeeding would reduce formula manufacturing, thus mitigating climate change, reducing

climate risks to food security and improving resilience. Breastfeeding should be recognized as a carbon offset in global financing arrangements. Member States should include breastfeeding as a low-cost strategy with high returns in the draft global action plan.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIR, commended the draft global action plan and called for the active engagement of youth in its development, implementation and evaluation, and that of national health adaptation plans. Clear indicators and robust monitoring mechanisms should be established to assess the implementation and impact of the draft global action plan. Clear guidance for collaboration between national ministries and United Nations organizations would ensure that health remained a central priority in all climate action initiatives.

The representative of the WORLD COUNCIL OF CHURCHES, speaking at the invitation of the CHAIR, said that climate change required international cooperation on mitigation, adaptation and loss and damage, taking account of common but differentiated responsibilities and respective capabilities. However, the draft global action plan fell short of addressing those principles. Additionally, it did not adequately acknowledge that climate resilience was only possible when healthcare facilities were equipped with medicines and vaccines and were able to withstand crises, nor did it address loss and damage for health systems affected by climate change events. Efforts to reduce health sector emissions should include an assessment of relative emissions of developing and developed countries' health systems, estimate transition cost and establish support mechanisms for developing countries. Diverting resources from universal health coverage or access to medicines to cut emissions would undermine public health priorities.

The ASSISTANT DIRECTOR-GENERAL (Universal Health Coverage/Healthier Populations), noting that decades of health progress were at risk due to the climate crisis, said that the Secretariat was working to integrate health into national, regional and global climate policies and was supporting national implementation based on States' priorities and needs. She took note of requests to consider co-benefits, health systems strengthening and a One Health approach in work on climate change and health, and underscored the Secretariat's commitment to working more efficiently across programmes. She welcomed the support for the draft global action plan and for the concerns expressed and suggestions made. The draft plan would help WHO to align global health and climate efforts, and facilitate the provision of country support in the area of climate-resilient health systems, particularly for populations in vulnerable situations. The role of the Alliance for Transformative Action on Climate and Health would be fundamental in that regard. The Secretariat had mobilized over US$ 150 million to support low- and middle-income countries in carrying out national assessments on climate change and health, and developing national health adaptation plans, and would continue to mobilize the required resources. Requests to produce practical guidance had also been noted.

The Board noted the report.

The CHAIR took it that the Board wished to suspend consideration of the draft decision contained in document EB156/25 pending the outcome of the broader discussion on the costing implications of resolutions and decisions recommended by the 156th session of the Executive Board for adoption by the Seventy-eighth World Health Assembly.

It was so agreed.

(For the adoption of a decision, see the summary record of the eighteenth meeting, section 12.)

Pillar 4: More effective and efficient WHO providing better support to countries (continued)

3. Management and governance matters: Item 24 of the agenda (continued)

Global strategies or action plans that are scheduled to expire within one year: Item 24.3 of the agenda

- **Global strategic directions for nursing and midwifery 2021–2025** (documents EB156/34 and EB156/34 Add.1)
- **Global strategy on digital health 2020–2025** (documents EB156/35 and EB156/35 Add.1)
- **Global action plan on the public health response to dementia 2017–2025** (documents EB156/36 and EB156/36 Add.1)
- **Comprehensive implementation plan on maternal, infant and young child nutrition** (document EB156/37 and EB156/37 Add.1)

The CHAIR drew attention to four draft decisions before the Board. The first draft decision, which contained a draft decision to be submitted to the Seventy-eighth World Health Assembly, on extending the global strategic directions for nursing and midwifery 2021–2025 until 2030 was contained in document EB156/34; the second draft decision, which contained a draft decision to be submitted to the Seventy-eighth World Health Assembly, on extending the global strategy on digital health 2020–2025 to 2027 was contained in document EB156/35; the third draft decision, which contained a draft decision to be submitted to the Seventy-eighth World Health Assembly, on extending the global action plan on the public health response to dementia 2017–2025 to 2031, in line with the intersectoral global action plan on epilepsy and other neurological disorders 2022–2031, was contained in document EB156/36. The financial and administrative implications of those three draft decisions were contained in documents EB156/34 Add.1, EB156/35 Add.1 and EB156/36 Add.1, respectively.

The draft decision contained in document EB156/37 had been replaced by a draft decision on the extension of the comprehensive implementation plan on maternal, infant and young child nutrition proposed by Albania, Bangladesh, Brazil, Ethiopia, Georgia, Ghana, Hungary, Ireland, Jamaica, Japan, Lesotho, the Federated States of Micronesia, Namibia, Pakistan, Paraguay, Peru, Romania, Samoa, South Africa, the United Republic of Tanzania, Ukraine, the United Kingdom of Great Britain and Northern Ireland and Vanuatu. The draft decision read:

The Executive Board, having considered the report by the Director-General,[8]

Decided to request the Director-General, in consultation with Member States, to further develop operational targets on the comprehensive implementation plan on maternal, infant and young child nutrition, for consideration and adoption by the Seventy-eighth World Health Assembly;

Also decided to recommend to the Seventy-eighth World Health Assembly, the adoption of the following resolution:

The Seventy-eighth World Health Assembly,

[8] Document EB156/37.

(PP1) Having considered the report by the Director-General;

(PP2) Having considered the report on the comprehensive implementation plan on maternal, infant and young child nutrition;

(PP3) Recalling resolution WHA65.6 (2012) through which the Sixty-fifth World Health Assembly endorsed the comprehensive implementation plan on maternal, infant and young child nutrition;

(PP4) Reaffirming the commitment made [in the 2030 Agenda for Sustainable Development, including] to end all forms of malnutrition by 2030;

(PP5) Recalling resolution WHA69.2 (2016) "Committing to implementation of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)";[9]

(PP6) Reiterating the recommendations for the prevention and management of obesity over the life course contained in the WHO acceleration plan to stop obesity;[10]

(PP7) Reiterating also the importance of the International Code of Marketing of Breast-milk Substitutes and subsequent Health Assembly resolutions[11] on infant nutrition;

(PP8) Recognizing the need to promote exclusive breastfeeding practices, as well as the need to promote optimal complementary feeding practices for children, in accordance with national dietary guidelines;

(PP9) Taking note of the comprehensive framework for action on accelerating anaemia reduction;[12] the Global Action Plan on Child Wasting (2021–2030);[13] and the policy priorities outlined in the Global Breastfeeding Collective call to action on breastfeeding;[14]

(PP10) Taking note also of the WHO essential nutrition actions framework,[15] to advance the attainment of the global nutrition targets;

(PP11) Acknowledging the significant progress made towards achieving the global nutrition target on exclusive breastfeeding and assuring no increase in childhood overweight, but recognizing that further progress is needed;

(PP12) Expressing concern that progress made towards achieving the global nutrition targets on stunting, anaemia, low birthweight and wasting has been inadequate and remains off track,

(OP)1. EXTENDS the comprehensive implementation plan on maternal, infant and young child nutrition to 2030 [in order to align with the 2030 Agenda for Sustainable Development];

(OP)2. PROLONGS the time frame and calls for progress on achieving the global nutrition targets on stunting, anaemia, low birthweight and wasting, exclusive breastfeeding and childhood overweight, while aiming towards accelerating progress on childhood overweight and exclusive breastfeeding;

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[9] https://data.unicef.org/wp-content/uploads/2017/02/EWEC_globalstrategyreport_200915_FINAL_WEB.pdf.

[10] https://iris.who.int/bitstream/handle/10665/370281/9789240075634-eng.pdf?sequence=1.

[11] https://www.who.int/teams/nutrition-and-food-safety/food-and-nutrition-actions-in-health-systems/code-and-subsequent-resolutions.

[12] https://www.who.int/publications/i/item/9789240074033.

[13] https://www.childwasting.org/media/1126/file/GAP-Framework-All-FINAL-2021-11-15.pdf.

[14] https://www.who.int/publications/m/item/global-breastfeeding-collective---a-call-to-action.

[15] https://www.who.int/publications/i/item/9789241515856.

[(OP)3. ADOPTS process targets including; improving dietary diversity in women and children, increasing early initiation of breastfeeding, delivering nutrition counselling that includes infant and young child feeding, providing or ensuring access to iron-containing supplements as necessary during pregnancy, and reducing or preventing the consumption of sugar-sweetened beverages, or other process targets as recommended following the consultation process requested by EB156];

(OP)4. CALLS on all relevant regional and/or international organizations, stakeholders, United Nations organizations, multilateral partners including Development Banks and financial institutions and, food systems, food security and nutrition focussed summits to strengthen their efforts, and to focus their food systems, food security and nutrition discussions on integrating nutrition objectives across all sectors and to track investments on nutrition;

(OP)5. URGES Member States[16] to sustain and accelerate actions on implementing the comprehensive implementation plan on maternal, infant and young child nutrition, as appropriate and taking into account national contexts and priorities including by:

(1) adopting or extending nutrition policies that address all forms of malnutrition through multisectoral coordination and application;

(2) aiming to increase domestic funding for nutrition-specific and nutrition-sensitive programmes with clear budget lines and financial targets;

(3) fully integrating essential nutrition actions in routine preventive and curative healthcare services, in advancing towards universal health coverage;

(4) building the capacity of health workers to deliver essential nutrition actions through improved pre-service and in-service training and routine competency assessment;

(5) strengthening community health workforce programs to extend the reach of health systems and nutrition service delivery;

(6) aiming to transform and/or promote food systems that advance universal access to affordable, safe and healthy foods to meet the dietary needs and food preferences for an active and healthy life;

(7) taking steps to promote healthier diets including by regulating effectively the marketing of breastmilk substitutes and foods for infants and young children;

(8) strengthening monitoring and evaluation systems to provide regular information on nutrition policy implementation, programme delivery and outcomes;

(9) strengthening efforts to integrate nutrition objectives across all sectors and to track investments on nutrition;

(OP)6. REQUESTS the Director-General:

(1) to provide technical support to Member States upon request, in the development of policies and programmes to accelerate progress on improving maternal, young child and infant nutritional status and to assist in the monitoring and evaluation of these actions;

(2) to report on progress made in the implementation of the comprehensive implementation plan on maternal, infant and young child nutrition, together with the report on implementation of the International Code of Marketing of Breast-milk Substitutes and related Health Assembly resolutions, in biennial

[16] And, where applicable, regional economic integration organizations.

reports to the Health Assembly, through the Executive Board, until 2030 (to be issued in 2026, 2028 and 2030, respectively);
(3) to conduct a review of existing nutrition standards and policies that determine the quality and healthiness of food provided in pre-school and school nutrition programmes and to report on the findings to the Seventy-ninth World Health Assembly in 2026, together with the report indicated above in paragraph 2.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[17]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:
3.1.2. Countries enabled to strengthen equitable access to safe, healthy and sustainably produced foods through a One Health approach

3.2.1. Countries enabled to address risk factors through multisectoral actions

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:
Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:
Not applicable.

4. Estimated time frame (in years or months) to implement the decision:
Six years (2025–2030).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:
US$ 3.38 million.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:
US$ 1.01 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:
Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:
US$ 1.05 million.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:
US$ 1.31 million.

[17] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic “bridge” between results structures can be provided as needed.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions

– **Financial resources available to fund the decision in the current biennium:**
US$ 0.91 million.

– **Remaining financing gap in the current biennium:**
US$ 0.10 million.

– **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Grant applications have been submitted for 2025 activities and staff that would cover the financing gap of US$ 0.10 million.

Table. Breakdown of estimated resource requirements (in US$ millions)[a]

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	0.04	0.03	0.03	0.03	0.03	0.03	0.22	0.39
	Activities	0.05	0.05	0.05	0.05	0.05	0.05	0.32	0.62
	Total	0.09	0.08	0.08	0.08	0.08	0.08	0.54	1.01
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	0.04	0.03	0.03	0.03	0.03	0.03	0.22	0.41
	Activities	0.05	0.05	0.05	0.05	0.05	0.05	0.33	0.64
	Total	0.09	0.08	0.08	0.09	0.08	0.08	0.56	1.05
B.4. Future bienniums cost of resources to be planned	Staff	0.06	0.04	0.04	0.05	0.04	0.05	0.35	0.64
	Activities	0.05	0.05	0.05	0.05	0.05	0.05	0.35	0.67
	Total	0.11	0.10	0.10	0.11	0.10	0.10	0.70	1.31
B.1. Total planned costs required to implement the decision									3.38

[a] The row and column totals may not always add up, owing to rounding.

The representative of the REPUBLIC OF KOREA supported the extension of the instruments under discussion, as proposed in the four draft decisions. Emphasizing the critical role of nursing and care staff members in achieving universal health coverage, he said that ensuring a stable and well-distributed workforce was an urgent priority. Digital health technologies should be integrated into broader healthcare policies, including universal health coverage. While progress had been made in global dementia management, particularly through the Global Dementia Observatory Knowledge Exchange Platform, only 26% of Member States were implementing national dementia strategies and further efforts were required. He supported an integrated primary healthcare-centred approach, aligning dementia prevention with broader noncommunicable disease strategies to ensure sustainable management. Early life nutrition management for lifelong health was also important. To meet global nutrition goals, measurable targets should be introduced, including targets on nutrition education coverage for women of childbearing age and on the implementation rate of breastfeeding awareness programmes.

The representative of the COMOROS, speaking on behalf of the Member States of the African Region, welcomed the Secretariat's consultative approach in developing the reports but

noted that the Programme budget 2024–2025 posed problems for the African Region. Financial constraints were a risk factor for country offices. There must be a paradigm shift in primary healthcare in order to better address noncommunicable diseases such as cancer and diabetes. WHO's normative work should lead to country programmes that ensured universal health coverage, shared procurement, training and digital health. Noting that good governance should be grounded in pragmatism and realism, he supported the extension of the global strategy on digital health 2020–2025 to 2027, so that regional and global efforts could be aligned. Country contexts, particularly those vulnerable to climate change or conflict, should be taken into account. Digital health mechanisms should be strengthened, including through artificial intelligence, to make governance more responsive. Sustainable financing would ensure equity and implementation of priority programmes such as the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030). There was a need to enhance epidemiological surveillance in Africa. Global interoperability standards should be introduced to ensure more efficient sharing of data and systems. He called for investment to open new training sites and build capacity. WHO should set up platforms for sharing best practices and innovations and learn to better leverage resources. The Member States of the African Region supported the draft resolution on the extension of the comprehensive implementation plan on maternal, infant and young child nutrition.

The representative of SENEGAL expressed support for the draft decision on extending the global strategy on digital health 2020–2025 to 2027.

The representative of CHILE recognized the efforts made by the Secretariat and Member States in implementing the global action plan on the public health response to dementia 2017–2025 and supported the proposal to extend that plan. Despite some progress, many of the plan's goals had not been achieved, with major gaps remaining in access to healthcare, support for carers, research and efforts to fight stigma. Noting that the coronavirus disease (COVID-19) pandemic had delayed the implementation of key policies and increased the vulnerability of people living with dementia, she called on WHO to continue prioritizing dementia on the global public health agenda. Extending the global action plan on the public health response to dementia would strengthen international cooperation and guarantee that all Member States could fully and effectively implement their national strategies on dementia.

The representative of CANADA welcomed the renewal of the global strategies and action plans, cognizant that discussions on the prioritization and costing of resolutions and decisions were ongoing.

The global action plan on the public health response to dementia 2017–2025 was a vital reminder of the importance of incorporating dementia into broader health promotion and chronic disease prevention efforts and work to strengthen healthcare systems. More should be done to reduce the risk of developing dementia and to improve the quality of life of those living with dementia and of those providing support and care to them. As such, her Government supported work to update the WHO Guidelines on risk reduction of cognitive decline and dementia and work to support Member States in formulating national dementia responses by adapting WHO tools and products to the country context.

She welcomed the future priorities identified to support nurses across employment, education, service delivery and leadership. Her Government supported the extension of the global strategic directions for nursing and midwifery 2021–2025, noting that much work remained to be done.

The report on the comprehensive implementation plan on maternal, infant and young child nutrition was technically sound. Her Government placed high priority on maternal infant and

young child nutrition, and thus supported the extension of the comprehensive implementation plan to 2030 and the request for progress reports to be shared at future Health Assemblies.

The representative of NORWAY supported the extension of the comprehensive implementation plan on maternal, infant and young child nutrition to 2030. Operational targets, as requested in the new draft decision, would accelerate much needed global action towards reaching global nutrition targets and achieving Sustainable Development Goal 2 (End hunger, achieve food security and improved nutrition and promote sustainable agriculture). Targeted interventions were needed, particularly for the most vulnerable, leaving no one behind.

Recognizing the need to address the rising prevalence of dementia globally, she said that international cooperation for dementia prevention, early detection, treatment and development of effective interventions was crucial and agreed that WHO should continue playing an important role in that work beyond 2025.

Her Government supported the proposed extension of the global strategic directions for nursing and midwifery and emphasized the importance of prioritizing efforts to strengthen the health and care workforce, which was crucial in reaching universal health coverage. The strategic directions had had a positive impact on health systems, education, employment and working conditions and she commended the widespread implementation of the strategic directions and the work done to adapt them to national and subregional contexts.

The positive results in the area of digital health were commendable. WHO should provide Member States with guidance on evaluating, developing and introducing digital technologies for health. She supported the draft decision extending the global strategy on digital health and suggested that a new strategy be developed for 2028–2033. However, she noted that any decision to extend a plan or strategy would need to be reviewed in the light of ongoing discussions about budgetary constraints.

The representative of SWITZERLAND said that WHO had contributed to global progress on digital health but noted that significant challenges still existed globally, nationally and regionally. International cooperation and knowledge sharing were essential to promote further progress in digital health. The platforms and regional action frameworks developed by WHO were valuable tools in facilitating coordination and strategy harmonization. Her Government therefore supported the extension of the global strategy on digital health 2020–2025 to 2027. She also welcomed the proposal to extend the global strategic directions for nursing and midwifery 2021–2025 to 2030 and the global action plan on the public health response to dementia 2017–2025 to 2031. Given current demographic trends, it was important that dementia remained a priority for public health policy.

The representative of TOGO recognized that digital health was a transformative tool for achieving universal health coverage, especially in low- or middle-income countries, and commended the significant progress made towards the strategic objectives contained in the global strategy on digital health 2020–2025. He also expressed appreciation for the progress made towards the targets set out in the comprehensive implementation plan on maternal, infant and young child nutrition. Acknowledging the problems hindering the implementation and roll out of digital health solutions and the difficulties experienced in achieving the targets on maternal, infant and young child nutrition, he supported the extension of the two related instruments to 2027 and 2030, respectively.

The Secretariat should continue strengthening governance mechanisms to promote digital health transformation, particularly through artificial intelligence, and should invest in training programmes to improve skills tied to the implementation of digital health. It was important to establish platforms to exchange best practices and innovations adapted to the African context.

The Secretariat should mobilize resources for staff training and infrastructure development, and to reduce funding deficits.

The representative of CHINA supported the extension of the strategies and plans under discussion. His Government endorsed the 12 policy priorities outlined in the global strategic directions for nursing and midwifery 2021–2025. The Secretariat should compare the projected shortage of nurses and midwifes with other health workforce shortages, and align that analysis with the Global Strategy on Human Resources for Health: Workforce 2030.

Regarding the global strategy on digital health 2020–2025, the Secretariat should continue to facilitate cooperation among Member States in research and development into frontier technologies, data sharing and professional capacity-building; and encourage further application of artificial intelligence in the medical field to support countries in developing new digital infrastructure.

He supported the continued implementation of the global action plan on the public health response to dementia 2017–2025, which would further enhance the quality of life of individuals living with dementia while strengthening health and social systems. He also supported the continued implementation of the comprehensive implementation plan on maternal, infant and young child nutrition and recommended that the Secretariat should facilitate comprehensive consultation on the operational targets.

The representative of BRUNEI DARUSSALAM supported the extension of the global strategic directions for nursing and midwifery beyond 2025, which would ensure sustained investment in nursing and midwifery, particularly in enhancing education, employment, leadership and service delivery.

The global strategy on digital health 2020–2025 had been instrumental in guiding Member States towards interoperability, cyber security and equitable access to digital health tools. However, as technology rapidly evolved, there was a continued need for collaboration, investment in digital literacy and ethical governance of artificial intelligence in health. He therefore supported the extension of the strategy, allowing for further alignment with global digital health advancements and sustainable development efforts.

Although the global action plan on the public health response to dementia 2017–2025 remained crucial in tackling one of the most pressing challenges of global demographic change and aging, global progress remained off track. He therefore supported extending the plan to 2031 thus ensuring continuity in efforts to improve diagnosis, long-term care and caregiver support.

He supported an extension to the comprehensive implementation plan on maternal, infant and young child nutrition which would ensure continued progress in global nutrition efforts and reinforce commitments to healthier diets, food security and improved health outcomes for all.

The representative of THAILAND, noting that the COVID-19 pandemic had delayed the implementation of many policies and plans at the country and global levels and that targets had not been achieved, expressed support for the four draft decisions. Extending the strategies and plans would allow for continuity and provide time to assess progress and formulate actions.

(For continuation of the discussion, see the summary record of the sixteenth meeting, section 2.)

The meeting rose at 17:35.

Sixteenth meeting

Monday, 10 February 2025, at 10:05

Chair: Dr J.X. Walcott (Barbados)

Pillar 4: More effective and efficient WHO providing better support to countries (continued)

1. Budget and finance matters: Item 23 of the agenda (continued)

Financing and implementation of the Programme budget 2024–2025: Item 23.1 of the agenda (documents EB156/26 Rev.1, EB156/INF./1 and EB156/INF./5) (continued from the third meeting)

Proposed programme budget 2026–2027: Item 23.2 of the agenda (documents EB156/27 and EB156/INF./6) (continued) (continued from the third meeting)

The CHAIR drew attention to document EB156/INF./6, which contained information on the draft calculations, prepared by the Secretariat, of Member States' assessed contributions for the year 2026 of the biennium 2026–2027.

He also drew attention to a draft decision on resolutions and priorities proposed by Norway, which read:

> The Executive Board, having considered the report by the Director-General[1] and the debate at its 156th session,
>
> Decided:
>
> (1) to consider the implications of resolutions and decisions recommended by the 156th session of the Executive Board for adoption by the Seventy-eighth World Health Assembly in the overall prioritization process as part of the development of the Proposed programme budget 2026–2027, in line with the guidance provided to the Secretariat by the Programme, Budget and Administration Committee at its forty-first meeting;[2]
> (2) to subject the implementation of the resolutions and decisions recommended by the 156th session of the Executive Board for adoption by the Seventy-eighth World Health Assembly to the operationalization of the Programme budget 2026–2027 once approved, while still allowing their use for advocacy, awareness, and continuation of ongoing activities;
> (3) to request the Director-General to inform Member States of the outcome of the prioritization and operationalization processes, including with respect to the resolutions and

[1] Document EB156/INF./5.

[2] Document EB156/4, paragraph 23.

decisions recommended by the 156th session of the Executive Board for adoption by the Seventy-eighth World Health Assembly.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[3]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:
4.2.1. Leadership, governance and external relations enhanced to implement GPW 13 and drive impact in an aligned manner at the country level, on the basis of strategic communications and in accordance with the Sustainable Development Goals in the context of United Nations reform

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:
Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:
Not applicable.

4. Estimated time frame (in years or months) to implement the decision:
One year, covering reporting to the Seventy-eighth World Health Assembly and the operationalization of the Programme budget 2026–2027, once approved.

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:
US$ 0.06 million. This figure reflects interpretation and IT costs during Member State consultations. Human resources costs will be absorbed as part of programme budget development.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:
US$ 0.04 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:
Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:
US$ 0.02 million.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:
Not applicable.

[3] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic “bridge” between results structures can be provided as needed.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions

- **Financial resources available to fund the decision in the current biennium:**
  US$ 0.04 million.
- **Remaining financing gap in the current biennium:**
  Zero.
- **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
  Not applicable.

GPW 13: Thirteenth General Programme of Work, 2019–2025.

Table. Breakdown of estimated resource requirements (in US$ millions)

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.04	0.04
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.04	0.04
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.02
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.02
B.4. Future bienniums cost of resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.1. Total planned costs required to implement the decision									0.06

The representative of NORWAY said that continued openness and transparency were crucial to the development of the draft Proposed programme budget 2026–2027, as was Member States' commitment to the scheduled 20% increase in assessed contributions, which would ensure more sustainable, flexible and predictable financing for WHO. The purpose of the proposed draft decision on resolutions and priorities was to follow up on the recommendation of the Programme, Budget and Administration Committee of the Executive Board for the Board to carefully consider the costing of draft resolutions and decisions in the light of the proposed US$ 4.9 billion for the base segment of the draft Proposed programme budget 2026–2027, and to provide clarity for the Secretariat and Member States on how resolutions and decisions recommended for adoption by the Health Assembly would be handled going forward. The draft decision did not include a request for the Director-General to continue to consult with Member States on the finalization of the draft Proposed programme budget, as the Programme, Budget and Administration Committee had already issued a recommendation to that effect.

The representative of CHINA said that Member States had demonstrated strong support for WHO by agreeing to an initial 20% increase in assessed contributions for the biennium 2024–2025. His Government had already stated its position concerning the proposed 20% increase in assessed contributions for the biennium 2026–2027 and had taken note of the positions and views of many developing countries in that regard, particularly those in the African Region. WHO needed stable and sustainable funding, but the Secretariat should also enhance transparency concerning the use of funds, ensure their equitable allocation and prioritize areas of concern for developing countries. Measures should be taken to reduce operational costs, strengthen performance assessments and improve the representation of underrepresented countries. Following any increase in assessed contributions, the Secretariat should also report in a timely manner on the cost effectiveness and outcomes of resource allocation.

The representative of SENEGAL, speaking on behalf of the Member States of the African Region, requested the Secretariat to include in its reporting a key performance indicator to measure the extent to which financial and other resources were being allocated equitably. It was necessary to ensure sustainable, flexible funding for WHO so that the majority of resources could be allocated to high-priority areas. His Region remained committed to WHO's investment round and would continue to advocate for strong mechanisms to ensure that funds were allocated equitably and matched the priorities identified by Member States. Such an approach should be centred on accountability, taking into account all three levels of the Organization and all WHO regions, with a view to better supporting countries and strengthening their capacities. The Secretariat was urged to better integrate programmes to enhance efficiency and mobilize more resources for health promotion and prevention in order to limit the spread of noncommunicable diseases.

Concerning the costing implications of draft resolutions and decisions, his Region invited the Board to proceed with the adoption of draft resolutions and decisions but to postpone their implementation until the review of the draft Proposed programme budget 2026–2027 had been completed, except where the costing implications were minimal or for advocacy-related resolutions and decisions. The Member States of the African Region had also developed a proposal on the matter and stood ready to work with the Secretariat and the delegation of Norway to build consensus on the wording of the draft decision.

He reaffirmed his Region's support for the 20% increase in assessed contributions, which was a crucial step towards achieving shared goals. He urged Member States to approve the increase, in keeping with the commitment made at the Seventy-fifth World Health Assembly in May 2022, to ensure that WHO could continue to meet people's needs, particularly within the African Region, and provide support to those countries most affected by the current financial crisis.

The representative of POLAND, speaking on behalf of the European Union and its Member States, requested the Secretariat to provide further clarification on the proposed timeline for the prioritization process for the draft Proposed programme budget 2026–2027 in the run up to the Seventy-eighth World Health Assembly; on the number of consultations that would be held with Member States during that period; and on the timing of the proposed "deep dive" briefing and whether the necessary documentation would be shared with Member States beforehand to ensure a collaborative dialogue.

Given the importance of ensuring coherence between the prioritization process and the resolutions and decisions recommended by the Board for adoption at the Seventy-eighth World Health Assembly, he welcomed the consultative process outlined by Norway. It was crucial to provide Member States with all relevant information, including more detailed and updated information on existing and emerging funding gaps, to enable an inclusive and informed prioritization process. He expressed concern about the impact of the current financial situation on the implementation of the budget for the year 2025.

The representative of THAILAND said that the draft decision should be amended to reflect the fact that the prioritization process affected only the implementation of requests made to the Director-General contained in resolutions and decisions. Requests to Member States would not be affected.

The representative of BULGARIA, reiterating that WHO needed to perform within the limits of its available financial resources, said that more information was needed on funding gaps. The prioritization process should be conducted within the financial constraints of the budget for the year 2025 and for subsequent bienniums. WHO needed to be agile and flexible in order to adapt to constant change. She expressed support for the draft decision, on the understanding that it would not entail an increase in the draft Proposed programme budget 2026–2027.

The representative of ETHIOPIA expressed support for the proposed 20% increase in assessed contributions as part of efforts to move towards a sustainably financed WHO that provided more and better support to countries. Additional time was needed to refine the language of the draft decision.

The representative of MALDIVES, speaking on behalf of the Member States of the South-East Asia Region, noted that assessed contributions allowed funds to be used flexibly. The next step in the process of securing sustainable and predictable funding would be the approval of the draft Proposed programme budget 2026–2027, including the 20% increase in assessed contributions. Member States in her Region recognized the importance of streamlining and ensuring transparency in the budget reporting process to enhance efficiency. Sustainable financing and the equitable distribution of mobilized resources, would ensure that WHO could meet the needs of a diverse world and improve health outcomes.

The representative of TOGO expressed support for the Secretariat's prioritization efforts in the light of the current financial constraints on WHO and for the 20% increase in assessed contributions. Further consultations were needed on the draft decision.

The representative of the REPUBLIC OF KOREA expressed support for the draft decision and suggested that intersessional consultations should be held with Member States on the plan for the implementation of the programme budget, including priorities, taking into account WHO's current financial and budgetary situation.

The representative of SWITZERLAND supported the statements made by the representatives of Bulgaria and Poland and welcomed the draft decision. More clarity was needed on the status and evolution of the programme budget and on the roles and timeline for a meaningful consultative process during the intersessional period.

The representative of the COMOROS expressed support for the draft decision and for a 20% increase in assessed contributions; once that increase had been approved it would be possible to make adjustments to the draft Proposed programme budget 2026–2027. The Programme, Budget and Administration Committee had presented a realistic budget scenario that should enable the Organization to maintain its priority activities.

The representative of the RUSSIAN FEDERATION[4] said that his Government had agreed to the initial 20% increase in assessed contributions on the condition that the Secretariat would provide information on key items of expenditure and on staffing, both of which were missing from

[4] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

the Secretariat's reports to the Board. Under such circumstances, and given that the draft Proposed programme budget 2026–2027 failed to provide the necessary level of transparency and accountability, his Government was not ready to support another increase in assessed contributions at the World Health Assembly.

The representative of SPAIN[5] said that, in such challenging times, it was important to continue to adopt draft resolutions and decisions and to focus on prioritizing WHO's key activities. To that end, the Board would need to act cautiously, intelligently and with courage, ensuring that it was aware of the budgetary situation without being paralysed by it and remaining mindful of the need to continue to address global health problems.

The representative of CHAD[5] reiterated his Government's support for the investment round and efforts to ensure equitable development, support health system resilience in the face of climate change and promote innovation, research and technology transfer.

The representative of GERMANY[5] expressed strong support for the draft decision, which would ensure clear prioritization and budgetary planning for the biennium 2026–2027. The prioritization process should be consultative and inclusive, with a clear timeline provided in a timely manner. Support for the 20% increase in assessed contributions was particularly important in a time of crisis, especially since the budget envelope for the draft Proposed programme budget 2026–2027 had been determined based on the assumption that the increase in assessed contributions would be approved. Providing predictable funding was in Member States' collective and individual interest.

The representative of BELGIUM[5] said that, given the complex challenges faced by the Organization, it was important to align the limited resources available with priorities. That required clear decision-making, coordination across all levels and departments of WHO, flexibility from both the Secretariat and donors, and the continued involvement of Member States. The prioritization process should be steered in a structured and efficient manner.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND[5] expressed support for the consultative process outlined by the Secretariat but concern that the proposed US$ 4.9 billion for the base segment of the draft Proposed programme budget 2026–2027 might be unrealistic. Active and rapid prioritization was critical and would require strong leadership from the Secretariat. WHO should work to its comparative advantage and focus on providing technical expertise without replicating the work of other organizations. It was important for Member States to contribute to the development of indicators so that WHO's intended impact in key areas could be clearly communicated. She expressed concern that the record number of draft resolutions and decisions proposed at the Board's current session sent out a signal of business as usual.

The representative of FRANCE[5] said that, in the light of the reduction in resources, it was important to integrate current draft resolutions and decisions into the prioritization process for both the Programme budget 2024–2025 and the draft Proposed programme budget 2026–2027. While she supported the draft decision, there also needed to be a clear timeline for the budget consultations leading up to the Seventy-eighth World Health Assembly, including new proposals for the Programme budget 2024–2025. She asked for clarification of the expected total amount of

[5] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

the base segment for the draft Proposed programme budget 2026–2027, should the 20% increase in assessed contributions not be approved.

The representative of JAPAN[6] said that the recommendation of the Programme, Budget and Administration Committee for a base budget of US$ 4.9 billion for the draft Proposed programme budget 2026–2027 remained an ambitious target, especially in view of the current economic challenges faced by many Member States. Echoing requests for the Secretariat to continue to hold informal consultations with Member States to review the financial outlook for the year 2025 and consider the draft Proposed programme budget 2026–2027, he expressed support for the draft decision, which should be linked to the implementation of governance reforms. WHO was urged to pass fundamental reforms in the management of draft decisions and resolutions alongside broader WHO reforms.

The representative of MALAYSIA,[6] speaking also on behalf of Bangladesh, Brazil, Guatemala, India, Indonesia, Mexico, Namibia, Peru, Palestine, the Philippines and South Africa, said that the resolutions and decisions adopted by the Board served several functions, including in terms of resource mobilization, and the process was a central part of WHO's work. In addition, budgets were always aspirational in nature. Where financial challenges persisted, it was important for the Secretariat to engage with Member States to ensure strategic resource allocation based on Member States' priorities; that could in part be achieved by adopting resolutions and decisions to signal where such efforts should be focused.

More time was needed to consider critical prioritization issues, including in terms of budgeting and resource mobilization. She therefore suggested that the Board should continue to recommend resolutions and decisions for adoption by the Seventy-eighth World Health Assembly, so that progress could be made on addressing the financial challenges faced by the Organization and the work requested of the Secretariat under the proposed decisions and resolutions could be reviewed in the light of those challenges and the prospect of addressing them.

Speaking in her national capacity, she added that the language used in the draft decision should be more advisory, given that the Board recommended resolutions and decisions for adoption by the Health Assembly; it was the Health Assembly that would ultimately decide whether to adopt them. Further consultations were needed on the draft decision.

The representative of the KINGDOM OF THE NETHERLANDS[6] expressed support for the draft decision and for the further 20% increase in assessed contributions as a means of improving the sustainable financing of WHO. She asked the Secretariat to clarify what the implication of not agreeing to the increase in assessed contributions would be for the proposed US$ 4.9 billion for the draft Proposed programme budget 2026–2027.

The representative of PANAMA[6] expressed support for the consultative prioritization process, which should take into account WHO's mandate and the role of Member States as key decision-makers within the Organization. It was essential to objectively cost resolutions and determine their capacity to address global health challenges and governance issues. Strengthening resource mobilization capacity should continue to be used by WHO as a mechanism to support implementation of the general programme of work and governing bodies' resolutions and decisions. All stakeholders were responsible for ensuring that WHO was an agile, flexible and strong organization. He expressed support for the draft decision.

[6] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of GHANA,[7] expressing support for the proposed 20% increase in assessed contributions, said that it was important for Member States to work together and fulfil their commitment with respect to sustainable financing. He looked forward to further consultations on the draft decision.

The representative of ZAMBIA[7] said that the principle of equity should inform all of the Board's decisions. It was important to continue adopting resolutions and decisions and to prioritize activities through reviews of, and adjustments to, the general programme of work and programme budget, which should be considered as a whole. The cost of inaction was too big, especially for low- and middle-income countries.

The representative of BANGLADESH[7] said that, while it was vital to have a budget envelope in order to set the framework for the remit of WHO's work, it was also essential to take account of Member States' priorities, in part by proposing draft resolutions and decisions, which could be used to address region- and country-specific issues. Such resolutions and decisions should therefore not be limited, and flexible funding was needed to implement them. Unpredictability meant that it was important to maintain the aspirational nature of budgets rather than reducing them.

The representative of BOTSWANA[7] welcomed the inclusive bottom-up process for the development of the programme budget. She expressed support for the commitment made by Member States in the year 2022 to increase assessed contributions by 20% for the biennium 2026–2027, and for the principles of transparency, efficiency and accountability in programme budgeting. WHO should ensure equity in the allocation of all available resources, while prioritizing countries and regions whose health and development indicators were below the global average. She endorsed the statements made by the representatives of Thailand and Zambia regarding the consideration of draft resolutions and decisions.

The representative of the PHILIPPINES[7] said that her Government endorsed the draft decision but asked whether the Board had the mandate to decide on the implementation of resolutions and decisions recommended for adoption by the Health Assembly, or whether more recommendatory language should be used.

The representative of SOUTH AFRICA[7] expressed support for the statement made by the representative of the Philippines. She encouraged Member States to maintain their decision to increase assessed contributions as the primary way of guaranteeing predictable and sustainable funding for WHO.

The representative of NORWAY, responding to queries and comments on the draft decision, agreed that the Board should continue to recommend decisions and resolutions for adoption by the Health Assembly and that the prioritization process should cover only requests for actions to be implemented by the Director-General. She noted the calls for advisory language to be used and for more clarity on the consultative process going forward. The Programme, Budget and Administration Committee had already issued a recommendation for the Secretariat to consult with Members States on the finalization of the draft Proposed programme budget 2026–2027; as such, the same request had not been included in the draft decision. She expressed the hope that the Secretariat would provide a timeline for those consultations. Her delegation would continue to work with Member States and the Secretariat to update the draft decision.

[7] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The ASSISTANT DIRECTOR-GENERAL (Business Operations) thanked Member States for their broad support for the proposed increase in assessed contributions, which was essential in order to place WHO on a strong footing. If such an increase was not agreed by Member States, the impact on the proposed US$ 4.9 billion for the base segment of the draft Proposed programme budget 2026–2027 would have to be considered, in terms of both WHO's sustainability and its priorities. The high level of earmarked funding posed challenges for the equitable allocation of resources, although flexible funds were allocated equitably across major offices and countries. Member States and other stakeholders should recognize their role in ensuring equitable resource allocation.

In terms of the timeline for the intersessional consultations for the draft Proposed programme budget 2026–2027, he said that the first stage would be to determine budget envelopes for all major offices, with consultations expected to begin the following week. That would then drive the initial prioritization process, ensuring equity across regions and priority areas, which would be followed by an in-depth consideration of costings. The Secretariat stood ready to engage with Member States as much and as often as required, and a more detailed timetable of regular consultations would be made available shortly. Concerning the budget for the year 2025, the Secretariat was looking at how to prioritize its work based on the current financial situation and considering potential cost savings and options for resource mobilization. Given the limited resources, it would be necessary to combine the prioritization processes for the current budget and the draft Proposed programme budget 2026–2027.

The Secretariat had committed to including expenditure items in its reporting and stood ready to include available human resources information in the draft Proposed programme budget 2026–2027. However, it would be necessary to consider the level – for example, budget centre or major office level – at which the information would be provided. The Secretariat was willing to work with Member States to ensure that they had the information needed to advance WHO's work, on the understanding that such information was indicative.

The underrepresentation of countries remained an issue, and the Secretariat was looking at additional measures to include more candidates from underrepresented and unrepresented countries in selection and appointment processes. While outreach programmes were in place, more work needed to be done.

The LEGAL COUNSEL, responding to queries, said that it may be more appropriate for the Board to recommend, rather than decide, that the decisions and resolutions recommended for adoption by the Health Assembly should be subject to the operationalization process, given that it would take place after the Seventy-eighth World Health Assembly and such decisions were usually taken by the Health Assembly.

The DIRECTOR-GENERAL called on Member States to agree to the proposed US$ 4.9 billion for the draft Proposed programme budget 2026–2027 as a starting point, bearing in mind that the amount could be subsequently revised. While there was broad support from Member States for the proposed 20% increase in assessed contributions, which was a key part of the WHO transformation agenda, the concerns of certain countries had also been noted. If Member States further delayed the 20% increase in assessed contributions, the target of funding 50% of the base budget through assessed contributions would not be achieved until the biennium 2034–2035 at the earliest. He therefore urged Member States to honour the pledge made in the year 2022 in order to widen the donor base, ensure flexibility and provide support to countries based on their priorities. Not doing so would only aggravate the situation caused by the decision of the United States of America to withdraw from the Organization and would seriously impact WHO's work. The Secretariat stood ready to consult with and update Member States regularly, particularly

those with concerns about the proposed increase; it would also work to enhance transparency and to address any issues raised.

The representative of SENEGAL said that the Member States of the African Region had submitted a request to work with the Secretariat and the delegation of Norway on the draft decision but had not received a response on that matter. Such collaboration was important to ensure that there was no ambiguity in the draft decision.

The representative of NORWAY confirmed that her Government would work with the Member States of the African Region, the European Union and other Member States to amend the draft decision.

The CHAIR took it that the Board wished to suspend its consideration of the agenda items pending further discussions on the draft decision.

It was so agreed.

(For continuation of the discussion, see the summary record of the seventeenth meeting, section 5.)

2. Management and governance matters: Item 24 of the agenda (continued)

Global strategies or action plans that are scheduled to expire within one year: Item 24.3 of the agenda (continued from the fifteenth meeting, section 3)

- **Global strategic directions for nursing and midwifery 2021–2025** (documents EB156/34 and EB156/34 Add.1) (continued from the fifteenth meeting, section 3)
- **Global strategy on digital health 2020–2025** (documents EB156/35 and EB156/35 Add.1) (continued from the fifteenth meeting, section 3)
- **Global action plan on the public health response to dementia 2017–2025** (documents EB156/36 and EB156/36 Add.1) (continued from the fifteenth meeting, section 3)
- **Comprehensive implementation plan on maternal, infant and young child nutrition** (documents EB156/37 and EB156/37 Add.1) (continued from the fifteenth meeting, section 3)

The CHAIR recalled that the Executive Board had before it four draft decisions: a draft decision on the extension of the global strategic directions for nursing and midwifery 2021–2025; a draft decision on the extension of the global strategy on digital health 2020–2025; a draft decision on the extension of the global action plan on the public health response to dementia 2017–2025; and a draft decision on the extension of the comprehensive implementation plan on maternal, infant and young child nutrition.

The representative of the DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA said that the prevalence of mental health disorders among nurses was concerning. As the frequency and severity of health emergencies were increasing globally, practical measures should be taken to improve the mental health of nurses and midwives. She therefore expressed support for the proposed extension of the global strategic directions for nursing and midwifery 2021–2025 to

2030 and of the three other global strategies and actions plans scheduled to expire within one year.

The representative of the FEDERATED STATES OF MICRONESIA expressed support for the extension of the four global strategies and actions plans scheduled to expire within one year. Concerning the global strategic directions for nursing and midwifery 2021–2025, he said that the global shortage of nurses and midwives remained a critical challenge, and support for expanding competency-based training programmes should remain a priority. Investment in eHealth and distance education was needed to enhance accessibility and capacity-building. Turning to digital health, he urged the Secretariat and Member States to consider the unique digital health needs of small island developing States and develop suitable electronic medical record systems.

Dementia was a growing yet neglected public health challenge, and the higher prevalence in low- and middle-income countries highlighted the need for targeted interventions. He expressed support for the action areas of the global action plan on the public health response to dementia 2017–2025 and urged WHO to prioritize dementia globally. With regard to maternal, infant and young child nutrition, Member States were urged to reassess strategies and allocate resources.

The representative of BARBADOS said that it was essential to extend the global strategic directions for nursing and midwifery 2021–2025 to ensure the continued support for, and development of, the nursing and midwifery workforce, while the extension of the global strategy on digital health 2020–2025 would promote continued innovation and collaboration on digital health technologies. It was vital to extend the global action plan on the public health response to dementia 2017–2025 in line with the intersectoral global action plan on epilepsy and other neurological disorders 2022–2031, in order to address the growing burden of dementia and ensure comprehensive care and support for affected individuals. The comprehensive implementation plan on maternal, infant and young child nutrition should also be extended in order to tackle malnutrition, overweight and obesity and promote the health and well-being of mothers, infants and young children. The Secretariat should continue to provide technical and financial support to Member States in relation to all four global strategies and action plans.

The representative of LEBANON said that, while she supported the extension of the global strategic directions for nursing and midwifery 2021–2025 and the proposal to integrate reporting on its implementation into reporting on the Global Strategy on Human Resources for Health: Workforce 2030, some adjustments needed to be made to the global strategic directions in the light of technological advancements, the shortage of nurses and the inequitable distribution of midwifery personnel, especially in low- and middle-income countries. The four areas of the global strategic directions should be thoroughly reviewed through an equity and innovation lens under the broader umbrella of the health workforce. There continued to be a lack of senior positions for nursing and midwifery in health and academic systems, education programmes needed to be fit for the future, and the skills mix at provider level needed to be reconsidered in the light of advancements in medical technologies.

She supported the extension of the global strategy on digital health 2020–2025 to the year 2027 and the development of a draft global strategy on digital health for the period 2028–2033. Commending the work done thus far on the comprehensive implementation plan on maternal, infant and young child nutrition, she supported its extension to the year 2030, the proposed operational targets and the related draft decision.

The representative of ETHIOPIA, expressing support for the statement by the representative of Ireland, said that the draft decision proposed by her Government on the extension of the comprehensive implementation plan on maternal, infant and young child nutrition provided an

opportunity to accelerate efforts and address the unfinished agenda of ending malnutrition in all its forms. It would also help to strengthen collaboration and partnerships, and to redesign and transform food systems to ensure universal access to sustainable, affordable, safe and healthy food, particularly for women and children. She invited all Member States to support the draft decision and called on stakeholders to work together towards specific and actionable solutions to accelerate efforts to meet collective commitments on nutrition.

The representative of COSTA RICA said that the global strategy on digital health 2020–2025 provided a comprehensive and well-grounded vision of global advances, challenges and priorities in digital health. The vision for the future was evident in the proposal to extend the global strategy to the year 2027, in order to take advantage of emerging technologies such as artificial intelligence and quantum computing; continuous adaptation was essential. While the global strategy served as a solid and ambitious strategic guide that highlighted the transformative role of digital health in healthcare systems, it could benefit from clear and specific indicators to measure the success of initiatives and the implementation of objectives and a more inclusive and detailed focus on global and regional challenges, offering a more balanced vision that was applicable at the local level.

The representative of MOROCCO said that it was essential to increase investment in nursing and midwifery in order to guarantee universal access to high-quality healthcare and address the persistent shortage of qualified health workers. With regard to digital health, he recommended harmonizing international standards, strengthening ongoing training and promoting the secure use of artificial intelligence. The global action plan on the public health response to dementia 2017–2025 should be extended and aligned with the intersectoral global action plan on epilepsy and other neurological disorders 2022–2031, while the comprehensive implementation plan on maternal, infant and young child nutrition had played a key role in combating malnutrition in all its forms.

The representative of SLOVAKIA expressed strong support for the extension of the four global strategies and action plans scheduled to expire within one year. Dementia, in particular, was a global health priority and she emphasized the urgent need for stronger national and international efforts in that regard. Many countries, like hers, lacked an officially approved national action plan on dementia, which left patient and caregiver support fragmented. It was important to raise awareness of dementia and foster dementia-friendly societies through national initiatives that engaged the public and helped to reduce stigma. There also needed to be support for caregivers, with structured policies to reduce the caregiver burden and improve training and psychological support. Another major challenge to be addressed globally was the lack of comprehensive national information systems for dementia, which limited effective policy planning and service delivery. She called for stronger global collaboration and investment in innovation and research on dementia.

The representative of UKRAINE supported the extension of the comprehensive implementation plan on maternal, infant and young child nutrition. The findings of a review of nutrition standards and policies in schools, to be presented at the Seventy-ninth World Health Assembly, would provide valuable insights for evidence-based policy improvements across regions and Member States. Given the multiple crises affecting food security and nutrition worldwide, collective action was needed to strengthen policies that safeguarded children’s health.

The representative of the REPUBLIC OF MOLDOVA expressed support for the draft decision on extending the global strategic directions for nursing and midwifery 2021–2025 to 2030. Given the shortage of health workers worldwide, nurses and midwives could take over certain responsibilities from doctors. Focus should therefore be on strengthening the capacities of nurses

and midwives through training, while also considering country-level differences in training programmes.

The representative of IRELAND[8] said that the draft decision proposed by her Government on the extension of the comprehensive implementation plan on maternal, infant and young child nutrition was aligned with the Fourteenth General Programme of Work, 2025–2028, and would encourage Member States to extend their commitments to address maternal, infant and child nutrition, including by scaling up the delivery of nutrition-related actions, improving food systems and integrating nutrition objectives across sectors.

The representative of PERU[8] expressed support for the extension of the global action plan on the public health response to dementia 2017–2025, particularly in the light of the growing prevalence of dementia driven by rapid population ageing. Extending the plan would help to consolidate efforts for the prevention, early detection, treatment and comprehensive care of dementia. Her country had made significant progress in implementing the strategic objectives of the global strategy on digital health 2020–2025.

The representative of the KINGDOM OF THE NETHERLANDS[8] expressed appreciation for the Secretariat's support on digital health and Member States' constructive and continued engagement in that area, particularly in relation to the Global Digital Health Partnership. WHO's standard-setting activities and guidance on dementia were also appreciated, and she supported the extension of the global action plan on the public health response to dementia 2017–2025, bearing in mind the ongoing discussions on prioritization.

The representative of BOTSWANA[8] endorsed the extension of the global strategy on digital health 2020–2025 in order to address the challenges of the digital transformation by strengthening governance and regulatory frameworks, digital health infrastructure financing and workforce development. She also supported the extension of the global strategic directions for nursing and midwifery 2021–2025.

The representative of SPAIN[8] expressed support for the draft decision on extending the comprehensive implementation plan on maternal, infant and young child nutrition to the year 2030. It was necessary to adopt actions and policies based on equity and to establish science-based healthcare protocols for infants and young children, maintaining a focus on the social determinants of health. Countries needed comprehensive nutrition policies, with multisectoral coordination to ensure their effective implementation. It was also necessary to regulate the advertising and marketing of breast-milk substitutes and food products aimed at children and adolescents, prevent conflicts of interest within the food industry and establish effective monitoring systems.

The representative of OMAN[8] said that, given the key role of nurses and midwives in improving health outcomes and ensuring equitable access to quality nursing and midwifery services, he supported the extension of the global strategic directions for nursing and midwifery 2021–2025.

The representative of the PHILIPPINES[8] expressed support for the extension of the four global strategies and action plans scheduled to expire within one year. In relation to the global strategic directions for nursing and midwifery 2021–2025, she supported actions to strengthen evidence generation and investment in the health workforce. As digital health remained essential

[8] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

for ensuring the responsiveness of health systems, she supported the development of a draft global strategy on digital health for the period 2028–2033. In the light of the growing challenge of population ageing, the extension of the global action plan on the public health response to dementia 2017–2025 would allow more time to integrate action plans on dementia care into primary healthcare and community-based interventions. Her Government continued to prioritize maternal, infant and young child nutrition.

The representative of PARAGUAY[9] expressed support for the extension of the global strategies and action plans scheduled to expire within one year. It was essential to strengthen nursing and midwifery, and maternal and infant nutrition remained a challenge in her Region. Her Government was committed to the implementation of the global strategy on digital health 2020–2025. The global action plan on the public health response to dementia 2017–2025 was aligned with legislation in her country. To enable all countries to contribute to strengthening global health, the Republic of China (Taiwan)[10] should be allowed to participate in the Health Assembly and WHO technical meetings as an observer.

The representative of SINGAPORE[9] expressed strong support for the extension of the global strategy on digital health 2020–2025 to the year 2027 and the development of a draft global strategy on digital health for the period 2028–2033. The development and implementation of practical digital health strategies and infrastructure must go hand in hand with governance and regulatory frameworks, equitable digital inclusivity and a whole-of-government approach to digital literacy. Digital health strategies should complement the role of health workers, who uniquely understood their patients' holistic needs. Advances in artificial intelligence meant that global collaboration on digital health was all the more important. He looked forward to working with the Secretariat, Member States and other stakeholders by sharing experience, best practices and lessons learned. He expressed support for the draft decision on the global action plan on the public health response to dementia 2017–2025.

The representative of COLOMBIA[9] welcomed the focus of the global strategy on digital health 2020–2025, the extension of the global action plan on the public health response to dementia 2017–2025 and the draft decision on the comprehensive implementation plan on maternal, infant and young child nutrition.

The representative of ECUADOR[9] expressed support for the extension of the global strategy on digital health 2020–2025, whose implementation would strengthen health systems, ensure more equitable access to health services and enhance the availability of data for timely and effective decision-making. It was important for multilateral organizations and Member States with successful experience of digital health to provide support.

The representative of PANAMA[9] said that the global strategic directions for nursing and midwifery 2021–2025 provided viable and necessary strategic options, that maternal and infant nutrition was a national priority, and that global action was needed to improve the complex social situations of those living with dementia. It was important to continue strengthening the global strategy on digital health 2020–2025 and build robust and interoperable information systems. She expressed support for the draft decisions under discussion.

[9] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[10] World Health Organization terminology refers to "Taiwan, China".

The representative of the RUSSIAN FEDERATION[11] expressed support for the extension of the four global strategies and action plans scheduled to expire with one year, which had been useful for countries in developing national plans. He called for more sharing of best practices in the area of digital health and looked forward to future work on the comprehensive implementation plan on maternal, infant and young child nutrition.

The representative of BURUNDI[11] expressed support for the extension of the global strategy on digital health 2020–2025 and outlined her country's vision and achievements in that area.

The representative of INDONESIA[11] expressed concern about the slow progress towards global nutrition targets and said that her Government wished to be added to the list of sponsors of the draft decision on the extension of the comprehensive implementation plan on maternal, infant and young children nutrition, which provided a framework to consolidate efforts, align time frames and galvanize momentum to scale up essential nutrition actions. Member States should continue to support the comprehensive implementation plan.

The representative of ZAMBIA[11] said that, despite significant advances in technology and connectivity, lack of access to the internet and to digital tools remained a challenge, particularly in developing countries. The integration of equity throughout the lifecycle of digital healthcare solutions must be prioritized. The Global Digital Compact, which was co-facilitated by his Government, called for equitable and affordable access to the internet and to digital tools. The innovation and use of healthcare technologies should be centred on the needs of patients and communities. He expressed support for the extension of the global strategy on digital health 2020–2025.

The Observer of PALESTINE said that children in the Gaza Strip were suffering from malnutrition as a result of the conflict, and the chronic diseases caused by malnutrition required the international community to respond to that humanitarian health crisis. He expressed the hope that Palestine would be included in emails concerning support for draft resolutions and decisions in the future.

The representative of BANGLADESH[11] said that the full potential of digital health products and services had yet to be realized, noting that the high cost of such products created digital divides and widened health inequalities across societies. The global strategy on digital health 2020–2025 should focus on building digital health infrastructure at the operational level within countries, with due attention paid to data flow beyond borders. He urged the Secretariat and Member States to establish safeguards, limit cross-border data transfer, support Member States in achieving digital self-reliance and promote transparent and accountable systems to ensure that digital health drove health equity. The Health Assembly should discuss options for ensuring proper health data governance, which was lacking.

The representative of NAMIBIA[11] said that the Global Digital Compact and other such instruments would be key to advancing the digital health agenda at all levels, ensuring that equity remained at its core. He expressed support for the draft decision on the extension of the global strategy on digital health 2020–2025.

[11] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of INDIA[12] expressed support for the extension of the four global strategies and action plans scheduled to expire within one year. The mandate of the global strategy on digital health 2020–2025 should be incorporated into the draft global strategy on digital health for the period 2028–2033. The response to dementia required increased public awareness and an adequately skilled health workforce at all levels. Developing operational targets with measurable indicators for the comprehensive implementation plan on maternal, infant and young child nutrition would enhance accountability and accelerate progress towards reducing malnutrition in all its forms. Recognizing the critical global shortage of nurses and midwives, he emphasized the need to empower nurses through advanced roles and to adopt a multifaceted approach that encompassed investment, nursing education and training, improved employment opportunities, and the promotion of workforce retention.

The representative of THE SAVE THE CHILDREN FUND, speaking at the invitation of the CHAIR, urged Member States to support the draft decision on the extension of the comprehensive implementation plan on maternal, infant and young child nutrition and to close critical gaps, such as the exclusion of adolescents from the anaemia target. While operational targets were essential, there should also be a treatment target for child wasting.

The representative of the NCD ALLIANCE, speaking at the invitation of the CHAIR, urged Member States to extend the global action plan on the public health response to dementia 2017–2025 and integrate it into national strategies on noncommunicable diseases to improve diagnostic and caregiver support services. Member States should also extend the comprehensive implementation plan on maternal, infant and young child nutrition, implement evidence-based nutrition policies and make related commitments at the 2025 Nutrition for Growth summit.

The representative of the INTERNATIONAL PHARMACEUTICAL STUDENTS' FEDERATION, speaking at the invitation of the CHAIR, called for the structured engagement of healthcare learners and professionals in digital health policy regulation and innovation, and their involvement in increasing digital literacy and implementing digital health initiatives in communities.

The representative of FDI WORLD DENTAL FEDERATION, speaking at the invitation of the CHAIR and also on behalf of the International Association for Dental Research, called on Member States to endorse the higher targets for childhood overweight prevalence and exclusive breastfeeding, and to align national guidelines accordingly. The proposed operational targets and indicators to accelerate action on nutrition were welcome. Oral health should be recognized as a key component of healthy nutrition policies, with priority given to research on the oral health benefits of nutrition.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of the CHAIR, expressed support for the extension of the global strategic directions for nursing and midwifery 2021–2025 but was concerned about their slow implementation. WHO was urged to prioritize actionable commitments and provide the resources and policies needed to strengthen the nursing workforce and meet global health demands.

The representative of THE WORLDWIDE HOSPICE PALLIATIVE CARE ALLIANCE, speaking at the invitation of the CHAIR and expressing support for the extension of the global action plan on the public health response to dementia 2017–2025, said that there was a dire need for accessible palliative care for people living with dementia.

[12] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of INTERNATIONAL LACTATION CONSULTANT ASSOCIATION, speaking at the invitation of the CHAIR, expressed support for the extension of the comprehensive implementation plan on maternal, infant and young child nutrition, including global nutrition targets, to the year 2030. The higher target for exclusive breastfeeding would help to improve health, reduce mortality and inequality, and protect children's right to optimal health and nutrition. Early initiation of breastfeeding and access to counselling and clinical care were critical to successful breastfeeding, and related data could be used to plan improvements and show progress.

The representative of ALZHEIMER'S DISEASE INTERNATIONAL, speaking at the invitation of the CHAIR, said that the global action plan on the public health response to dementia 2017–2025 remained the best tool available to Member States to support those living with dementia, their carers, health systems and society more broadly. It was to be hoped that Member States would fulfil their commitments under the global action plan, including by developing and implementing national dementia plans.

The representative of PUBLIC SERVICES INTERNATIONAL, speaking at the invitation of the CHAIR and expressing deep concern about the challenges faced by nurses and midwives due to reduced health budgets and health system privatization, urged Member States to invest in the training, absorption and retention of nurses and midwives and provide them with decent work, fair payment and a manageable workload. It was essential to move away from profit-driven models and adequately fund public health systems that guaranteed workers' rights.

The CHEF DE CABINET thanked Member States for their guidance and strong support for the four global strategies and action plans scheduled to expire within one year. The Secretariat had taken note of, and would seek to incorporate, the recommendations for strengthening those global strategies and actions plans.

The CHAIR took it that the Board wished to note the reports contained in documents EB156/34, EB156/35, EB156/36 and EB156/37.

The Board noted the reports.

The CHAIR took it that the Board wished to suspend consideration of the draft decisions pending the outcome of the discussion on the draft decision on resolutions and priorities.

It was so agreed.

(For the adoption of decisions, see the summary record of the eighteenth meeting, section 13.)

3. Committees of the Executive Board: Item 26 of the agenda

Foundation committees and selection panels: Item 26.1 of the agenda (document EB156/43)

Dr LEE Jong-wook Memorial Prize for Public Health

Decision: The Executive Board, having considered the report of the Dr LEE Jong-wook Memorial Prize for Public Health Selection Panel, awarded the Dr LEE Jong-wook Memorial Prize for Public Health for 2025 to Professor Helen Rees of South Africa.[13]

United Arab Emirates Health Foundation Prize

Decision: The Executive Board, having considered the report of the United Arab Emirates Health Foundation Prize Selection Panel, awarded the United Arab Emirates Health Foundation Prize for 2025 to Dr Jožica Maučec Zakotnik of Slovenia.[14]

Sasakawa Health Prize

Decision: The Executive Board, having considered the report of the Sasakawa Health Prize Selection Panel, awarded the Sasakawa Health Prize for 2025 to Dr Merete Nordentoft of Denmark.[15]

State of Kuwait Health Promotion Foundation's His Highness Sheikh Sabah Al-Ahmad Al-Jaber Al-Sabah Prize for the Promotion of Health Ageing

Decision: The Executive Board, having considered the report of the State of Kuwait Health Promotion Foundation Selection Panel, awarded the State of Kuwait Health Promotion Foundation's His Highness Sheikh Sabah Al-Ahmad Al-Jaber Al-Sabah Prize for the Promotion of Healthy Ageing for 2025 to Professor Huali Wang of China and to the Geriatric Healthcare Directorate of the Ministry of Health of the State of Kuwait.[16]

Nelson Mandela Award for Health Promotion

Decision: The Executive Board, having considered the report of the Nelson Mandela Award for Health Promotion Selection Panel, awarded the Nelson Mandela Award for Health Promotion for 2025 to Dr Majed Zemni of Tunisia.[17]

The representative of POLAND suggested that the Board consider the possibility of introducing mechanisms to ensure equal regional representation in the foundation prize selection panels.

The CHAIR took it that the Board wished to request the Secretariat to prepare a report that included proposals to enhance the equitable participation of members of the Board in the selection panels for consideration by the Board at its 158th session. In line with past reports

[13] Decision EB156(5).

[14] Decision EB156(6).

[15] Decision EB156(7).

[16] Decision EB156(8).

[17] Decision EB156(9).

requested by the Board on the procedures for the administration of the prizes, he suggested that the report should also review the increasing costs of managing the awards and suggest measures to further streamline their administration, while encouraging candidate applications from all regions.

It was so agreed.

4. Standing Committee on Health Emergency Prevention, Preparedness and Response:

Item 26.3 of the agenda (documents EB156/44, EB156/44 Add.1 and EB156/45)

Report of the Standing Committee on Health Emergency Prevention, Preparedness and Response: Item 5 of the agenda (document EB156/5) (continued from the eighth meeting, section 1)

The CHAIR invited the Board to resume its consideration of the report contained in document EB156/5, in particular the proposed amendments to the terms of reference of the Standing Committee on Health Emergency Prevention, Preparedness and Response, and also drew attention to the reports contained in documents EB156/44 and EB156/45. He invited the Board to provide guidance in respect of the questions set out in paragraph 15 of document EB156/45 and to consider the draft decision on the dates of the sixth meeting of the Standing Committee contained in paragraph 2 of document EB156/44.

The representative of LESOTHO, speaking on behalf of the Member States of the African Region, said that the Standing Committee provided an opportunity for Member States to engage during public health emergencies of international concern, helping to narrow the gap between WHO scientific advice and actual policies implemented by Member States. While she welcomed the Secretariat's feedback on the review on the functioning and impact of the Standing Committee, she noted that the 9% response rate was not representative.

Her Region supported the proposed extension of the mandate of the Standing Committee until the closure of the Seventy-ninth World Health Assembly in the year 2026, to enable the Standing Committee to further consider its functioning and added value, and allow time for the establishment of the States Parties Committee for the Implementation of the International Health Regulations (2005) and any committees envisioned under the proposed pandemic agreement. She nevertheless underscored the importance of ensuring that the Standing Committee operated within a sustainable and efficient financing framework, that the cost implications of the Standing Committee did not divert essential resources from critical health programmes, and that its work was guided by sustainable financing, efficiency and inclusivity.

The representative of SOMALIA, speaking on behalf of the Member States of the Eastern Mediterranean Region, recognized the Standing Committee's contribution in providing updates on health emergencies, engaging Member States in critical discussions and ensuring that the Board was informed and prepared to act when necessary. He noted the challenges faced by the Standing Committee and the areas of concern. There was merit in extending the Standing Committee's mandate beyond the Seventy-eighth World Health Assembly, provided that its terms of reference were updated to address the challenges outlined. The Standing Committee's effectiveness could be improved by establishing clearer objectives, streamlining roles, enhancing coordination with other oversight bodies and addressing logistical concerns, such as the timely sharing of documents and better engagement with external experts. It was important to ensure that the Standing

Committee's work added tangible value to the broader health emergencies response system, through a more focused and efficient approach.

The representative of THAILAND said that there was a risk that the Standing Committee could duplicate the work of other governance mechanisms, such as the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme and some of the review committees convened in accordance with the provisions of the International Health Regulations (2005). That could lead to governance inefficiency and limited added value in responses to public health emergencies of international concern. In the light of current severe financial constraints, the cost of convening the in-person Standing Committee twice a year could instead be used to stockpile vaccines, strengthen countermeasures and support on-the-ground responses to major outbreaks. The mandate of the Standing Committee should therefore not be extended beyond the closure of the Seventy-eighth World Health Assembly in May 2025, and the sixth meeting of the Standing Committee, scheduled for April 2025, should be held in virtual format.

The representative of MOROCCO, speaking in his capacity as Chair of the Standing Committee, recalled that the Standing Committee had been established to ensure continued coordination and strategic analysis during health emergencies and to provide a platform for Member States to share views. He considered that the reasons for establishing the Standing Committee were still relevant and that the Standing Committee had fulfilled its objectives, ensuring greater coordination among Member States in preparing for and managing health emergencies. The Standing Committee had reacted promptly to the declaration of mpox as a public health emergency of international concern, convening within 24 hours and issuing clear recommendations to the Board and the Director-General. Member States had an opportunity to consider not only the future of the Standing Committee but also the structure of global health governance in response to public health emergencies. They should not be held back by budgetary constraints; instead, they should be ambitious and enable the Standing Committee to continue its work.

The representative of BULGARIA said that her Government saw value in the Standing Committee, which could promote multilateral action, provide a forum for the exchange of views and practices and for timely feedback from Member States, thereby bridging the gap between the advice from expert advisory panels and groups and Member States' political actions. The proposed amendments to the Standing Committee's terms of reference and the standard operating procedures for extraordinary meetings would help to operationalize the Standing Committee and enable it to respond adequately to global and regional health emergency challenges.

Documentation should be made available to Standing Committee members at least one week in advance of regular meetings. Concerning the proposal to replace extraordinary meetings of the Standing Committee with special sessions of the Board for events requiring immediate action, she said that it would be important to consider resource efficiency, given that the Standing Committee was more agile, and its membership smaller, than that of the Board. Extraordinary meetings of the Standing Committee could be kept short and effective, be held online and adhere to strict timelines. The potential of the Standing Committee should be explored further, with a discussion on how it could better fulfil its substantial mandate.

The representative of CANADA said that it was important to focus on ensuring that the Standing Committee added value to the health emergency governance structure and was cost effective. To allow for greater flexibility, she suggested amending the second paragraph of the draft decision on the dates of the sixth meeting of the Standing Committee to read:

Decided that the Standing Committee on Health Emergency Prevention, Preparedness and Response should hold its sixth meeting, in hybrid or virtual format, for one or two days as required, on Monday and Tuesday, 14 and 15 April 2025.

The representative of SWITZERLAND, recognizing the relevance of the Standing Committee in addressing health emergencies, said that, by facilitating in-depth discussions, the Standing Committee should enable Member States to address challenges in a more structured manner and effectively inform Board discussions. The Standing Committee was particularly useful in offering Member States more agility and pragmatism in the face of health crises. By rigorously monitoring the complexity and operational aspects of health emergencies, the Standing Committee could strengthen the coordination and coherence of related actions. However, a concise report of its open and informed discussions should be provided, with targeted recommendations to optimize the management of the Board's agenda.

To enable the Standing Committee to fulfil its objective of providing strategic guidance to the Board, including in relation to situations not formally recognized as public health emergencies of international concern, it would be necessary to adjust the Standing Committee's mandate, extend it beyond the closure of the Seventy-eighth World Health Assembly in May 2025 and optimize the Standing Committee's functioning, in particular by looking at options for holding regular meetings in hybrid or virtual format to reduce costs. The outcome of the review of the Standing Committee should be integrated into WHO's prioritization process.

The representative of AUSTRALIA said that, while the Secretariat's review of the Standing Committee would have benefited from specific recommendations for improvements, it was a welcome first step towards stronger global health governance, indicating clear benefits as well as challenges. Those challenges must be addressed in the light of the global health security governance architecture, including the governance arrangements introduced in the amended International Health Regulations (2005). As that governance architecture was still evolving, an updated report on the Standing Committee should be prepared for consideration by the Board at its 158th session, which should include recommendations based on the Secretariat's current analysis and ensure alignment with the broader health emergency governance architecture. He agreed with the targeted amendments to the Standing Committee's terms of reference and requested that the Standing Committee should adopt a similar approach to that of the Programme, Budget and Administration Committee of the Executive Board by providing clear guidance and recommendations in its meetings and meeting reports and by focusing on strategic discussions.

The representative of CHINA said that the Secretariat's review of the Standing Committee had shown that some aspects of its mandate required clarification and overlapped with those of other oversight committees, such as the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme, the Global Preparedness Monitoring Board and some of the review committees convened in accordance with the provisions of the International Health Regulations (2005); its added value and role thus remained unclear. Given the financial situation faced by the Secretariat and the need for cost effectiveness, further discussion was needed on whether it would be useful to extend the mandate of the Standing Committee beyond the closure of the Seventy-eighth World Health Assembly.

The representative of BARBADOS said that, while the Standing Committee had been effective in aligning its activities with its terms of reference, significant challenges needed to be addressed. The mandate of the Standing Committee should be extended beyond the closure of the Seventy-eighth World Health Assembly to allow more time for the Standing Committee to fulfil

its role, ensure continued support for the WHO Health Emergencies Programme and provide a platform for Member States to engage on critical health emergency issues. In addition, the proposed amendments to the terms of reference of the Standing Committee should include clear guidelines for providing documented guidance and recommendations to the Board in order to enhance the Standing Committee's role in strategic planning, policy-setting and decision-making. Standing Committee members should be given adequate time to prepare for meetings and relevant external experts should be present to facilitate meaningful discussions and informed decision-making.

The representative of SLOVAKIA said that the current focus, impact, benefits and composition of the Standing Committee did not fully reflect the need for a more expert-oriented body that could effectively inform the Secretariat and Member States by circulating appropriate and timely information.

It was necessary to change the functioning of the Standing Committee so that it could conduct real-time analysis of critical situations in close collaboration with other technical advisory groups and platforms. In the light of current financial constraints and the ongoing prioritization process, all forthcoming meetings of the Standing Committee should be held online through a secure platform. The Standing Committee should also incorporate more emergency- and science-related methods of work. An expert review of the Standing Committee should be conducted, with proposals for improvements to be submitted to the Board following online consultations.

The representative of COSTA RICA said that the Standing Committee had partially fulfilled its mandate by providing a platform to exchange information, but its capacity to provide strategic guidance should be enhanced. It would be beneficial to extend the mandate of the Standing Committee beyond the closure of the Seventy-eighth World Health Assembly, provided that adjustments were made to strengthen its capacity for action, avoid duplication and enhance its impact in preparing for, and responding to, health emergencies. Clear processes were needed on issuing recommendations, involving external experts in meetings, improving meeting planning and preparation, and holding consultations that were relevant to Member States.

The representative of PANAMA[18] underscored that, while the Standing Committee was of strategic value, improvements should be made to enhance its efficiency and relevance within the global health emergency architecture.

The representative of FRANCE[18] expressed support for the extension of the mandate of the Standing Committee beyond the closure of the Seventy-eighth World Health Assembly, as the Standing Committee provided a useful link between the Secretariat and the Board. The meetings held thus far had enabled the Standing Committee to gradually find its place within the global health governance structure. He agreed that the Standing Committee's functioning needed to be improved, and that the extension of its mandate should go hand in hand with collective efforts to rationalize costs and eliminate any duplication of efforts. It should be possible to hold meetings in virtual format and for shorter periods, in order to ensure targeted and interactive discussions on issues affecting the WHO Health Emergencies Programme.

The representative of JAPAN[18] expressed concern about the small sample size of the survey used for the Secretariat's review. To ensure more comprehensive data collection in future, the survey format and duration should be refined. The Standing Committee was yet to provide

[18] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

guidance and recommendations to the Board, suggesting that it had not fulfilled its intended role. In that regard, the Secretariat was urged to ensure appropriate agenda-setting and framing of discussion points. It would also be helpful to define the topics for discussion at extraordinary meetings in advance.

The representative of INDONESIA,[19] recognizing the Standing Committee's role in the global health emergency framework, took note of the proposed amendments to the Standing Committee's standard operating procedures and terms of reference. The role and functioning of the Standing Committee should continue to be reviewed, taking into account the mechanisms to be established under the amended International Health Regulations (2005). If the mandate of the Standing Committee were to be extended beyond the closure of the Seventy-eighth World Health Assembly, it should be on the understanding that it should provide stronger guidance and actionable recommendations to the Board. In addition, Standing Committee meetings should be open to all Member States to ensure informed decision-making and the meaningful participation of those affected by health emergencies. Standing Committee members should be optimally prepared for meetings, including through the timely advance circulation of documents.

The representative of the RUSSIAN FEDERATION[19] said that the functioning of the Standing Committee was not entirely clear, its reports failed to contain recommendations to the Board, and it often lacked sufficient time to discuss conclusions and reports thoroughly. The Standing Committee should seek to avoid duplication and overlap in its work relative to that of other oversight bodies to ensure that it contributed effectively to the agenda of the Board.

The representative of PARAGUAY[19] said that, from a technical standpoint, the Standing Committee had fulfilled its mandate. However, it was necessary to avoid overlap and duplication of mandates among oversight committees. Member States' lack of familiarity with the WHO Health Emergencies Programme, together with the insufficient participation in meetings, limited the Standing Committee's effectiveness and capacity to influence critical decisions. Member States were urged to work together to redefine the Standing Committee's roles and responsibilities.

The representative of MALAYSIA[19] said that the critical role played by the Standing Committee in conducting in-depth assessments of WHO's health emergency work was highly valued. She supported the proposed improvements to enhance the efficiency of the Standing Committee and the extension of its mandate beyond the closure of the Seventy-eighth World Health Assembly, provided that affected countries were invited to attend the Standing Committee's extraordinary meetings to ensure interactive dialogue and prioritize needs; key stakeholders were involved in responding to public health emergencies of international concern in areas such as vaccine procurement and resource mobilization; the Chair of the Executive Board, the Vice-Chair of the Standing Committee and the Director-General were able to convene extraordinary meetings of the Standing Committee outside of public health emergencies of international concern; and clarity was provided on timelines for meetings and arrangements concerning requests from countries affected by health emergencies. Those improvements should be reflected in the amended standard operating procedures and terms of reference. If the mandate of the Standing Committee was extended, it should subsequently be reviewed within the context of the work of the States Parties Committee for the Implementation of the International Health Regulations (2005).

[19] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of BANGLADESH[20] said that it was important to review the functioning and mandate of the Standing Committee in the light of the amendments to the International Health Regulations (2005), as it may be possible for the States Parties Committee for the Implementation of the International Health Regulations (2005) to take over the Standing Committee's function, once the amended Regulations came into effect. It may therefore not be expedient to extend the Standing Committee's mandate beyond the closure of the Seventy-eighth World Health Assembly, and a detailed discussion should be held at the Health Assembly in that regard.

The EXECUTIVE DIRECTOR (WHO Health Emergencies Programme) said that the landscape of health emergency governance and oversight had continued to evolve since the Standing Committee had been established in the year 2022. The Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme remained the Programme's primary oversight mechanism, while the Standing Committee had been established primarily to ensure that the Director-General could immediately brief the governing bodies in the event that a public health emergency of international concern was declared. In that sense, it had fulfilled its mandate, as it had been convened within 24 hours of the one such public health emergency that had been declared since its establishment. The amended International Health Regulations (2005) provided for two further governance mechanisms – the States Parties Committee for the Implementation of the International Health Regulations (2005) and the Coordinating Financial Mechanism – with the exact terms of reference to be discussed once the amended Regulations came into force in September 2025. The proposed pandemic agreement may also provide for other forms of governance and oversight.

With that in mind, it would be important not to overburden the WHO Health Emergencies Programme with oversight and evaluation, and Member States needed to strike the right balance in that regard, to ensure that the Programme remained effective. Before reaching a decision on the Standing Committee, Member States may wish to consider the possibility of conducting a review of all oversight mechanisms for the WHO Health Emergencies Programme to determine the effectiveness of those mechanisms and their impact on the effectiveness of the Programme.

The CHAIR took it that the Board wished to note the reports contained in documents EB156/5, EB156/44 and EB156/45.

The Board noted the reports.

The meeting rose at 13:05.

[20] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board

Seventeenth meeting

Monday, 10 February 2025, at 14:40

Chair: Dr J.X. Walcott (Barbados)

Pillar 4: More effective and efficient WHO providing better support to countries (continued)

1. Committees of the Executive Board: Item 26 of the agenda (continued)

Standing Committee on Health Emergency Prevention, Preparedness and Response: Item 26.3 of the agenda (documents EB156/44, EB156/44 Add.1 and EB156/45) (continued)

Report of the Standing Committee on Health Emergency Prevention, Preparedness and Response: Item 5 of the agenda (document EB156/5) (continued)

At the invitation of the CHAIR, the SECRETARY read out the proposed amendments to the draft decision on the dates of the sixth meeting of the Standing Committee on Health Emergency Prevention, Preparedness and Response, contained in document EB156/44. The second paragraph would be amended to read:

> Decided that the Standing Committee on Health Emergency Prevention, Preparedness and Response should hold its sixth meeting, in hybrid or virtual format, for one or two days, as required, on Monday and Tuesday, 14 and 15 April 2025.

The CHAIR took it that the Board wished to adopt the draft decision on dates for the sixth meeting, with the proposed amendments.

The decision, as amended, was adopted.[1]

The CHAIR also took it that the Board wished to extend the mandate of the Standing Committee until the closure of the Seventy-ninth World Health Assembly in 2026, request the Director-General to prepare a report outlining the mandate and functions of the governance and oversight mechanisms for health emergency preparedness and response for consideration at the 158th session of the Executive Board, and adopt the proposed amendments to the terms of reference of the Standing Committee, as contained in Appendix 2 of document EB156/5.

It was so agreed.

[1] Decision EB156(10).

The CHAIR took it that the Board wished to suspend consideration of the item and request the Secretariat to prepare a draft decision on the Standing Committee on Health Emergency Prevention, Preparedness and Response.

It was so agreed.

(For continuation of the discussion and the adoption of a decision, see the summary record of the nineteenth meeting, section 1.)

2. Management and governance matters: Item 24 of the agenda (continued)

International Health Regulations (2005): proposed procedure for the correction of errors in the text of the instrument: Item 24.5 of the agenda (documents EB156/40, EB156/40 Add.1; EB156/INF./2)

The CHAIR drew attention to the report contained in document EB156/40, and to the draft decision contained in paragraph 11 of document EB156/40, the financial and administrative implications of which were contained in document EB156/40 Add.1.

The representative of TOGO, speaking on behalf of the Member States of the African Region, supported the procedure proposed for the correction of errors in the International Health Regulations (2005), which aligned well with the United Nations practice for multilateral treaties. She was pleased that the Secretariat was taking account of corrections proposed by Member States.

The representative of YEMEN, speaking on behalf of the Eastern Mediterranean Region, said that ensuring the accuracy and consistency of the International Health Regulations (2005), as the key legal framework for global health security, was crucial. He was grateful for the Secretariat's efforts to develop a fair and inclusive procedure and for Member States' constructive contributions during the informal consultations. A standardized correction procedure would ensure that the Regulations were applied uniformly, and thus effectively, across all WHO regions.

The representative of CHINA said that the non-amended segments of the Regulations should be reviewed to ensure their alignment with the amended segments and accuracy in all language versions. Ideally, the review should be completed prior to the Seventy-eighth World Health Assembly to enable the entry into force of the amended Regulations on 19 September 2025.

The representative of THAILAND welcomed the proposed procedure to rectify errors in typing, spelling and punctuation, and mistranslations to ensure uniformity across all six language versions. The 90-day deadline for States parties to submit corrections and endorsed adoption of the draft decision was also appreciated.

The representative of AUSTRALIA supported the proposed procedure, which would enable a uniform understanding of States parties' obligations. It would be helpful for the Director-General to communicate the outcome of the correction procedure to all States parties. She wished to know whether the corrections would be finalized by the time of entry into force of the amended Regulations on 19 September 2025. The proposed correction process could serve as a model for revision of other WHO instruments in future.

The SECRETARY explained that any outstanding language corrections yet to be identified would be captured in the dialogue with Member States prior to the Seventy-eighth World Health Assembly.

The Board noted the report.

The CHAIR took it that the Board wished to suspend discussion of the draft decision pending the outcome of the discussion on the draft decision on resolutions and priorities.

It was so agreed.

(For continuation of the discussion and the adoption of a decision, see the summary record of the eighteenth meeting, section 14.)

Prevention of sexual exploitation, abuse and harassment: Item 24.1 of the agenda (document EB156/28)

The CHAIR drew attention to the report contained in document EB156/28, and to the report of the Programme, Budget and Administration Committee of the Executive Board, contained in document EB156/4, paragraphs 34–37.

At the invitation of the CHAIR, the CHAIR OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE read out the recommendations on the Secretariat's implementation of existing mandates pertaining to the prevention of sexual exploitation, abuse and harassment, contained in paragraphs 37(a) to (g) of the Committee's report.

The representative of POLAND, speaking on behalf of Albania, Armenia, Australia, Austria, Belgium, Bulgaria, Canada, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Ireland, Israel, Italy, Latvia, Lithuania, Luxembourg, Malta, Mexico, Monaco, the Republic of Moldova, New Zealand, the Kingdom of the Netherlands, North Macedonia, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, Ukraine and the United Kingdom of Great Britain and Northern Ireland, called for sustained efforts and clear, robust accountability frameworks. Key WHO priorities should include: strengthening preventive measures, including comprehensive, tailored training programmes, robust screening procedures and clear reporting mechanisms, across WHO, in particular in emergency settings; ensuring all prevention of sexual exploitation, abuse and harassment policies and responses remain underpinned by victim and survivor centred gender-based approaches; including confidential accessible reporting mechanisms, equal application of policies and comprehensive survivor support, balancing transparency against privacy in investigations, and ensuring survivors' empowerment to engage meaningfully in decision-making and policy-making in addressing sexual misconduct; and strengthening internal oversight mechanisms, sharing best practices and lessons learned with Member States and other organizations, and reporting regularly on the impact of measures taken. All activities must adopt a gender-responsive perspective, acknowledging that sexual exploitation, abuse and harassment were deeply rooted in power imbalances and gender inequality. Future closer engagement with Member States, other entities of the United Nations system and collaborating partners was crucial to ensure coherence in preventing and responding to sexual exploitation, abuse and harassment.

The representative of COSTA RICA said that reporting, transparency and accountability must be strengthened further, including in field operations. The Secretariat should report regularly on complaints received, investigations carried out and disciplinary measures applied. Priority must be

given to the establishment of affordable, safe, confidential and effective victim protection mechanisms, especially in vulnerable settings. Training activities should be rolled out in the regions to ensure that cultural and regulatory specificities were taken into account. Independent monitoring and effective sanctions were crucial. WHO must sustain its global leadership in creating safe environments for its staff and the communities it served.

The representative of NORWAY said that better coordination and the sharing of resources across the United Nations system was a prerequisite for effective victim support at the country level. The proposed roll-out of WHO's behaviourally informed culture change strategy in 2025 was welcome. Sexual exploitation, abuse and harassment must be addressed holistically, along with other forms of serious misconduct such as discrimination, abuse of authority, fraud and corruption. Although the increase in reported cases of allegations was likely to be related to new policies and progress in the "speak-up culture", indicating a safe environment for reporting, it was also a clear signal of misconduct continuing to occur. A behavioural culture change in line with good ethics was therefore needed.

The representative of SENEGAL, speaking on behalf of the Member States of the African Region, provided details of the considerable progress made in the Region in implementing the recommendations of Executive Board decision EB148(4) (2021). He called on the Secretariat to: advocate for achieving the target to designate focal points in health ministries in all Member States in 2025; encourage Member States to institutionalize training in the prevention of sexual exploitation, abuse and harassment for all Ministry of Health staff; advocate for increased Member State accountability to protect joint government and WHO operations from sexual misconduct; and promote a multisectoral approach to the prevention of sexual exploitation, abuse and harassment.

The representative of SLOVAKIA called for: expanded culture change, addressing all misconduct in cooperation with the education sector and humanitarian and emergency response teams; stronger accountability, with Member States working with WHO country offices, incorporating appropriate evidence-based and culturally sensitive services into national policies; and the development of a structural framework for WHO's work and sustainable financing.

The representative of THAILAND commended WHO's zero-tolerance policy approach to sexual exploitation, abuse and harassment. Transparency and accountability would foster a culture of responsibility within the Organization. However, the lack of systematic coordinated support for survivors and the need for improved reporting mechanisms were critical areas requiring urgent attention, including sustained coordinated efforts across WHO and between the Secretariat, Member States and the wider United Nations system to ensure zero tolerance of sexual misconduct.

The DIRECTOR (Prevention of and Response to Sexual Misconduct) said that the Secretariat had taken note of Member States' calls for sustained efforts. WHO was at a pivotal moment that required the institutionalization of the plethora of initiatives launched. On prevention, an evidence-based prevention guide for the Secretariat and Member States was being developed, following consultations with other entities in the United Nations system, academic institutions and nongovernmental organizations. On the lack of victim support at the country level, given the current resource constraints, victim support services could only be expanded in collaboration with health ministries and other United Nations agencies. On the accountability framework for Member States, the Secretariat was ready to support on policy training and other issues. In terms of monitoring and evaluation, a stocktaking report and the Joint Inspection Unit report would be made public shortly, but also data on reported allegations and disciplinary action taken were

updated monthly. Although resource constraints might impact internal oversight capacities, the Secretariat remained committed to problem solving and finding creative solutions.

The CHAIR invited the Board to note the report contained in document EB156/28.

The Board noted the report.

3. Staffing matters: Item 27 of the agenda (continued)

Statement by the representative of the WHO staff associations: Item 27.3 of the agenda (document EB156/INF./3)

The CHAIR drew attention to the statement by the representative of the WHO staff associations contained in document EB156/INF./3, and to the report of the Programme, Budget and Administration Committee of the Executive Board contained in document EB156/4, paragraphs 38–41.

The representative of the WHO STAFF ASSOCIATIONS, speaking on behalf of the staff associations of WHO, PAHO, IARC and UNAIDS, said that despite challenging circumstances, the workforce remained steadfastly committed to the Organization's mission.

Noting the recent announcement of the United States regarding its intention to withdraw from WHO, he echoed the call for a sustainably financed WHO that could invest in its workforce and thus address complex health challenges. While the staff associations stood ready to support management in finding solutions that protected staff and helped to advance the collective mission, funding shortfalls, hiring freezes, attrition and non-replacement of critical staff had already placed a high burden on staff, who could not continually do more with less. Many staff undertaking core functions had been on precarious contracts for years. Management must ensure transparency in all decision-making, meaningful collaboration with the staff associations on solutions, and consistent treatment of all staff, with dignity and respect.

In a context where many staff continued to struggle with burnout, trauma and other mental health conditions, often while working in unpredictable environments or under precarious contracts, management must prioritize mental health support, including increased availability of staff counsellors, as a prerequisite for a healthy workforce.

While staff mobility must be accelerated, staff at D and E hardship duty stations must be rotated in a way that protected their well-being. It was unfortunate that the mobility policy failed to address key feedback from the staff associations, and that the implementation approach and policy were unaligned, creating confusion. Sustainable and fair mobility required strong support mechanisms and criteria for deferrals, particularly considering impact on dual-career households, children at key stages of education and those with care responsibilities. The imperative of retaining specialized knowledge and technical stills essential to WHO's normative functions at all levels of the Organization must also be reflected in the policy.

To enhance internal justice, investigations must be expedited. The establishment of an independent internal justice system, reporting directly to WHO governing bodies and offices, that would provide legal assistance to staff offices in all regions, as per earlier recommendations, and the decentralization of the Office of Internal Oversight Services would help to build credibility and trust.

Staff remuneration and purchasing power remained a critical issue. Around the world, staff were seeing their wages fall as a result of fluctuating exchange rates. As local pay was often constrained by national requirements, Member States must cooperate with the International Civil

Service Commission and the Secretariat to ensure fair and equal treatment of staff at all duty stations. Measures should also be taken to protect staff working outside category H duty stations from additional difficulties.

Contractual modalities had a significant impact on staff mental health and well-being. Consultant contracts must be restricted to temporary, time-limited projects and robust contractual modalities were needed for staff performing core functions. As uncertainty was likely to increase, the staff associations sought more and meaningful collaboration with management and transparency.

The representative of SLOVAKIA said that, in order to sustain the commendable efforts made to improve staff health and well-being, accountability and mutual support among Member States, country offices, regions and WHO headquarters were paramount. While staff must be provided all the support they needed, mobility was crucial to make best use of human resources in difficult times. Fully supporting efforts thus far in mental health, he called for services for staff to be expanded and strengthened at the country level, in collaboration with Member States and country offices.

The representative of SENEGAL, speaking on behalf of the Member States of the African Region, welcomed the commitment of WHO staff to fulfilling the Organization's mission and providing technical and development support to Member States around the world. It would be useful to review the methodologies used by the International Civil Service Commission for staff remuneration and to provide legal advice and ombudsperson services for staff at all levels and in all regions of WHO. Access to staff counsellors at D and E duty stations should be expanded and mental health support, support services for victims of abuse and staff security must be improved, especially in times of crisis. While commendable efforts were being made to create respectful and dignified workplaces and ensure transparent management, financial sustainability and adequate contractual modalities were crucial to creating safe, harmonious work environments in line with WHO values.

The representative of FRANCE[2] praised the dedication, resilience and flexibility of WHO staff at all three levels of the Organization. Without a qualified and motivated workforce, WHO would not be where it was today. While swift decisions were needed in the current complex situation, in the long run, better transparency between management and staff and clarity in career progression were needed to build mutual and sustainable trust. The prioritization process under way in collaboration with Member States must not be to the detriment of staff well-being.

The DIRECTOR (Human Resources and Talent Management) said that sustained mental health support for staff, while crucial, required strong collaboration with the various stakeholders. As the Organization was operating within an increasingly difficult context, existing support mechanisms would be strengthened over the coming weeks. Work on a framework on contractual modalities was in progress, following several rounds of consultations, with a final framework expected by late 2025 or early 2026.

The FORMER DIRECTOR (Human Resources and Talent Management) said that, in the area of mobility, the emphasis had been on moving staff from D and E hardship stations to lower hardship duty stations and on responding to expressions of interest; mandatory approaches would only be applied if there was insufficient interest. Thus, deferrals and other ways to address staff unable to move should not come into play. On internal justice, better ways to provide legal support to staff

[2] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

were being explored, and a report on measures taken to improve internal justice would be published in 2025. Staff concerns around remuneration had been noted. The International Civil Service Commission was discussing options for addressing those concerns, including changes in methodology related to compensation to help to address exchange rate fluctuations.

Report of the Ombudsperson: Item 27.4 of the agenda (document EB156/INF./4)

The CHAIR drew attention to the statement contained in document EB156/INF./4, and to paragraphs 42–43 of the report the Programme, Budget and Administration Committee contained in document EB156/4.

The OMBUDSPERSON, speaking on behalf of all WHO ombudspersons, said that financial constraints and contracting modalities affected individuals, working relationships and, potentially, people's capacity to act in line with WHO values. Many staff seeking ombudsperson support, with some coaching and encouragement, found that they could address their concerns directly. Others might draw on mediation and, in some cases, an entire team or a referral might be necessary. Ombudsperson services were available to all, regardless of the type of contractual relationship with WHO. All staff (including managers) were encouraged to consider an informal solution first before taking formal action.

Too often, staff remained silent or chose to escalate matters that could easily be addressed informally because they lacked trust or feared that their concerns might not be heard. Financial challenges had become a daily stressor and action taken to address those challenges, however well communicated, further exacerbated the situation, with possible implications for staff health or behaviour. Although most behaved in accordance with WHO values, the failure to do so often went unchecked and exposed highly skilled, dedicated personnel to frustration and uncomfortable working conditions. In a knowledge-based organization, dialogue and respectful disagreement, rather than threats, blaming, stonewalling or contempt should be the order of the day. Even if the current climate was scary, people within WHO should not be scared of each other. If more people spoke up and more listened, there would be less need to report up; together, deeper understanding and better outcomes could be achieved. WHO values were there to support people and were an asset in difficult times, and should be strengthened within WHO as they were championed globally.

The representative of SENEGAL, speaking on behalf of the Member States of the African Region, said that WHO ombudspersons played an important role in mediating disputes and supporting victims of abuse in the workplace. A respectful work environment was crucial to performance and productivity. The African Region was committed to creating such environments, promoting well-being and motivation at work, expanding psychosocial support for staff, and promoting ongoing social dialogue with staff representatives at all WHO offices in the Region. It was important to ensure sustainable funding and to address issues around contractual modalities, in particular to end precarious employment arrangements, and to strengthen ombudsperson services to respond more effectively to staff concerns.

Human resources: update: Item 27.5 of the agenda (documents EB156/48 and EB156/49)

Amendments to the Staff Regulations and Staff Rules: Item 27.6 of the agenda (documents EB156/50 Rev.1 and EB156/50 Add.1)

Report of the International Civil Service Commission: Item 27.7 of the agenda (document EB156/51)

The CHAIR drew attention to the reports contained in documents EB/156/48, EB156/49, EB156/50 Rev.1 and EB156/51. Document EB156/50 Rev.1 contained four draft resolutions, two of which contained a draft resolution to be submitted to the Seventy-eighth World Health Assembly, the financial implications of the draft resolutions were contained in document EB156/50 Add.1. He also drew attention to the report of the Programme, Budget and Administration Committee contained in document EB156/4, paragraphs 44–50.

The representative of the COMOROS, speaking on behalf of the Member States of the African Region, said that the Member States of the Region greatly appreciated the hard work of WHO staff, the efforts to foster a good work culture within the Organization, and the consultative approach taken to address staffing matters. Despite the financial constraints afflicting the Organization, staff rights and well-being must be a priority. The proposed amendments to the Staff Regulations and Staff Rules sent a positive signal to staff and demonstrated global solidarity.

The representative of NORWAY, expressing concern over the persistently high levels of reported cases of harassment, discrimination, abuse of authority and other forms of misconduct within WHO, urged the Secretariat to address the underlying structural and systemic drivers of misconduct. Given the substantial increase in the use of affiliate staff, ongoing efforts to improve WHO's contractual landscape were welcome. Since the challenges were intrinsically linked to finances, her Government reaffirmed its commitment to flexible and predictable funding.

The representative of CHINA urged the Secretariat to address the long-standing issue of underrepresentation of some countries in WHO and requested that future reports include information on specific improvement measures and comparative indicators in that regard. He wished to know why staff costs had increased over the past year, even though the number of permanent WHO staff had remained relatively stable and fewer affiliate, consultant and special service agreements had been issued. He requested specific information on geographical mobility and mobility trends. He also wished to know which agencies were included in the Global Shared Services category and whether they were at the headquarters, national or regional levels.

The representative of POLAND expressed his Government's appreciation for all efforts to improve women's participation in WHO's work and to achieve a gender balance at all staff levels. It also appreciated the implementation of the United Nations Disability Inclusion Strategy at all levels of the Organization.

The representative of TOGO commended progress made on geographical distribution and diversity and on the status of staff, gender parity, the Global Internship Programme, and staff training and mobility. Her delegation supported the proposed 9.5% increase in the base salary scale for the Professional and higher categories and the amendments to the standards of conduct for staff members, dependants' allowances and special education grants for children with disabilities. More emphasis should be placed on country initiatives, more resources should be allocated to regions and countries as compared to headquarters, and more should be done to retain staff.

The representative of AUSTRALIA said that, while the progress towards achieving gender parity and greater geographical diversity, including representation of low- and middle-income countries, was commendable, continued attention was needed to address the underrepresentation of women in higher-grade roles. Noting efforts to overcome challenges to implementing the United Nations Disability Inclusion Strategy, he encouraged discussions at all levels of the Organization to find solutions that would foster disability inclusion across all business

operations and programme areas. He called for continued efforts to achieve an inclusive, equitable and diverse workforce across all levels.

The representative of THAILAND said that, in times of reform, financial constraints and uncertainty, human resources remained the most precious WHO asset. Although gender parity had been achieved at the lower professional levels, a significant gender gap in senior leadership remained. Given the crucial importance of staff mental health services, especially in high-demand offices and humanitarian contexts, ongoing efforts to strengthen mental health services, promote a work-life balance and provide targeted well-being programmes to improve staff morale were welcome.

The representative of SLOVAKIA said that, not only WHO's financial resilience but also its organizational resilience must be strengthened, across all levels. Strategic workforce planning, optimized resource allocation, and a well-supported workforce that was equipped to meet global health challenges effectively were essential. He therefore called for an audit of personnel to be conducted at all three levels of the Organization to ensure that committed, competent and professional staff were already in place.

The representative of TÜRKIYE[3] said that more should be done to address inequalities in the health workforce and meet the mental health needs of health workers, especially in crisis contexts. Training and career development strategies must be equitable, and access to training in digital health and telemedicine services and distance learning modalities should be available to all staff. Strengthening the resilience of the health workforce to global threats such as pandemics, climate change and armed conflicts must be a priority. Particular emphasis should be placed on improving working conditions and expanding psychosocial and other support to staff in low-income and developing countries. Digital solutions were crucial to remove barriers for persons with disabilities.

The representative of INDONESIA[3] said that he was pleased to note the progress made with regard to gender parity and the representation of low- and middle-income countries in long-term professional roles. More needed to be done to improve geographical representation, especially at the senior management level. Transparent recruitment and fair treatment of all staff were crucial. He wished to know more about the challenges encountered when seeking to attract talent from geographically diverse backgrounds and how Member States could support the Secretariat in that regard. Member States should be provided with regular updates on the impact of the current financial situation on staffing, retention and new recruitment, as well as adaptation and mitigation efforts.

The representative of JAPAN[3] said that with the number of WHO full-time staff at a record high, maintaining stable employment in the context of a serious financial situation would be the biggest challenge. Clarification was needed on whether the 9.5% increase in the base salary for the professional and higher categories, even if offset by a decrease in post adjustment pay, generated an increase in total personnel costs, including welfare expenses. Since staffing was already WHO's greatest expense, the timing of the salary increase – amid financial difficulties – was questionable.

The representative of PANAMA[3] said that the progress made towards greater representation of women and staff from low- and middle-income countries, including in leadership and in the Global Internship Programme, was commendable. At the same time, more needed to be done to

[3] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

increase global geographical mobility and ensure representation of countries that were currently not represented in the WHO workforce.

The representative of COLOMBIA,[4] welcoming the Secretariat's efforts to integrate the United Nations Disability Inclusion Strategy across its operations and programme areas, said that persons with disabilities and their representative organizations must be actively involved in decision-making. To enable the effective roll-out of disability inclusion at the country level, the achievements and challenges encountered by individual Member States must be taken into account. Sharing best practices would enrich the debate and strengthen Member States' commitment.

The representative of BANGLADESH[4] paid tribute to WHO staff, especially those working in health emergencies, war zones and conflict settings. It was discouraging that management was responding to financial constraints with a recruitment freeze and the non-renewal of contracts instead of exploring financing options to retain staff. Concrete measures were needed for greater geographical representation and to promote equitable recruitment from low- and middle-income countries.

The DIRECTOR (Human Resources and Talent Management) said that all of the Organization's human resource initiatives aimed at identifying and addressing the root causes of staff concerns would be sustained, including creating a respectful and healthy workplace environment through the organizational culture change process. Outreach campaigns were being conducted to address the underrepresentation of some countries and the Secretariat was working closely with Member States to identify and harness domestic recruitment platforms to reach potential candidates. Efforts to increase gender diversity would also continue. Since 2023, job openings that failed to yield at least 30% female applicants and at least two women on the shortlist were reopened to facilitate additional outreach to underrepresented groups. Work was under way with the transformation team, staff associations and the Office of the Ombudsperson to develop a people strategy that leveraged and built on some of those initiatives, which would address some of the concerns raised.

The FORMER DIRECTOR (Human Resources and Talent Management) said that the increase in staff costs resulted from a small increase in the overall number of staff, measures to offset currency fluctuations and increases in local salary rates in various geographical locations. Following the successful roll-out of the voluntary mobility exercise in 2023–2024, the mobility policy had been revised to incorporate the lessons learned to enable an even more successful exercise in 2025. The increase in base salary did not generate any additional cost for the Organization and was aligned with the relevant International Civil Service Commission and United Nations General Assembly decisions and resolutions. A new WHO service agreement for affiliate staff was currently being developed, precluding the recruitment of affiliate staff for core functions. Contractual modalities for staff positions were also being reviewed to enable more effective use of temporary appointments.

The DIRECTOR-GENERAL reassured the Board that efforts to ensure gender equality, geographical diversity and inclusivity in the workforce would continue; talent was universal but opportunity was not. WHO had always taken a cautious approach to recruitment, even in times of financial stability. The WHO transformation agenda and efforts to address the weaknesses identified in the coronavirus disease (COVID-19) response had led to the creation of new divisions

[4] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

and mechanisms that needed to be staffed. Recruitment had therefore been conducted carefully and with a focus on essentials.

To manage the current financial crisis, WHO would undertake careful analysis of the root cause and explore of the full range of possible solutions. Meanwhile, available resources must be spent in the most essential areas. The changing role of affiliate staff was part of transformation and Member States would be kept abreast of developments in that regard. Staff at WHO collaborating centres often shared their expertise pro bono and represented a resource that had yet to be used to the full extent.

He was deeply grateful to all staff for their dedication and hard work.

The CHAIR took it that the Board wished to note the reports contained in documents EB/156/48, EB156/49, EB156/50 Rev.1 and EB156/51.

The Board noted the reports.

The CHAIR took it that the Board wished to adopt the four draft resolutions contained in document EB156/50 Rev.1.

The resolutions were adopted.[5]

4. Provisional agenda of the Seventy-eighth World Health Assembly and date and place of the 157th session of the Executive Board: Item 25 of the agenda (documents EB156/41 Rev.1 and EB156/42)

The CHAIR drew attention to the report contained in document EB156/41 Rev.1 on the provisional agenda of the Seventy-eighth World Health Assembly, and invited the Board to consider a draft decision to approve the provisional agenda. He also drew attention to the report contained in document EB156/42 on the date and place of the Board's 157th session, which invited the Board to consider a draft decision to convene its 157th session on 28 and 29 May 2025.

The SECRETARY drew attention to item 21.8 of the provisional agenda of the Seventy-eighth World Health Assembly, Amendments to the Financial Regulations and Financial Rules. The Programme, Budget and Administration Committee of the Executive Board would be considering amendments to the Financial Regulations and Financial Rules and would make recommendations directly to the Health Assembly.

An item would be added to the provisional agenda of the 157th session of the Executive Board on the appointment of the Regional Director for the African Region. Following the discussion on governance reform, it was also proposed to add an additional bullet point to item 6.2, Governance reform that would read: Proposals for improving the effectiveness of the governing bodies.

The representative of ISRAEL said that, in the current circumstances, for WHO to refocus on its core role in global health and the fulfilment of its mandate as a specialized agency, it was necessary to re-evaluate needs, including the time allocated to items on the provisional agenda of the Health Assembly. Political discussions should not be a part of the Health Assembly's limited time. The focus on the Israeli-Palestinian conflict under two stand-alone items had zero impact on global or local health; while his Government had no objection to WHO's programme for assistance

[5] Resolutions EB156.R4, EB156.R5, EB156.R6 and EB156.R7.

to the Palestinians, it was a prominent example of the insufficient allocation of time and resources. There was no place for the proposed stand-alone item when there were no such stand-alone items on other countries in urgent need of health assistance, such as Sudan, the Democratic Republic of the Congo, or the Syrian Arab Republic. Since those needs were discussed at meetings of the Standing Committee, all assistance programmes such be discussed at the latter, and the Health Assembly should merely note or approve continuation of the programmes. The annual abuse of the Health Assembly through long political discussions with attacks against Israel must end. He strongly urged the Board to place items 17.3 and 20 under item 17.1 of the provisional agenda.

The CHAIR invited the Board to consider the proposal by the representative of Israel to combine items 17.3. and 20 under item 17.1.

The representative of QATAR, supported by the representatives of BANGLADESH,[6] BRUNEI DARUSSALAM, CHINA, the COMOROS, CUBA,[6] the DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA, INDONESIA,[6] LEBANON, NICARAGUA,[6] OMAN,[6] SOMALIA and YEMEN, rejected the proposal.

The Observer of PALESTINE[6] said that, when Israel had been elected as an Executive Board member, his delegation had predicted that it would politicize the work of the Board.

The representative of ISRAEL, speaking on a point of order, recalled that the Board was considering item 25 of the agenda and the discussion should therefore remain focused on that item.

The Observer of PALESTINE[6] said that the proposed agenda items in question were focused solely on the catastrophic health conditions in the occupied Palestinian territory and how to reconstruct the health sector, not on singling out what Israel was doing in the occupied Palestinian territory.

The representative of ISRAEL, speaking on a point of order, said that the discussion should remain focussed on item 25, on the provisional agenda of the Health Assembly.

The Observer of PALESTINE reiterated that the focus was on the health conditions in the occupied Palestinian territory, which was at the heart of WHO's work.

The representative of ARGENTINA[6] supported the position put forward by the representative of Israel. It was important to avoid the politicization of sensitive issues, irrespective of views on the situation on the ground.

The representative of BANGLADESH[6] rejected the proposal by the representative of Israel. The inclusion of the two proposed agenda items on the health situation in Palestine on the agenda of the Health Assembly was not a matter of politicization, but an appeal for respect for human dignity and an end to attacks on civilians and health facilities.

The representative of PAKISTAN,[6] also rejecting the proposal by the representative of Israel, said that the agenda of the Health Assembly concerned all WHO Member States and it was not for one Member State to change it. The two proposed agenda items were different in nature and served different purposes.

[6] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of TUNISIA[7] said that the proposal by the representative of Israel was unlikely to attract consensus and it would be preferable to move on to other agenda items.

The Observer of PALESTINE[7] said that the two proposed agenda items were completely different: one on the health conditions in the occupied Palestinian territory, including east Jerusalem; and the other on a decision related to the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan.

The representative of ISRAEL said that his proposal served the sole purpose of making the best use of time and resources by bringing the discussions under a single heading, it did not seek to eliminate the topics. It was clear from the comments by representatives of other Member States that the intention was to attack Israel, not to improve the situation on the ground.

The CHAIR said that, in the absence of a consensus, the Secretariat would proceed with a vote by show of hands on the proposal by the representative of Israel to combine items 17.3. and 20 under item 17.1.

At the invitation of the CHAIR, the LEGAL COUNSEL explained the procedure for a vote by show of hands.

The representative of AUSTRALIA requested that the vote be deferred until the following day to give Member States time to consider the proposal and seek instructions from capital.

The representative of BRAZIL objected to the proposal by the representative of Australia to postpone the discussion.

At the invitation of the CHAIR, the LEGAL COUNSEL explained that, if one Board member requested the suspension of a discussion under Rule 39 and another objected, that Rule indicated that the matter should immediately be put to a vote. The vote would be taken by show of hands.

The CHAIR invited the Secretariat to proceed with a vote on whether voting on the proposal by the representative of Israel should be deferred until the following day, as requested by the representative of Australia. Once the vote was complete, he announced the results, stating that 34 Board members had the right to vote, but that 2 were absent or not voting. Two Members had abstained, 11 had voted in favour and 19 had voted against.

The proposal to defer the vote was therefore rejected by 19 votes to 11, with 2 abstentions.

The CHAIR invited the Secretariat to proceed with a vote by show of hands on the amendments to the provisional agenda of the Seventy-eighth World Health Assembly proposed by the representative of Israel. Once the vote was complete, he announced the results, stating that 34 Board members had the right to vote, but that 2 were absent or not voting. Six Members had abstained, 2 had voted in favour and 24 had voted against.

The amendments proposed by Israel were therefore rejected by 24 votes to 2, with 6 abstentions.

[7] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The CHAIR took it that the Board wished to adopt the draft decision on the provisional agenda of the Seventy-eighth World Health Assembly, without amendment, as contained in paragraph 4 of document EB156/41 Rev.1, paragraph 4.

The representative of ISRAEL objected, requesting that the Board vote on the draft decision.

The CHAIR invited the Secretariat to proceed with a vote by show of hands on the adoption of the provisional agenda of the Seventy-eighth World Health Assembly, without amendment, as contained in paragraph 4 of document EB156/41 Rev.1. Once the vote was complete, he announced the results, stating that 34 Board members had the right to vote, but that 1 was absent or not voting. Two Members had abstained, 29 had voted in favour and 2 had voted against.

The draft decision was therefore approved by 29 votes to 2, with 2 abstentions.

The draft decision was adopted.[8]

The representative of ISRAEL dissociated himself from the draft decision. Member States should strive for efficiency and not to be swayed by political wishes; that was not the way to secure the future of the Organization.

The CHAIR took it that the Board wished to adopt the draft decision to convene the 157th session of the Executive Board on 28 and 29 May 2025, which was contained in paragraph 4 of document EB156/42.

The draft decision was adopted.[9]

The CHAIR took it that the Board wished to note the reports contained in documents EB156/41 Rev.1 and EB156/42.

The Board noted the reports.

5. Budget and finance matters: Item 23 of the agenda (continued)

Financing and implementation of the Programme budget 2024–2025: Item 23.1 of the agenda (documents EB156/26 Rev.1, EB156/INF./1 and EB156/INF./5) (continued from the sixteenth meeting, section 1)

Proposed programme budget 2026–2027: Item 23.2 of the agenda (documents EB156/27 and EB156/INF./6) (continued from the sixteenth meeting, section 1)

The CHAIR drew attention to a revised draft decision on resolutions and priorities, proposed by Norway, which read:

> The Executive Board, having considered the report by the Director-General and the debate at its 156th session; recognizing the resolutions and decisions recommended by the

[8] Decision EB156(11).

[9] Decision EB156(12).

156th session of the Executive Board for adoption by the Seventy-eighth World Health Assembly,

Decided:
(1) to recommend to the Seventy-eighth World Health Assembly that the implementation of the requests to the Director-General contained in resolutions and decisions, including those recommended by the 156th session of the Executive Board for adoption by Seventy-eighth World Health Assembly, be subject to the operationalization of the Programme budget 2026–2027 once approved, without prejudice to their use for advocacy, awareness, and continuation of ongoing activities;
(2) to request the Director-General to consider the implications of the requests to the Director-General in resolutions and decisions, including those recommended by the 156th session of the Executive Board for adoption by Seventy-eighth World Health Assembly, in the overall development process of the Programme budget 2026–2027, in line with the guidance provided to the Secretariat by the Programme, Budget and Administration Committee of the Executive Board at its forty-first meeting;
(3) to request the Director-General to consult with Member States throughout the prioritization process for the Programme budget 2026–2027, to include the implications of the requests to the Director-General in resolutions and decisions recommended by the 156th session of the Executive Board for adoption by the Seventy-eighth World Health Assembly in this process, and to report back to the Seventy-eighth World Health Assembly, through the forty-second meeting of the Programme, Budget and Administration Committee of the Executive Board;
(4) to request the Director-General to continue efforts in resource mobilization.

The representative of NORWAY expressed the hope that the Board would reach a consensus on the agenda item.

The representative of ZAMBIA,[2] said that, while she acknowledged that the decision was being made in the light of the current financial and economic situation, it should be indicated in the report that it should not set a precedent for future decisions.

The representative of MALAYSIA[2] proposed that, in paragraph (1), the words “be subject to” be replaced by “take into account”, which was less prescriptive.

The representative of CHINA supported the proposed amendment by the representative of Malaysia. He proposed amending the title to read: “Decision point on resolutions and priorities recommended by the 156th session of the Executive Board for adoption by the Seventy-eighth World Health Assembly”, to avoid setting a precedent for future resolutions and decisions.

The representative of the OFFICE OF THE LEGAL COUNSEL suggested that the words, “including those”, should be inserted before the word “recommended”, in the amendment proposed by the representative of China, as the draft decision did not only concern resolutions and decisions adopted by the Board at the current session.

The representative of ETHIOPIA proposed that, in paragraph (1), the word “awareness” be amended to read “awareness-raising”.

The representative of LEBANON suggested that a sentence be added to state that resolutions and decisions could be excluded without significant financial implications.

The representative of the OFFICE OF THE LEGAL COUNSEL said that the draft decision under discussion did not deal with the most recent resolutions and decisions, which was why his suggestion to add the words “including those” before the word “recommended” would be more consistent with the text of the draft decision. It would be the clearest way of identifying the resolutions and decisions that were part of the draft decision but would not be limited to only those.

It was so agreed.

The meeting rose at 18:25.

Eighteenth meeting

Monday, 10 February 2025, at 18:55

Chair: Dr J.X. Walcott (Barbados)

Pillar 4: More effective and efficient WHO providing better support to countries (continued)

1. Budget and finance matters: Item 23 of the agenda (continued)

Financing and implementation of the Programme budget 2024–2025: Item 23.1 of the agenda (documents EB156/26 Rev.1, EB156/INF./1 and EB156/INF./5) (continued)

Proposed programme budget 2026–2027: Item 23.2 of the agenda (documents EB156/27 and EB156/INF./6) (continued)

The CHAIR took it that the Board wished to adopt the revised draft decision on resolutions and priorities, as amended during the Board's seventeenth meeting.

The decision, as amended, was adopted.[1]

Pillar 1: One billion more people benefiting from universal health coverage (continued)

2. Universal health coverage: Item 6 of the agenda (continued)

- **Primary healthcare** (document EB156/6) (continued from the fifth meeting, section 1)

The CHAIR took it that the Board wished to adopt the draft decision on strengthening national capacities in evidence-based decision-making for the uptake and impact of norms and standards.

The decision was adopted.[2]

The CHAIR invited the Board to adopt the draft decision on rare diseases: a global health priority for equity and inclusion.

[1] Decision EB156(13).

[2] Decision EB156(14).

The representative of ARGENTINA,[3] highlighting his country's new political and economic path, said that his Government maintained reservations on all references in draft decisions and resolutions that were not aligned with its foreign policy, in particular those in the 2030 Agenda for Sustainable Development, which it considered to be non-binding and up to each Member State to interpret freely, and in the Pact for the Future; those referring to climate change, any action on which should be based solely on scientific evidence; all paragraphs that ran counter to its guiding principles on the protection of life, liberty and private property; and all paragraphs referring to the term "gender", which it understood, pursuant to Article 7.3 of the Rome Statute of the International Criminal Court, referred to the two sexes, male and female, within the context of society.

His Government wished to dissociate itself from the thirteenth preambular paragraph of the draft decision on rare diseases.

The CHAIR took it that the Board wished to adopt the draft decision.

The decision was adopted.[4]

The CHAIR invited the Board to adopt the draft decision on strengthening health financing globally.

The representative of ARGENTINA[3] said that his Government dissociated itself from the references to the Sustainable Development Goals in the second preambular paragraph and in paragraph 3(3). Regarding the third preambular paragraph, his Government could not accept the references to the latest amendment to the International Health Regulations (2005), as it was still assessing the impact on sovereignty and the national scope to implement specific policies. The excessive focus of the text on public financing and domestic resource mobilization, without properly recognizing the key role of the private sector in innovation, efficiency and the financial sustainability of health systems, limited the potential for realistic and scalable solutions. Moreover, the promotion of an expansion of WHO's role beyond its mandate, particularly in the areas of health financing and economics, and the insistence on fiscal measures such as taxes on tobacco, sugar and alcohol as main sources of financing for health were causes of concern. Any health financing strategy must respect state sovereignty and the diversity of national systems and consider national political, economic and regulatory contexts.

The CHAIR took it that the Board wished to adopt the draft decision.

The decision was adopted.[5]

The CHAIR took it that the Board wished to adopt the draft decision on strengthening medical imaging capacity.

The decision was adopted.[6]

[3] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[4] Decision EB156(15).

[5] Decision EB156(16).

[6] Decision EB156(17).

3. Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases: Item 7 of the agenda (document EB156/7) (continued from the sixth meeting, section 1)

- **Reducing the burden of noncommunicable diseases through strengthening prevention and control of diabetes** (continued from the sixth meeting, section 1)
- **Oral health** (continued from the sixth meeting, section 1)
- **Comprehensive mental health action plan 2013–2030** (continued from the sixth meeting, section 1)
- **Global strategy to accelerate the elimination of cervical cancer as a public health problem and its associated goals and targets for the period 2020–2030** (continued from the sixth meeting, section 1)

The CHAIR took it that the Board wished to adopt the draft decision on a dedicated report on mental health for WHO's governing bodies.

The decision was adopted.[7]

The CHAIR took it that the Board wished to adopt the draft decision on promoting and prioritizing an integrated lung health approach.

The decision was adopted.[8]

The CHAIR took it that the Board wished to adopt the draft decision on reducing the burden of noncommunicable diseases through promotion of kidney health and strengthening prevention and control of kidney disease.

The decision was adopted.[9]

The CHAIR invited the Board to adopt the draft decision on primary prevention and integrated care for sensory impairments including vision impairment and hearing loss, across the life course.

The representative of SLOVAKIA requested that, in the draft decision on primary prevention and integrated care for sensory impairments, footnote 7, which had been proposed by his delegation, be deleted.

The representative of ARGENTINA[10] expressed his Government's wish to dissociate itself from the fourteenth preambular paragraph.

The CHAIR took it that the Board wished to adopt the draft decision, as amended.

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[7] Decision EB156(18).

[8] Decision EB156(19).

[9] Decision EB156(20).

[10] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The decision, as amended, was adopted.[11]

The CHAIR invited the Board to adopt the draft decision on World Cervical Cancer Elimination Day.

The representative of ARGENTINA[11] said that his Government was opposed to all forms of discrimination and made no distinction of any kind. It therefore considered that listing categories for non-discrimination purposes always left someone behind, as lists could never be exhaustive. He reiterated that the Government agreed with the meaning of the term "gender" as per Article 7.3 of the Rome Statute. Moreover, the emphasis on one aspect of women's health – sexual and reproductive health – to the exclusion of the main causes of female deaths was limiting; a comprehensive health approach should be adopted. His Government therefore wished to dissociate itself from the third, fifth and sixth preambular paragraphs of the draft decision.

The CHAIR took it that the Board wished to adopt the draft decision.

The decision was adopted.[12]

4. Communicable diseases: Item 9 of the agenda (document EB156/9) (continued)

- **Global road map on defeating meningitis by 2030** (document EB156/10) (continued from the eleventh meeting, section 2)

The CHAIR took it that the Board wished to adopt the draft decision on accelerating the eradication of dracunculiasis (Guinea-worm disease).

The decision was adopted.[13]

The CHAIR took it that the Board wished to adopt the draft decision on skin diseases as a global public health priority.

The decision was adopted.[14]

5. Substandard and falsified medical products: Item 10 of the agenda (documents EB156/11, EB156/11 Add.1 and EB156/12) (continued from the eleventh meeting, section 3)

The CHAIR invited the Board to adopt the draft decision on the Member State mechanism on substandard and falsified medical products, contained in document EB156/11.

The decision was adopted.[15]

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[11] Decision EB156(21).

[12] Decision EB156(22).

[13] Decision EB156(23).

[14] Decision EB156(24).

[15] Decision EB156(25).

6. Health and care workforce: Item 12 of the agenda (continued from the twelfth meeting, section 2)

- **WHO Global Code of Practice on the International Recruitment of Health Personnel** (documents EB156/14 and EB156/14 Add.1) (continued)

- **Global strategy on human resources for health: workforce 2030** (document EB156/15) (continued)

The CHAIR invited the Board to adopt the draft decision contained in document EB156/14.

The decision was adopted.[16]

The CHAIR invited the Board to adopt the draft decision on accelerating action on the global health and care workforce by 2030.

The representative of CANADA said that the square brackets in paragraph 3(2) should be deleted.

The representative of the OFFICE OF THE LEGAL COUNSEL explained that the Board was agreeing to recommend a draft decision to the Seventy-eighth Health Assembly for adoption. Efforts should be made during the intersessional period to resolve any bracketed text.

The representative of the PHILIPPINES clarified that the proposers and sponsors of the draft decision had not intended to table it with bracketed text.

The representative of ARGENTINA[17] expressed his Government's wish to dissociate itself from the third preambular paragraph and paragraphs 1(3), 3(2) and 3(3) of the draft decision.

The CHAIR took it that the Board wished to adopt the draft decision.

The decision was adopted.[18]

7. Draft global traditional medicine strategy (2025–2034): Item 13 of the agenda (documents EB156/16 and EB156/16 Add.1) (continued from the thirteenth meeting, section 1)

The CHAIR invited the Board to consider the draft decision on the draft global traditional medicine strategy: 2025–2034, contained in document EB156/16.

The representative of POLAND, speaking on behalf of the European Union and its Member States, requested further consultations on the draft global traditional medicine strategy: 2025–2034 and its financial implications in the programme budget before the presentation of the draft decision for consideration by the Health Assembly.

The ASSISTANT DIRECTOR-GENERAL (Universal Health Coverage/Life Course) confirmed that additional consultations would be held during the intersessional period.

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[16] Decision EB156(26).

[17] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[18] Decision EB156(27).

The representative of the DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA expressed support for the draft decision.

The CHAIR took it that the Board wished to adopt the draft decision.

The decision was adopted.[19]

8. Global Strategy for Women's, Children's and Adolescents' Health: Item 14 of the agenda (document EB156/17) (continued from the fourteenth meeting, section 1)

The CHAIR invited the Board to adopt the draft decision on the incorporation of the World Prematurity Day into the WHO calendar, to strengthen approaches to prevent preterm births and treat and care for preterm infants.

The representative of ARGENTINA[20] said that his Government wished to dissociate from the second and fifth preambular paragraphs and paragraphs 1(4) and 2(6) of the draft decision.

The CHAIR took it that the Board wished to adopt the draft decision.

The decision was adopted.[21]

The CHAIR took it that the Board wished to adopt the draft decision on regulating the digital marketing of breast-milk substitutes.

The decision was adopted.[22]

Pillar 2: One billion more people better protected from health emergencies (continued)

9. WHO's work in health emergencies: Item 15 of the agenda (document EB156/18) (continued from the ninth meeting, section 1)

The CHAIR said he took it that the Board wished to adopt the draft decision on strengthening the evidence-base for public health and social measures.

The decision was adopted.[23]

[19] Decision EB156(28).

[20] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[21] Decision EB156(29).

[22] Decision EB156(30).

[23] Decision EB156(31).

Pillar 3: One billion more people enjoying better health and well-being (continued)

10. The impact of chemicals, waste and pollution on human health: Item 20 of the agenda (document EB156/23) (continued from the fourteenth meeting, section 2)

The CHAIR noted that informal consultations on the draft decision on the [effects of [nuclear weapons and] nuclear war on health and [health] services would continue during the intersessional period, with a view to reaching consensus.

He invited the Board to consider the draft decision on galvanizing global support for a lead-free future.

The representative of ARGENTINA[24] said that his Government wished to dissociate itself from paragraph 2(3) of the draft decision.

The CHAIR took it that the Board wished to adopt the draft decision.

The decision was adopted.[25]

11. Updated road map for an enhanced global response to the adverse health effects of air pollution: Item 21 of the agenda (documents EB156/24 and EB156/24 Add.1) (continued from the fifteenth meeting, section 1)

The CHAIR took it that the Board wished to adopt the draft decision on the updated road map for an enhanced global response to the adverse health effects of air pollution, contained in document EB156/24.

The decision was adopted.[26]

12. Climate change and health: Item 22 of the agenda (documents EB156/25 and EB156/25 Add.1) (continued from the fifteenth meeting, section 2)

The CHAIR invited the Board to consider the draft decision on the draft global action plan on climate change and health, contained in document EB156/25.

The representative of QATAR, supported by the representative of SOMALIA, said that further consultations were needed.

The CHAIR took it that the Board wished to postpone consideration of the draft decision, pending further consultations.

It was so agreed.

(For continuation of the discussion and the adoption of a decision, see the summary record of the nineteenth meeting, section 3.)

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[24] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[25] Decision EB156(32).

[26] Decision EB156(33).

Pillar 4: More effective and efficient WHO providing better support to countries (resumed)

13. Management and governance matters: Item 24 of the agenda (continued)

Global strategies or action plans that are scheduled to expire within one year: Item 24.3 of the agenda (continued from the sixteenth meeting, section 2)

- **Global strategic directions for nursing and midwifery 2021–2025** (documents EB156/34 and EB156/34 Add.1) (continued from the sixteenth meeting, section 2)
- **Global strategy on digital health 2020–2025** (documents EB156/35 and EB156/35 Add.1) (continued from the sixteenth meeting, section 2)
- **Global action plan on the public health response to dementia 2017–2025** (documents EB156/36 and EB156/36 Add.1) (continued from the sixteenth meeting, section 2)
- **Comprehensive implementation plan on maternal, infant and young child nutrition** (documents EB156/37 and EB156/37 Add.1) (continued from the sixteenth meeting, section 2)

The CHAIR took it that the Board wished to adopt the draft decision on global strategic directions for nursing and midwifery 2021–2025, contained in document EB156/34.

The decision was adopted.[27]

The CHAIR took it that the Board wished to adopt the draft decision on the global strategy on digital health 2020–2025, contained in document EB156/35.

The decision was adopted.[28]

The CHAIR took it that the Board wished to adopt the draft decision on the global action plan on the public health response to dementia 2017–2025, contained in document EB156/36.

The decision was adopted.[29]

The CHAIR invited the Board to adopt the draft decision on the extension of the comprehensive implementation plan on maternal, infant and young child nutrition.

The representative of ARGENTINA[30] said that his Government wished to dissociate itself from the fourth preambular paragraph and paragraph 1 of the draft decision.

The CHAIR took it that the Board wished to adopt the draft decision.

The decision was adopted.[31]

[27] Decision EB156(34).

[28] Decision EB156(35).

[29] Decision EB156(36).

[30] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

[31] Decision EB156(37).

14. International Health Regulations (2005): proposed procedure for the correction of errors in the text of the instrument: Item 24.5 of the agenda (documents EB156/40, EB156/40 Add.1 and EB156/INF./2) (continued from the seventeenth meeting, section 2)

The CHAIR took it that the Board wished to adopt the draft decision on the International Health Regulations (2005): proposed procedure for the correction of errors in the text of the instrument, contained in document EB 156/40.

The decision was adopted.[32]

The meeting rose at 19:40.

[32] Decision EB156(38).

Nineteenth meeting

Tuesday, 11 February 2025, at 10:10

Chair: Dr J.X. Walcott (Barbados)

Pillar 4: More effective and efficient WHO providing better support to countries (continued)

1. Committees of the Executive Board: Item 26 of the agenda (continued)

Standing Committee on Health Emergency Prevention, Preparedness and Response: Item 26.3 of the agenda (documents EB156/44, EB156/44 Add.1 and EB156/45) (continued from the seventeenth meeting, section 1)

Report of the Standing Committee on Health Emergency Prevention, Preparedness and Response: Item 5 of the agenda (document EB156/5) (continued from the seventeenth meeting, section 1)

The CHAIR drew attention to a draft decision, which contained a draft decision to be submitted to the Seventy-eighth World Health Assembly, on the Standing Committee on Health Emergency Prevention, Preparedness and Response, which read:

> The Executive Board, having considered the reports by the Director-General,[1,2] and recognizing the Executive Board's discussions on prioritization and efficiencies within the work of the Secretariat,
>
> Decided to recommend to the Seventy-eighth World Health Assembly the adoption of the following decision:
>
> > The Seventy-eighth World Health Assembly,
> > (PP1) Having considered the report by the Director-General and recognizing the Executive Board's discussions at its 156th session on prioritization and efficiencies within the work of the Secretariat,
> > Decided:
> > (OP)1. to extend the mandate of the Standing Committee on Health Emergency Prevention, Preparedness and Response until the closure of the Seventy-ninth World Health Assembly in 2026;

[1] Document EB156/5.

[2] Document EB156/45.

(OP)2. to adopt the amended Terms of reference of the Standing Committee on Health Emergency Prevention, Preparedness and Response;[3]
(OP)3. to request the Director-General to prepare a report, for consideration by the Executive Board at its 158th session, on the mandates and the functions of the different governance and oversight mechanisms for health emergencies, including the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme, the Standing Committee on Health Emergency Prevention, Preparedness and Response, the States Parties to the International Health Regulations (2005), and the Coordinating Financial Mechanism under the International Health Regulations (2005), and mechanisms that may be included in the proposed pandemic agreement with a view to identify any gaps or duplications.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[4]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:
4.2.1. Leadership, governance and external relations enhanced to implement GPW 13 and drive impact in an aligned manner at the country level, on the basis of strategic communications and in accordance with the Sustainable Development Goals in the context of United Nations reform

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:
Not applicable.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:
Not applicable.

4. Estimated time frame (in years or months) to implement the decision:
Seventeen months until the closure of the Seventy-ninth World Health Assembly in May/June 2026.

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:
US$ 0.29 million. This figure reflects interpretation and IT costs during anticipated virtual meetings, including additional human resources for that purpose. Human resources costs for report development will be absorbed as part of programme budget implementation.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:
US$ 0.16 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:
Not applicable.

[3] See document EB156/5, Appendix 2.

[4] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic “bridge” between results structures can be provided as needed.

3. **Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:**
US$ 0.13 million.

4. **Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:**
Not applicable.

5. **Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions**
   - **Financial resources available to fund the decision in the current biennium:**
     US$ 0.16 million.
   - **Remaining financing gap in the current biennium:**
     Zero.
   - **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
     Not applicable.

GPW 13: Thirteenth General Programme of Work, 2019–2025.

Table. Breakdown of estimated resource requirements (in US$ millions)

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.09	0.09
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.07	0.07
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.16	0.16
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.10	0.10
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.03	0.03
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.13	0.13
B.4. Future bienniums cost of resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.1. Total planned costs required to implement the decision									0.29

The representative of CANADA emphasized that the purpose of the draft decision on the Standing Committee on Health Emergency Prevention, Preparedness and Response was to ensure a robust strategic year ahead. The report requested in the draft decision, which was for consideration by the Executive Board at its 158th session, could be circulated in advance in order to enable meaningful discussion at the seventh meeting of the Standing Committee, in September 2025. Any specific recommendations arising out of the seventh meeting of the

Standing Committee concerning that body's future could then be presented to the Executive Board at its 158th session in January 2026.

The representative of SLOVAKIA reiterated that, in the light of the current financial constraints, the forthcoming meetings of the Standing Committee should be held online.

The representative of NORWAY said that she had previously expressed concern about the added value of the Standing Committee, particularly in the light of the challenging financial situation. The draft decision, however, might represent a way forward. If the Standing Committee was involved in follow-up to declarations of public health emergencies of international concern, the timing of its meeting should be revised to allow the Secretariat more time to prepare its recommendations and share them with Committee members.

The representative of LESOTHO supported the draft decision, underscoring the need to review the work of the Standing Committee at its seventh meeting.

The DEPUTY DIRECTOR-GENERAL (WHO Health Emergencies Programme), emphasizing that the Secretariat was at the disposal of Member States to implement decisions adopted by them, asked whether the proposal entailed one evaluation of all governance mechanisms or two evaluations: the first an evaluation of all governance mechanisms, and the second an evaluation of the Standing Committee. Outlining the rationale behind the draft decision, he said that oversight mechanisms were in place for regular reporting to the Health Assembly on matters related to the management of emergencies. In addition, two processes had been agreed within the amended International Health Regulations (2005), the establishment of a new States Parties Committee for the Implementation of the International Health Regulations (2005) and of a Coordinating Financial Mechanism, both of which would be set up following the entry into force of the amended International Health Regulations (2005) in 2025. Member States would determine the functioning and composition of those bodies. Additionally, the Intergovernmental Negotiating Body to draft and negotiate a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response was actively negotiating the form of governance required to oversee a successful conclusion of its negotiations. The Standing Committee itself had been established to ensure that the Director-General remained accountable to Member States, enabling them to engage directly with the Secretariat on recommendations and decisions immediately after a declaration of a public health emergency of international concern. It was currently considered that convening the Standing Committee only when there was a public health emergency of international concern did not endow it with the continuity and experience needed to oversee programmes and make recommendations. The Standing Committee was governed by Member States, while the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme was governed by the Health Assembly. The draft decision concerned recommendations on the continuation of the Standing Committee according to its terms of reference.

The representative of CANADA said that the draft decision required Member States to consider whether the Standing Committee had a role in shaping discussions on the structure of the various governance mechanisms and identifying any gaps or duplication, and, on that basis, whether the Committee should be continued. The proposed one-year extension would enable Member States to engage in strategic discussions in that regard. She underscored that the proposal comprised one broad evaluation of all governance mechanisms, with the Standing Committee as the forum for that discussion.

The representative of MOROCCO underlined that the draft decision included a request to the Director-General to conduct a broad evaluation to review the mandate of all the bodies involved in public health emergencies of international concern and to redefine, where necessary, the place of the Standing Committee among those bodies.

The DEPUTY DIRECTOR-GENERAL (WHO Health Emergencies Programme) said that it fell to the Member States to decide which bodies were involved in the review process, although the Standing Committee was necessarily involved. It was for the Board to decide whether to request the Secretariat to conduct a review of the governance mechanisms and report back.

The SECRETARY said that the current draft decision constituted a request that this matter be included on the agenda of the seventh meeting of the Standing Committee in September 2025, the dates of which would be set at the following session of the Executive Board, in May 2025. The Board would also decide on the agenda of the seventh meeting of the Standing Committee.

The CHAIR took it that the Board wished to adopt the draft decision on the Standing Committee on Health Emergency Prevention, Preparedness and Response.

The decision was adopted.[5]

2. Report on meetings of expert committees and study groups: Item 28 of the agenda

- **Expert advisory panels and committees and their membership** (document EB156/52 and EB156/52 Add.1)

The CHAIR took it that the Board wished to note the reports contained in documents EB156/52 and EB156/52 Add.1.

The Board noted the reports.

Pillar 3: One billion more people enjoying better health and well-being (continued)

3. Climate change and health: Item 22 of the agenda (documents EB156/25 and EB156/25 Add.1) (continued from the eighteenth meeting, section 12)

The CHAIR reminded the Board that it had before it a draft decision on the draft global action plan on climate change and health, which was contained in document EB156/25.

The representative of ETHIOPIA, speaking on behalf of the Member States of the African Region, recalled that her group had indicated that the draft global action plan would benefit from further consultation. She therefore proposed an amendment to the draft decision, so that the preambular paragraph read:

> "The Executive Board, having considered the report by the Director-General, decides that informal consultations on the global action plan on climate change and health 2025–2028 will continue to be facilitated by the Secretariat in an inclusive and transparent manner prior

[5] Decision EB156(39).

to the Seventy-eighth World Health Assembly with a view to enabling the following draft decision to be submitted to the Seventy-eighth World Health Assembly for adoption."

The representative of SENEGAL said that, while the draft decision focused on mitigation, the African Region actually needed to further strengthen health system adaptation to, and resilience against, the current and future impact of climate change. He therefore supported the proposed amendment to the draft decision.

The representative of POLAND, speaking on behalf of the European Union and its Member States, expressed support for consultations on the draft global action plan and for the draft decision.

The representative of BRAZIL, supported the amendment and noting the different reasons for the request for further consultations, drew attention to the importance of balancing the issues of adaptation and mitigation in consultations. He also called for a discussion on climate-sensitive disease.

THE CHAIR took it that the Board wished to adopt the draft decision, as amended.

The decision, as amended, was adopted.[6]

Pillar 4: More effective and efficient WHO providing better support to countries (resumed)

4. Management and governance matters: Item 24 of the agenda (continued)

Governance reform: Item 24.2 of the agenda (continued)

- **Process for handling and investigating potential allegations against WHO Directors-General** (documents EB156/30, EB156/30 Add.1, EB156/30 Add.2 and EB156/30 Add.2 Corr.1) (continued from the second meeting, section 4)

The CHAIR recalled that, at the second meeting of the current session, a decision had been adopted that requested the Executive Board to work to resolve remaining areas of divergence on the development of a process for handling and investigating potential allegations against WHO Directors-General, with a view to submitting a text to the Seventy-eighth World Health Assembly. That decision had been adopted on the understanding that the Board could return to it before the end of the current session, depending on the outcome of consultations. Some progress had been made in such consultations, on which basis the Board might wish to replace the decision adopted with a revised draft decision. It was important to move from long-established positions to coalesce around consensus.

If adopted, the revised draft decision would replace the decision on the same matter that had been adopted the previous week. The revised draft decision represented a middle ground that had been found following consultations. The revised draft decision read:

The Executive Board, having considered the report by the co-leads for Member State-led governance reform and the report of the Programme, Budget and Administration

[6] Decision EB156(40).

Committee;[7] affirming the longstanding commitment of Member States, including at meetings of the governing bodies held in 2019, 2021, 2022, 2023 and 2024 to formalize a process for handling and investigating potential allegations against WHO Directors-General; noting the Health Assembly's decision in May 2024 to return to this matter for discussion in May 2025;[8] recognizing that broad representation of Member States, including across all regions, is essential to achieving consensus in drafting such a process; and acknowledging the formal mandate of the Executive Board, through the Programme, Budget and Administration Committee, to consider and make proposals to the Health Assembly on governance matters,

Decided:

(1) to express appreciation for the report of the co-leads for Member State-led governance reform on a process for handling and investigating potential allegations against WHO Directors-General;[9]

(2) to request the Chairs of the Executive Board and the Programme, Budget and Administration Committee:

(a) to develop a draft process for handling and investigating potential allegations against WHO Directors-General, based on the framework contained in document EB156/30 Add.2 and document EB156/30 Add.2 Corr.1, drawing upon elements of agreement in previous work and consultations conducted by the Independent Expert Oversight Advisory Committee and by Member States, for consideration by the Seventy-eighth World Health Assembly, through the Programme, Budget and Administration Committee at its forty-second meeting;

(b) to present the draft process at a Member States consultation prior to the forty-second meeting of the Programme, Budget and Administration Committee;

(3) to request the Director-General to facilitate the support of the Independent Expert Oversight Advisory Committee and make available the necessary resources within the Secretariat, including WHO's Office of Internal Oversight Services and Legal Counsel, as requested.

The financial and administrative implications for the Secretariat of its adoption were:

A. Link to the approved Programme budget 2024–2025[10]

1. Output(s) in the approved Programme budget 2024–2025 under which this draft decision would be implemented if adopted:

4.2.2. The Secretariat operates in an accountable, transparent, compliant and risk management-driven manner, including through organizational learning and a culture of evaluation

2. Short justification for considering the draft decision, if there is no link to the results as indicated in the approved Programme budget 2024–2025:

Not applicable.

[7] Documents EB156/30 and EB156/4, respectively.

[8] Decision WHA77(15) (2024).

[9] Document EB156/30.

[10] Please note that the results structure for the Programme budget 2026–2027 (under the Fourteenth General Programme of Work, 2025–2028) is currently under development. For this reason, the results structure of the Programme budget 2024–2025 (under the Thirteenth General Programme of Work, 2019–2025) will continue to be used. A programmatic "bridge" between results structures can be provided as needed.

3. Any additional Secretariat work during the biennium 2024–2025 that cannot be accommodated within the approved Programme budget 2024–2025 ceiling:
Not applicable.

4. Estimated time frame (in years or months) to implement the decision:
Six months (to June 2025).

B. Budget and resource implications for the Secretariat for implementation of the decision

1. Total planned costs required to implement the decision, in US$ millions:
US$ 0.10 million.

This only includes the support that the Secretariat is requested to provide in the decision. Potential future costs to support the conduct of any intake assessment, preliminary review and/or full investigation, if warranted, are not included.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2024–2025 ceiling, in US$ millions:
US$ 0.10 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2024–2025, in US$ millions:
Not applicable.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2026–2027, in US$ millions:
Not applicable.

4. Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US$ millions:
Not applicable.

5. Level of financial resources already available to fund the implementation of the decision in the current biennium, in US$ millions

- **Financial resources available to fund the decision in the current biennium:**
  US$ 0.10 million.
- **Remaining financing gap in the current biennium:**
  Zero.
- **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
  Not applicable.

Table. Breakdown of estimated resource requirements (in US$ millions)

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2024–2025 cost of resources already planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.09	0.09
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.01
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.10	0.10
B.2.b. 2024–2025 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2026–2027 cost of resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.4. Future bienniums cost of resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.1. Total planned costs required to implement the decision								0.10	0.10

The representative of NORWAY, speaking in her capacity as Chair of the Programme, Budget and Administration Committee of the Executive Board, expressed the hope that consensus would be reached, particularly since several Member States had shown willing to compromise in the interests of finding middle ground.

The representative of SENEGAL, speaking on behalf of the Member States of the African Region, reiterated the importance of establishing procedures to ensure transparency and accountability in the context of any allegations against senior staff, including Directors-General of the Organization. The overriding responsibility of the governing bodies was the protection of the Organization's best interests and those bodies must therefore be involved as decision-makers at key stages of investigations. Accordingly, the decision to open a full investigation in response to an allegation must fall to the Executive Board, with the inclusive and transparent participation of Member States in a private sitting and with confidentiality ensured throughout the process. His region was willing to participate in consultations with all Member States in order to reach a consensus on the revised draft decision.

The representative of BARBADOS, expressing support for the revised draft decision and the quest for consensus, said that the matter should be brought to a swift conclusion. He agreed that investigations should be conducted by an independent entity external to the Secretariat, which would issue recommendations.

The representative of the REPUBLIC OF KOREA supported the revised draft decision, which sought to further strengthen the roles of WHO governing bodies, while harmoniously ensuring the independent role of the external investigative entity. It was nevertheless necessary to devise more concrete measures to ensure the expertise and credibility of that entity.

The representative of CANADA noted that the election process for the position of Director-General was driven by Member States in the initial stages, prior to the Board's involvement. The revised draft decision sought to ensure independence and due diligence, and included checks and balances established and agreed by Member States. It was a pivotal moment to adopt the revised draft decision and thereby demonstrate the solidarity of the Board and due diligence of the Organization.

The representative of TOGO said that it was important to enhance inclusivity and accountability by including Board members in any investigations into potential allegations against WHO Directors-General and by establishing measures for respect and confidentiality throughout such processes.

The representative of AUSTRALIA said that, while the revised draft decision was not considered perfect by all Member States, it represented a compromise that addressed concerns and ensured accountability and procedural fairness. It was supported by the majority of Board members and Member States. The biggest risk remained the absence of a defined process. The revised draft decision provided for independent investigation, strong and appropriate oversight, accountable governance, integrity and transparency. There was no more important time to establish a process to protect the Organization and its Directors-General. He supported the revised draft decision.

The representative of ETHIOPIA underscored the importance of accountability and transparency and looked forward to an established process that was balanced and legitimate, and to constructive engagement in that regard.

The representative of CHINA asked whether the revised draft decision provided for only one consultation with Member States prior to the forty-second meeting of the Programme, Budget and Administration Committee. He asked whether a second consultation would be held if consensus was not reached.

The representative of POLAND expressed support for the revised draft decision.

The representative of NORWAY, speaking in her capacity as Chair of the Programme, Budget and Administration Committee, said that the revised draft decision was intended to advance the finalization of the process for handling and investigating potential allegations against WHO Directors-General by, first, developing a draft process for such allegations, based on the framework agreed in previous consultations conducted by the Independent Expert Oversight Advisory Committee and by Member States, which was to be presented for consideration to the Seventy-eighth World Health Assembly, through the Programme, Budget and Administration Committee at its forty-second meeting; and, second, presenting the draft process at a Member State consultation prior to the forty-second meeting of the Programme, Budget and Administration Committee. Since many – but not all – Member States had supported the initial decision, which had been adopted, the current proposal was a compromise that struck a balance between various principles, such as the governing bodies' involvement and the independence of the investigations. The approach set out in the revised draft decision was focused on finding consensus based on the agreed framework. If Member States were not able to find consensus on the revised draft decision, more time would be needed to address the issue, when it was urgent that the Organization adopt a decision on the matter.

The representative of SLOVAKIA supported the statements made by the representatives of Australia and Norway.

The CHAIR, responding to a question by the representative of China, said that any discussion could be suspended, reconvened and continued – consultation would not be limited to one instance.

The representative of JAPAN[11] appreciated that the current process should be completed as soon as possible but noted that discussions had not necessarily taken place to reach a consensus. It was important to prevent politicization and maintain confidentiality in the Member State consultations to avoid any negative impact on WHO's governance. Unlike the previous decision, which was not aligned with such principles, the revised draft decision allowed for continued discussion of the proposal. She therefore supported the revised draft decision. She would continue to engage in the discussion and looked forward to reaching a consensus.

The representative of CHILE supported the revised draft decision, underlining that its adoption would not mean that it was written in stone and could not be amended in the future.

The representative of YEMEN supported the revised draft decision.

The representative of LEBANON said that, as long as the discussion continued, issues for consideration would always be found. After two years of consultation, the revised draft decision was ready for adoption as it stood and it had her support. There would always be the opportunity to make amendments but there needed to be a starting point.

The representative of EGYPT[11] supported the revised draft decision.

The representative of SENEGAL said that he would like clarification regarding the content and modalities of the consultations with Member States. It was important to maintain the authority of the Executive Board and the Member States, as well as the Director-General's accountability to the Member States through the Executive Board.

The CHAIR, responding to the question by the representative of Senegal, said that the consultations related to the draft process. There was already some agreement on the draft framework but minor amendments in that respect were expected. With regard to the format of the consultations, virtual, hybrid or in-person meetings could be held. Formal consultations would be necessary if interpretation was required.

The representative of SENEGAL said that reservations had been expressed about the involvement of the Board in the draft framework because, as it stood, it seemed that only the Officers of the Board were involved. He requested that consultations with Member States be conducted throughout the whole process.

The representative of CHINA requested further clarification of whether the Member State consultation referred to the draft framework or the draft process or both. It did not seem that consensus had been reached with regard to the draft framework.

The CHAIR explained that the revised draft decision set out the development of a draft process for handling and investigating potential allegations against WHO Directors-General, based on the framework under discussion. The draft process was to be presented at a Member State consultation prior to the forty-second meeting of the Programme, Budget and Administration Committee, to enable decisions to be made by members of the Executive Board. Hence, in the

[11] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

interim, consultations would concern the draft framework from which the draft process would evolve.

The representative of NORWAY agreed that, once there was a framework in place, a consultation on the draft process could be held.

The representative of SENEGAL asked whether the draft framework was fixed or could be amended.

The LEGAL COUNSEL clarified that the revised draft decision set forth, firstly, the development of a draft process for handling and investigating potential allegations against WHO Directors-General, based on the framework under discussion. That draft process would subsequently be presented for formal consideration to the Seventy-eighth World Health Assembly through the Programme, Budget and Administration Committee at its forty-second meeting. The process would be drawn up on the basis of the framework and the consultations. The revised draft decision set out, secondly, a consultation on the draft process prior to the forty-second meeting of the Programme, Budget and Administration Committee, in order to inform discussion at that meeting. That Committee and the Health Assembly would then decide whether to agree to the draft process that had been developed through the draft framework.

The CHAIR said that efforts would be made to resolve areas of concern, which would entail amendments to the framework. Some points remained which would be renegotiated in order to reach an understanding. He took it that the Board wished to adopt the revised draft decision to develop a draft process for handling and investigating potential allegations against WHO Directors-General and to present the draft process at a Member State consultation prior to the forty-second meeting of the Programme, Budget and Administration Committee. He took it that the Board wished to adopt the revised draft decision on the understanding that it replaced the decision on the same matter that had been adopted the previous week.

The revised decision was adopted.[12]

The meeting rose at 12:00.

[12] Decision EB156(2).

Twentieth meeting

Tuesday, 11 February 2025, at 14:30

Chair: Dr J.X. Walcott (Barbados)

Pillar 4: More effective and efficient WHO providing better support to countries (continued)

1. Engagement with non-State actors: Item 24.4 of the agenda

- **Report on the implementation of the Framework of Engagement with Non-State Actors** (document EB156/38)

- **Non-State actors in official relations with WHO** (documents EB156/39, EB156/39 Add.1 and EB156/39 Add.2)

The CHAIR drew attention to the reports contained in documents EB156/38 and EB156/39, and to the draft decision on non-State actors in official relations with WHO contained in document EB156/39 Add.1, the financial and administrative implications of which were contained in document EB156/39 Add.2. He also drew attention to the report of the Programme, Budget and Administration Committee of the Executive Board contained in document EB156/4, paragraphs 51–55. A member of the Board had raised a concern with the Secretariat that the Israeli organization of the International Federation of Medical Students' Associations (FIMS Israel) had been suspended from the Federation in August 2024. While the Secretariat's technical assessment nevertheless remained the basis for the Committee's recommendation on the renewal of official relations, the Federation's leadership had recently informed the Secretariat of its intentions on the matter, which the Secretariat would share with the Board for information.

The DIRECTOR (Governing Bodies) said that the leadership of the International Federation of Medical Students' Associations had agreed to share the relevant information with the Board. The correspondence read:

> We have decided to table a motion at our upcoming General Assembly during the March meeting to lift the suspension of FIMS Israel. This decision follows thorough deliberation on the available information and the challenge to get a conclusive legal assessment that could have clarified the process earlier.

The representative of SENEGAL, speaking on behalf of the Member States of the African Region, welcomed WHO's Framework of Engagement with Non-State Actors and training and material to foster its full implementation. Collaboration with non-State actors was important, as it allowed for the wider dissemination of best practices and greater effectiveness of development initiatives, in accordance with national values and policies. While recognizing the benefits of public–private partnerships, his Region nevertheless invited the Secretariat and the Conference of

the Parties to the WHO Framework Convention on Tobacco Control to mitigate the risks associated with collaboration with the tobacco industry and to support the ratification and implementation of the Protocol to Eliminate Illicit Trade in Tobacco Products, to protect public health. He reiterated his Region's concern regarding the establishment of official relations with The Center for Reproductive Rights, Inc. The Director-General had proposed evaluating the activities of that organization after a year of collaboration to enable Member States to assess its work before raising the issue at the Health Assembly.

The representative of CHINA commended the contributions of non-State actors in official relations with WHO to advance global health. Member States should support the Secretariat in implementing the Framework of Engagement, which enabled the Organization to strengthen relations while safeguarding its reputation and public health mission. She opposed any actions or statements that undermined the Framework. More resources should be allocated to the Framework's annual review to maximize the benefits of engagement with non-State actors. Rigorous reviews should be conducted of any non-State actor under dispute.

The representative of YEMEN recalled the positions expressed by the Member States of the African Region and the Eastern Mediterranean Region during the previous session of the Board on the review of engagement with The Center for Reproductive Rights, Inc., at the Seventy-eighth World Health Assembly, after one year of engagement, instead of three years. He would welcome information on developments in that regard, including an update on The Center's activities, to enable Member States to assess the nature of The Center's work before raising the matter at the Health Assembly. His Region was committed to fostering collaboration with non-State actors, and to transparency and accountability in alignment with regional health priorities.

The representative of NORWAY, speaking also on behalf of the Nordic and Baltic countries and the Kingdom of the Netherlands, said that the group of countries made the current statement with the full understanding that Member States, through the governing bodies, directed the work of WHO. The Framework of Engagement defined the terms on which the WHO Secretariat could engage with non-State actors, including those in official relations. Granting official relations did not imply any privilege for a non-State actor. She expressed support for the draft decision, recalling that the Framework had been adopted in 2016 after a long and inclusive Member State-led process and that WHO technical work and outreach were strengthened by including a wide range of partners, provided that they acted in conformity with the principles of the WHO Constitution and contributed to the advancement of public health. The non-State actors listed in the draft decision had been subject to thorough review by the Secretariat and fulfilled the criteria to enter into official relations. She encouraged all Member States to support the Secretariat's rigorous work in determining whether non-State actors seeking official relations met the Framework criteria. All non-State actors that fulfilled such criteria were to be accepted, otherwise the Organization risked undermining the Framework.

The representative of EGYPT[1] supported the statements made by Member States of the African and Eastern Mediterranean Regions, and by the representative of China. In response to the statement by the representative of Norway, he said that it was his understanding that, although the Framework of Engagement set out the main criteria for decisions to accept or reject any non-State actor engagement with WHO, any Member State had the right to object if it had any other concerns. He sought clarification from the Legal Counsel in that regard.

[1] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of the INTERNATIONAL BABY FOOD ACTION NETWORK, speaking at the invitation of the CHAIR, and noting that WHO was experiencing a financial crisis, said that assessed contributions should be increased. Using the Framework of Engagement as a funding source had reputational risks and threatened WHO's independence and integrity. The report under discussion on non-State actors in official relations with WHO listed non-State actors but did not specify their functions or potential conflicts of interest that might hamper public health policy development.

The representative of MOVENDI INTERNATIONAL, speaking at the invitation of the CHAIR, said that the alcohol industry derailed WHO-recommended alcohol policies and violated certain provisions of the global alcohol action plan 2022–2030. The Framework of Engagement should be used to protect WHO, and country-level alcohol policy work, from alcohol industry interference and conflicts of interest. He called on the Secretariat to terminate dialogue with the alcohol industry and strengthen work to protect alcohol policy initiatives from conflicts of interest at all levels.

The representative of PANAMA[2] called on the Secretariat to continue to take action to prevent interference from the tobacco industry, which posed a public health problem. It was imperative that the Organization reinforce its risk analyses and due diligence given the diversification of the tobacco industry's investments and activities. She asked whether pharmaceutical companies with investors from the tobacco industry were still entitled to collaborate with WHO. Implementation of the Framework of Engagement and Article 5.2 of the Framework Convention should be strengthened to minimize the interference of the tobacco industry and to fight noncommunicable diseases without conflicts of interest and interference from non-State actors that prioritized economic interests and thus hampered efforts to make healthy behavioural change.

The representative of BANGLADESH[2] said that the report on the implementation of the Framework of Engagement did not provide information on the number of engagement proposals rejected or accepted after the due diligence review. He asked for information on any secondments from non-State actors to headquarters, regional and national offices, including the departments and names of non-State actors involved. He requested that the commissioned study to analyse recent trends in tobacco industry investments within the pharmaceutical sector be submitted as part of the Executive Board documentation, and that the major findings of the study be presented to the Programme, Budget and Administration Committee.

The DIRECTOR (Office of Compliance, Risk Management and Ethics) explained that The Center for Reproductive Rights, Inc., was not part of the triannual review for the reporting period in question. As part of the review process, all entities were required to complete annual reports, which were published on the WHO register for non-State actors. The Secretariat stood ready to provide information on its technical collaboration with different parties, including non-State actors. Responding to questions, he said that the Secretariat was extremely careful in applying paragraph 44 of the Framework when reviewing engagement with a non-State actor and WHO did not engage with the tobacco industry or with entities that worked to further the interests of that industry. If a secondment was pursued, it was published on the WHO register.

The LEGAL COUNSEL, responding to questions about the decision-making process for non-State actors' engagement, said that the Programme, Budget and Administration Committee had a limited role to consider applications submitted and make recommendations to the Board,

[2] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

such as recommending postponement of consideration or rejection of an application, in accordance with paragraph 60 of the Framework. The Board's role was to decide on the desirability of maintaining official relations or to defer the decision on the review to the following year, in line with paragraph 64 of the Framework. The Director-General could propose earlier reviews of a non-State actor's official relations with WHO only if certain circumstances were met, as set out in paragraph 65 of the Framework. With regard to the suggestion that an earlier review of The Center for Reproductive Rights, Inc., had been decided in 2024, he recalled that extensive discussions had been held aimed at avoiding a vote on the issue, and a proposal had been made to enable the Board to approve the official relations for one year rather than three, but that option had not been adopted by the Board. Instead, the Board had decided, by vote, to establish official relations in the normal way, which had led to a three-year review period, unless the provisions of paragraph 65 had been met and the Director-General had ordered an earlier review, which had not been the case.

The CHAIR took it that the Board wished to note the reports contained in documents EB156/38 and EB156/39.

The Board noted the reports.

The CHAIR took it that the Board wished to adopt the draft decision contained in document EB156/39 Add.1.

The decision was adopted.[3]

The representative of SOMALIA, expressing support for the Framework of Engagement, emphasized that any renewal of technical cooperation with non-State actors must adhere to WHO's rules and respect Member States' values, cultures and principles. WHO's engagement with non-State actors must be strictly governed by the regulations set forth by Member States, which were the sole mechanism for assessing eligibility and ensuring objective decisions. The work of most of the non-State actors that were entitled to renewal in 2025 was welcome. However, after reviewing the relevant report, he had reservations with regard to the organization, Women Deliver, Inc. That organization's terminology and ideology, and its promotion of certain fields of work, made it clear that engagement with it would contradict gravely with his Region's values, culture and principles. His Region remained committed to upholding WHO's highest standards of governance and to engagement that enhanced WHO's technical cooperation, while safeguarding its independence and intergovernmental nature.

The representative of SENEGAL expressed support for the statement by the representative of Somalia and requested respect for national and plurinational values in collaboration with non-State actors.

The representative of the RUSSIAN FEDERATION[4] said that the protection of sexual rights was a contentious issue within WHO as the concept was unacceptable to most countries and involved areas outside the health sector. The organization, Women Deliver, Inc., worked on the promotion of sexual rights and gender diversity, which ran counter to the priorities agreed by all Member States. He therefore supported the position expressed by the representative of Somalia.

[3] Decision EB156(41).

[4] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of EGYPT[5] said that he did not understand the explanation of the Legal Counsel or the adoption of the decision, given that the African Region and the Eastern Mediterranean Region had raised issues regarding The Center for Reproductive Rights, Inc., and Women Deliver, Inc. In bilateral dialogue with the Secretariat, he had requested any information that would address and accommodate the two regions' concerns and reservations regarding the organizations in question, but that request had been overlooked. He would therefore reluctantly refer to the last option highlighted by the two regions at the previous session of the Board, namely that they would raise the issue within the wider quorum. He wondered on what basis the list of non-State actors in official relations undergoing a triannual review of their collaboration with WHO had been approved and the decision adopted, given those two regions' expressions of dismay and reservation regarding the inclusion of one organization listed in Annex 2 to document EB156/39.

2. **Closure of the session:** Item 29 of the agenda

The DIRECTOR-GENERAL, thanking all participants of the 156th session of the Executive Board, expressed particular appreciation to the Board for deciding to recommend the draft proposed Programme budget 2026–2027 to the Health Assembly. He thanked Board members for supporting the 20% increase in assessed contributions and for honouring the 2022 commitment to increase assessed contributions to 50% of the base budget. When he had assumed office, WHO's reliance on a handful of traditional donors had been identified as a major risk, and addressing that risk had become a priority under the Organization's transformation. Since then, great progress had been made in broadening the donor base and reducing exposure to volatile funding, and he thanked those Member States that had committed to making more flexible contributions to WHO. The Secretariat had listened to Member States and agreed that budget allocations should align with Member State priorities, that priorities should be based on realistic funding, that the workforce was the Organization's greatest asset, that efficiency and oversight should be improved, and unnecessary expenditures reduced, and work would continue to those ends. He appreciated the support demonstrated for the twin strategic goals that WHO was pursuing, namely resource mobilization and efficiency gains. It was important to remember that budget and financing were a means to an end, enabling the Organization's technical and operational work, and he thanked Board members for their commitment in adopting resolutions and decisions and for the spirit in which they had worked. The announcement by the Government of the United States of America of its intention to withdraw from the Organization was regrettable, as was its reduced participation over the past week. It was to be hoped that the Government of the United States of America would reconsider, and he would welcome the opportunity to engage in constructive dialogue.

The CHAIR said that the Executive Board, at its 156th session, had discussed complex issues and had faced new realities with the announcement of the withdrawal of the United States of America from WHO. Participants had, however, continued to demonstrate the true meaning of multilateralism. The Board's achievements over the previous week showed that global health remained in good hands. He urged Member States to work with the same spirit of collaboration during the intersessional period and declared the 156th session of the Executive Board closed.

The meeting rose at 15:15.

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[5] Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.