

Provisional summary record of the fourth meeting

**WHO headquarters, Geneva
Tuesday, 3 February 2026, scheduled at 14:30**

Chair: Mr B. Comley (Australia)

Contents

Page

Provide health

1. Communicable diseases (continued)	
• Immunization Agenda 2030 (continued)	2
• Road map for neglected tropical diseases 2021–2030 (continued).....	2
• End TB Strategy (continued)	2
2. Universal health coverage	
• Draft global strategy for integrated emergency, critical and operative care, 2026–2035	7
• Increasing availability, ethical access and oversight of transplantation of human cells, tissues and organs.....	7
• Rare diseases: a global health priority for equity and inclusion	7
3. Primary healthcare	7
4. Health in the 2030 Agenda for Sustainable Development:.....	7

Fourth meeting

Tuesday, 3 February 2026, at 14:30

Chair: Mr B. Comley (Australia)

Provide health

1. Communicable diseases: Item 8 of the agenda (continued)

- **Immunization Agenda 2030** (document EB158/8) (continued)
- **Road map for neglected tropical diseases 2021–2030** (document EB158/9) (continued)
- **End TB Strategy Documents** (documents EB158/10 and EB158/10 Add.1) (continued)

The CHAIR recalled that the Board had before it a draft decision on a post-2030 tuberculosis strategy.

The representative of CHINA¹ acknowledged progress in communicable disease response but noted that challenges remained. Under WHO's leadership, Member States should continue drafting and implementing immunization programmes tailored to local priorities. The Organization should continue to play a central role in addressing tuberculosis and neglected tropical diseases by coordinating international resources and supporting key initiatives. He called for non-interference in the internal affairs of China, affirming that Taiwan² was an indivisible part of China.

The representative of the DOMINICAN REPUBLIC¹ reaffirmed her Government's commitment to the Immunization Agenda 2030 as essential for achieving the Sustainable Development Goals and strengthening health systems based around primary healthcare. She described steps taken in her country to tackle vaccine-preventable diseases in a context of reduced external financing. She recognized the importance of technical cooperation and international support, calling for investments to be harmonized with domestic priorities and for greater innovation through an approach focused on enhancing equity and strengthening local systems.

The representative of BURUNDI,¹ noting progress on immunization coverage and neglected tropical diseases in his country, expressed support for the road map for neglected tropical diseases and health systems strengthening.

The representative of BOTSWANA¹ highlighted key achievements of countries in the African Region in the area of immunization, such as maintaining its wild poliovirus-free status since 2020, but also acknowledged challenges, including stagnating coverage for several antigens. He supported the strategic shift in the Immunization Agenda 2030, particularly the focus on subnational performance, strengthening capacity, increased domestic financing, integration of

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".

immunization within primary healthcare, and enhanced regional research, innovation and regulatory manufacturing capacity.

The representative of SOUTH AFRICA³ highlighted two fundamental aspects of the long-term immunization and equity agendas that were missing from the mid-term review of the Immunization Agenda 2030, namely increasing local and regional manufacturing capacity for vaccines and strengthening supply chains, and strengthening women's and girls' right to health while reducing preventable maternal mortality. Immunization delivery platforms should be linked to antenatal and postnatal care services in the Agenda.

The representative of ETHIOPIA³ supported the Immunization Agenda 2030 and the "build from here" approach, emphasizing that strong evidence and trusted data were essential for accountability, and described domestic measures taken to enhance immunization. WHO must continue supporting the scale-up of digital systems to facilitate cross-country learning and data governance; the Organization should also support local manufacturing and regional procurement. Partners were encouraged to support integration by aligning technical support with national strategies. It would be important to sustain gains on neglected tropical diseases; partners and stakeholders should support national sustainability plans for such diseases, and WHO should encourage cross-border collaboration. She supported the development of a post-2030 global tuberculosis strategy.

The representative of BELARUS³ supported the remarks made by the representative of China on the question of Taiwan.⁴

The representative of TÜRKIYE³ highlighted the importance of integrating immunization with international health and financing frameworks while rebuilding community trust and applying context-specific approaches. Since the world had fallen short of the 2025 tuberculosis milestone, closing gaps in diagnosis and treatment, reducing catastrophic costs and scaling up innovation for drug-resistant tuberculosis must remain priorities. He supported the development of a post-2030 tuberculosis strategy that was aligned with primary healthcare, universal health coverage and health security.

The representative of COLOMBIA³ welcomed the reports on the Immunization Agenda 2030, neglected tropical diseases and the End TB Strategy, and supported the draft decision on the post-2030 tuberculosis strategy. Describing his country's recent efforts to enhance immunization coverage, he reaffirmed the importance of strengthening surveillance, preparedness and community action, especially in contexts of social vulnerability.

Despite progress on tuberculosis in Colombia, challenges remained, such as geographical inequities, financial sustainability and social determinants such as housing and access to water. As such, it was important to strengthen community resilience through intersectoral approaches and community-led surveillance.

The representative of BURUNDI,³ addressing the issue of Taiwan,⁴ expressed support for the one-China principle.

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

⁴ World Health Organization terminology refers to "Taiwan, China".

The representative of INDIA⁵ noted the progress made in her country towards eliminating measles and rubella. She encouraged countries with endemic neglected tropical diseases to strengthen collaboration and investment in research and development with a view to advancing new vector control tools, therapeutics and vaccines. Her country's experience had shown that community stewardship and local governance could help to accelerate progress towards tuberculosis elimination.

The observer of GAVI, THE VACCINE ALLIANCE, urged Member States to continue investing in routine immunization, reach zero-dose children and strengthen outbreak preparedness and response. Gavi remained committed to supporting countries to implement national immunization strategies and to accelerate efforts to end tuberculosis to ensure that breakthrough vaccines could reach more people more equitably and rapidly.

The representative of the WORLD MEDICAL ASSOCIATION, speaking at the invitation of the CHAIR, welcomed the mid-term review of the Immunization Agenda 2030, stressing the need to address inequities, fragile settings, declining confidence and financial constraints. Member States were urged to recommit to the Agenda with a focus on equity and populations with a low vaccination status. Member States should adopt a life-course approach to vaccination, integrating immunization into primary healthcare and universal health coverage, including through routine booster programmes for older adults and health personnel. He called for sustainable financing, resilient delivery and a strengthened health workforce capacity, alongside truthful risk communication and community engagement.

The representative of the DRUGS FOR NEGLECTED DISEASES INITIATIVE, speaking at the invitation of the CHAIR, urged WHO and Member States to finalize the research and development blueprint for neglected tropical diseases; promote inclusive research addressing the specific medical needs of women and children; prioritize action on climate-sensitive diseases in line with the global action plan on climate change and health (2025–2028) and the Belém Health Action Plan for the Adaptation of the Health Sector to Climate Change; and close financing gaps through new models that integrated neglected tropical diseases into health budgets and universal health coverage packages.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of the CHAIR, emphasized that immunization must be strengthened as a core pillar of primary healthcare. Achieving the Immunization Agenda 2030 targets required the meaningful engagement of nurses in planning, delivery and leadership, and its priorities depended on a strong and well-supported nursing workforce. Nurses contributed essential expertise in behavioural and social strategies to address underimmunization, counter misinformation, build public confidence and improve coverage.

The representative of MÉDECINS SANS FRONTIÈRES INTERNATIONAL, speaking at the invitation of the CHAIR, said governments, donors and health actors must improve access to immunization in fragile, conflict and vulnerable settings and ensure that funding gaps did not impair equity. Political commitments should include sustained global health funding, meaningful partnerships between governments and humanitarian actors, dedicated funding at the country-level, investments in last-mile delivery innovation, and rapid access to vaccines and essential medical tools, especially during emergencies. Health facilities and staff must be

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

protected, and non-State actors should be allowed to provide emergency healthcare and immunization where needed.

The representative of the MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION, speaking at the invitation of the CHAIR, highlighted the progress made towards polio eradication and measles elimination; anti-vaccine sentiment must not be allowed to undermine those achievements or jeopardize the health of vulnerable groups. Noting that immunization was one of the strongest preventive measures against sepsis, she called on Member States to increase investments in immunization at the national, regional and global levels to meet the related 2030 targets.

The representative of MOVENDI INTERNATIONAL, speaking at the invitation of the CHAIR, said that the current End TB Strategy and corresponding report did not adequately address alcohol's contribution to the tuberculosis burden or the potential of alcohol policy to prevent tuberculosis incidence and mortality, despite the WHO global status report on alcohol and health identifying it as a major risk factor. There was therefore a serious inconsistency between WHO's evidence and actions. Alcohol must be included as a tuberculosis risk factor in the post-2030 tuberculosis strategy. Integrating alcohol screening into standard tuberculosis care, embedding alcohol policy best buys, and using alcohol taxation to finance tuberculosis prevention and treatment would boost the impact of any future tuberculosis strategy.

The representative of THE INTERNATIONAL LEAGUE OF DERMATOLOGICAL SOCIETIES, speaking at the invitation of the CHAIR, supported WHO's continued focus on integrated approaches to skin-related neglected tropical diseases. Resolution WHA78.15 (2025) on skin diseases as a global public health priority underscored the need to strengthen primary-level capacity to diagnose and manage common and neglected skin conditions as part of universal health coverage. She welcomed WHO's efforts to advance innovation, including the rollout of a mobile app to improve front-line diagnostic accuracy of skin-related neglected tropical diseases. Continued investment in skin health would help to ensure that affected communities could receive timely, high-quality care.

The representative of THE SAVE THE CHILDREN FUND, speaking at the invitation of the CHAIR, welcomed the mid-term review of the Immunization Agenda 2030 but noted that the state of progress remained a cause of concern, given the number of zero-dose children in fragile and conflict-affected settings. Amidst funding cuts, governments were encouraged to prioritize immunization funding as an essential component of integrated primary healthcare-centred systems to ensure child survival. Zero-dose targets must remain at the heart of the equity agenda. Member States should prioritize access to equitable immunization in conflict-affected settings; address disinformation that jeopardized child mortality reduction; support regional and local vaccine production for resilient, diverse and sustainable supply chains; and collaborate with expanded immunization partners, including civil society, to develop the next phase of the Immunization Agenda 2030.

The representative of THE WORLDWIDE HOSPICE PALLIATIVE CARE ALLIANCE urged the inclusion of palliative care in the End TB Strategy and highlighted the great potential of nurse-led palliative care for people affected by tuberculosis.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIR, highlighted ongoing challenges in the area of communicable diseases, including stalled immunization efforts and high out-of-pocket costs for tuberculosis interventions. Member States must prioritize zero-dose children and other vulnerable populations, especially in fragile and conflict-affected areas, and were encouraged to integrate

immunization into primary healthcare. She stressed the importance of the One Health approach and called for environmental and ecological drivers of emerging and neglected tropical diseases to be addressed. Health workers should be empowered to contribute meaningfully through health education that strengthened competency in disease prevention, outbreak response and pandemic preparedness.

The representative of INTERNATIONAL PHARMACEUTICAL STUDENTS' FEDERATION, speaking at the invitation of the CHAIR, called on WHO to strengthen normative guidance and encouraged Member States to formalize the role of pharmacists in national immunization strategies by embedding comprehensive immunization training in pharmacy curricula and professional education pathways and by leveraging pharmacists' community presence to advance equity from the ground up.

The OFFICER-IN-CHARGE OF THE WHO SOUTH-EAST ASIA REGION, speaking on behalf of all WHO regions, said that immunization remained a top priority across all regions. Despite progress, such as vaccination coverage rebounding to pre-pandemic levels, there was deep concern about the risk of backsliding. Progress remained uneven, and the combined pressures of constrained domestic budgets, reduced donor support and competing priorities threatened programme sustainability. To stay on track, Member States must prioritize immunization within constrained resource environments, protect essential programme functions and sharpen the focus on zero-dose and underimmunized populations, supported by strong governance and accountability.

While progress continued on neglected tropical diseases, and nearly 60 countries across all regions had eliminated at least one disease, major challenges persisted, including declining financing, climate change and supply and diagnostic gaps, threatening the achievement of the 2030 targets. Sustained political commitment and the integration of neglected tropical disease services in universal health coverage remained global priorities.

With the world off track on the global tuberculosis targets, and with drug-resistant tuberculosis and declining development assistance threatening to reverse gains, she called on Member States and partners, including communities, to engage actively in the development of a post-2030 tuberculosis strategy. The new strategy must reflect emerging realities, be anchored in primary healthcare, promote multisectoral action on social determinants, accelerate innovation, and strengthen cross-border and interregional collaboration.

She reaffirmed the Secretariat's commitment to supporting Member States in sustaining progress, preventing backsliding and advancing equitable and resilient health systems.

The ASSISTANT DIRECTOR-GENERAL (Health Promotion, Disease Prevention and Care) said that global action on immunization was more urgent than ever in the face of growing hesitancy and misinformation. The failure to act could lead to the resurgence of diseases that should have been resigned to history. The Secretariat would continue supporting Member States as they transitioned away from international aid and would refocus its own work in line with the outcome of its reprioritization process, working in science- and evidence-based partnerships with organization such as Gavi to reach zero-dose children, particularly in humanitarian and conflict settings. The Secretariat would also address subnational equity in access to vaccines and step up efforts on integrated surveillance of vaccine-preventable and other diseases. Proactive efforts must be made to counter misinformation and build trust in vaccines.

Neglected tropical diseases remained central to the WHO mission and required sustained attention, particularly in the context of climate change. There was a need for stronger integrated data systems and cross-sectoral collaboration, including through the Quadripartite alliance on One Health. While progress on tuberculosis should be recognized, it remained fragile and at risk from global health disruptions, which could lead to increased transmission and drug resistance.

Overall, global efforts must ensure that science was used to drive equity rather than to deepen inequalities in access to health around the world.

The CHAIR took it that the Board wished to note the reports contained in documents EB158/8, EB158/9 and EB158/10.

The Board noted the reports.

The CHAIR took it that the Board wished to adopt the draft decision on the post-2030 tuberculosis strategy contained in document EB158/10.

The decision was adopted.⁶

2. Universal health coverage: Item 9 of the agenda

- **Draft global strategy for integrated emergency, critical and operative care, 2026–2035** (documents EB158/11 and EB158/11 Add.1)
- **Increasing availability, ethical access and oversight of transplantation of human cells, tissues and organs** (documents EB158/12 and EB158/12 Add.1)
- **Rare diseases: a global health priority for equity and inclusion** (document EB158/13)

3. Primary healthcare: Item 10 of the agenda (document EB158/14)

4. Health in the 2030 Agenda for Sustainable Development: Item 11 of the agenda (document EB158/15)

The CHAIR drew attention to the draft decision on the draft global strategy for integrated emergency, critical and operative care, 2026–2035, contained in document EB158/11, and the draft decision on increasing availability, ethical access and oversight of transplantation of human cells, tissues and organs, contained in document EB158/12. The financial and administrative implications of those draft decisions for the Secretariat were contained in documents EB158/11 Add.1 and EB158/12 Add.1, respectively.

He also drew attention to four draft resolutions. The first draft resolution, which contained a draft resolution to be submitted to the Seventy-ninth World Health Assembly, entitled Precision medicine: a path towards targeted, personalized and equitable care, proposed by Armenia, Burundi, Chad, Chile, Egypt, Greece, Kuwait, Nigeria, Palestine, Paraguay, Qatar, Romania, Saudi Arabia, Thailand, Tunisia and the United Republic of Tanzania, read:

The Executive Board, having considered the report of the Director-General,⁷

RECOMMENDS to the Seventy-ninth World Health Assembly the adoption of the following resolution:

The Seventy-ninth World Health Assembly,
 (PP1) Having considered the report by the Director-General,
 (PP2) Acknowledging the rapid evolution of biomedical and digital health sciences, including genomics, proteomics, pharmacogenomics, bioinformatics, real-

⁶ Decision EB158(3).

⁷ Document EB158/11.

world data analytics, molecular diagnostics, and advanced therapies such as cell and gene therapies, and recognizing the cross-cutting and enabling role of artificial intelligence in supporting these domains, which collectively underpin precision medicine and have the potential to transform prevention, diagnosis, and treatment across the life course;

(PP3) Recognizing that “precision medicine” refers to the use of clinical, molecular, genomic, and other health-related data to inform prevention, diagnosis, and treatment decisions, taking into account individual variability in clinical characteristics, molecular and genomic profiles, with appropriate safeguards, including the use of health technology assessment, to promote ethical, equitable, and cost-effective implementation and improved health outcomes;

(PP4) Recognizing also that precision medicine represents a paradigm shift towards predictive, preventive, and participatory health systems, enabling targeted, effective and efficient interventions that enhance the efficiency and sustainability of universal health coverage by ensuring that the right intervention reaches the right patient at the right time;

(PP5) Recognizing further that precision medicine, through genomic sequencing, high-throughput diagnostics, and molecular targeting, and through the development and delivery of advanced therapies such as cell and gene therapies has shown measurable clinical benefit, and in several cases demonstrated cost-effectiveness, including by improving survival through targeted cancer therapies, shortening the diagnostic odyssey for rare diseases, reducing adverse drug reactions through pharmacogenomics;

(PP6) Recognizing the contribution of precision medicine to the prevention and management of noncommunicable diseases, infectious diseases, maternal, child, and mental healthcare, and its potential to improve health outcomes and greater health system efficiency;^{8,9,10}

(PP7) Noting that global investment in precision medicine is projected to grow substantially by 2030, reflecting its growing impact on clinical innovation, biotechnology, and public health, and the need to foster such investment yields equitable and sustainable benefits across all regions;^{11,12}

(PP8) Recalling, as appropriate, the 2023 United Nations high-level meeting on universal health coverage and the 2030 Agenda for Sustainable Development including commitments to promote equitable distribution of and increased access to quality, safe, effective, affordable and essential medicines, vaccines, diagnostics and health technologies, as enablers of affordable, quality healthcare services and their timely delivery for all throughout the life course;¹³

⁸ Liang S, Kennedy E, Gale N et al. Implementation of precision medicine in treating non-communicable diseases: a systematic review. *Journal of Translational Medicine*: 23, 1174 (2025). doi: 10.1186/s12967-025-07201-y.

⁹ [Strianese O, Rizzo F, Ciccarelli M, Galasso G, D’Agostino Y, Salvati A et al. Precision and personalized medicine: how genomic approach improves the management of cardiovascular and neurodegenerative disease. *Genes*. 2020 July;11\(7\):747. doi: 10.3390/genes11070747.](#)

¹⁰ [Precision health: emerging innovations for children and adolescents](#). New York: UNICEF; 2024 (accessed 31 January 2026).

¹¹ [Global precision medicine market size and outlook, 2023–2030](#). Grand View Horizon Databooks (accessed 31 January 2026).

¹² [Precision medicine market size and outlook, 2025–2033](#). Straights Research (accessed 31 January 2026).

¹³ [Political Declaration of the High-level Meeting on Universal Health Coverage](#) (accessed 31 January 2026).

(PP9) Recognizing the role of precision medicine in advancing universal health coverage and the WHO Fourteenth General Programme of Work (GPW 14), 2025–2028, particularly in strengthening primary healthcare, ensuring equity, and addressing health inequalities;

(PP10) Recognizing also that many populations, particularly women, children and older adults, remain underrepresented in the data and research that underpin precision medicine, and emphasizing the need to ensure diversity and inclusivity in the research and application of precision medicine, including meaningful representation of developing countries and historically underrepresented regions, so that emerging approaches equitably benefit all populations;

(PP11) Reaffirming the importance of deliberate and well-coordinated global and national efforts to ensure that advances in precision medicine contribute to reducing inequities and health disparities within and between countries, narrowing the digital divide, and promoting equitable access to affordable and timely care;

(PP12) Noting that current global capacities remain uneven, with developing countries facing limited laboratory infrastructure, underrepresentation in genomic and clinical datasets, shortage of skilled professionals, and inadequate governance mechanisms for ethical data use and sharing;^{14,15,16,17}

(PP13) Conscious of the ethical, legal, social, and economic implications of precision medicine, including patient privacy, informed consent, governance and stewardship of genetic and health data, respecting national laws, data protection and data sovereignty, algorithmic bias, equitable access to innovation;

(PP14) Recalling resolution WHA57.13 (2004) Genomics and world health, which urged Member States to strengthen capacity in genomics to improve health outcomes and to ensure that advances in this field is used ethically, equitably, and for the benefit of all populations;

(PP15) Recognizing also that the evolution of genomics and related biotechnologies, and the significant drop in costs in genome sequencing since the adoption of that resolution has led to the emergence of precision medicine, offering new opportunities to translate scientific discovery into equitable, needs-based, and data-driven healthcare, at both the individual and population level;^{18,19,20}

¹⁴ Girisha K and Moosa S. Genomic testing in low- and middle-income countries (LMIC). *European Journal of Human Genetics*, 2024; 32;119394. doi: 10.1038/s41431-024-01622-x.

¹⁵ Corpas M, Pius M, Poburennaya M, Guio H, Dwek M et al. Bridging genomics' greatest challenge: The diversity gap. *Cell Genomics*: 2025;5(1):100724. Doi: 10.1016/j.xgen.2024.100724.

¹⁶ [Health researcher \(in full-time equivalent\) per million inhabitants, by WHO Region \(first set of charts\)](#). World Health Organization, August 20205 (accessed 31 January 2026).

¹⁷ [Guidance for human genome data collection, access, use and sharing](#). Geneva: World Health Organization; 2024 (accessed 31 January 2026).

¹⁸ [Measuring genome sequencing costs and its health impact](#). World Intellectual Property Organization; 19 March 2025 (accessed 31 January 2026).

¹⁹ Ehman M, Sharma K, Weymann D, Maroille T, Mohajeri A et al. The cost and cost trajectory of genome sequencing and bioinformatics analysis for Indigenous children with suspected rare diseases. *Genetics in Medicine*. 2025;27(11):101568. doi:10.1016/j.gim.2025.101568.

²⁰ [The cost of sequencing a human genome](#). National Human Genome Research Institute; 2021 (accessed 31 January 2026).

(PP16) Recalling resolution WHA78.11 (2025) Rare diseases: a global health priority for equity and inclusion which recognizes the importance of early diagnosis, equitable access to treatment, and the inclusion of persons living with rare diseases;

(PP17) Recalling also the WHO Global Strategy on Digital Health (2020–2027) and related initiatives on data governance, artificial intelligence, and innovation, and recognizing their relevance in supporting the safe, ethical, and equitable integration of precision medicine into health systems;

(PP18) Recalling also the WHO Science Council Report (2022) on accelerating access to genomics for global health, which calls for inter alia equitable integration of precision technologies to reduce health disparities, and the WHO's normative and technical guidance on human genome editing, digital health ethics, and data governance, which offer a foundational policy framework for the responsible implementation of precision medicine;

(PP19) Emphasizing the urgent need to strengthen national and regional capacities in genomics, pharmacogenomics, digital infrastructure, bioinformatics, clinical research, regulatory sciences, and data governance, especially in developing countries, while ensuring transparency, data privacy and security, and promote safe and secure access to these data health literacy, and public engagement to build trust;

(PP20) Emphasizing that effective and equitable implementation of precision medicine requires robust governance, skilled human resources, interoperable and secure data systems, sustainable financing, and meaningful social participation, ensuring that no one is left behind;

(PP21) Noting with appreciation the initiatives of Member States and regional bodies that enhance collaboration, research, and equitable access to precision medicine and data-driven public health solutions;

(OP)1. URGES Member States,²¹ in accordance with national contexts and priorities:

- (1) to develop, implement, and strengthen national policies and strategies which promote precision medicine, aligned with universal health coverage goals and ethical standards, ensuring affordability, accessibility, equity, and sustainability;
- (2) to recognize precision medicine as an important enabler of universal health coverage, where appropriate and cost-effective, and to integrate it into health system strengthening efforts, encompassing prevention, early detection, diagnosis, treatment, and monitoring with particular attention to primary healthcare, as well as cancer control, rare diseases, noncommunicable diseases, infectious diseases, maternal and child health, and mental health and other nationally identified priority health areas;
- (3) to strengthen national and regional capacities by investing in laboratory and diagnostic infrastructure, genomic databases, digital health platforms, and relevant technologies including artificial intelligence and biomedical engineering, to support the implementation and integration of precision medicine with the respect of national data sovereignty;
- (4) to promote the inclusion of all populations in research, data systems, and evaluation frameworks that support precision medicine, with particular attention to women, children, older adults, and to address underrepresentation within the data, consistent with ethical standards including appropriate informed consent,

²¹ And, where applicable, regional economic integration organizations.

ensuring that approaches and interventions are rigorously assessed for safety and effectiveness across all populations and equitably benefit them;

(5) to establish, strengthen, or maintain legal, ethical, and regulatory frameworks that ensure effective data governance, privacy, transparency, interoperability, security, quality assurance, and that ensure the responsible, equitable, and sustainable integration of precision medicine into national health systems, as well as enhance equitable access to innovations;

(6) to foster capacity-building through comprehensive education and training programmes in genomics, data science, bioinformatics, and clinical interpretation targeting the health workforce, researchers, and policy-makers, to ensure and to foster the safe, effective, and equitable application of precision medicine;

(7) to encourage and promote equitable access to precision medicine services and technologies by investing in sustainable financing models, and implementing pooled procurement, thereby supporting affordability and inclusivity;

(8) to foster research collaboration and innovation in precision medicine that reflects the diversity of global populations and sex disaggregated data and addresses national and regional health priorities, including neglected and rare diseases;

(9) to strengthen existing or establish new national centres and institutions for genomics research, as needed, with a view to enhancing the national capacity and accelerating the ethical application of genomic advances in relation to national health problems;

(10) to empower individuals, families, and communities through health literacy, awareness, and participatory engagement, recognizing their essential role in the cocreation and implementation of precision medicine policies and programmes, and fostering inclusivity, transparency, public trust, in a way that no one is left behind;

(11) to establish or maintain evidence-based mechanisms for the assessment and prioritization of precision medicine technologies, to evaluate their clinical effectiveness, cost-effectiveness, safety, and quality;

(12) to strengthen collaboration among governments, academia, research institutions, civil society, the private sector, and other relevant stakeholders to promote the exchange of precision medicine technologies, knowledge-sharing, resource mobilization, and capacity-building, respecting international rules and national rules in line therewith, to advance equitable, inclusive, and sustainable innovation in precision medicine;

(13) to promote harmonization of data standards and interoperability frameworks, aligned with WHO's Global Strategy on Digital Health and international governance, ethics and regulatory guidelines on artificial intelligence and drawing on existing initiatives;

(OP)2. REQUESTS the Director-General:

(1) to review and map existing WHO guidance and recommendations relevant to precision medicine, and if necessary, consider the development of a Global Strategy on Precision Medicine in consultation with Member States and relevant stakeholders, in line with the Framework of Engagement with Non-State Actors, as applicable, and in line with GPW 14 and prioritization process, to set out guiding principles, ethical and technical standards, and a road map for equitable,

sustainable, and context-appropriate implementation of precision medicine within universal health coverage frameworks;

(2) to provide technical and normative support to Member States, particularly developing countries, upon request, in developing policies, governance mechanisms, regulatory frameworks, and capacity-building initiatives that enable the safe, effective, and equitable application of precision medicine, drawing on existing WHO guidance, tools, and expertise, including through further strengthening and coordinating existing WHO's institutional capacity in genomics, data science, bioinformatics and digital health;

(3) to develop, upon request of Member States, and in consultation with Member States and relevant stakeholders, in line with the Framework of Engagement with Non-State Actors, as applicable, a country maturity model consisting of a structured framework with progressive stages and measurable indicators, for the differentiated integration of precision medicine interventions, enabling Member States and institutions to assess current capacity, identify priorities, track progress, and guide phased implementation, in line with national contexts and health system readiness;

(4) to facilitate regional, and global platforms for knowledge exchange, best practices, and innovation in precision medicine, taking into consideration data privacy and security at the aggregated level, as well as countries' context, including but not limited to the development of population-diverse national genomic reference databases, ensuring equitable representation, transparency, and benefit-sharing;

(5) to facilitate, as appropriate, the establishment of new or the strengthening of existing regional networks and capacity-building hubs in genomics and related fields, with particular attention to the health needs of developing countries, building on and supporting existing regional initiatives;

(6) to strengthen global, regional, and national collaboration with relevant partners and stakeholders, academic and research institutions, and civil society, in line with the Framework of Engagement with Non-State Actors, as applicable, to mobilize resources, foster research and innovation, and promote equitable access to digital tools and technologies appropriate to precision medicine, respecting international rules;

(7) to report on the implementation of this resolution to the Eightieth and Eighty-second World Health Assemblies in 2027 and 2029, respectively, on the progress achieved;

(8) pursuant to OP2.a to submit the Global Strategy on Precision Medicine for consideration by the Executive Board at its 164th session, with a view to its submission for adoption by the Eighty-second World Health Assembly in 2029.

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

A. Link to the approved Programme budget 2026–2027

1. Output(s) in the approved Programme budget 2026–2027 under which this draft resolution would be implemented if adopted:

3.3.1. WHO builds country capacity and develops tools and platforms to support countries in developing and improving their national digital health and health information systems to improve resilience, coverage, equity and impact

7.2.2. Strengthening national and regional science ecosystems to improve health and provide opportunities and equity, active support for the digital health transformation, research, development and innovation, including manufacturing capacities of countries

2. Short justification for considering the draft resolution, if there is no link to the results as indicated in the approved Programme budget 2026–2027:

Not applicable.

3. Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:

Not applicable.

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

Three years.

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

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

US\$ 2.98 million.

2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:

US\$ 1.89 million.

2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:

Zero.

3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:

US\$ 1.09 million.

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

Zero.

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

– **Financial resources available to fund the resolution in the current biennium:**

US\$ 1.42 million.

– **Remaining financing gap in the current biennium:**

US\$ 0.47 million.

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

WHO has previously been approached by donors interested in supporting the genomics programme, which was not required at that point. These donors can be approached to reconsider opportunities related to precision medicine.

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. 2026–2027 cost of resources already planned	Staff	0.05	0.05	0.04	0.05	0.04	0.04	1.00	1.26
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.63	0.63
	Total	0.05	0.05	0.04	0.05	0.04	0.04	1.63	1.89
B.2.b. 2026–2027 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2028–2029 cost of resources to be planned	Staff	0.02	0.02	0.02	0.02	0.02	0.02	0.52	0.65
	Activities	0.05	0.05	0.05	0.05	0.05	0.05	0.12	0.44
	Total	0.08	0.08	0.07	0.08	0.07	0.07	0.64	1.09
B.4. Future bienniums cost of resources to be planned	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.1. Total planned costs required to implement the resolution									2.98

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

The second draft resolution, which contained a draft resolution to be submitted to the Seventy-ninth World Health Assembly, on strengthening equitable access to diagnostic imaging through teleradiology, proposed by Chile, Egypt, Georgia, Palestine and Tunisia, read:

The Executive Board,

Having considered the report by the Director-General,²²

RECOMMENDS to the Seventy-ninth World Health Assembly the adoption of the following resolution:

The Seventy-ninth World Health Assembly,

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

(PP2) Recalling resolutions WHA71.7 (2018) on digital health, WHA76.5 (2023) on strengthening diagnostics capacity, and the WHO Global Strategy on Digital Health 2020–2025,²³ which collectively emphasize the critical role of digital technologies and diagnostics in achieving Universal Health Coverage (UHC) and the health-related Sustainable Development Goals (SDGs);

(PP3) Having considered the report by the Director-General on digital health and equitable access to diagnostics;

²² Document EB158/11.

²³ [Global strategy on digital health 2020–2025](#). Geneva: World Health Organization; 2021 (accessed 2 February 2026).

(PP4) Recognizing that diagnostic imaging, including radiology, is an essential component of healthcare, vital for the timely detection, diagnosis, management, treatment planning, and monitoring of communicable diseases, noncommunicable diseases (NCDs), trauma, and maternal and child health conditions and other medical conditions, particularly in developing countries, including but not limited to small island developing States and remote and underserved areas;

(PP5) Acknowledging that access to radiology services remains limited in and within many countries particularly developing countries and remote or rural areas, and noting with concern the shortage of trained and certified radiologists and other imaging professionals, which contributes to delayed or missed diagnoses and poorer health outcomes and preventable deaths;

(PP6) Further noting that the absence of trained personnel to interpret the images or weak referral systems leads to suboptimal utilization of the equipment and may limit the effective use of existing imaging capacity;

(PP7) Recognizing that teleradiology, the use of telecommunications technology to transmit and interpret medical images remotely, can offer a scalable, cost-effective, and practical solution to help bridge the human resource gap and extend the reach of expert diagnostic services to underserved populations;^{24,25}

(PP8) Acknowledging that teleradiology, the secure and privacy preserving digital transmission and remote interpretation of diagnostic images, can expand access to imaging, optimize use of limited expertise, and improve quality of care provided that the laws, regulations, standards, and ethical rules governing this medical practice are respected;

(PP9) Noting that when appropriately implemented, teleradiology can contribute to the achievement of universal health coverage (UHC) by increasing efficiency, supporting continuous education, and strengthening preparedness and response capacities;

(PP10) Recognizing that, for the integration of artificial intelligence (AI) and digital health platforms, including teleradiology into radiology services, it is necessary to ensure that these tools are developed, validated, safely deployed and governed ethically for performance, and implemented under clinical oversight, while ensuring inclusive and equitable access, in order to optimize the use of limited expert resources, improve the quality of interpretation, and ensure timely diagnosis across diverse settings;

(PP11) Concerning that uncoordinated adoption, absence of national policy frameworks, weak data protection, and fragmented infrastructure may lead to unsafe deployment of teleradiology services;

(PP12) Considering that the effective and ethical adoption of teleradiology where appropriate requires robust national policy frameworks, regulatory standards, interoperability guidelines, and secure data protection mechanisms to ensure patient complete information, patient consent, patient safety and confidentiality;

(PP13) Recognizing the importance of international solidarity, cooperation and investment to facilitate the sharing of expertise, and best practices in teleradiology,

²⁴ Jing AB., Garg N., Zhang J., Brown J J. AI solutions to the radiology workforce shortage. *Npj Health Systems*. 2025;2(1): 20. doi: 10.1038/s44401-025-00023-6.

²⁵ Nigatu AM, Yilma TM, Gezie, LD, Gebreworld Y, Gullslett MK, Mengiste SA et al. (2024). Barriers and facilitators experienced during the implementation of web-based teleradiology system in public hospitals of the northwest Ethiopia: An interpretive description study. *International Journal of Telemedicine Applications*. 2024:5578056. doi: 10.1155/2024/5578056.

particularly through partnerships among countries while respecting patient privacy and respecting national data sovereignty;

(PP14) Conscious of the need to integrate teleradiology into national and regional health and digital strategies as a core component of strengthening health systems and accelerating progress towards achieving UHC and health equity,

(OP)1. URGES Member States, taking into account national and regional context and capacities, and priorities:

- (1) to integrate teleradiology within national health, digital health, and diagnostic strategies, aligned with universal health coverage objectives;
- (2) to develop or strengthen national policies, standards, and regulatory frameworks for safe, ethical, and effective teleradiology, including data governance, patient privacy, information, and cross-border consultations;
- (3) to explore sustainable finance options where appropriate for infrastructure and expand the use of digital platforms to enable reliable, secure, and sustainable image acquisition, transmission, and reporting, to enable the reliable and secure transmission and storage of medical images;
- (4) to strengthen workforce capacity through education, training, and mentorship programmes for all professionals involved, in partnership with academic and professional institutions;
- (5) to promote integration of teleradiology systems with national health information systems;
- (6) to promote regional and international cooperation and knowledge-sharing to maximize the impact of limited radiology expertise and facilitate the exchange of best practices and technical knowledge with consideration of developing countries, including but not limited to small island developing States;
- (7) to give due consideration to equity, including the needs of underserved, rural, and remote areas including vulnerable populations, in line with national priorities and existing health system arrangements;
- (8) to support the safe trustworthy, accurate, robust and ethical use of artificial intelligence and decision-support tools in teleradiology workflows, in an inclusive and equitable manner with appropriate validation, transparency, and human oversight according with appropriate regulatory protocols;

(OP)2. REQUESTS the Director-General:

- (1) to develop and disseminate normative guidance, standards, and technical tools that enable safe, ethical, and effective teleradiology implementation, including interoperability and data protection;
- (2) to provide technical assistance to Member States, especially in developing countries, to support policy development, capacity-building, and infrastructure planning;
- (3) to facilitate global and regional collaboration and partnerships, for training, research, and knowledge exchange in radiology and digital health;
- (4) to improve data collection on global teleradiology capacity through existing WHO instruments;
- (5) to promote regional cooperation, and knowledge exchange, to support training, quality assurance, and mutual assistance among Member States;
- (6) to implement (1) to (5) above in accordance with the Fourteenth General Programme of Work (GPW 14), 2025–2028, and within available resources, including through future resource mobilization efforts, and in the context of

implementation of relevant resolutions and strategies including resolution WHA76.5 on Strengthening diagnostics capacity, resolution WHA78.13 (2025) on Strengthening medical imaging capacity, and the Global strategy on digital health, 2020–2025 (extended to 2027)²⁶ and its successor;

(7) to report on progress in implementing this resolution using existing reporting streams to the World Health Assembly in 2030.

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

A. Link to the approved Programme budget 2026–2027

1. **Output(s) in the approved Programme budget 2026–2027 under which this draft resolution would be implemented if adopted:**
 - 3.2.3 WHO supports countries to implement measures for better access to, and use of, safe, effective and quality-assured health products
 - 3.3.1 WHO builds country capacity and develops tools and platforms to support countries in developing and improving their national digital health and health information systems to improve resilience, coverage, equity and impact
 - 7.2.1 Evidence-based and quality-assured normative products, including the living approach, are developed with and for countries, are digitally accessible and used for health, policy and practice impact
 - 7.2.2 Strengthening national and regional science ecosystems to improve health and provide opportunities and equity, active support for the digital health transformation, research, development and innovation, including manufacturing capacities of countries
2. **Short justification for considering the draft resolution, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
3. **Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
4. **Estimated time frame (in years or months) to implement the resolution:**
Five years.

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

1. **Total planned costs required to implement the resolution, in US\$ millions:**
US\$ 3.47 million.
- 2.a. **Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:**
US\$ 0.90 million.
- 2.b. **Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:**
Zero.
3. **Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:**
US\$ 1.86 million.

²⁶ See decision WHA78(22) (2025).

4. **Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:**
US\$ 0.72 million.
5. **Level of financial resources already available to fund the implementation of the resolution in the current biennium, in US\$ millions**
- **Financial resources available to fund the resolution in the current biennium:**
US\$ 0.10 million.
 - **Remaining financing gap in the current biennium:**
US\$ 0.80 million.
 - **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
US\$ 0.35 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. 2026–2027 cost of resources already planned	Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.20	0.20
	Activities	0.00	0.00	0.00	0.00	0.00	0.00	0.70	0.70
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.90	0.90
B.2.b. 2026–2027 cost of additional resources	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	0.00	0.00
	Total	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
B.3. 2028–2029 cost of resources to be planned	Staff	0.13	0.12	0.10	0.12	0.09	0.11	0.20	0.87
	Activities	0.16	0.16	0.16	0.16	0.16	0.16	0.04	0.98
	Total	0.28	0.28	0.26	0.28	0.25	0.26	0.24	1.86
B.4. Future bienniums cost of resources to be planned	Staff	0.06	0.06	0.05	0.06	0.05	0.05	0.10	0.45
	Activities	0.04	0.04	0.04	0.04	0.04	0.04	0.01	0.27
	Total	0.11	0.11	0.10	0.10	0.09	0.10	0.11	0.72
B.1. Total planned costs required to implement the resolution									3.47

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

The third draft resolution, which contained a draft resolution to be submitted to the Seventy-ninth World Health Assembly, entitled Reducing the burden of stroke: strengthening prevention, acute care, rehabilitation and health-system readiness, proposed by Chile, Egypt, Georgia, Palestine, Paraguay and Tunisia, read:

The Executive Board,

Having considered the report by the Director-General,²⁷

²⁷ Document EB158/11.

RECOMMENDS to the Seventy-ninth World Health Assembly the adoption of the following resolution:

The Seventy-ninth World Health Assembly,

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

(PP2) Recalling the commitment made by Heads of State and Government to reduce premature mortality from noncommunicable diseases (NCDs) by one third by 2030, and the need to accelerate progress toward these goals, as appropriate, as set out in Sustainable Development Goal (SDG) 3.4, and the extension of the WHO Global Action Plan for the Prevention and Control of NCDs 2013–2020 to 2030,²⁸ the Intersectoral Global Action Plan on Epilepsy and Other Neurological Disorders 2022–2031 (WHA75.11),²⁹ the Global Strategy on Digital Health 2020–2025;³⁰

(PP3) Having considered the reports by the Director-General on noncommunicable diseases, health systems resilience and universal health coverage;

(PP4) Recognizing that cardiovascular diseases (CVDs), primarily and leading to stroke, are the leading cause of NCD mortality, accounting for approximately 19 million deaths annually,³¹ and that stroke is the second-leading cause of death globally and the third-leading cause of disability,³² are a principal contributor to disability worldwide;

(PP5) Noting with deep concern that the burden of stroke has grown rapidly in low- and middle-income countries (LMICs), which account for approximately 87% of stroke deaths, and that the number of new cases and deaths from stroke increased by 70% and 44%, respectively, between 1990 and 2021;³³

(PP6) Noting with deep concern that stroke remains a leading cause of death and a major cause of disability, with differences in distribution of causes and risk factors across the life course, including for women during pregnancy, the post-partum period, and oral contraception and migraine, and further noting that women experience poorer functional recovery and higher mortality than men due to factors including age, more severe stroke, pre-stroke dependency and depression, while men experience a substantial burden of stroke at younger ages, including premature mortality and long-term disability therefore underscoring an approach that identifies and addresses gender inequalities across the life course, among other factors, in stroke research, prevention and treatment;

(PP7) Acknowledging that the high burden in developing countries is exacerbated by a lack of stroke-ready care, limited access to affordable essential medicines, inadequate rehabilitation services, and a high prevalence of uncontrolled risk factors

²⁸ [Global action plan for the prevention and control of noncommunicable diseases 2013–2020](#). Geneva: World Health Organization; 2013 (accessed 2 February 2026).

²⁹ [Intersectoral global action plan on epilepsy and other neurological disorders 2022–2031](#). Geneva: World Health Organization; 2022 (accessed 2 February 2026).

³⁰ [Global strategy on digital health 2020–2025](#). Geneva: World Health Organization; 2021 (accessed 2 February 2026).

³¹ [Global Burden of Disease 2023](#). Seattle, WA: Institute for Health Metrics and Evaluation; 2025. (accessed 25 September 2025).

³² Global stroke fact sheet 2025. *International Journal of Stroke*. 2025;20(2):132–144. doi:10.1177/17474930241308142.

³³ Global, regional, and national burden of stroke and its risk factors, 1990–2021: a systematic analysis for the Global Burden of Disease Study 2021. *Lancet Neurology*. 2024;23:973–1003. doi:10.1016/S1474-4422(24)00369-7.

and medical conditions such as but not limited to hypertension, diabetes, obesity, dyslipidaemia, physical inactivity, tobacco use, harmful use of alcohol and illicit drug use, air pollution, as well as undiagnosed or poorly managed atrial fibrillation and other cardiovascular diseases;

(PP8) Acknowledging that stroke imposes substantial social and economic costs, including direct healthcare expenditures and indirect costs due to loss of productivity and long-term care needs, often relying on informal caregiving, which undermine development and household financial security by increasing out-of-pocket expenditures and long-term dependency;³⁴

(PP9) Concerning that the health systems of several Member States, particularly in developing countries and in resource constrained regions, lack comprehensive, coordinated stroke services ranging from primary prevention, and stroke-ready emergency systems to timely access to imaging, reperfusion therapies, and essential medicines, through to rehabilitation, community support, and long-term follow-up care;

(PP10) Noting evidence of critical gaps in certain countries across the stroke continuum: low detection and treatment rates for hypertension and other risk factors; low public awareness of stroke signs and insufficient pre-hospital emergency care; limited access to essential neuroimaging; limited availability of stroke units thrombolysis/thrombectomy and neurosurgery services; suboptimal secondary prevention; inadequate rehabilitation and long-term support capacity; lack of or need for strengthening national stroke registries and data to guide policy and shortages of trained health workers across primary, emergency, acute and rehabilitative care pathways as well as significant geographical disparities in access;

(PP11) Conscious of the need for dedicated global leadership and coordinated action requiring the strengthening of WHO's technical capacity for NCDs and the establishment of multisectoral national stroke units within Member States,³⁵ to close the existing gaps and inequalities in the stroke care pathway, thereby reducing premature mortality and disability and strengthening health system resilience in line with SDG 3.4;

(PP12) Emphasizing that effective stroke care requires action across the life course and across health system levels, including strengthened primary prevention, and that many evidence-based and cost-effective interventions exist to reduce stroke incidence and improve outcomes, including hypertension control; diabetes management; and management of dyslipidaemia; screening for atrial fibrillation; salt reduction; promotion of healthy diets and physical activity; effective tobacco cessation; alcohol strategies, interventions and policies in line with the Action plan (2022–2030)³⁶ to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority; and responses to illicit drug use; reduction of air pollution; as well as timely and coordinated emergency medical services; access to organized stroke unit care and reperfusion therapies such as thrombolysis and mechanical thrombectomy; anticoagulation for atrial fibrillation; and long-term rehabilitation, community reintegration and social support, while noting with concern

³⁴ [Stroke: WHO fact sheet, 19 December 2025](#) (accessed 2 February 2026).

³⁵ Implementation roadmap 2023–2030 for the global action plan for the prevention and control of noncommunicable diseases 2013–2030. Document A75/2022/REC/1, Annex 8.

³⁶ [Global alcohol action plan 2022–2030](#). Geneva: World Health Organization; 2024 (accessed 2 February 2026).

that the adoption, scale-up and equitable implementation of these interventions remain insufficient in many countries;

(PP13) Emphasizing the critical need to continue to integrate stroke prevention, control, and management into national cardiovascular disease, neurological disorders strategies and universal health coverage plans to foster equitable access to the full spectrum of care, particularly persons in vulnerable situations, and to reduce health inequalities;

(PP14) Acknowledging the central role of health system strengthening, digital health, diagnostics (including imaging), workforce training, and rehabilitation services integration in achieving measurable reductions in stroke mortality and disability;

(PP15) Noting the absence to date of a focused WHO resolution addressing stroke comprehensively, prevention, acute care, rehabilitation and system readiness, recognizing its specific time-dependent nature requiring coordinated emergency care and the opportunity to stimulate coordinated national and global action;

(PP16) Affirming the importance of standardized national stroke registries and surveillance systems to accurately monitor the incidence, prevalence, mortality, disability, quality of care and patient-reported outcomes, which is essential for evidence-based policy-making and resource allocation;

(OP)1. URGES Member States, considering national context and capacities, and where appropriate:

(1) to include stroke as one of the major public health concerns within national cardiovascular disease, neurological disorders strategies and universal health coverage planning, with dedicated objectives, across the prevention, acute care and rehabilitation continuum;

(2) to implement and strengthen population-level prevention measures as well as measures to reduce health inequalities proven to reduce stroke risk, including but not limited to large-scale detection and control programmes for hypertension, diabetes, obesity and dyslipidemia; and legislation and regulation, policies and actions, as appropriate, to reduce excessive levels of saturated fats, free sugars and sodium such as reformulation, labelling, and public awareness; and effective tobacco cessation; alcohol strategies, interventions and policies in line with the Action plan (2022-2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority; promotion of healthy diets and physical activity and the implementation of health literacy and school-based education programmes to foster healthy habits among children and adolescents; and actions to reduce household and ambient air pollution, in line with national circumstances;

(3) to foster primary care readiness by developing and implementing national stroke care pathways for stroke prevention by scaling up and systematic screening for risk factors, including hypertension, hyperglycemia/diabetes, dyslipidemias and atrial fibrillation, fostering continuous supply and affordable access to essential medicines for blood-pressure, glycemic and lipid control, antiplatelet and anticoagulant therapies as appropriate, and integrating counselling for lifestyle risk modification into routine primary care contacts by using evidence based and effective methods; global coverage targets on hypertension prevention and control;

- (4) to strengthen emergency care systems so that patients with suspected acute stroke receive timely triage, rapid transport and access to imaging and reperfusion therapies where clinically indicated, by:
 - (a) defining and designating stroke-ready levels of emergency care facilities with minimum capability standards (imaging, laboratory, trained staff, capacity for thrombolysis);
 - (b) establishing prehospital stroke recognition and triage protocols, public awareness campaigns for early presentation, and streamlined referral pathways between primary care, emergency services and stroke units;
 - (c) raising awareness of health personnel in emergency care systems about the differences in stroke symptoms among women and men to ensure equitable care for all;
- (5) to expand access to timely diagnostic imaging, including CT/MRI or validated alternatives where appropriate and essential laboratory tests required for acute stroke management;
- (6) to scale up evidence-based acute interventions, including intravenous thrombolysis where indicated and systems to enable endovascular thrombectomy in referral centers, as well as the implementation of standardized care bundles for acute intracerebral hemorrhage, including rapid blood pressure control and coagulopathy reversal, and specialized management pathways for subarachnoid hemorrhage ensuring access to neurosurgical care in referral centres with protocols for timely transfer and interfacility cooperation;
- (7) to invest in multidisciplinary stroke units and rehabilitation, ensuring inpatient stroke units with multidisciplinary teams for example physiotherapy, occupational therapy, speech and language therapy, nursing and medical care, early supported discharge models, palliative and end of life care, where appropriate and community-based rehabilitation and social support for survivors to optimize functional recovery and reintegration;
- (8) to facilitate the development and maintenance of national stroke registries and surveillance systems to collect standardized data, including incidence, data on key indicators of stroke, disaggregated by sex, mortality, risk factors, service availability, reperfusion therapy rates, time-to-treatment, rehabilitation access, functional outcomes, patient reported outcomes (PROMS) and long term quality of life to guide policy, monitor progress and enable quality improvement;
- (9) to strengthen the health workforce by incorporating stroke prevention, acute care and rehabilitation into pre-service curricula and continuing professional development for physicians, nurses, allied health professionals and community health workers; support task-sharing where appropriate with clear competency frameworks and clinical governance; and implement retention and incentive strategies for underserved areas;
- (10) to promote equitable and affordable access by targeting investments and service expansion to underserved, rural and low-income populations, ensuring financial protection mechanisms to reduce out-of-pocket costs for stroke care and rehabilitation;
- (11) to adopt and implement clinical protocols and quality-assurance mechanisms, including national clinical guidelines for stroke prevention and care, audit and peer-review systems, performance indicators, and continuous quality improvement processes across the stroke care pathway;

- (12) to foster regional and cross-country collaboration for shared training, referral networks, pooled procurement for essential medicines and consumables, for example telemedicine/teleradiology arrangements, and regional centers of excellence that can provide mentorship and surge capacity during emergencies;
- (13) to explore and mobilize as appropriate sustainable financing for stroke prevention and care, including domestic and international resources, innovative pooled financing mechanisms, alignment with relevant donor programmes, and integration of stroke services into universal health coverage benefit packages to foster long-term affordability and scalability;
- (14) to engage communities and civil society, including stroke survivor organizations and caregivers, in designing and monitoring policies and services, supporting public awareness and secondary prevention adherence and reducing stigma associated with disability;
- (15) to integrate digital health solutions, for example including registries, telemedicine, teleradiology, clinical decision support and mobile health for follow-up and rehabilitation, in a manner that ensures interoperability, data protection, inclusion, and alignment with national digital health strategies; and
- (16) to build workforce capacity by training health professionals across the continuum of care, from primary care providers to emergency personnel, neurologists, and rehabilitation specialists, in evidence-based stroke management;

(OP)2. REQUESTS the Director-General:

- (1) to develop normative guidance and technical tools for Member States on comprehensive stroke prevention, acute care readiness, rehabilitation and long-term support, that focuses on advancing health equity, rights and gender equality;
- (2) to integrate stroke into existing cardiovascular and neurological global strategies that can be adapted to each country's context;
- (3) to support Member States, especially developing countries, in strengthening their capacity for stroke system models adapted to resource levels;
- (4) to facilitate global stroke monitoring and reporting, harmonized with existing WHO cardiovascular disease, neurological disorders and universal health coverage monitoring systems;
- (5) to promote research and evidence generation on context-appropriate, cost-effective interventions for prevention, acute management and rehabilitation in developing countries;
- (6) to support equitable access to essential medicines and identify priority lists for stroke prevention and acute care, including blood-pressure medicines, medicine for management of dyslipidaemias, antiplatelets, anticoagulants, thrombolytic agents, basic imaging capability, advising on procurement strategies and supply-chain resilience, and exploring pooled procurement mechanisms where feasible;
- (7) to encourage regional cooperation and technical partnerships, including, when appropriate, the establishment or designation of regional centers of excellence for stroke care that can provide training, quality assurance and surge capacity support;
- (8) to report on the progress in the implementation of this resolution to the World Health Assembly through the report submitted in response to decision

WHA72(11) (2019) on the follow-up to the 2018 political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, which also covers the outcome of the fourth high-level meeting of the General Assembly on the prevention and control of non-communicable diseases and the promotion of mental health and well-being on progress made in addressing stroke as part of the global NCD agenda and of the Intersectoral Global Action Plan on Epilepsy and Other Neurological Disorders 2022–2031;³⁷

(OP)3. ENCOURAGES relevant stakeholders, including intergovernmental organizations, philanthropic agencies, academic institutions, professional societies, civil society, private-sector partners and donors, to support Member States and, in line with the Framework of Engagement with Non-State Actors where applicable, WHO in implementing the actions called for in this resolution, as appropriate.

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

A. Link to the approved Programme budget 2026–2027

- 1. Output(s) in the approved Programme budget 2026–2027 under which this draft resolution would be implemented if adopted:**
 - 4.1.1. WHO develops evidence-based policies and supports the implementation, scale-up and measurement of best buys and other actions to strengthen person-centred prevention, control and management of noncommunicable diseases
 - 4.1.2 WHO supports the design, scale-up, implementation and measurement of the coverage of people-centred, equitable services for key mental health, neurological and substance use conditions
- 2. Short justification for considering the draft resolution, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
- 3. Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
- 4. Estimated time frame (in years or months) to implement the resolution:**
Five years (2026–2030).

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

- 1. Total planned costs required to implement the resolution, in US\$ millions:**
US\$ 4.53 million.
- 2.a. Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:**
US\$ 1.57 million.
- 2.b. Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:**
Not applicable.
- 3. Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:**
US\$ 1.63 million.

³⁷ See decision WHA75(11) (2022).

4. **Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:**
US\$ 1.33 million.
5. **Level of financial resources already available to fund the implementation of the resolution in the current biennium, in US\$ millions**
- **Financial resources available to fund the resolution in the current biennium:**
US\$ 1.25 million.
 - **Remaining financing gap in the current biennium:**
US\$ 0.32 million.
 - **Estimated financial resources, which are currently being mobilized, if any, that would help to close the financing gap in the current biennium:**
Efforts are under way to obtain funds for the areas of cardiovascular disease, cerebrovascular diseases and neurological disorders, of which stroke forms part.

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. 2026–2027 cost of resources already planned	Staff	0.05	0.04	0.03	0.04	0.03	0.04	0.22	0.44
	Activities	0.07	0.07	0.07	0.07	0.07	0.07	0.73	1.13
	Total	0.11	0.10	0.10	0.11	0.10	0.10	0.94	1.57
B.2.b. 2026–2027 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2028–2029 cost of resources to be planned	Staff	0.05	0.04	0.03	0.04	0.03	0.04	0.23	0.46
	Activities	0.07	0.07	0.07	0.07	0.07	0.07	0.75	1.17
	Total	0.12	0.11	0.10	0.11	0.10	0.11	0.98	1.63
B.4. Future bienniums cost of resources to be planned	Staff	0.07	0.06	0.05	0.06	0.05	0.06	0.35	0.72
	Activities	0.04	0.04	0.04	0.04	0.04	0.04	0.39	0.61
	Total	0.11	0.10	0.09	0.10	0.09	0.09	0.74	1.33
B.1. Total planned costs required to implement the resolution									4.53

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

The fourth draft resolution, which contained a draft resolution to be submitted to the Seventy-ninth World Health Assembly, on advancing smart, efficient pharmacovigilance as an essential tool for robust, sustainable, resilient and responsive health systems, for everyone, everywhere, proposed by Chile, Egypt, Kuwait, Peru, Qatar, Tunisia and the United Republic of Tanzania, read:

The Executive Board,

Having considered the report of the Director-General,³⁸

RECOMMENDS to the Seventy-ninth World Health Assembly the adoption of the following resolution:

The Seventy-ninth World Health Assembly,

(PP1) Having considered the report by the Director-General on universal health coverage;

(PP2) Recalling resolution WHA16.36 (1963) urging the systematic reporting of serious adverse drug reactions and the establishment of international drug safety monitoring, including the WHO Programme for International Drug Monitoring (PIDM) and the designation of the Uppsala Monitoring Centre;

(PP3) Noting resolutions WHA60.20 (2007), WHA61.21 (2008), WHA62.16 (2009), WHA63.12 (2010), WHA65.17 (2012), WHA65.19 (2012), WHA66.22 (2013), WHA67.20 (2014), WHA67.21 (2014), WHA67.22 (2014), WHA68.7 (2015), WHA71.8 (2018) and WHA72.8 (2019), all of which encompass aspects of the need to promote access to quality, safe, effective and affordable medicines and other health technologies³⁹ as appropriate;

(PP4) Recalling resolution WHA61.21, decision WHA71(9) (2018) and document A71/12, insofar as they address the role of technology transfer and local production of medicines and other health technologies on improving access as appropriate;

(PP5) Recalling resolution WHA73.1 (2020) on a comprehensive and coordinated response to the coronavirus disease (COVID-19) pandemic, which calls for intensified international cooperation and solidarity to contain, mitigate and overcome the pandemic and its consequences through responses that are people-centred and address gender inequalities;

(PP6) Reaffirming the commitment to Sustainable Development Goal 3.8 to achieve universal health coverage, including access to safe, effective, quality and affordable essential medicines and vaccines for all;

(PP7) Acknowledging the lessons from the COVID-19 pandemic and other public health emergencies, which highlighted the essential role of functional pharmacovigilance systems for rapid detection and management of safety signals associated with novel health products, including vaccines and medical devices, and, equally, of timely, transparent, and accurate risk communication as a way to inform the public, support informed decision-making and reinforce confidence in public health interventions;

(PP8) Recognizing that pharmacovigilance data suggest distinct safety profiles across sexes and ages where differences in reporting, outcomes and vulnerability to adverse events may exist;⁴⁰

³⁸ Document EB158/11.

³⁹ Medicines and other health technologies includes pharmaceuticals, vaccines, biopharmaceuticals and medical devices.

⁴⁰ Watson S, Caster O, Rochon PA, den Ruijter H. Reported adverse drug reactions in women and men: aggregated evidence from globally collected individual case reports during half a century. *eClinicalmedicine*. 2019 Dec;17:100188. doi: 10.1016/j.eclinm.2019.10.001.

Aurich B, Apele-Freimane D, Banaschewski T, Chouchana L, Day S, Kaguelidou F et al. c4c: Paediatric pharmacovigilance: Methodological considerations in research and development of medicines for children – A c4c expert group white paper. *British Journal of Clinical Pharmacology*. 2021 Oct 26;88(12):4997-5016. doi: 10.1111/bcp.15119.

(PP9) Recognizing also that despite global progress, significant inequities persist in pharmacovigilance capacity, with many developing countries facing capacity and resource constraints and contributing a disproportionately small share of global safety data, resulting in populations being unequally protected against adverse events and limiting the quality and completeness of global safety data;

(PP10) Acknowledging the emergence of a multitude of parallel safety monitoring systems in countries across various disease treatment programmes that often operate in silos, and may lead to inefficient use of resources and scattered data;

(PP11) Recognizing the critical role of national and regional regulatory authorities and global institutions, their collaboration, the need for comprehensive and integrated pharmacovigilance systems that enable robust, timely evidence-based, benefit-risk assessment of medicines and other health technologies;

(PP12) Recognizing also that collaboration between national and regional authorities and global institutions is also key to addressing capacity-building gaps;

(PP13) Recognizing further that good vigilance practices, including in local production, are essential to foster access to safe, effective and quality assured medicines and other health technologies in a country;

(PP14) Noting the transformative potential of digital technologies, real-world data and artificial intelligence to enhance safety surveillance, signal detection and regulatory decision-making;

(PP15) Recognizing the challenges related to the principles of data governance, privacy, interoperability, access to data,^{41,42} and acceptance by regulators;

(PP16) Stressing that smart, risk-based, integrated and collaborative pharmacovigilance strategies can maximize the impact of limited public health resources, enhance the timeliness of safety signal detection, avoid duplication, and foster reliance and work-sharing and harmonized decision-making among Member States and regions;

(PP17) Acknowledging that misinformation and disinformation about the safety of medicines, vaccines and medical devices, and more broadly about science, can seriously undermine public confidence and trust in these life-saving products and public health programmes and cause harm;

(PP18) Affirming that strengthening pharmacovigilance contributes to public trust in health systems and immunization programmes,^{43,44} improves patient safety, and is an essential component for achievement of the goals of universal health coverage and preparedness for future health emergencies, including the uptake and impact of norms and standards on smart pharmacovigilance; additionally, it has a significant economic impact, as it optimizes resource allocation and reduces the broader costs associated with adverse events;

⁴¹ [Vigibase data access conditions](#) (accessed 29 January 2026).

⁴² [Vigiaccess: frequently asked questions](#) (accessed 29 January 2026).

⁴³ Iessa N, Sarinic VM, Ghazaryan L, Romanova N, Alemu A, Rungapiromnan W et al. Smart Safety Surveillance (3S): multi-country experience of implementing the 3S concepts and principles. *Drug Safety*. 2021 Oct;44(10):1085–98. doi: 10.1007/s40264-021-01100-z.

⁴⁴ WHO Technical meeting report: [Unmasking safety signals during a pandemic, 6 December 2021](#). Geneva: World Health Organization; 2022 (accessed 29 January 2026).

(PP19) Noting that Member States continue to access and benefit from all the resources and services that are already offered by WHO through the Uppsala Monitoring Centre as the WHO Collaborating Centre for International Drug Monitoring,

(OP)1. URGES Member States,⁴⁵ in accordance with their national context and priorities:

- (1) to drive the integration of vigilance systems in order to optimize the use of vigilance data and evidence, for a more comprehensive regulation of medicines and other health technologies and patient care;
- (2) to strengthen national pharmacovigilance systems including patient/consumer reporting systems so that patients and caregivers can easily report adverse events to health authorities/institutions and to support education and awareness efforts on how to identify and report such events;
- (3) to strengthen and modernize national pharmacovigilance systems as an integral part of regulatory systems where applicable, including where appropriate through adequate governance, domestic and international financing, and human resource capacity (in addition to the resources that are provided by WHO to Member States, free of cost, through the Uppsala Monitoring Centre);
- (4) to consider or strengthen the application of safety and vigilance principles beyond medicines and vaccines to include other relevant health products;
- (5) to adopt evidence-based, smart and effective approaches to pharmacovigilance, addressing the most significant risks and prioritizing high-impact activities and products, and to participate where appropriate in regional or global work and reliance mechanisms to optimize resource use;
- (6) to develop or strengthen relevant legal and regulatory frameworks, guidelines and manuals to support where appropriate, good pharmacovigilance practices as an essential responsibility of manufacturers, including in local production, for quality assured essential medicines;
- (7) to leverage real-world data, digital platforms, and innovative tools, including artificial intelligence and machine learning, in a safe, transparent and ethical manner to improve safety signal detection and response, while also maintaining public trust;
- (8) to promote the integration of sex- and age-related safety considerations throughout the development, regulation and use of medicines and to strengthen pharmacovigilance systems that routinely collect, analyse and use sex- and age-disaggregated data on adverse events for diverse population groups;
- (9) to integrate pharmacovigilance within relevant strategies that advance universal health coverage, ensuring patient safety monitoring across all levels of care;
- (10) to integrate pharmacovigilance training in teaching institutions and strengthen regulatory capacity-building and workforce training in pharmacovigilance;
- (11) to collaborate with local, regional and global stakeholders, including public health programmes, academia, the private sector where appropriate, and patients' organizations – to strengthen pharmacovigilance and knowledge sharing;

⁴⁵ And, where applicable, regional economic integration organizations.

(12) to establish or further utilize, where appropriate, pharmacovigilance coordination platforms with partners and stakeholders at the national, regional and global levels for resource optimization and timely decision-making;

(OP)2. REQUESTS the Director-General:

- (1) to continue to update the existing or, if necessary, to develop global normative guidance and technical tools in consultation with Member States to support “smart pharmacovigilance”, taking into consideration real world evidence and the ethical use of artificial intelligence for pharmacovigilance purposes and align with existing initiatives in this area;
- (2) to consolidate performance metrics for pharmacovigilance systems, and provide technical support to Member States upon their request in assessing and improving their pharmacovigilance systems, including the uptake and impact of norms and standards on smart pharmacovigilance;
- (3) to continue enhancing international collaboration and information sharing, reliance, and work-sharing for effective pharmacovigilance among Member States and regions; to continue to take measures to strengthen health literacy on pharmacovigilance to counter disinformation and misinformation, including by facilitating access to evidence-based and science-based information;
- (4) to support data quality, interoperability, and equitable participation of all Member States including developing countries, building on global databases⁴⁶ while respecting data sovereignty and data security;
- (5) to promote capacity development through training programmes for workers in the healthcare and related sectors, including knowledge exchange, and the dissemination of best practices in pharmacovigilance system design and operation;
- (6) to report back to the World Health Assembly, in 2028, 2030 and 2032 on progress in implementing this resolution and on the state of global pharmacovigilance systems, including their contribution to universal health coverage and health emergency preparedness.

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

A. Link to the approved Programme budget 2026–2027

1. **Output(s) in the approved Programme budget 2026–2027 under which this draft resolution would be implemented if adopted:**
3.2.3. WHO supports countries to implement measures for better access to, and use of, safe, effective and quality-assured health products
2. **Short justification for considering the draft resolution, if there is no link to the results as indicated in the approved Programme budget 2026–2027:**
Not applicable.
3. **Any additional Secretariat work during the biennium 2026–2027 that cannot be accommodated within the approved Programme budget 2026–2027 ceiling:**
Not applicable.
4. **Estimated time frame (in years or months) to implement the resolution:**
Seven years (2026–2032).

⁴⁶ [The global medicines safety database](#) (accessed 30 January 2026).

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

1. **Total planned costs required to implement the resolution, in US\$ millions:**
US\$ 17.26 million.
- 2.a. **Estimated planned costs required that can be accommodated within the approved Programme budget 2026–2027 ceiling, in US\$ millions:**
US\$ 5.58 million.
- 2.b. **Estimated planned costs required in addition to those already budgeted for in the approved Programme budget 2026–2027, in US\$ millions:**
Not applicable.
3. **Estimated planned costs required to be budgeted for in the proposed programme budget for 2028–2029, in US\$ millions:**
US\$ 5.82 million.
4. **Estimated planned costs required to be budgeted for in the proposed programme budgets of future bienniums, in US\$ millions:**
US\$ 5.86 million.
5. **Level of financial resources already available to fund the implementation of the resolution in the current biennium, in US\$ millions**
 - **Financial resources available to fund the resolution in the current biennium:**
US\$ 5.58 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)^a

Biennium	Costs	Region						Headquarters	Total
		Africa	The Americas	South-East Asia	Europe	Eastern Mediterranean	Western Pacific		
B.2.a. 2026–2027 cost of resources already planned	Staff	0.14	0.14	0.12	0.14	0.11	0.12	2.78	3.57
	Activities	0.34	0.13	0.22	0.06	0.17	0.22	0.88	2.01
	Total	0.48	0.27	0.34	0.21	0.28	0.34	3.66	5.58
B.2.b. 2026–2027 cost of additional resources	Staff	–	–	–	–	–	–	–	–
	Activities	–	–	–	–	–	–	–	–
	Total	–	–	–	–	–	–	–	–
B.3. 2028–2029 cost of resources to be planned	Staff	0.15	0.15	0.13	0.15	0.12	0.13	2.89	3.72
	Activities	0.35	0.13	0.23	0.07	0.17	0.23	0.92	2.10
	Total	0.50	0.28	0.35	0.22	0.29	0.35	3.81	5.82
B.4. Future bienniums cost of resources to be planned	Staff	0.16	0.16	0.13	0.15	0.12	0.13	2.89	3.74
	Activities	0.37	0.14	0.24	0.07	0.18	0.24	0.88	2.12
	Total	0.53	0.30	0.37	0.22	0.30	0.37	3.77	5.86
B.1. Total planned costs required to implement the resolution									17.26

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

The representative of NORWAY said that, amid resource constraints it was vital to prioritize activities in alignment with the objectives and strategic directions set out in the Fourteenth General Programme of Work, 2025–2028. In that context, she welcomed the draft global strategy for integrated emergency, critical and operative care, 2026–2035. Regarding rare diseases, requests to the Secretariat should be aligned with the Fourteenth General Programme of Work, 2025–2028, expected impact and available resources. Her Government supported postponing the development of the proposed global strategy on donation and transplantation, and she commended the Secretariat for its consideration of resource implications when determining feasible levels of implementation. Initiatives proposed through new decisions and resolutions, such as the draft resolution on reducing the burden of stroke, must be integrated into existing processes; a similar approach should also be taken to reporting.

The representative of BULGARIA, 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 and Georgia, as well as Armenia, aligned themselves with the statement. Equitable access to healthcare required addressing persistent barriers, such as gender inequality, financial obstacles and discrimination, and safeguarding access to essential health services and information in the face of demographic change, disruption caused by conflict and climate change.

The Secretariat should support Member States in addressing the projected global shortfall of health workers, including by promoting fair and ethical international recruitment, preventing brain drain, optimizing the skills mix and advancing digitalization. The WHO Academy could play a critical role in efforts to adequately train the health workforce. Efforts were also needed to promote financial sustainability and social protection, including by scaling up inclusive social protection systems, investing in quality, cost-effective healthcare services. He encouraged Member States to identify and assess domestic resources and efficient, innovative, equitable and sustainable financing mechanisms with a view to reducing out-of-pocket health expenditure and economic barriers to health services, particularly for the most vulnerable people. The Secretariat should advance the development of the proposed global strategy on donation and transplantation to promote equitable access and foster innovation in that area.

Member States should also receive support from the Secretariat in improving access to treatment for rare diseases. Expansion of universal health coverage must include efforts to reduce disparities between countries in that regard, which might require strengthening healthcare beyond primary care, in line with national social protection systems. The Secretariat's efforts to map existing standards, prepare a technical report, address data gaps and establish a workstream promoting universal health coverage for people living with rare diseases were crucial.

The representative of SPAIN, speaking on behalf of the sponsors of resolution WHA78.11 (2025) on rare diseases, thanked the Secretariat for its work mapping existing standards, engaging centres of excellence and providing technical support on rare diseases. While the adoption of that resolution had marked a historic milestone in recognizing rare diseases as a global health priority, it was vital to accelerate its implementation, particularly the development of a global action plan, which would be essential for guiding coordinated, evidence-based action worldwide. The plan would help to strengthen health systems, improve early diagnosis and ensure equitable access to care. Even in a difficult financial landscape, the vision of the resolution must be realized, as investments made today would yield significant human, social and economic returns in the future.

The representative of ISRAEL welcomed the report on primary healthcare. The primary care physician was best placed to perform preventive functions such as providing screening, vaccinations and lifestyle advice and to treat chronic diseases. It was essential to develop policies

to reduce heavy patient loads, such as encouraging safe home hospitalization, optimizing workforce use, enhancing collaboration among health professions, enhancing the use of digital tools by patients and providers, and pursuing national health quality indicators. Facilitating best practices and setting standards must be foundational to those efforts.

The representative of EL SALVADOR said that the path to a healthy future by 2030 relied on a commitment to the Sustainable Development Goals; placing primary healthcare – the first point of contact in communities – at the core of that work would help to save lives through early prevention and diagnosis. Universal health coverage was crucial to ensuring access to healthcare based on need rather than ability to pay. Strengthening primary healthcare and universal health coverage, without exclusion, would lead to equitable and resilient health systems. Success by 2030 would not only be measured by technological progress but by the extent to which no one was left behind.

The representative of JAPAN expressed appreciation for progress made in strengthening health systems based on primary healthcare but noted that progress towards many health-related targets remained off track due to under-resourced health systems, unsustainable financing and persistent inequities impeding access to essential services. Primary healthcare was the essential foundation for overcoming siloed approaches and integrating diverse health programmes to build resilient, equitable and sustainable health systems; universal health coverage was fundamental to achieving those goals. His Government supported the Universal Health Coverage Knowledge Hub, which provided capacity-building and collaboration opportunities for policy-makers to improve health financing, policy dialogue and peer learning. It was encouraging that the Hub's activities had been incorporated into the Programme budget 2026–2027, and had been welcomed by Member States at the Seventy-eighth World Health Assembly.

The representative of TOGO, speaking on behalf of the Member States of the African Region, welcomed the draft global strategy for integrated emergency, critical and operative care, which would help countries to ensure continuity of services including palliative care and rehabilitation. He appreciated that the six strategic objectives were coherent and aligned with expected impact for 2035. Equally, he welcomed progress made towards the proposed global strategy on donation and transplantation, and he expressed appreciation for the Secretariat's work on rare diseases, including the surveying of existing standards and preparation of technical reports. However, he raised concerns about low organ donation rates, which had led to increased organ trafficking; inadequate legislative frameworks, governance structures and health worker capacity-building; and significant data gaps, limiting effective evidence-based policy-making and follow-up.

In that context, the Secretariat was requested to advocate for the explicit inclusion of resource-constrained areas in the proposed global strategy on donation and transplantation, ensuring progressive implementation tailored to local contexts; to step up efforts to promote robust legislative frameworks aimed at preventing organ trafficking and protecting donors and recipients; to promote regional and subregional collaboration, knowledge-sharing and cross-border cooperation; and to develop a plan of action to support implementation of the draft global strategy for integrated emergency, critical and operative care.

The representative of BARBADOS commended the Secretariat on the draft global strategy for integrated emergency, critical and operative care. Strengthening the emergency, critical and operative care continuum was a national security issue for small island developing States, especially in the context of the climate crisis, where surge capacity needs were greater and vector-borne diseases more widespread. To advance the draft global strategy, she recommended five strategic pillars: unified governance for a seamless continuum between emergency departments

and operating theatres; climate-resilient infrastructure, advancing smart facility standards so that hospitals remained operational during disasters; workforce resilience, including investment in a skilled workforce trained in crisis response; scaled-up digital integration for real-time clinical decision-making; and regional solidarity, leveraging the WHO/PAHO Emergency Operations Centre in Barbados.

Noting that primary healthcare was the most effective pathway to universal health coverage, her Government called for a radical health system reorientation, aligned with the Lusaka Agenda and focused on multisectoral collaboration and workforce development. A three-pillar approach was needed to accelerate progress towards the Sustainable Development Goals: regional collaboration via pooled medicine procurement and shared disease surveillance; financing mechanisms specific to small island developing States that recognized their specific vulnerabilities and fiscal limitations; and data sovereignty through routine interoperable digital health records beyond donor-funded surveys.

She requested support to ensure the ethical application of artificial intelligence and health informatics to protect national data assets. The digital and financial resilience of vulnerable States should be prioritized in the implementation of the Fourteenth General Programme of Work, 2025–2028.

The representative of UKRAINE, noting that universal health coverage was the foundation of national resilience, said that critical care should be approached as a continuum from quality pre-hospital aid to specialized surgery and early rehabilitation. There was a need to address the global organ shortage, which was the root cause of unethical practices related to organ transplantation, by developing practical tools to expand the donor pool and strengthen oversight to prevent trafficking; regulation alone was insufficient. Noting that his Government supported a global network of centres of excellence and cross-border pathways for rare diseases, he highlighted inequities in access between high-income and low-income countries, in particular owing to weaker procurement capacity and purchasing power. The Secretariat should provide practical tools, policies and instruments to support pooled procurement, differential pricing structures, access agreements, voluntary licensing and patent pooling to improve access to orphan medicines. Mental health and rehabilitation must be integrated into primary healthcare. He called on the Secretariat to provide expert guidance on task shifting: specifically, on the expansion of clinical competencies for primary care physicians, the enhanced role of nursing personnel and the use of digital solutions, including artificial intelligence, to optimize workforce capacity amid shortages.

The representative of SOLOMON ISLANDS said that Pacific Island countries faced challenges in primary healthcare due to geographic dispersion, limited human and financial resources, climate vulnerability and a high disease burden. Addressing those challenges required targeted, context-sensitive support, including in the form of tailored and sustainable primary healthcare financing as well as technical support to develop costed primary healthcare road maps, integrate primary healthcare into national health financing strategies and access blended financing mechanisms. The WHO peer-to-peer learning programme on primary healthcare financing should be expanded to include models specific to the Pacific Islands. In addition, there was a critical need to train and retrain primary healthcare workers, including through regional training programmes and digital learning platforms, with a view to strengthening the health workforce. Support for climate-resilient primary healthcare infrastructure was also needed, with a focus on environmental health, disaster preparedness, and water, sanitation and hygiene, to ensure continuity of care during emergencies. WHO and partners should prioritize the above actions ahead of the third high-level meeting of the General Assembly on universal health coverage.

The representative of THAILAND supported the draft resolution on precision medicine, emphasizing the need to strengthen genomics capacity to ensure equitable benefits for all nations; the draft resolutions on strengthening equitable access to diagnostic imaging through teleradiology and on advancing smart, efficient pharmacovigilance, which offered cost-effective digital solutions; and the draft resolution on reducing the burden of stroke, highlighting the need to integrate the full stroke care continuum into universal health coverage.

WHO must position primary healthcare as the core framework for health system reform with system-wide investment in financing and the workforce. Support must address structural constraints such as fiscal sustainability to ensure resilience in the context of ageing populations.

His Government urged the Secretariat to provide policy shortcuts through operational manuals for primary healthcare localization. Digital technology and artificial intelligence were essential tools for resource optimization and reducing workforce burdens.

The representative of CAMEROON, describing his Government's efforts to achieve universal health coverage, called for increased political will on universal health coverage, which should be translated into action through the development of policies, regulatory frameworks and strengthened governance structures. Evidence-based and people-centred approaches were needed alongside public-private financing and strengthened international cooperation.

The representative of the DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA commended advancements made towards improving health information systems, including the use of artificial intelligence to address data gaps. She called on Member States to accelerate progress towards the Sustainable Development Goals, which were currently off track, and requested the Secretariat to prioritize high-impact areas while supporting countries to identify national priorities and strengthen financing, information and human resource capacities in the health sector. WHO must support critical health system functions including diagnostic solutions, decision-making support tools, health trend forecasting, supply chain management, tracking of health expenditure and claims reconciliation.

The representative of NEPAL called on WHO to accelerate progress towards universal health coverage by prioritizing integrated emergency, critical and operative care, strengthening rare disease responses, and expanding equitable access to transplantation services. Future strategies must focus on building a competent health workforce, establishing global safety and quality standards, and scaling digital innovations.

Primary healthcare, as the foundation of resilient, equitable health systems and the most effective pathway to universal health coverage, should be the core platform for integrated health systems organizing essential services across noncommunicable diseases, mental health, maternal and child health, infectious diseases, emergency care, rehabilitation and palliative care. Increased investment in primary healthcare quality, digital transformation and climate-resilient infrastructure was needed to ensure continuity of care in all settings. Sustainable primary healthcare financing and multisectoral action must anchor national universal health coverage benefit packages.

Expressing deep concern that the world was off track to achieve the health-related Sustainable Development Goals, he called on WHO to prioritize high-impact interventions and high-quality, tailored technical support to ensure that no one was left behind. Sustainable Development Goal 3 (ensure healthy lives and promote well-being for all at all ages) could not be achieved without addressing the interlinkages with other areas, such as poverty reduction, nutrition, education, gender equality, climate action and sustainable financing.

The representative of the CENTRAL AFRICAN REPUBLIC, speaking on behalf of the Member States of the African Region, welcomed the report on health in the 2030 Agenda for Sustainable Development but expressed concern regarding the lack of progress made towards the health-related Sustainable Development Goals. High-impact interventions must be prioritized, including actions to reduce maternal, child and newborn mortality, promote routine vaccination, strengthen primary healthcare and ensure effective emergency preparedness and response.

He stressed the need to increase national investment in public health. Priorities should include strengthening financial protection for the population, deploying skilled health personnel and adopting national road maps on the ethical use of artificial intelligence to improve health services. Achieving the health-related Sustainable Development Goals required strengthened international solidarity, effective multilateralism, and innovative, predictable and sustainable financing mechanisms.

The representative of LEBANON welcomed the draft global strategy for integrated emergency, critical and operative care, commending in particular the evidence-based approach taken in its development. Service delivery processes must be tailored to conflict-affected and low-resource contexts to ensure inclusiveness and equity.

She supported the proposal to defer consideration of the proposed global strategy on donation and transplantation, emphasizing the need to address ethical challenges, particularly in humanitarian settings. The continued attention paid to rare diseases following the adoption of resolution WHA78.11 was welcome. Addressing gaps in diagnostic capacity, newborn screening and financing required investment in workforce training and integration of rare disease services into universal health coverage strategies under a primary healthcare approach.

She highlighted efforts made to foster strong coordination platforms involving academia, multilateral organizations and civil society with a view to accelerating progress towards the Sustainable Development Goals. She raised the concern that, in conflict-affected settings with fragmented health information systems, vital events often went unregistered, which distorted health indicators and undermined the credibility of progress metrics. Corrective action must be taken immediately to ensure that achievements would be judged against real trends rather than false evidence. The Secretariat was encouraged to convene a task force of experts and Member States to develop technical guidance on robust denominator estimation under data disruption conditions and to provide continued targeted support to Member States for data systems strengthening, especially in conflict-affected countries where the risk of data disruption was high.

The representative of the REPUBLIC OF KOREA, outlining steps taken in her country to prioritize primary healthcare approaches, noted that country-specific learning programmes could facilitate the exchange of knowledge and experience among Member States, with a view to enhancing primary healthcare systems worldwide. Her Government planned to expand its support for the expansion of the Strengthening Primary Health Care Leadership: Global Capacity Building Course and universal learning programmes in the Western Pacific Region. Current discussions must lead to concrete outcomes in time for the third high-level meeting of the General Assembly on universal health coverage in 2027.

The representative of PANAMA said that emergency services were the gateway to clinical care, a pillar of health security and crucial to disaster response. Operative, palliative and emergency care must be integrated into first-level hospital care, in line with national health systems, particularly in emergency and humanitarian settings. Addressing rare diseases was essential to ensuring equitable and inclusive access to services. In that context, scientific evidence, data systems and records should be strengthened to improve systematic data collection, research and surveillance with a view to enhancing screening, monitoring and comprehensive treatment;

doing so would provide the foundation for timely detection and diagnosis, with access to treatment options, effective coordination between national authorities, knowledge sharing and promotion of investment and research.

A sustainable approach to primary care was vital for achieving universal health coverage, incorporating international cooperation, bank-financed programmes, coherent public health programmes and the definition of globally harmonized standards. Countries should prioritize strategic investments in resilient local digital infrastructure through the integration of interoperable digital platforms, as well as the development of institutional data analysis capacities. The Secretariat should step up technical support on the ethical use of artificial intelligence to help anticipate outbreaks, optimize resources and bridge gaps, especially for vulnerable populations. She expressed support for the draft resolutions.

The representative of QATAR welcomed the report on primary healthcare, noting that primary healthcare was a fundamental pillar of national health systems strengthening. Member States of the Eastern Mediterranean Region, in line with the One Health approach, were working to provide integrated healthcare services on an intersectoral basis for the entire population. Efforts included primary healthcare reforms adapted to varying national contexts; regional programmes to build capacities in primary healthcare and emergency and critical care; and the strengthening of health infrastructure through artificial intelligence and other new technologies.

The representative of CHILE welcomed the reports on universal health coverage, primary healthcare and the 2030 Agenda for Sustainable Development, underscoring that universal health coverage based on primary healthcare was essential to achieving the Sustainable Development Goals. She expressed supported for the draft global strategy for integrated emergency, critical and operative care, noting that such care must be integrated at the primary healthcare level through robust communication, transportation and referral systems. In that context, it was necessary to strengthen infrastructure and capacity for minor surgery at the primary care level, including minor outpatient surgery, to reduce unnecessary hospitalizations. She expressed support for WHO's work on organ transplantation and efforts to develop a global action plan on rare diseases, welcoming plans to strengthen newborn screening.

The representative of EGYPT welcomed the draft global strategy for integrated emergency, critical and operative care and the reports on donation and transplantation, and on rare diseases. Despite the varying contexts across the Eastern Mediterranean Region, all countries faced growing demands for emergency, critical and operative care; a system-based integrated approach was therefore needed, alongside a regional road map tailored to diverse country needs.

He outlined the challenges faced in his Region with regard to organ donation and transplantation, which differed in line with the wide variation in socioeconomic conditions, health systems, regulatory frameworks and cultural contexts. He expressed concerns about organ trafficking and inequitable access to transplantation, calling for stronger ethical oversight, and stressed the need to establish an expert committee on the matter, with inclusive regional consultations and sustained technical support.

National health strategies on rare diseases were needed to strengthen workforce capacity, research and data systems, patient engagement, regional collaboration and service integration. Barriers included limited diagnostic tools, treatment access, health literacy and newborn screening. He requested continued technical support and partnership on rare diseases, adding that a global action plan on the topic should reflect regional priorities.

The representative of BRUNEI DARUSSALAM supported the adoption of the draft global strategy for integrated emergency, critical and operative care and its emphasis on people-centred

pathways, workforce protection and system-wide integration. An integrated approach linking primary care, referral pathways, workforce planning and financing would be essential to avoid fragmentation and inefficiencies. He supported the continued development of the proposed global strategy on donation and transplantation, as well as the proposal to defer its consideration to allow for more expert input and Member State consultations. The Secretariat's work on rare diseases, which was key to ensuring equity and inclusion, was welcome. Particular emphasis should be placed on early identification, timely referral and equitable access to care, supported by strong health information systems and appropriate use of digital tools. Regional and cross-border collaboration, including through centres of excellence, could play an important role in enhancing clinical decision-making and supporting national responses.

The representative of SOMALIA said that countries in the Eastern Mediterranean Region faced significant sustainable development challenges due to fragility, conflict and displacement, including challenges on maternal and child mortality, immunization and noncommunicable disease prevention, which required accelerated action. Integrated primary healthcare was needed, with targeted support for vulnerable groups. Strengthening health information systems was critical in a context where a reliance on donor-supported surveys, disruptions in civil registration and failing statistics systems impeded the collection of disaggregated data and limited evidence-based policy-making. Improved data governance, digital transformation and the safe use of technologies, including artificial intelligence, were essential for resilient and equitable health monitoring. He called for intensified support to accelerate implementation of the Sustainable Development Goals through equity-driven action, enhanced national data and digital systems, and stronger investment in universal health coverage, primary healthcare, essential services and health protection capacities.

The representative of BULGARIA supported strengthening primary healthcare, noting its key role in building capacities in areas such as healthy lifestyles, disease prevention, vaccination, screening, early diagnosis, timely treatment, monitoring of conditions and rational prescription of medicines. WHO should support the benchmarking of good practices and lessons learned in key areas such as quality assurance, artificial intelligence, human resources retention and financial management. The Secretariat should share up-to-date primary healthcare knowledge, design approaches for the development of human resources and shape modalities for addressing gaps in quality medical care and patient safety. To ensure effective knowledge exchange, the Secretariat should seek to enhance international collaboration and sharing of good practices among countries.

The representative of the CENTRAL AFRICAN REPUBLIC said that developing countries, including those in fragile situations, must exercise greater sovereignty in health governance. It would be important to strengthen the capacities of such States to identify, secure predictable financing for and autonomously implement health policies by mobilizing national resources in the first instance, complemented by technical, strategic and financial partnerships, to ensure equitable and resilient health systems. To support that new paradigm, WHO regional and country offices must advocate for a whole-of-government and whole-of-society approach, supporting health ministers in their dialogue with heads of state, finance ministers and parliaments to ensure the sustainable financing of national health plans and resilient healthcare systems.

The representative of ZIMBABWE, speaking on behalf of the Member States of the African Region, expressed appreciation for WHO's support in reorienting health systems in the Region towards primary healthcare and strengthening political commitment, partnerships and health financing. The Member States of the Region had reviewed, developed and implemented essential

packages for universal health coverage and had expanded the health workforce to include 850 000 community health workers.

He urged the Executive Board to support the endorsement and adaptation of the regional primary healthcare road map, tailored to national contexts; encourage Member States to strengthen commitment and resource allocation for primary healthcare, with a focus on prepayment mechanisms, quality improvement and resilient community-based services; and prioritize support for countries with the lowest levels of universal health coverage to reduce disparities.

The representative of COSTA RICA, referring to the draft global strategy for integrated emergency, critical and operative care, requested the establishment of clear mechanisms to strength coordination between primary, hospital and emergency care, emphasizing the need for effective referrals and counter-referrals. The draft global strategy should promote innovative sustainable financing mechanisms to enable investment in infrastructure that provided social protection and avoid catastrophic out-of-pocket costs. In the area of human resources, priority should be given to talent retention, specialized training and psychosocial support for staff, particularly in high-demand and emergency contexts. She stressed the importance of strengthening digital health through interoperable systems, integrated recordkeeping systems and telemedicine, while ensuring data security and privacy. WHO should provide technical support to adapt guidelines to national contexts.

She supported the development of a proposed global strategy on donation and transplantation with a focus on improved internal standards, capacity-building and coordinated action. Sustainable investment in primary healthcare should be prioritized to improve quality, ensure patient safety and integrate essential public health functions into primary healthcare.

The representative of CABO VERDE said that universal health coverage was essential for resilient, equitable and people-centred health systems and, for small island developing States, a prerequisite for social stability, economic development and climate resilience. She commended WHO for supporting Member States in accelerating progress towards universal health coverage through strengthened primary healthcare, sustainable health financing and a competent and protected health workforce.

She welcomed the draft global strategy for integrated emergency, critical and operative care, particularly in the light of challenges such as the coronavirus disease (COVID-19) pandemic, climate emergencies and the increasing noncommunicable disease burden, which had demonstrated the crucial need for timely access to emergency and critical care to reduce avoidable mortality. Integrated and well-coordinated emergency care systems were indispensable for small island developing States with geographic challenges. Emergency and critical care capacity must be reinforced at every level of the health system, utilizing adaptable models such as telemedicine, regional referral pathways and standardized protocols to ensure quality care regardless of location. Continued investment in the health workforce was also necessary.

The representative of OMAN⁴⁷ emphasized the need to advance health systems, primary healthcare and universal health coverage alongside sound resource utilization in order to achieve the Sustainable Development Goals. It was important to address the social determinants of health and accelerate progress towards the Goals despite resource scarcity.

⁴⁷ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of CANADA⁴⁸ said that gender-responsive, community-driven and integrated primary healthcare was foundational to building resilient and equitable health systems and to achieving the Sustainable Development Goals, including universal health coverage. WHO and partners should ensure that sexual and reproductive health and nutrition were integrated into essential service packages. She recognized the importance of a One Health approach and the need to improve water, sanitation and hygiene, particularly at the community level. In the light of declining official development assistance, a sharper focus on sustainable primary healthcare financing was necessary. Initiatives supporting country ownership and increased domestic resource mobilization for health were welcome. National health compacts could help to align external resources with country-level plans, including for primary healthcare functions. WHO and partners should continue sharing and aligning best practices, including through the new Universal Health Coverage Knowledge Hub.

The representative of COLOMBIA⁴⁸ described his Government's efforts to expand primary healthcare through a prevention-focused approach and welcomed the draft global strategy for integrated emergency, critical and operative care as a useful tool for strengthening health systems. The draft global strategy should incorporate sustainable financing, clear indicators and technical cooperation tailored to national realities.

The representative of the NCD ALLIANCE, speaking at the invitation of the CHAIR, and also on behalf of the International Society of Nephrology, The Worldwide Hospice Palliative Care Alliance, the World Stroke Organization, the European Association for Injury Prevention and Safety Promotion, Alzheimer's Disease International, PATH, World Cancer Research Fund International, the International Society on Thrombosis and Haemostasis, Inc., the International Society for Biomedical Research on Alcoholism, the International Alliance of Patients' Organizations, HelpAge International, the International Diabetes Federation, the World Heart Federation, The Royal Commonwealth Society for the Blind – Sightsavers, Vital Strategies, Inc., and the International Association for Suicide Prevention, welcomed the emphasis on advancing primary healthcare in the 2025 political declaration of the fourth high-level meeting of the United Nations General Assembly on the prevention and control of non-communicable diseases and the promotion of mental health and well-being. She noted, in particular, commitments to ensure affordable access to essential noncommunicable disease services in primary healthcare, and highlighted the Global Coalition of Countries on Primary Healthcare and the Universal Health Coverage Partnership as platforms advancing the noncommunicable disease agenda by providing technical and policy support to integrate primary healthcare into national health strategies. Despite the critical importance of integrating noncommunicable diseases into primary healthcare, it had only been marginally addressed in the report, which was a cause of concern.

Member States were encouraged to implement the targets set out in the political declaration, including the target to ensure that WHO-recommended essential medicines for noncommunicable diseases and mental health conditions were available at affordable prices in at least 80% of primary healthcare facilities worldwide by 2030. Other actions should focus on integrating noncommunicable disease prevention and care into primary healthcare, including the integration of rehabilitation and palliative care in health benefit packages; ensuring people-centred approaches with meaningful community and patient involvement in the design, implementation and evaluation of services; and increasing financing, while reducing financial barriers at the primary healthcare level to avoid out-of-pocket expenses.

⁴⁸ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of MEXICO⁴⁹ said that integrating emergency, critical and operative care into universal health coverage was essential to reducing mortality and disability, especially when combined with primary healthcare and effective referral and counter-referral systems; to that end, adequate infrastructure, sufficient human resources and clear evaluation and prioritization mechanisms were needed.

To ensure ethical and sustainable access to transplantation of cells, tissues and organs, it would be crucial to strengthen regulatory frameworks, protect against illicit practices and support gradual specialized skills development that was aligned with national contexts. Access to robust newborn screening systems and equitable diagnostic tools and treatments were key to tackling rare diseases and reducing care inequalities. To advance towards universal health coverage, it would be vital to consolidate primary healthcare, guarantee access to care without financial barriers and strengthen information and surveillance systems for evidence-based decision-making.

The Observer of PALESTINE emphasized the need for comprehensive universal health coverage and strong health systems for all, recalling the Declaration of Astana and the importance of health as a foundation for peace. Commitments must be translated into concrete actions amid ongoing war and humanitarian crises. He detailed challenges in implementing measures to enhance universal health coverage in the occupied Palestinian territory, including east Jerusalem, particularly in Area C of the West Bank, due to daily attacks on medical personnel, humanitarian staff and Palestinian families.

The representative of BELGIUM⁴⁹ applauded progress in many health areas but expressed concern about the overall shortfall in delivery on the health-related Sustainable Development Goals. Global health was a global public good that required all stakeholders to contribute according to their capacities. In the final five years of the 2030 Agenda, a laser focus on the Availability, Accessibility, Acceptability and Quality Framework would be indispensable. She called for the prioritization of high-impact health areas, evidence-based approaches and reinforced domestic financing for health.

The representative of THE SAVE THE CHILDREN FUND, speaking at the invitation of the CHAIR and also on behalf of Humatem, the International Planned Parenthood Federation, The Center for Reproductive Rights, Inc., Amref Health Africa, the International Alliance of Patients' Organizations, the European Association for Injury Prevention and Safety Promotion, World Vision International, Médecins Du Monde, Action Contre la Faim International, The Royal Commonwealth Society for the Blind – Sightsavers, Women Deliver, Inc., the International Federation on Ageing, CBM Christoffel-Blindenmission Christian Blind Mission e.V., Global Health Council, Inc., the International Lactation Consultant Association and The International Society for Quality in Health Care Company Limited by Guarantee, urged Member States to ensure that the third high-level meeting of the General Assembly on universal health coverage in 2027 would be action-oriented and take stock of achievements, and that meaningful civil society participation would be ensured throughout the preparatory process. Critical elements of primary healthcare and universal health coverage must be embedded in the high-level meeting road map, including an inclusive life-course approach, essential nutrition actions, climate-resilient health systems, secured supply chains for essential health products, investment in health technology management, sexual and reproductive health and rights, mental health and psychosocial support, injury prevention, and humanitarian response. It was important to prioritize sustainable financing for primary healthcare and universal health coverage in alignment with country-led strategies. Primary healthcare, universal health coverage and child rights should be at the centre of discussions to reform the global health

⁴⁹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

architecture and on the UN80 Initiative. A focus must be placed on humanitarian settings, the impact of conflict and disasters on child health, safety and mortality, and advancing country-led interventions on universal health coverage and primary healthcare.

The representative of ITALY⁵⁰ described health reforms implemented at the national level to strengthen the role of primary healthcare in line with the principles of the Alma-Ata Declaration, noting that primary healthcare was a tool for health and well-being, socioeconomic development and peace. She thanked the Secretariat for providing strategic guidance and expertise as a reference for those reforms.

The representative of SRI LANKA⁵⁰ expressed appreciation for the technical support provided by WHO to improve quality of care and patient safety. Continuous policy dialogue and technical support, alongside strong political commitment to public healthcare, were necessary for improving implementation of key health measures. She highlighted the importance of strengthening primary healthcare through digital health infrastructure and integrating essential primary health functions to support prevention, resilience and effective implementation. Data collection, ensuring patient privacy, was key to identifying focus areas and improving policy implementation.

The representative of the KINGDOM OF THE NETHERLANDS⁵⁰ commended WHO for the results achieved in advancing primary healthcare as the foundation for universal health coverage. She acknowledged the leadership of WHO, the World Bank, Japan and other Member States in launching the Health Works initiative to align external and domestic resources in pursuit of expanded primary healthcare access. The third high-level meeting of the General Assembly on universal health coverage would provide an opportunity to recognize that worldwide access to essential health services was critical for global health security, well-being and socioeconomic stability. The high-level meeting should be leveraged to promote the coherent and efficient engagement of global health actors in support of primary healthcare.

The representative of the RUSSIAN FEDERATION⁵⁰ requested to be added to the list of sponsors of the draft resolutions on precision medicine and on advancing smart, efficient pharmacovigilance.

The representative of LUXEMBOURG⁵⁰ called for coordinated global action on rare diseases, including through the rapid development of an action plan. Civil society and patient organizations had a vital role to play, as their expertise would be crucial in improving data quality, raising awareness and guiding public policies. Noting that equity must remain central, he stressed that cross-border action was crucial to ensure that small States could access quality care, including for rare diseases. Integrating rare diseases into universal health coverage was essential for ensuring access to high-quality care.

The representative of GEORGIA⁵⁰ recognized that investment in primary healthcare was not only a health priority but a political and economic choice, outlining measures taken in her country to expand primary healthcare access. Successfully implementing primary healthcare required bold reforms, including strengthening the workforce, integrating mental health and using digital innovations.

⁵⁰ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of URUGUAY⁵¹ recognized the importance of the draft global strategy for integrated emergency, critical and operative care for universal health coverage and emergency preparedness, and welcomed the linkages made therein to primary healthcare as a way to reduce avoidable mortality and improve timely access. Her Government supported the proposals concerning the proposed global strategy on donation and transplantation and concurred with the assessment of access gaps, ethical challenges and the need to strengthen governance. She reaffirmed her Government's commitment to building resilient health systems based on universal health coverage and primary healthcare and to strengthening information systems and the digital transformation in line with ethical principles. It was deeply concerning that progress towards the 2030 Agenda was not advancing as expected.

The representative of SINGAPORE⁵¹ said that, to achieve Sustainable Development Goal 3, robust, integrated health systems were required. She highlighted the role of digital infrastructure in that regard, describing her Government's efforts to implement a national electronic health record system. She supported the strengthening of integrated emergency, critical and operative care, including by improving equity in addressing rare diseases and developing ethical organ transplantation strategies.

The representative of INDONESIA⁵¹ said that accelerating progress towards the health-related Sustainable Development Goals required a focus on high-impact system actions that protected essential services. Support from the Secretariat was most useful when it helped countries to translate ambitions related to the Goals into decisions on universal health coverage. Progress depended on stronger health information and data systems; his Government was investing in measures including routine reporting, civil registration and interoperable digital platforms. Primary healthcare could be most effectively prioritized when sustained political leadership was matched by a clear legal mandate and embedded within financing for universal health coverage. Investment was needed in frontline capacity, including community health workers, effective referral management and digital tools to reduce workload.

The representative of the UNITED REPUBLIC OF TANZANIA⁵¹ recognized the importance of ethical access to, and effective oversight of, human cells, tissues and organs, and called for the expedited implementation of related resolutions WHA63.22 (2010) and WHA77.4 (2024). She described steps taken in her country to strengthen emergency, critical and operative care, transplantation services and management of rare diseases. She called on Member States to support the draft resolution on advancing smart, efficient pharmacovigilance, which reflected the need to do more with less to advance patient safety and universal health coverage in an era of constrained resources.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND⁵¹ said that WHO's leadership on universal health coverage was vital to galvanize Member States and promote a primary healthcare approach towards universal health coverage. Sustainable financing should remain a central focus to improve the coverage of essential service packages. Global leadership on primary healthcare was critical, and her Government would welcome a reinvigorated effort to bring together the wide range of relevant stakeholders to maximize impact.

The representative of BRAZIL⁵¹ said that universal health coverage required resilient health systems; a skilled workforce; access to high-quality, effective and affordable health products and services; integrated emergency, critical and operative care; equitable access to transplantation;

⁵¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

and comprehensive rare disease management. Despite progress, inequities and access gaps remained to be addressed, and financial protection for all needed to be ensured. Welcoming recognition in the report on primary healthcare of his country's experience of expanding access to healthcare through digital transformation, he encouraged WHO to support country-led digital health strategies that were aligned with primary healthcare, equity and interoperability and to promote knowledge exchange among regions. Given recent disruptions in development assistance and declining global health resources, the UN80 Initiative should strengthen system coherence while preserving the effectiveness of specialized bodies that advanced the 2030 Agenda.

The representative of PARAGUAY⁵² supported the draft global strategy for integrated emergency, critical and operative care. It would be appropriate to defer consideration of the topic of increasing availability, ethical access and oversight of transplantation of human cells, tissues and organs and continue with the development of the proposed global strategy on donation and transplantation in advance of the Eightieth World Health Assembly; in that regard, she stressed the importance of robust ethical principles and regional cooperation. While welcoming progress made on rare diseases, she emphasized the need to prioritize early diagnosis and access to effective treatment in early childhood. A coordinated, inclusive and evidence-based global action plan on rare diseases was needed to improve care for those affected. She highlighted domestic measures taken to expand primary healthcare coverage.

The representative of CHINA,⁵² noting the challenges often faced in low- and middle-income countries in access to relevant health services, said that the Secretariat should prioritize promotion of new technology, including through staff training, in supporting developing countries to improve service quality and accessibility. He commended the Secretariat's efforts to explore how artificial intelligence and other emerging technologies could help in collecting health data and accelerating service delivery, and he called for enhanced communication with Member States regarding the use of such technologies, including on topics such as privacy protection. His Government supported the draft resolution on precision medicine and wished to be added to the list of sponsors.

The representative of ECUADOR⁵² said that addressing rare diseases was an area of priority in efforts to increase equity and inclusion in the scope of universal health coverage, highlighting relevant national measures taken. He requested specialized technical support from the Secretariat to strengthen national strategies on rare diseases and develop information systems. He called for the gradual implementation of resolution WHA78.11, in line with national capacities.

The representative of NIGERIA⁵² said that the proposed global strategy on donation and transplantation must be practical, equitable and responsive to the needs of low- and middle-income countries. She called for support in building strong national governance systems, investment in capacity-building, and technical support for the establishment of culturally appropriate donor programmes and frameworks for ethical collaboration. The steps taken by the Secretariat on rare diseases were commended as they demonstrated a clear commitment to ensuring that rare diseases were no longer invisible in global health policy. Political momentum generated by the high-level meetings of the Global Coalition of Countries on Primary Healthcare should be translated into measurable commitments on primary healthcare financing and workforce quality, and monitored via global dashboards to demonstrate their relevance to ministries of finance and heads of State.

⁵² Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The representative of KAZAKHSTAN,⁵³ noting that systems based on primary healthcare were more resilient, cost-effective and responsive to people's needs, welcomed the support provided to Member States by WHO through the Universal Health Coverage Partnership and its work on primary healthcare financing, workforce development and integration of essential public health functions. She invited more Member States to join the Global Coalition of Countries on Primary Healthcare, launched by her Government, to sustain high-level political commitment and promote practical exchanges among countries. Three priorities for the future were: sustainable financing that shifted resources to primary healthcare; investment in the primary healthcare workforce; and stronger country-to-country learning on implementation.

The representative of PORTUGAL⁵³ emphasized that universal health coverage was central to resilient and inclusive health systems as it represented a sustained commitment to equity, social cohesion and the right to health. Primary healthcare was central to the effective delivery of universal health coverage, as reflected in his country's experience. He expressed strong support for WHO's leadership in advancing universal health coverage; at a time of global uncertainty, universal health coverage remained one of the most concrete expressions of effective multilateralism and the shared responsibility to build healthier and more equitable societies.

The representative of INDIA⁵³ welcomed the draft global strategy for integrated emergency, critical and operative care and supported its adoption. Equally, she supported the development of the proposed global strategy on donation and transplantation, emphasizing the importance of prioritizing hospital-based deceased donation programmes, building a robust transplant coordinator workforce, enhancing data transparency and establishing guidelines to safeguard against exploitation while addressing emerging ethical challenges related to donation after circulatory death and xenotransplantation.

There was an urgent need to develop global normative standards for the diagnosis and management of rare diseases, ensuring that standardized evidence-based protocols were adaptable to resource-constrained settings. A global action plan on rare diseases must explicitly include a dedicated workstream on universal newborn screening and genomic diagnostic capacity-building.

The representative of ICELAND⁵³ said that effective integration of services across all levels of care, anchored in strong primary healthcare, was necessary to achieve universal health coverage. Primary healthcare, as the first point of contact, was essential; insufficient primary healthcare led to unnecessary pressure on hospitals and specialist services, thereby reducing overall efficiency. The prevention and management of noncommunicable diseases should be part of primary healthcare. She commended the WHO Regional Office for Europe for its alignment with global WHO priorities, its focus on prevention and its support for countries to integrate noncommunicable disease management into primary healthcare.

The representative of ETHIOPIA⁵³ welcomed the draft global strategy for integrated emergency, critical and operative care. She emphasized the value of an integrated approach within the emergency, critical and operative care continuum in addressing high-burden conditions, including in emergency and humanitarian contexts. She called on the Secretariat to translate the draft global strategy into an action plan and urged partners to mobilize resources for its effective implementation. She expressed support for the draft resolution on advancing smart, efficient pharmacovigilance.

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

Regarding the primary healthcare agenda, the WHO–UNICEF primary healthcare measurement framework should be institutionalized with flexibility for local adaptation. Local investment in leveraging strategic entry points, such as immunization, should be increased to accelerate primary healthcare service integration, and Secretariat support for reliable and disaggregated primary healthcare data should be enhanced. WHO must continue to put health on the global political agenda and leverage health diplomacy to accelerate achievement of the Sustainable Development Goals.

The representative of PERU⁵⁴ welcomed the draft global strategy for integrated emergency, critical and operative care, recognizing that geographic gaps in timely access to such services persisted, particularly affecting vulnerable groups, including newborns and children. His country's experience in coordination between pre-hospital care, medical regulation and timely referral demonstrated the importance of effective integration across different services. Human resources, clinical management and quality of care should be strengthened through a comprehensive, people-centred approach across the life course. He supported the draft decision on the draft global strategy for integrated emergency, critical and operative care.

The representative of BOTSWANA⁵⁴ commended WHO for its leadership in advancing universal health coverage through primary healthcare reforms, welcoming in particular the improved universal health coverage service coverage index in the African Region, despite disparities across countries. He endorsed the regional primary healthcare road map for 2026–2030 and urged Member States to strengthen political commitment to, and ensure adequate resource allocation for, primary healthcare in order to enhance financial protection and reduce out-of-pocket expenditures. He recommended the adoption of the draft global strategy for integrated emergency, critical and operative care, and requested the Director-General to report on its implementation in the coming years.

The representative of GERMANY,⁵⁴ recognizing that primary healthcare was crucial for ensuring early access, prevention and continuity of care, said that in order to achieve universal health coverage, essential health services must be accessible to all, especially the most vulnerable. Universal access to sexual and reproductive health and rights must be made a reality. Sustainable financing for universal health coverage and social protection, primarily through domestic resources, was essential. A more efficient process for proposing resolutions must be put in place to ensure added value across all regions.

The representative of the SUDAN⁵⁴ said that primary healthcare was vital for universal health coverage, especially for developing countries. He expressed concern about sanctions, embargos and militia activity in his country, including attacks on health infrastructure, personnel and equipment. He highlighted the importance of knowledge exchange, health system restructuring and overall reform.

The representative of TÜRKIYE⁵⁴ welcomed the draft global strategy for integrated emergency, critical and operative care as a key pillar of universal health coverage. Timely and quality care required strong referral pathways linked to primary healthcare, a strong health workforce and phased country-specific implementation. The Secretariat should support Member States through costed, implementable road maps, evidence-based guidance and robust monitoring. He supported continued work on the proposed global strategy on donation and transplantation, stressing the importance of early diagnosis and effective use of the International

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

Classification of Diseases (11th revision). There was also strong value in WHO developing practical implementation guidance on digital health and artificial intelligence, including compilations of good practice and case studies from different income settings.

The representative of IRELAND⁵⁵ emphasized the need for strong, efficient and equitable health systems that supported, and were rooted in, the communities that they served; improved access to primary healthcare services was the most effective and cost-efficient way to achieve that. She described steps taken in her country to invest in primary healthcare and support people living with rare diseases.

The representative of NICARAGUA⁵⁵ expressed support for the one-China principle, maintaining that Taiwan⁵⁶ was an inalienable part of China's territory.

Global momentum was needed to advance implementation of the 2030 Agenda, especially the health-related Sustainable Development Goals. It was particularly important to strengthen health systems by advancing strategies based around data and digital technologies to promote equity. Concerns were raised about lagging progress on maternal and child health, infectious diseases and universal health coverage; greater global commitment was needed in those areas, which should also be prioritized at the national level. She supported national and regional efforts to strengthen primary healthcare.

The representative of FRANCE⁵⁵ said that gender considerations, including the health of women and girls, as well as sexual and reproductive health and rights, must remain central to international action on universal health coverage. It was unacceptable that women often received delayed or no diagnosis compared to men, encountered bias when presenting with symptoms, and had limited access to appropriate treatment. It would also be important to address rare diseases, including by strengthening early detection and adequate care, ensuring access to quality healthcare services, while taking into account the social determinants of health and protecting against financial risks.

The representative of SOUTH AFRICA⁵⁵ said that universal health coverage through a primary healthcare approach was fundamental not only for improving health and well-being but also for reforming and building resilient health systems. She supported the adoption of the draft global strategy for integrated emergency, critical and operative care.

The representative of the DOMINICAN REPUBLIC⁵⁵ recognized the Secretariat's efforts to address organ donation and transplantation through a multisectoral approach and took note of its work on rare diseases and primary healthcare. She reaffirmed her Government's commitment to equity, universal health coverage and international cooperation. Noting that a lack of specificity hindered practical application, she called for greater clarity on methodology, governance and prioritization criteria, which should be tailored to national capacities, especially for low-income countries. It was vital to continue strengthening primary healthcare through integrated policies, human resources, digital health and information systems. Financing must be aligned with sustainable priorities.

The representative of the ISLAMIC REPUBLIC OF IRAN⁵⁵ raised concerns about unilateral coercive measures, which restricted access to essential health services and products, including medicines, medical equipment, diagnostic tools and technologies, and thereby undermined health

⁵⁵ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

⁵⁶ World Health Organization terminology refers to "Taiwan, China".

system resilience and continuity of care. Such measures disproportionately affected emergency and critical care services, where timely access to supplies was life-saving. The needs and priorities of developing countries, particularly equitable access to financing, technologies and essential health products, must be central to global strategies. Achieving universal health coverage would require international cooperation, solidarity and the full removal of barriers that interfered with the right to health.

The Observer of the HOLY SEE, affirming that the human body must never become an object of trade, supported the emphasis on donor dignity, equitable access and voluntary, non-remunerated donation in the proposed global strategy on donation and transplantation. On xenotransplantation, he stressed the absolute guarantee of patient safety, the preservation of personal identity – to ensure that the recipient’s psychological and genetic integrity remained intact – and the ethical stewardship of animals involved in those processes. On biotechnology, he strongly condemned the use of embryonic stem cells or foetal tissues to address organ shortages and urged a strict focus on adult stem cells and ethical alternatives that respected human life.

The representative of the WORLD MEDICAL ASSOCIATION, speaking at the invitation of the CHAIR, said that effective implementation required a protected and sustainably financed primary healthcare workforce that was fairly remunerated and worked in safe and supportive environments. Long-term sustainability depended on the attraction and retention of health professionals to ensure continuity of care and strong system performance, especially at the community level. The continued prioritization of primary healthcare was the most effective pathway towards universal health coverage and should inform preparations for the third high-level meeting of the General Assembly on universal health coverage in 2027.

The representative of PUBLIC SERVICES INTERNATIONAL, speaking at the invitation of the CHAIR, said that poor progress towards the Sustainable Development Goals highlighted the need for a comprehensive primary healthcare approach and fundamental reforms based on international solidarity, public ownership accountability and community engagement. The original vision of health for all, which prioritized people’s health over wealth and geopolitics, had been abandoned in favour of free market fundamentalism under the veneer of multistakeholderism. Technical competence alone was insufficient to urgently transform the global finance architecture and public health – that required Member States’ political will.

The representative of the MEDICAL WOMEN’S INTERNATIONAL ASSOCIATION, speaking at the invitation of the CHAIR, said that, to address the health-related Sustainable Development Goals, governments must reaffirm their commitment to global health, increase domestic funding and strengthen engagement with parliamentarians to co-create evidence-based health policies and budgets. It would also be crucial to prioritize sepsis. She welcomed the draft global strategy for integrated emergency, critical and operative care, emphasizing the importance of ensuring a continuum of integrated people-centred care and integrated clinical pathways rather than fragmented silos.

The representative of MOVENDI INTERNATIONAL, speaking at the invitation of the CHAIR, welcomed the decline in global per capita alcohol consumption and noted alcohol taxation as an effective tool in reducing health service demand while mobilizing sustainable domestic revenue for primary healthcare and universal health coverage. The Secretariat was encouraged to unlock the potential of alcohol taxation and to integrate alcohol policy best buys into universal health coverage guidance in preparation for the third high-level meeting of the General Assembly on universal health coverage in 2027.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIR, noted that fragmented health systems undermined care quality; it was difficult to meet ambitious goals with underfunded clinic and missing essential services. She questioned whether the struggle to fulfil the 2030 Agenda for Sustainable Development stemmed from the separation of primary healthcare and surgical care priorities. Universal health coverage would not succeed if life-saving emergency care remained optional. She urged Member States to institutionalize the draft global strategy for integrated emergency, critical and operative care; integrate emergency, critical and operative care into universal health coverage to prevent avoidable deaths; protect the health workforce; and support healthcare professionals, medical students and community responders with strong legal and financial frameworks. Digital tools, including artificial intelligence, should be used ethically to lessen rather than deepen inequities.

The representative of the INTERNATIONAL ASSOCIATION FOR HOSPICE AND PALLIATIVE CARE, INC., speaking at the invitation of the CHAIR, welcomed the draft global strategy for integrated emergency, critical and operative care but noted with concern that palliative care, pain relief, symptom management and essential palliative medicines for adults and children, had been omitted. She welcomed the report on primary healthcare but noted with further concern that palliative care had not been referenced as an essential component of primary healthcare, despite its inclusion in the Declaration of Astana and the political declaration of the fourth high-level meeting of the General Assembly on the prevention and control of non-communicable diseases and the promotion of mental health and well-being. There was an urgent need to integrate palliative care into primary healthcare to ensure equity, continuity of care and health for all, particularly in developing countries.

The representative of the INTERNATIONAL ASSOCIATION OF COMMUNICATION SCIENCES AND DISORDERS, speaking at the invitation of the CHAIR, welcomed the draft resolution on reducing the burden of stroke, which recognized the need to strengthen not only prevention and acute care but also rehabilitation and health system readiness. Rehabilitation was currently insufficiently embedded within primary healthcare, despite evidence that it improved functional outcomes and quality of life, and reduced long-term impairments post-stroke. Member States were encouraged to endorse the draft resolution and ensure its operationalization through the integration of rehabilitation into national stroke and noncommunicable disease strategies, investment in rehabilitation services and workforce capacity, and the inclusion of functioning as a third health indicator in monitoring frameworks.

The representative of the GLOBAL SELF-CARE FEDERATION, speaking at the invitation of the CHAIR, said that self-care was a practical, people-centred approach that supported prevention, early action, adherence and continuity of care, especially where access to health services was limited. However, self-care must not shift responsibility from governments or health systems and must be enabled through quality products and services, trusted information and referral pathways connecting people to timely facility-based care, including for urgent and life-saving interventions. WHO and Member States were encouraged to integrate self-care within universal health coverage reforms and service delivery to expand access, reduce inequalities and strengthen health systems.

The representative of RARE DISEASES INTERNATIONAL, speaking at the invitation of the CHAIR, said that a global action plan on rare diseases would be essential for enabling coordinated action, supporting Member States in developing coherent, equitable and sustainable responses and ensuring that people living with rare diseases were recognized and supported. WHO was

urged to advance work on a global action plan by preparing a clear timeline and initiating an inclusive consultation process.

The representative of WOMEN IN GLOBAL HEALTH, INC., speaking at the invitation of the CHAIR, welcomed the report on primary healthcare and its focus on community engagement, workforce strengthening and the integration of essential public health functions, including in humanitarian and emergency settings. Women constituted the majority of the primary healthcare workforce, yet gender-responsive governance, leadership pathways and workforce protections remained uneven. Gender equality and women's leadership must be systematically embedded into primary healthcare reforms, including through gender-responsive financing, leadership, accountability and sex- and gender-disaggregated data.

The representative of the INTERNATIONAL COLLEGE OF SURGEONS, speaking at the invitation of the CHAIR, recognized the draft global strategy for integrated emergency, critical and operative care as a key component of universal health coverage and health system resilience. He highlighted the importance of building nationwide telemedicine infrastructure for emergency, critical and operative care and strengthening human resource capacities in that regard; telemedicine was an important tool to improve cost-effective access to specialty care, reduce avoidable mortality and suffering, and strengthen medical and surgical expertise. He expressed deep concern about the dramatic reduction in WHO technical capacity in that area and urged WHO and Member States to prioritize it despite resource constraints.

The representative of the EUROPEAN SOCIETY FOR MEDICAL ONCOLOGY, speaking at the invitation of the CHAIR, called on Member States to implement resolution WHA78.11 and tackle rare cancers. Rare cancers should be explicitly integrated into the objectives of a draft global action plan on rare diseases, focusing on strengthening early diagnosis and timely referral; supporting evidence-based models of specialized care; advancing research on ultra-rare tumours and rare molecular alterations; enabling global collaboration on data, registries and clinical trials, including cross-border participation; and ensuring equitable access to precision medicine.

The representative of the INTERNATIONAL FEDERATION OF PHARMACEUTICAL MANUFACTURERS AND ASSOCIATIONS, speaking at the invitation of the CHAIR, supported the rapid co-creation of a global action plan on rare diseases as a critical tool to strengthen national rare disease strategies. People living with rare diseases faced challenges requiring strong multisectoral collaboration, including through global networks of experts. It was important to expand research and development collaborations through global partnerships that accelerated knowledge sharing and ultra-rare disease research; strengthen data ecosystems by supporting cross-border registries; improve diagnostic capabilities, including through genomic sequencing and artificial intelligence-enabled decision-making tools; advance dedicated regulatory pathways such as adaptive or collaborative review models; and promote sustainable, regionally tailored access models, including outcome-based agreements and partnerships, to build local care capacity.

The representative of the INTERNATIONAL PHARMACEUTICAL STUDENTS' FEDERATION, speaking at the invitation of the CHAIR, welcomed the recognition of rare diseases as a global health priority and the preparatory work for a global action plan. Rare diseases must be explicitly included in universal health coverage benefit packages, health information systems and the implementation of the International Classification of Diseases (11th revision), with financial protection for patients and families. People living with rare diseases, their families and health students, including pharmacy students, must be involved in co-designing people-centred rare disease policies, education and access strategies, especially in low- and middle-income settings.

The representative of the INTERNATIONAL SOCIETY OF PHYSICAL AND REHABILITATION MEDICINE, speaking at the invitation of the CHAIR, said that rehabilitation was a non-negotiable pillar of universal health coverage. Rehabilitation and functioning should be integrated into universal health coverage monitoring frameworks, including Sustainable Development Goal indicator 3.8.1 on coverage of essential health services, to ensure visibility and accountability. Member States must fully include rehabilitation in national health systems through robust data systems, financial protection, workforce investment and integration at all levels of care.

The representative of THE WORLDWIDE HOSPICE PALLIATIVE CARE ALLIANCE, speaking at the invitation of the CHAIR, expressed appreciation for the inclusion of rehabilitative and palliative care in the report on emergency, critical and operative care but noted with concern the lack of access to effective analgesics in at least three quarters of Member States. The lack of balanced and appropriate medical treatment for both acute and chronic pain was a major global health problem that needed to be addressed. He urged Member States to ensure the availability of pain medication, according to the WHO Model List of Essential Medicines, for palliative care as well as emergency, critical and operative care. Palliative care must be included in the forthcoming report on rare diseases.

The representative of the WORLD FEDERATION OF SOCIETIES OF ANAESTHESIOLOGISTS, speaking at the invitation of the CHAIR, welcomed the draft global strategy for integrated emergency, critical and operative care and commended WHO for prioritizing integrated services to improve patient safety, quality of care and health system resilience. To fully realize the draft global strategy, Member States must invest in and strengthen anaesthesiology and the surgical workforce as foundational components of ensuring continuity, coordination and safety across the patient pathway. Persistent workforce shortages remained a major barrier to safe and integrated emergency, critical and operative care.

The representative of the WORLD STROKE ORGANIZATION, speaking at the invitation of the CHAIR, welcomed the draft resolution on reducing the burden of stroke as key to accelerating progress towards global health and development goals, and urged the Executive Board to support it. Advances in stroke prevention and treatment offered cost-effective opportunities to transform stroke care and address growing global inequities in access and patient outcomes. Member States were commended for their commitment to a comprehensive and coordinated stroke response as part of a strategic response to noncommunicable diseases.

The representative of KNOWLEDGE ECOLOGY INTERNATIONAL, INC., speaking at the invitation of the CHAIR, said that there was significant inequality in access to small molecule drugs, even greater inequality in access to biologic drugs, and almost no access to newer cell and gene-based therapies in many countries. The Secretariat should collaborate with WIPO and WTO to provide technical support to Member States on the flexibilities in international agreements that allowed exceptions to patent rights for treatments classified as services, such as autologous CAR T-cell therapy. The WHO Model List of Essential Medicines should include a category for treatments that were essential if available at affordable prices.

The representative of the INTERNATIONAL LACTATION CONSULTANT ASSOCIATION, speaking at the invitation of the CHAIR, said that protocols for surgery or emergency treatment of breastfeeding dyads must include preservation and protection of breastfeeding. In many countries, donated human breast milk was regulated as human cells and tissues, and breast milk should therefore be included in the proposed global strategy on donation and transplantation. Paid donations to for-profit milk banks that produced products for commercial sale gave rise to ethical concerns, including of the exploitation of women and the risk of depriving infants of their

mother's milk. Non-State actors specializing in breastfeeding should be involved in the drafting committee for the proposed global strategy.

The representative of THE INTERNATIONAL SOCIETY OF BLOOD TRANSFUSION, speaking at the invitation of the CHAIR, noting that restructuring at WHO headquarters had integrated blood systems into its work on biological standardization, requested clarification on how the Organization's mandate regarding the availability, safety and quality of blood products, as outlined in resolution WHA63.12 (2010), would be implemented beyond work on norms and standards. She expressed concern about the potential loss of focus and dedicated resources for WHO work on blood systems. She suggested maintaining blood systems within the scope and title of the new team working in that area; retaining a senior expert position at headquarters; and considering supplemental funding for blood systems that were essential to supporting emergency care and transfusion and transplantation programmes.

The representative of the FDI WORLD DENTAL FEDERATION, speaking at the invitation of the CHAIR, said that integrating oral health into primary healthcare was recognized as a cost-effective approach that strengthened prevention, expanded access to essential oral health services across the life course and advanced health equity. To address widening disparities in access to oral healthcare, Member States must prioritize oral health in primary healthcare reforms by empowering communities, addressing broader determinants and ensuring access to essential oral healthcare.

The representative of the WONCA ASSOCIATION, speaking at the invitation of the CHAIR, welcomed the report on primary healthcare and outlined three priorities. First, it was important to invest in frontline family doctors, nurses, community health workers and multidisciplinary teams by ensuring sustainable financing and safe working conditions. Second, with the expansion in digital health, continuity and person-centred care must be protected to ensure that technology strengthened relationships rather than replaced them. Third, the meaningful engagement of family doctors and communities was essential to drive implementation, trust and accountability.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of the CHAIR, highlighted the effectiveness of nurse-led models, including in rural clinics and community mental health and vaccination programmes, in expanding access to high-quality, cost-effective services. Chronic underinvestment in the nursing workforce limited its scale and impact, however, and slowed progress towards universal health coverage. She urged Member States to invest in creating a primary healthcare-enabled nursing workforce with decent working conditions, safety and protection, career opportunities, equal pay, and measures to prevent burnout and work-related mental health challenges.

The representative of the WORLD OBESITY FEDERATION, speaking at the invitation of the CHAIR, called on Member States to accelerate action on obesity as an integral component of primary healthcare, noting that obesity prevention, management and treatment was increasingly essential to resilient health systems. Addressing obesity required routine monitoring of population burden and risk and sustained investment throughout the life course. Integrating obesity prevention and care into primary healthcare as part of universal health coverage was particularly critical in low- and middle-income countries, where prevalence was rising fastest and inequities were increasing. She urged all Member States to ensure equitable access to the full continuum of obesity prevention and care within universal health coverage, in line with WHO recommendations.

The representative of the WORLD FEDERATION OF NEUROLOGY, speaking at the invitation of the CHAIR, urged implementation of the intersectoral global action plan on epilepsy and other

neurological disorders 2022–2031 to effectively integrate brain health into primary healthcare frameworks. Brain health and neurology were underrepresented in primary healthcare structures, which left frontline providers underequipped to manage common neurological disorders. Primary healthcare was vital for implementing preventive strategies against brain diseases and noncommunicable diseases and addressing modifiable risk factors for stroke, dementia and other chronic neurological conditions. Providing primary healthcare practitioners with neurological training, diagnostic tools and clear referral pathways was essential for building effective, sustainable healthcare systems.

The representative of the DRUGS FOR NEGLECTED DISEASES INITIATIVE, speaking at the invitation of the CHAIR, said that, with the world far off-track on the health-related Sustainable Development Goals, sustained investment in new, effective health tools was needed, including in paediatric formulations. Inclusive, equitable partnerships across sectors were important to ensure continued progress, particularly to address gaps in research and development. With only five years left until 2030, bold coordinated action was urgently needed.

The representative of MMV MEDICINES FOR MALARIA VENTURE, speaking at the invitation of the CHAIR, said that, in the context of stagnating malaria eradication progress, it was important to accelerate the development and availability of affordable next-generation innovations for prevention and treatment. She welcomed the inclusion of a discussion on malaria elimination progress on the provisional agenda of the Seventy-ninth World Health Assembly; it was to be hoped that innovation would be a central part of that discussion. She looked forward to the development of a robust action plan on the topic.

The representative of the WORLD FEDERATION OF ACUPUNCTURE-MOXIBUSTION SOCIETIES, speaking at the invitation of the CHAIR, noted that traditional medicine offered accessible, cost-effective preventive care for vulnerable populations. He welcomed the establishment of the WHO Global Traditional Medicine Centre and its work in different countries and regions. He recommended the introduction of an inclusive framework that represented major evidence-based traditional systems. WHO was encouraged to collaborate with organizations such as his to develop global guidelines for traditional medicine research, education and clinical practice. He advocated an integrated approach to promote sustainable, equitable healthcare that was aligned with WHO's mission in advance of 2030.

The representative of the NCD ALLIANCE, speaking at the invitation of the CHAIR, welcomed progress on Sustainable Development Goal indicator data coverage and the planned revision of universal health coverage indicators. While commending Member States for progress on reducing per capita alcohol consumption, she expressed concern that the world was off-track on all health-related Sustainable Development Goals, including on target 3.4, to reduce by one third premature mortality from noncommunicable diseases. Member States were urged to accelerate action on noncommunicable disease risk factors by investing in prevention, strengthening accessible health systems and reinforcing health information systems, ensuring accountability and using real-time disaggregated data to support stakeholder engagement and implementation of the Sustainable Development Goals.

The CHAIR took it that the Board wished to note the reports contained in documents EB158/11, EB158/12, EB158/13, EB158/14, EB158/15.

The Board noted the reports.

The CHAIR took it that the Board wished to adopt the draft decision on the draft global strategy for integrated emergency, critical and operative care, 2026–2035, contained in document EB158/11.

The decision was adopted.⁵⁷

The CHAIR took it that the Board wished to adopt the draft decision on transplantation of human cells, tissues and organs, contained in document EB158/12.

The decision was adopted.⁵⁸

The CHAIR took it that the Board wished to adopt the draft resolution on precision medicine.

The resolution was adopted.⁵⁹

The CHAIR took it that the Board wished to adopt the draft resolution on strengthening equitable access to diagnostic imaging through teleradiology.

The resolution was adopted.⁶⁰

The CHAIR took it that the Board wished to adopt the draft resolution on reducing the burden of stroke.

The resolution was adopted.⁶¹

The CHAIR took it that the Board wished to adopt the draft resolution on advancing smart, efficient pharmacovigilance.

The resolution was adopted.⁶²

The meeting rose at 17:45.

⁵⁷ Decision EB158(4).

⁵⁸ Decision EB158(5).

⁵⁹ Resolution EB158.R2.

⁶⁰ Resolution EB158.R3.

⁶¹ Resolution EB158.R4.

⁶² Resolution EB158.R5.