



**156th session of the WHO Executive Board
3-11 February 2025**

Statements by Bangladesh

Item 2: Report by the Director General

Thank you, Chair.

We thank the Director General for the report and WHO team for their services even risking lives in war zones and conflict-stricken areas of the world.

Health issues are uncompromising when it comes to an individual person. Similar spirit is essential at national level. When countries are resource-constrained at national level, international support is exigent. That is why, international organizations came into being. Naturally, if the countries and people in need of external support don't receive support any more, it will cost their reliance and trust on traditional international partners.

Based on COVID-19 pandemic experience, we all came together for mobilizing resources for equitable access to health services – particularly, access to vaccines, therapeutics, diagnostics etc. at an affordable cost. Hence, we strongly advocate for diversification of production facilities across the continents to make them available to the people.

We are deeply concerned at the attacks on hospitals and health services in conflict-stricken areas of the world. Bangladesh urges for necessary support to the people of

Gaza and Palestine so that the dilapidated health facilities become functional as soon as possible.

Despite financial constraints, any punctuation to the vital ongoing WHO programme in vulnerable societies is unfortunate. It is the responsibility of the entire membership to strive for saving those programme.

We caution against fitting WHO staffs within financial envelope. We apprehend that in future, experts might not cherish to be in International Organizations like WHO because of uncertainty in career.

Finally, we hope that we all can join our hands to augment low-cost solutions as per the First WHO Global Status report to minimize preventable deaths from drowning.

I thank you, Chair.

Item 24: Management and governance matters

Item 24.2 Governance reform – SCHEDULED IN THE AFTERNOON OF 3 FEB

The following three bullets will be taken together:

- **Member State-led governance reform**
 - **Process for handling and investigating potential allegations against WHO Directors-General**
 - **Secretariat implementation plan on reform**
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We thank the Secretariat for the reports.

Reform is a dynamic and continuous process. So, the Member State-led discussion may be continued to make the reform process responsive to contemporary requirement.

We notice proliferation of resolutions beyond the capacity of small delegations to attend them. However, we don't support to limit the resolutions within General Programme of Work because new pressing initiatives may remain unattended with time. In this regard, Bangladesh echoes the suggestion made by Thailand that Member States' right to propose resolutions shall be preserved. We suggest to finalize the conception of resolutions through a consultation of the Secretariat with the Member States. This would help avoid conception of unnecessary resolutions.

In handling and investigating potential allegations against WHO Directors-General, Member States' participation in decision making would help avert politicization by any quarter. We welcome further discussion in this regard to arrive at a consensus-based decision on the remaining divergent issues.

Finally, we appreciate Secretariat's ongoing efforts in implementation of governance reform.

I thank you, Chair.

Item 24.2: Governance reform

- ☐ **Draft terms of reference to strengthen the effectiveness of the functioning of the Officers of the Executive Board**
 - ☐ **Involvement of non-State actors in WHO's governing bodies**
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Thank you, Chair. We thank the Secretariat for the report.

We draw the attention of the Secretariat seeking more information in some paragraphs of the report 33 on the Involvement of non-State actors in WHO's governing bodies.

In para 11, agreement of over 55% of the respondents and disagreement of 6% respondents are mentioned. In paragraph 13, it is mentioned that 75% responded agreed. Similar kind of approach is also mentioned in paragraph 14. We would like to know from the Secretariat how many respondents were consulted in those consultations.

In paragraph 15, it is concluded that overall, the experience of constituency statements was positive among both Member States and non-State actors in official relations. The affirmation from 55% of the respondent MS does not seem to be a correct figure to justify such a conclusion. This is our naïve view.

In paragraph 19, we are of the view that constituency statements on agenda items would be useful. And they may be allowed to make joint statement. Member States may benefit from specific statements of individual Civil Society Organizations.

I thank you, Chair.

Item 23.1

Financing and implementation of the Programme budget 2024–2025

Thank you, Chair. We appreciate the Secretariat for the report.

GPW 13 is in the final biennium while GPW 14 is in the offing. At this critical juncture, flexible fund from the donors would be vital in addressing the financing gap in the base budget.

During the PBAC meeting, it was well manifested that the financing gap in the budget can be managed if a small portion of the earmarked funds from the voluntary contributions are set aside as flexible fund. This would help continue the critical functions of WHO in a predictable manner.

We would like to flag that it would be unfortunate if WHO's healthy emergency program and critical operations on Polio, Tuberculosis and HIV suffer a setback owing to a shortage of fund for the base programme.

In output 3.2.3, we have a specific observation. We notice that WHO's technical support in technology transfer is not adequately reflected. Hence, we urge for adequate attention of the Member States to create enablers for WHO in promoting technology transfer. This would create the passage for diversifying manufacturing of health products across all regions. At the same time, it would ascertain equitable access to health products.

During the COVID-19 pandemic, we felt very well that our fate in health is intertwined. So, we all should demonstrate our solidarity to safeguard health for all through our efforts in crafting the appropriate budgetary provisions.

I thank you, Chair.

Item 23.2: Budget and finance matters
Proposed programme budget 2026–2027

Statement 1

Thank you, Chair.

We appreciate the Secretariat for the proposed draft programme budget for the next biennium. We welcome the bottom-up approach in the base budget. In going forward in the next biennium, accountability and transparency in governance will be useful in realizing efficiency gains.

We, the MS need to be bold to uphold the required level of budgetary aspirations. In the current context, we all need to exercise the spirit of solidarity to safeguard WHO's ongoing functions. Our unity can keep to the expectation of those in need of external support for health services. Hence, we suggest for flexible donor funding to fill out the financing gap in the base budget. As an immediate measure, WHO may enter into negotiations with the donors to secure flexible fund.

Finally, we would like to flag that it would be unfortunate if WHO's critical functions – particularly, at country level are compromised through lowering ambitions in the base budget.

I thank you, Chair.

Statement 2

Thank you, Chair.

Bangladesh aligns with the statements delivered by Sri Lanka and Malaysia.

In addition, we flag the following:

Financial envelope is vital to set the circumference of WHO's remit of business. At the same time, we must not get rid of the Member States' priorities such as through crafting new resolutions in setting direction of WHO's work.

Resolutions create a passage for addressing region and country specific issues which in general have low profile in case of attention. Limiting such resolutions would set a precedent in WHO's traditional discourse being followed over the years.

Budget is aspirational. So, we urge for flexible donor funding to finance for the resolution while the budgetary ambition should not be lowered because of unpredictability.

We support adoption of resolutions.

I thank you, Chair.

Item 6:
Universal health coverage
Primary healthcare

Thank you, Chair. We appreciate the Secretariat for the report.

We commend WHO for its continued technical support in monitoring and advancing Primary Health Care in the run up to achieving Universal Health Coverage.

We would like to remind the floor that we should not lose sight of the rise in out-of-pocket expenditure and stagnancy in reduction of maternal mortality which will gradually cost the progress in Universal Health Coverage.

On the report, we have following observations and questions, and seek further information:

Segregated information on WHO's efforts vis-à-vis Member States' own efforts in reform in paragraph 10, would bring clarity to the progress in Primary Health Care.

Health Expenditure data tracking and analysis, mentioned in paragraph 11, is a good policy tool. Application of similar approach to international financial assistance can reduce fragmentation in health financing landscape.

In paragraph 13, on pooled procurement, further information on the following can be useful to the process: first, what kind of medicines were selected; second, criteria behind selection; third, whether novel medicines are included in the selection list and fourth, whether there is any monitoring of such procurement.

In paragraph 16, we would like to know about WHO's efforts in debt restructuring in line with the Lusaka Agenda as well as in aligning health institutions like The GAVI, The Global Fund etc. to support Primary Health Care at country level.

In paragraph 20, further information on Health Impact Investment Platform through WHO's website can enhance transparency.

If it is not possible to provide more information in the Board meeting, we would request to address them in the report of the next health assembly.

On the resolution on rare disease, we would appreciate if WHO could shed light on what the Member States can do to facilitate access to vaccines, therapeutics, diagnostics etc. under the aegis of the Global Action Plan.

Thank you Chair.

Item 7: Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases

- **Reducing the burden of noncommunicable diseases through strengthening prevention and control of diabetes**
- **Oral health**
- **Comprehensive mental health action plan 2013–2030**
- **Global strategy to accelerate the elimination of cervical cancer as a public health problem and its associated goals and targets for the period 2020–2030**

Documents EB156/7, EB156/CONF./4, EB156/CONF.4 Add.1, EB156/CONF./5, EB156/CONF./5 Add.1, EB156/CONF./6, EB156/CONF./6 Add.1, EB156/C

Thank you, Chair. We thank the Secretariat for the reports.

We have found WHO Global Action Plan on prevention and control of NCDs very useful in shaping up our national policies and plan. Accordingly, we have adopted comprehensive measures accounting NCDs as the leading cause of death.

We would like to draw special attention of the Member States and WHO on the following:

First, Bangladesh urges for stringent measures to punctuate tobacco use as a part of global drive to reduce NCDs. We are consistently increasing taxes on tobacco every year and on the way to establishing a ‘quit line’ to stop the use of tobacco in the country.

Second, Bangladesh would like to see consolidated global efforts to address dietary and nutritional risk factors causing the rise of NCDs. We are happy to inform that taxation on sugar sweetened beverages, implementation of the roadmap for reducing salt contents in food and labeling of the harmful impact of processed foods are in progress in our country.

In the context of alcohol's negative health impact, Bangladesh joins Thailand's plea for seeing WHO as an alcohol-free organization. We hope, others in the floor will echo the same.

Third, as a co-sponsor, Bangladesh congratulates Nigeria and South Africa for the penmanship of the resolution on Establishing World Cervical Cancer Elimination Day. We take this opportunity to urge the Member States to facilitate access to vaccines, therapeutics and diagnostics at an affordable cost to achieve Cervical Cancer elimination targets in LMICs.

And finally, we join others for making mental health services available to the people – particularly, to the young generation and creating social awareness across the globe.

Thank you Chair.

Item 8: Mental health and social connection

Documents EB156/8, EB156/CONF./18 and EB156/CONF./18 Add.1

Thank you Chair. We appreciate the Secretariat for the report.

We commend WHO's continued support to Member States in mental health care and services.

To address mental health challenges, Bangladesh has adopted Policy and Strategic Action Plan, and enacted National Mental Health Act. Bangladesh has joined the WHO Special Initiative for Mental Health to facilitate access to affordable mental health care for all.

We echo the challenges pointed out in paragraph 11 of the report – such as social media and remote work, decline of extended family structure etc. affecting mental health of the people to a great extent.

On the specific questions of the report, we have following observations and suggestions:

First, Policy and programme may be undertaken at national level to uphold and strengthen social fabric and family bondage through nurturing traditional ethos, inter-generational values and cultural practices.

Second, cultural and physical activities should be promoted – particularly, for the children to promote social cohesion.

Third, mental health has disproportionate impact across societies. Hence, WHO's action has to be tailored with a full respect to social and cultural sensitivities of the people. Special attention would be exigent for those in war zones and conflict-stricken areas of the world.

Fourth, social and economic determinants of health of vulnerable populations are to be addressed for efficacy in mental health approach.

And finally, work ambience and life style greatly affect social connection and mental health. Hence, value of social connection is to be reflected in a holistic manner in designing healthy work ambience and fostering healthy life style.

I thank you, Chair.

**Item 5: Report of the Standing Committee on Health Emergency Prevention,
Preparedness and Response
Document EB156/5**

Thank you Chair.

We are worried at the attacks on hospitals and health service facilities in war zones and conflict-stricken parts of the world. The Member States need to voice strongly and unitedly to put a stop to this unacceptable propensity.

The Government of Bangladesh despite all limitations and resource constraints are extending all possible support to the forcibly displaced Rohingyas staying in Bangladesh. We appreciate the international community including WHO for their support to us in this regard. We urge the international partners and community, and WHO to continue their support until the Rohingyas are able to return their homes in Myanmar.

We appreciate the work by SCHEPPR. However, WHO is financially constrained at the moment and IHR Implementation Committee can take over their task once amended IHR comes into effect. Therefore, like many others in the room, we also think that it would not be expedient to extend its term beyond May 2025.

We find the absence of a process of hearing of affected parties for expressing their needs as per terms of reference in para 5.a.

I thank you, Chair.

Item 15: WHO's work in health emergencies**Documents EB156/18, EB156/CONF./15 and EB156/CONF./15 Add.1**

Thank you, Chair.

We commend WHO for life-saving services to the people during health emergencies.

We are alarmed at 1080 attacks on healthcare workers and facilities. Such attacks are deeply disturbing, completely unacceptable and unjustifiable as per International Humanitarian law.

On Secretariat's questions, we have following observation and suggestions:

Since 2021, in all discussions, the developing countries have been loud and clear on the exigency of mobilizing more fund to address health emergencies including future pandemics. Despite that, the Member States have not been able to create any space for additional fund rather focused on managing the existing fund as if there is ample fund to address health emergencies. In this regard, we point out the requirement of humanitarian assistance for 300 million people in 2024 vis-a-vis the target of 181 million people because of financial cuts.

We are of the view that absence of legally binding commitments for new and additional financial resources in Article 20 of the proposed Pandemic Agreement is a clear manifestation of our collective failure.

We do believe that additional and new fund can be garnered for health emergencies including pandemic through crafting an effective legally binding PABS System in the Pandemic Agreement. Therefore, we take this opportunity to call upon the Member States and the Intergovernmental Negotiating Body to create an accountable and transparent PABS System with monetary and non-monetary benefit sharing commitments including ensuring access to vaccines, therapeutics and diagnostics.

In addition to the above, flexible donor fund can ascertain predictability in financing health emergency programme.

Bangladesh always highlights that our fate in health is intertwined. Therefore, we reiterate the same to stand beside the vulnerable populations during health emergencies.

I thank you, Chair.

Item 17 Health conditions in the occupied Palestinian territory, including east Jerusalem

Documents EB156/20, EB156/CONF./19 and EB156/CONF./19 Add.1

Thank you, Chair.

Bangladesh expresses deep concern at the grave health and humanitarian crises in Occupied Palestinian territory, including East Jerusalem. Bangladesh condemns in strongest possible term the most barbaric attacks by Israel on hospitals and health infrastructure in Gaza.

Bangladesh expresses deepest condolence at the heavy loss of lives in the attack. We appreciate WHO for the continued support to the people in Palestine and Gaza.

The challenges of the health system and the entire population, as a matter of fact, are beyond description of this report. It is a great pity that the available fund covers only 47% of humanitarian and emergency health response. Donors and international partners should rush to fill out the financing gap.

Under the above circumstances, Bangladesh calls for continuity of the following in an unhindered manner:

First, passage for humanitarian relief including access of medical personnel and ambulances and humanitarian equipment;

Second, exit permits for patients in need of medical treatment outside the Gaza Strip;

Third, supply and replenishment of medicine and medical equipment;

Fourth, respect and protection of all medical personnel and humanitarian personnel exclusively engaged in medical duties;

Fifth, the root cause of the problem is the prolonged occupation. Hence, we urge the international community to take every possible measure to immediately end this illegal occupation.

Sixth, we stress upon full and immediate implementation of the ICJ's provisional measures on Occupied Palestine.

And finally, we reaffirm our unwavering support to the Palestinian people's legitimate struggle for self-determination till the establishment of a sovereign State of Palestine, based on the two-state solution and pre-1967 borders with East Jerusalem as its Capital.

Bangladesh supports and cosponsors the resolution proposed by Palestine and Qatar.

I thank you, Chair.

Item 18 Universal Health and Preparedness Review

Document EB156/21

Thank you, Chair.

Brazil has rightly pointed out proliferation of monitoring and assessment. With UHPR alongside such an approach in the IHR and further attempt in the Pandemic Agreement, we have 3 pathways for the same purpose and objectives.

We are not against assessment and monitoring which are rather exigent to chalk out measures for better performance of the health system. But singularity of the approach is vital to avoid duplication of works. Otherwise, we are going to experience administrative and financial overhead not only at the Member State level but also at the Secretariat.

In the current context, we assume possible downsizing of workforce across 3 levels of WHO. So, it does not seem to be feasible to open a new avenue of reporting.

In addition to the above, such monitoring and assessment should be carried out in an inclusive manner where all Member States would participate. In that consideration, IHR would be the appropriate instrument to have such a measure that would ascertain inclusivity of the Member States.

In previous briefings, we heard mixed experience of the Member States that undertook UHPR because of absence of support measures. We should keep that into account in deciding UHPR as a resort for preparedness of health emergencies.

Every country has its own context and capacity. This apart, health systems of developing countries are constrained in resources. Hence, multiple avenues of assessment and monitoring should be avoided.

I thank you, Chair.

Item 19: Poliomyelitis

Thank you, Chair. We appreciate the Secretariat for the report.

Bangladesh has successfully maintained a polio-free status since 2006, meeting the certification standard for Acute Flaccid Paralysis (AFP) surveillance. Alongside the rest of the Southeast Asian countries, Bangladesh was certified as polio-free in 2014.

Despite resource constraint, under the aegis of EPI Programme, the Government of Bangladesh is administering polio vaccines to the Rohingyas currently, sheltering in Bangladesh. We take this opportunity to thank WHO, UNICEF, IOM, UNHCR and other international partners for their support to Bangladesh in this regard. We seek continued support of international partners and WHO to sustain our success and particularly, to avoid appearance of poliomyelitis in the Rohingya community staying in Bangladesh.

Esteemed Member States, no children should be subject to poliomyelitis because of the country they are domiciled, do not have the capacity to administer polio vaccines. Therefore, we all must be uncompromising to allow WHO to continue its Polio programme in resource-constrained countries and vulnerable societies across the globe.

Unfortunately, we apprehend a likely exit from polio vaccination in some vulnerable countries owing to downsizing of WHO's Programme Budget in the current context of political ramification. We remind the floor that the envisaged picture has been rightly deliberated by the WHO Secretariat during the discussion on Programme Budget.

To keep the ambition of a polio-free world, we suggest for collective understanding and efforts of the Member States and provide requisite fund for polio programme – particularly, to the vulnerable countries. We would urge for flexible donor fund to reach the goal of a polio-free future for the current and future generations.

I thank you, Chair.

Item 9 Communicable diseases

**Documents EB156/9, EB156/CONF./8, EB156/CONF./8 Add.1,
EB156/CONF./9 and EB156/CONF./9 Add.1**

- **Global road map on defeating meningitis by 2030
Document EB156/10**
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Thank you, Chair. We appreciate the Secretariat for the report.

Bangladesh statement would be focused on the specific questions in document 9.

On addressing the unmet need for the prevention and management of M-pox like skin diseases that have the potential to escalate to the level of public health emergencies of international concern, we suggest that the measures should be based on our experience in accessing vaccines, therapeutics and diagnostics.

If we want to avoid adversaries in future, we have to create enablers for making vaccines, therapeutics and diagnostics available to the doorsteps of the people at an affordable cost. To realize that on the ground, we have to geographically diversify and augment the capacity of local production. This will not happen until we facilitate access to technology and knowhow.

Negotiation of the pandemic agreement is scheduled after the Board Meeting. We hope the Member States can work together to create enablers for local production including through facilitating access to technology and knowhow. Naturally, a paradigm shift in traditional approach would be necessitated to make that happen.

I thank you, Chair.

Item 10: Substandard and falsified medical products
Documents EB156/11, EB156/11 Add.1 and EB156/12

Thank you, Chair. We appreciate the Secretariat for the report.

We commend the work of the Member State Mechanism.

In the recommendation 5 of the Independent Evaluation of the Member State Mechanism (in document EB156/12), it is recommended that "improve external engagement by developing differentiated engagement strategies (in line with the Framework of Engagement with Non-State Actors)."

We would appreciate further information on differentiated engagement strategies and the reason behind putting "in line with FENSA" in bracket.

In line with our usual position, we suggest for avoiding conflict of interests with the Non-State Actors and upholding the spirit of FENSA in WHO's engagement with them.

Esteemed Member States, we are happy to be one of the lead cosponsors of the resolution on 'Galvanizing global support for a lead-free future'. We are happy that the Member States upheld their support to the resolution despite an apparent shift in the landscape of political ramifications.

Bangladesh has introduced standards on lead containment in products. We have put in place Environment Conservation Act and Environment Conservation Rule. Apart from these laws, we have several laws for controlling air pollution, managing solid waste and hazardous E-waste, which include different standard limits for lead emission depending on different types of sources.

A comprehensive legal approach is needed to address transboundary sources of lead. We hope that in the coming days, WHO would play a vital role in the landscape of prevention of lead pollution.

I thank you, Chair.

Item 12

• WHO Global Code of Practice on the International Recruitment of Health Personnel

Documents EB156/14 and EB156/14 Add.1

• Global strategy on human resources for health: workforce 2030

Documents EB156/15, EB156/CONF./14 and EB156/CONF./14 Add.1

Thank you, Chair. We appreciate the Secretariat for the comprehensive report.

Despite the voluntary nature, we find the Code of Practice useful in guiding ethical international recruitment.

In Article-wise narrative of the Expert Advisory Group, relevance and effectiveness of the Code of Practice are well manifested. In addition, we would like to shed light on the following drawing special attention of the Member States:

First, push factors in source countries act as drivers of mobility of the health workforce. From such mobility, naturally, destination countries harvest benefit of the investment made by the source countries. Therefore, we would urge for co-investment from the destination countries for win-win benefits which can take place in the form of training and investment in the education sector of the source countries.

Second, migration of health workforce cannot be seen in an isolated manner. Therefore, data on recruitment of overseas health workforce by the recruitment agencies for both the government and private sectors should be reported to WHO to identify movement of health workforce.

Third, as per recommendation of the Expert Advisory Group, Bangladesh urges for ensuring equal opportunities for professional education and career progression, as well as objective criteria for recruitment, promotion and remuneration of the migrant health workforce.

Fourth, in the context of low reporting on health workforce data, WHO can undertake Code of Practice specific awareness campaign in the public domain to avoid undesired impact likely to be emanating from migration of health workforce.

We congratulate Morocco and The Philippines for leading the discussion on the resolution on health workforce. We are happy to cosponsor the resolution.

I thank you, Chair.

Item 13: Draft global traditional medicine strategy (2025–2034)
Documents EB156/16 and EB156/16 Add.1

Thank you Chair.

Bangladesh welcomes the draft global traditional medicine strategy (2025 – 2034). The strategy is in line with our priorities and needs.

Bangladesh has made considerable efforts towards strengthening regulation and service of traditional medicine and alternative medical care. In this regard, we thank WHO for its support to us.

We have undertaken dedicated program for the alternative medical care and developed essential medicine list for traditional medicines in our National Drug policy. Pharmacopeia of Unani, Ayurvedic and Homeopathic Medicine and its corresponding treatment guidelines has been published.

We have integrated traditional medicines into the mainstream health-care services in our country. We have herbal gardens at our health complexes for easy collection of herbal medicines.

We take note of the caution in the floor for ensuring efficacy of traditional medicines for safety of the patients. We need to keep in mind that traditional medicine has found its relevance with the passage of time because of its positive impact in the recovery from diseases. In modern time, naturally, it does not evaporate all of a sudden because of dominance of allopathic medicine.

We do hope that once Jamnagar Centre in India becomes fully functional, there will be more useful studies for a paradigm shift in our traditional approach to traditional medicine. We hope that there will be full scale commercialization of traditional medicine in near future not because of traditional attachment to traditional medicine but because of its efficacy.

In conclusion, we ask for enhanced support in enhancing cross-sectoral coordination and collaboration to harness the full potential of traditional and complementary medicine in advancing universal health coverage.

I thank you, Chair.

**Item 14 Global Strategy for Women's, Children's and Adolescents' Health
Documents EB156/17, EB156/CONF./12, EB156/CONF./12 Add.1,
EB156/CONF./16 and EB156/CONF./16 Add.1**

Thank you, Chair.

Bangladesh has made noticeable progress in reducing maternal and infant mortality rate. The success came in the backdrop of successful implementation of action plan and strategies on maternal and neo-natal health.

Despite resource constraint, we have put our efforts to make the health systems adolescent-responsive and undertaken nutrition programs for adolescents to address issues of under-nutrition and over-nutrition. This includes provision of micro-nutrient supplements and education on healthy eating habits.

We express concern at the trends of mortality of the children as stated in the report. We further draw the attention of the Member States on the report's remark that out-of-pocket health expenses can limit the use of health services. This was prominently featured during the COVID-19 pandemic which now continues unabated.

In the days ahead, it would be exigent for the Member States to upkeep their commitment to sustainable financing to reach the related targets of Sustainable Development Goals. While apparent shift in that commitment is visible, flexibility in donor funding would be the possible leeway. Hence, we would urge the Secretariat to begin discussion to encourage the donors for flexible funding.

Esteemed delegates, Bangladesh, along with all other members of the South East Asia, takes pride in registering highest prevalence of exclusive breastfeeding in the world. People of Bangladesh enjoy social and cultural appeal in breastfeeding. Hence, Bangladesh does not support promotion of breastmilk substitutes as a natural choice of nutrition for the children.

Bangladesh congratulates Brazil for its leadership in crafting the resolution on ‘Regulating the digital marketing of breast-milk substitutes’. We are happy to join Brazil as a cosponsor.

I thank you, Chair.

Item 22 Climate change and health
Documents EB156/25 and EB156/25 Add.1

Thank you, Chair. We appreciate the secretariat for the draft Global Action Plan.

Bangladesh is one of the most climate vulnerable countries in the world. Despite being the least contributor to climate change, Bangladesh is one of the worst sufferers of its impact.

We are dismayed at the departure of the biggest contributors to climate change from their commitment and responsibility to the vulnerable countries.

On the draft Global Action Plan, we flag, among others, following concern:

First, the draft includes 4 frameworks and 15 principles but Common But Differentiate Responsibility and Respective Capabilities (CBDR-RC) is not one of them.

Second, the draft side-steps legal regimes of UNFCCC and Paris Agreement as it does not recognize or operationalize CBDR-RC.

Third, principle of equity is absent in the action plan.

And fourth, mitigation centric approach risks diversion of limited resources available for health sector leading to potential increase in out-of-pocket expenses and health inequity.

In view of the above, we would like to suggest to include the following in the action plan:

First, enablers to facilitate access to health products at an affordable cost needed for addressing diseases emerging or re-emerging owing to climate change;

Second, details on building climate resilient health systems;

Third, sources of sustainable financing for addressing health impact of climate change;

Fourth, access to technology and know-how for adaptation and mitigation measures related to health;

We join China and iterate that there is much room for improvement of the draft. Hence, we suggest to have further discussion on it. We also ask for the provision of written submission from the Member States to improve the draft.

To conclude, it would be unfair, unjust and unacceptable to conceive an action plan in WHO leaving the historical responsibility of the big emitters out of its scope.

I thank you, Chair.

24.3 Global strategies or action plans that are scheduled to expire within one year

- **Global strategic directions for nursing and midwifery 2021–2025**

Documents EB156/34 and EB156/34 Add.1

- **Global strategy on digital health 2020–2025**

Documents EB156/35 and EB156/35 Add.1

- **Global action plan on the public health response to dementia 2017–2025**

Documents EB156/36 and EB156/36 Add.1

- **Comprehensive implementation plan on maternal, infant and young child nutrition**

Documents EB156/37, EB

Thank you, Chair.

Potential of e-health products and services are yet to be fully harvested. They are yet to be available for all at an affordable cost that can create digital divide and widen health inequities across societies. Hence, the strategy should focus on building digital health infrastructure at operational level of the countries.

In digital platform, data flow beyond the border should be given due attention.

We urge WHO and Member States to establish safeguards, limit cross-border data transfers, support Member States in achieving digital self-reliance, and promote transparent, and accountable systems to ensure digital data flow.

We suggest to conceive a broader discussion after the health assembly on data governance under the aegis of the strategy.

I thank you, Chair.

26.3 Standing Committee on Health Emergency Prevention, Preparedness and Response

Documents EB156/44, EB156/44 Add.1 and EB156/45

Thank you, Chair.

We join Malaysia in thanking SCHEPPR for its work.

SCHEPPR emerged in the wake of the COVID-19 pandemic. Hence, such a conception should pass through a discussion in the Health Assembly to make it fit for purpose.

SCHEPPR has limited membership. So, it seems to be expedient that we review its function and mandate it in light of recent amendments in IHR.

SCHEPPR can be tasked to carry forward the function of IHR Implementation Committee and we can abrogate it once the amended IHR comes into effect.

Hence, we would suggest to have a detailed discussion in the Health Assembly for assigning the task of the IHR Implementation Committee to the SCHEPPR.

I thank you, Chair.

27.5 Human resources: update
Documents EB156/48 and EB156/49

Thank you, Chair.

We appreciate and thank WHO staffs for their services - particularly, those working in health emergencies, war zones and conflict-stricken parts of the world risking their lives.

We take note of the staff union's concern in the previous statement surrounding financial cuts and its possible impact on the staffs.

We are saddened at the recruitment freeze and non-renewal of contracts as immediate measures to fit the staffs in the financial envelope. We hope that financing for retaining staffs will be explored as one of the important drives of WHO.

We would like to see concrete measures to enhance geographical representation in staffing. The criteria for recruitment should be calibrated to promote equitable recruitment from LMICs.

I thank you, Chair.

**Item 25: Provisional agenda of the Seventy-eighth World Health Assembly and
date and place of the 157th session of the Executive Board
Documents EB156/41 Rev.1 and EB156/42**

Thank you, Chair.

Bangladesh supports Qatar's proposal and rejects Israel's proposal to combine Items 3 and 20.

Bangladesh echoes the concern expressed by Palestine. Inclusion of two separate items in the agenda of the health assembly is not politicization rather a call of humanity to end perpetration of human dignity committed through attacks on hospitals and health facilities.

I thank you, Chair.
