Health for All Now!
People's Health Movement

**PHM daily briefing of the 78th World Health Assembly Meeting**
**Day 5 (Friday, May 23, 2025)**

Report prepared by PHM's WHO Watch team

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## Committee A

**Polio eradication: a long-term objective at risk?**

In the morning Committee A discussed Item 17.5 Poliomyelitis. The world is on the verge of **eradicating wild poliovirus (WPV1)**, with transmission now confined to Pakistan and Afghanistan. However, **vaccine-derived poliovirus (cVDPV) remains a major obstacle**, particularly in conflict-affected and under-vaccinated regions like S**udan, Somalia, DRC, and Chad**.

Many countries, including India, Nigeria, and Bangladesh, have eliminated polio through strong immunization campaigns. Africa has seen notable success, with **Burkina Faso, Kenya, and Togo certified wild polio-free—yet cVDPV2 outbreaks persist** due to low vaccination rates. Meanwhile, conflict zones like **Gaza, Yemen, and Sudan struggle with access,** leaving thousands of children unprotected. Declining funding (Kenya, Australia) and **vaccine misinformation (Israel, Grenada) further threaten progress.**

Countries emphasized sustainable financing (**UK, Saudi Arabia**) and community trust-building (**Pakistan, Nigeria**) are essential to reach zero-dose children. Additionally, the need for stronger surveillance **(Cameroon, Zambia)**, cross-border coordination **(Tanzania, Chad)** was mentioned. The topic of transition from OPV (oral) to IPV (injected) was brought up by **Russia** and **Israel**. The idea is  to prevent cVDPV spread, yet **Russia** mentioned that IPV usage can only come with a cost effective availability of the vaccine, while **Israel** was concerned that cVDPV migrates into their country from surrounding countries still using OVP. The **Philippines** highlighted the necessity of fair vaccine pricing supply and promoted collaborations between member states for their own production.

The final push on Polio eradication requires global solidarity, flexible funding, and conflict-sensitive vaccination campaigns. Without urgent action, decades of progress could unravel.

**Non-communicable diseases**

Committee A then took up items 12 and 13.1 focusing on non-communicable diseases. **Item 12** – on the role of the global coordination mechanism on the prevention and control of NCDs was accompanied by Document A78/INF./2, which provided an independent evaluation of the Global Coordinating Mechanism (GCMNCD). **Item 13.1,** which was a follow-up to the political declaration arising from the UN General Assembly's High Level Meeting on NCDs, was accompanied by several reports. Of note as well is Document EB156/7, the DG's report on the topic from January's Executive Board.

Countries universally endorsed the Global Coordinating Mechanism (e.g. **China, Kenya**), with **China** recognizing the GCMNCD as a tool to facilitate "*WHO's governance of multistakeholder participation*" and suggesting that, going ahead, "*GCMNCD should continue to guide countries in taking stock of successful cases and practices to promote the effective dissemination of knowledge and experiences.*" **Pakistan** and others drew attention to the need for multisectoral collaboration in the control and NCDs. Pakistan added that:

> "*Only through sustained commitment, global solidarity, and strategic coordination can we reverse the burden due to NCDs and mental health, and achieve the targets set under the Sustainable Development Goal 3.*"

Echoing the sentiments of many of the low-income countries in the assembly, **Zimbabwe** "*request[ed] the continued financial and technical support from WHO and our partners*" and "*continued and unlimited access to online training platforms in collaboration with the WHO to address NCDs and mental health.*" **Barbados** requested technical support, particularly for developing countries, and pointed to "*the need to embed mental health and psychosocial support across preparedness and response frameworks.*"


***"People can die because they cannot get insulin, dialysis, or medicine for mental health" – Palestine delivering their statement on items 12 and 13.1***

In their floor statement, **Palestine** drew attention to the often overlooked but nonetheless crucially important challenges of delivering NCD care amidst emergencies, conflict and humanitarian crises:

> *"For people living with chronic health diseases and NCDs, providing essential medical services remains difficult and sometimes impossible. People can die because. People die because they can not get insulin or dialysis or getting medicine for mental health [...] Addressing NCDs during emergencies and in the humanitarian setting is very important."*

In a pattern that has emerged across several items at WHA78, countries referred to the potential of artificial intelligence and "digital technologies" as hopeful developments in the health sector. **China** requested support from WHO for developing countries in taking up the latest digital technologies to support NCD prevention and response, but did not elaborate on what this would entail. **Iraq**

Some of the non-state actor (NSA) statements were especially critical and enlightening. The delegate for **Knowledge Ecology International** **(KEI)** argued:

> "*The only way to have anything remotely equal in terms of access to medicines is to fundamentally change the way we finance biomedical research and development. Specifically we need to progressively delink the incentives to invest in biomedical R&D from the granting of temporary monopolies. Legal monopolies on medicines predictably lead to high prices and appalling inequities of access and outcomes.*"

The **People's Health Movement** statement – delivered alongside **Medicus Mundi International** – asserted that "*neoliberal economic policies, particularly with the increasing power of big corporations, have significantly, both directly and indirectly, contributed to the rise of NCDs in developed and developing countries*" and called for "*stronger regulation of private sector practices, particularly those of transnational corporations, to protect population health.*"


***Intervention from Knowledge Ecology International***

**Mental health and social connection**

Committee A moved on to discuss **item 13.2: Mental Health and Social Connection**, which picked up on discussions that took place at the 156th Executive Board meeting, where a report on mental health and social connection was noted and a resolution began to be developed on " role of social connection in combating loneliness, social isolation and inequities in health." An updated version of that draft resolution – now Document A78/A/CONF./2 – was on the floor of the Health Assembly for discussion.

Some member states, including **Namibia,** expressed appreciation for "*the inclusion of mental health as a standalone item*" on the WHA agenda. **South Sudan**, speaking on behalf of the **African region**, said that the mental health burden is increasing , especially in countries like South Sudan where conflict is present. It advocated for more mental health policies and how it should be a public health priority , with mental health services integrated into the health system.

**South Africa**, also, suggested that mental health must be integrated with primary health care. They further recognized that family mental health and well-being is deeply connected to relationships and communities. Once again, it reaffirmed its commitment by integrating mental health services into primary care in their *2023-2030 Mental Health policy framework*.

Discussing the complex set of challenges facing their country – "*natural disasters, instability, insecurity as well as poverty*" – **Haiti** argued that these challenges "affect mental health *and social connection*" and that "*all too often, mental health is neglected despite the fact that it's essential for community cohesion and national resilience*." They concluded by encouraging adoption of the resolution.

**Slovenia's** statement was delivered from the perspective of the country's youth delegate. It read in part: "*youth in my country face growing loneliness and mental health issues. [...] We need policy changes that protect our health and foster real – rather than virtual – social connections. We appreciate the WHO's recognition of this issue as a public health priority.*"

## Committee B

In the first part of the morning session, Committee B addressed **Item 24.2 and and 24.3,** on expiring global strategies and action plans, reviewing **documents A78/4 and EB156/2025/REC/1** and adopting **draft decisions EB156(34), EB156(35), EB156(36), and EB156(37)** with no objections. These decisions extended four key strategies: the *Global Strategic Directions for Nursing and Midwifery 2021–2025*, the *Global Strategy on Digital Health 2020–2025*, the *Global Action Plan on the Public Health Response to Dementia 2017–2025*, and the *Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition 2012–2025*.

Delegates strongly supported the extension of the *Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition* through 2030. **Ethiopia** and **Ireland** introduced the draft resolution, earning widespread co-sponsorship from Member States including **Estonia**,

**Ecuador**, **Indonesia**, **Egypt**, **Uruguay**, and **Luxembourg**. Many highlighted the urgency of addressing persistent malnutrition, stunting, and anemia, especially among vulnerable populations, while noting the rising challenge of childhood obesity. **Estonia** stressed that *"children are the foundation of our shared future,"* and noted the intergenerational impact of maternal health: *"Too many women still suffer from anemia [...] These are not just health issues; these are intergenerational challenges."* Countries such as **Kenya** and **Uruguay** stressed the need for improved monitoring systems and community engagement, with **Indonesia** outlining recent national efforts to expand breastfeeding and antenatal care. **MSF** criticized the absence of TB in the maternal nutrition plan, pointing out that *"malnutrition is a key risk factor for TB,"* and called for dismantling the *"vertical walls between malnutrition and TB."*

In parallel, the Committee endorsed the extension of three additional expiring frameworks: the *Global Strategy on Digital Health*, the *Global Strategic Directions for Nursing and Midwifery*, and the *Global Action Plan on Dementia*. Member States, including **Indonesia**, **Iceland**, and the **Philippines**, emphasized the vital role of digital health in strengthening primary care and advancing equity.

On the *Global Action Plan on the Public Health Response to Dementia*, Member States expressed strong support for its extension, recognizing the growing burden of dementia worldwide. **Gambia** highlighted its efforts, including the establishment of a National Geriatric Centre and caregiver support programs.

Regarding the *Global Strategic Directions for Nursing and Midwifery*, support was expressed for the extension, particularly by the **International Council of Nurses (ICN)**. While endorsing the continuation of the strategy, ICN voiced concern about the slow pace of implementation and called for an updated progress report. Several Member States reaffirmed their commitment to strengthening the nursing and midwifery workforce as critical components of resilient health systems, though detailed national statements on this item were limited.

The Secretariat underscored the transformative potential of AI and digital infrastructure to enhance outbreak prediction, optimize vaccine logistics, and reduce health inequities. Further, the secretariat emphasized that *"technology is reshaping global health"* and called AI a *"once-in-a-generation opportunity"* to transform systems, noting that a *"shift from option to obligation is underway for all of us"* and that *"we must co-create a new strategy creating an ethical, secure and people-centred AI to complement the health workforce, break access barriers, and leave no one behind."*

Under Item 24.3, Committee B reviewed **documents A78/4, A78/INF./5, and EB156/2025/REC/1**, focusing on the *proposed procedure for the correction of errors in the text of the International Health Regulations (2005),* with emphasis on the need for consistency across

WHO's six official languages. The draft decision EB156(38) was approved without objection, and the **report A78/4 was noted**.

**Kuwait**, speaking on behalf of the Eastern Mediterranean Region, underscored that accurate and coherent translations are critical for maintaining the IHR's integrity and relevance. **Iran** highlighted the potential of revised IHR texts to promote global health equity, particularly during public health emergencies, and outlined national efforts to review the amendments through an established multisectoral committee. **Kenya** and **Iraq** stressed the urgency of initiating the correction process immediately after the Assembly, citing discrepancies between Arabic and English versions. **Saudi Arabia, China** and the **Philippines** echoed support for a standardized and transparent approach, with the latter emphasizing that inclusivity in such procedures is key to strengthening global health security. The Secretariat confirmed a 90-day timeframe to finalize the aligned versions, and with no objections raised, the decision was formally approved by the Committee.

**Discussion on laboratory biosafety**

Under Item 28, laboratory biosafety was discussed. Many countries commended WHO for the tools and presented their efforts and progress towards biosafety such as policy frameworks, training and capacity building of laboratory personnel and surveillance system advances. **Bangladesh** called for making research efforts accessible to all. **India** commented that live viral stocks are unnecessary and in future synthetic recombinant viruses can be usedWith respect to laboratory biosafety, **Iran** requested the WHO to provide "*1) high-level biosafety facilities to strengthen the performance of national reference laboratories working with high-risk microorganisms, 2) portable laboratory equipment for conducting tests related to dangerous infectious diseases [...] 3) access to mobile laboratories to quickly address potential outbreaks*."

**Discussion of Pillar 3: The 'silent tragedy' of drowning, the health effects of the climate emergency, and other issues**

Committee B later moved on to discuss the various strategies, reports and plans of action under the WHO's "Pillar 3: One billion more people enjoying better health and well-being." Under discussion were the following:

- WHO global strategy on health, environment and climate change: the transformation needed to improve lives and well-being sustainably through healthy environments (decision WHA74(24))
- Plan of action on climate change and health in small island developing States (decision WHA72(10))
- Behavioural sciences for better health (resolution WHA76.7)
- Accelerating action on global drowning prevention (resolution WHA76.18)

- WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children (resolution WHA69.5) and Ending violence against children through health systems strengthening and multisectoral approaches (resolution WHA74.17)
- WHO global action plan on promoting the health of refugees and migrants, 2019–2030 (resolution WHA76.14)

In relation to the climate-related plans of action, several developing countries and small island states (e.g., **Antigua and Barbuda, Barbados, Bahamas** and **Tonga)** expressed gratitude toward the Secretariat for its work on climate and health and requested ongoing technical support. **Tonga** for instance acknowledged the "*leadership and coordination that WHO provides in the climate change and health agenda.*" **Bahamas** "*commend[ed] WHO for advancing the climate change and health discussion*" and noted that, "*as a highly vulnerable member state, we value WHO's presence at the Framework Convention on Climate Change's annual COP meetings. We call for the release of funding to activate technically-sound, innovative plans developed with stakeholder engagement.*" Speaking on behalf of the **African Region**, **Burundi** welcomed the WHO strategy on health, environment and climate change, and argued that "*this is a transformation that is necessary and urgent to build healthy, sustainable and protective environments that are essential to the health and wellbeing of our populations. In this spirit we underscore the importance of the [plan of action] in small island developing states*."

With respect to ***Behavioural sciences for better health*****,** several countries advertised their use of "behavioural insights" in their health policy and programs, revealing something of a one-dimensional, instrumental understanding of the value of social sciences in health. The **United Kingdom** – one of the leading proponents of behavioural science in policy-making (see for instance the work of its Behavioural Insights Team, now privatized) – "*the continued expansion of behavioural science in health communication across priority topic areas, community protection and resilience, is encouraging. We would like to see further progress in the routine use of behavioural science in policy development and evaluation.*" **India** noted that it "*mainstreams behavioural and social sciences in all health programs, using structured social and behavioural communication and behavioural insights in campaigns such as polio, HIV and COVID-19.*" They added that they support "*WHO's development of toolkits, training and culturally-adapted interventions*."

With respect to the violence prevention and response agenda, **Iraq** requested "*technical support and capacity building for early detection and management of violence [...] we call on the international community and UN agencies to support Iraq's efforts to protect its children and break the cycle of violence.*"

Many member states intervened on ***Accelerating action on global drowning prevention.*** **Burundi**, speaking for the **African region**, said that the "*silent tragedy [of drowning] continues to be a source of avoidable mortality, particularly for children in Africa, and an accelerated and coordinated response is needed to save lives.*" Many member states emphasised the preventability of drowning. For example, **Ireland** made a call for evidence-based drowning prevention, and argued that lives can be saved: "*every life lost from this largely preventable cause of death is one too many*." Highlighting the particular drowning risk faced by fisherfolk and children, the **Philippines** called for further "*evidence-based, locally-driven action*" and asked WHO to "*continue providing technical assistance for capacity building, especially in vulnerable areas.*" **Bangladesh** highlighted their own child daycare program, commenting on the importance of such programs in preventing child drowning, while **Panama** recommended including drowning prevention into the educational curricula of countries with high rates of drowning.

Finally, refugee and migrant health was discussed. Welcoming WHO's global action plan on promoting the health of refugees and migrants, **Bangladesh** commented that, "*in the context of the vulnerabilities of refugees and migrants, there should be differentiated approaches in mobilizing resources for providing health services to them.*" **Egypt** gave strong support for building migration and equity into health systems with an emphasis on human rights, noting "*health for all means health for all everywhere.*" **Panama** recognised mental health and social protection in the migration and refugee health agenda.